Health Care Update

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IN THIS ISSUE

If you have any questions or suggestions about *Health Care Update* contact the editor, Kerri Thomas on +61 3 9291 2305 or *kerri.thomas@sparke.com.au*

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Kerri Thomas

Editor-in-chief

Partner, Commercial Insurance

Welcome to the seventh issue of *Health Care Update* and the first one in our new format. I hope you enjoy the new look and feel, and I'd love to hear what you think.

This month we look at how health care providers can be affected by privacy breaches and what they need to do to protect themselves from the main threats. Litigation can be a difficult process to navigate, especially under stressful circumstances. We examine some of the additional challenges that people with a terminal illness face when engaging in this process.

We investigate the rise in health care providers defending or launching defamation claims, how this is affecting the industry and what happens after a claim is made. We also walk you through Victoria's landmark voluntary euthanasia laws that are now in effect, including the criteria and processes set out in the Act.

There has been an increase in claims for physical and psychological injury for cosmetic procedures that have gone wrong—and we look at the issues insurers face, particularly when "practitioners" are not medically qualified.

Finally, we round-up the latest news from Victoria, South Australia, New South Wales and Tasmania that practitioners and insurers need to know about.

I hope you enjoy the new and improved *Health Care Update*. If there are any topics you'd like us to cover, please send me an email at *kerri.thomas@sparke.com.au*

Kerri Thomas, Partner, Commercial Insurance, Sparke Helmore Lawyers

WGEA Employer of Choice for Gender Equality

PHISHING FOR YOUR PERSONAL INFORMATION

Written by Jehan Mata,
Special Counsel, based in Melbourne

Health information on the dark web (a well-known platform for criminal activity, including the purchase of illegally obtained credit card numbers, personal information, software to hack computers and illegal substances) is highly sensitive and perceived to be incredibly valuable. A cyber or privacy breach can be extremely disruptive and damaging for organisations, from a financial and a reputational perspective. As health providers hold large volumes of information, they must ensure they protect their data from loss, unauthorised access and/or unauthorised disclosure.

A breach may also result in a claim being commenced against a medical practitioner or health provider for negligence, or for breach of confidentiality. Although it is almost impossible to guard against every cyber and privacy risk, steps and precautions can and must be taken to protect personal and sensitive information.

Given the advancements in technology and the increased risks of cyber and privacy breaches faced today, health service providers ought to consider preparing an incident response plan and obtaining cyber insurance to protect them from the damage that may result from a breach.

The Notifiable Data Breaches scheme

The Notifiable Data Breaches scheme (NDB scheme) came into effect on 22 February 2018 and applies to bodies that are bound by the *Privacy Act 1988* (Cth). An organisation that provides a health service and holds health information is bound by the Act even if it is a small business or if providing a health service is not the organisation's primary activity. A health service provider will include (among other things) general practitioners, medical practitioners, blood/tissue banks, private hospitals, dentists, pharmacists and psychologists. The Office of the Australian Information Commissioner (OAIC) is responsible for enforcing the Act.

The NDB scheme requires bodies to notify the OAIC and affected individuals of an "eligible data breach". Under the Act, an eligible data breach occurs if:

- there is unauthorised access to, unauthorised disclosure of, or loss of personal information held by an entity
- the access, disclosure or loss is likely to result in serious harm to any of the individuals to whom the information relates, and
- the entity has been unable to prevent the likely risk of serious harm with remedial action.

The term "serious harm" is not defined in the Act. Nevertheless, s 26WG of the Act provides a non-exhaustive list of factors to consider when assessing whether serious harm is likely to result from the access, disclosure or loss. The list of factors to consider includes the kind(s) and sensitivity of information, the persons (or the kind of persons) that has or could obtain the information, and the security technology (such as an encryption key).

Photo by HQuality.

The statistics one year in

Between April 2018 and March 2019, the OAIC was notified of 964 eligible data breaches under the NDB scheme. Of these breaches:

- 60% were caused by malicious or criminal attacks—e.g. hacking, stolen credentials or phishing
- 35% were caused by human error—e.g. losing a USB containing personal information, and
- 5% were caused by system faults.

Of the 964 eligible data breaches reported to the OAIC under the NDB scheme, health service providers accounted for more than 200 notifications. When the statistics were broken down into sectors, the health service sector made the largest number of notifications to the OAIC, followed by the finance sector. The OAIC considers the high number of notifications it received from the health service sector is reflective of its high-volume data holdings. In the health service sector, human error was the leading cause of data breaches, accounting for 55% of the eligible data breaches. This is significant when juxtaposed with the 35% of eligible data breaches that occurred because of human error across all sectors. The value of health information on the dark web is significant when compared with other personal and sensitive information. The current "going rate" for health information is $20 to $50, whereas credit card information is $5 to $8.

Unfortunately, the Act does not allow an individual to make a claim for a privacy breach. Instead, it only allows the Commissioner to bring proceedings to enforce a determination it has made.

Tort of privacy, negligence and confidentiality

There is great uncertainty in Australia as to whether a common law tort for an invasion of privacy exists. Since the decision of *Victoria Park Racing and Recreation Grounds Co Ltd v Taylor* (1937) 58 CLR 479 (*Victoria Park*), the general consensus has been that a cause of action for a breach of privacy does not exist in the common law. The High Court of Australia, in the decision of *Australian Broadcasting Corporation v Lenah Game Meats Pty Ltd* (2001) 208 CLR 199, observed that as a result of the Victoria Park decision, a general tort of privacy was unable to develop in Australia.

Despite this limitation, if a health service provider has breached an individual's privacy, then it may be possible for that individual to bring a claim for negligence or for a breach of confidentiality.

As far as we are aware, there have been no court decisions in Australia regarding allegations that a medical practitioner was negligent and/or in breach of doctor-patient confidentiality by reason of an authorised disclosure, access or loss of personal and/or sensitive information.

Most health service providers will owe their patients a duty of care. Therefore, a privacy breach by a health service provider may result in a breach of the duty of care it owed to the patient, which may, in turn cause damage and/or loss to the patient. In the decision of *Furniss v Fitchett* (1958) NZLR 396 (*Furniss*), the New Zealand Court confirmed that a privacy breach by a doctor can amount to negligence. We consider that there is no reason why the principles distilled in *Furniss* cannot be equally applied in Australia.

At common law and under the Australian Medical Association's Code of Ethics, a medical practitioner owes a patient a duty of confidentiality in relation to information the practitioner has obtained in the course of treating the patient. This duty is far reaching and extends after the patient's death (subject to some exceptions). It is possible for an individual to commence legal proceedings claiming damages against the relevant medical practitioner.

Photo by Billion.

What does this mean for insurers and claimants?

From an insurance perspective, we have seen the number of claims made against health service providers for cyber and privacy breaches rise exponentially. With the number of claims on the rise, organisations within the health services sector need to be mindful of the information they hold and take necessary steps to protect that information. To help protect personal information, entities should (among other things) develop a data security plan and policy, ensure that staff are adequately trained on cyber risks and their privacy obligations, computers and laptops should be locked with strong passwords and should contain a privacy shield, USBs should contain encryption keys and regularly back up their data.

Even when all necessary steps are taken to protect information, cyber risks and privacy breaches will still arise, given the ever-changing online landscape. For this reason, health service providers ought to consider obtaining cyber insurance. In doing so, health service providers need to ascertain the level of cover they require, including whether the insurance policy will cover them for first party interference, third party interference and/or human error, as well as potential claims for breaches of confidentiality and negligence.

It can be difficult for the standard policy wording to keep up with the advancement of technology, so insurers need to be alert to the risks they are offering to insure. Insurers also need to ensure they are comfortable covering risks arising from mistakes (given that approximately 35% of breaches are caused by human error), or whether they are only prepared to provide cover for first party or third party interference.

Regional health care under attack

On 30 September 2019 a number of hospitals and health service providers in Gippsland and South-West Victoria were impacted by a ransomware attack, which blocked access to a number of the hospitals' systems. The main hospitals impacted were located in Warrnambool, Colac, Geelong, Warragul, Sale and Bairnsdale. Victorian Premier Daniel Andrews said the incident was a criminal attack and noted it would take days or even weeks to re-secure the impacted network. To manage the incident, the Victorian Government is working closely with the impacted health service providers, Victoria Police and the Australian Cyber Security Centre.

At this stage, there has been no suggestion that any personal information has been accessed as a result of the incident. However, the impacted hospitals and health service providers have had to take precautionary measures, such as isolating and disconnecting a number of its systems. For example, Barwon Health Hospital suspended clinical applications and put in place manual systems to ensure that patient care could continue. The Hospital has rescheduled a number of elective surgeries and daily outpatient appointments. This again exemplifies the crippling effect of cyberattacks and the long term ramifications on both the health service providers and the public.

Assistance for health service providers to improve their privacy practice

In the last three years, "health service providers" have been identified as one of the top three sources of privacy complaints made to the OAIC. In recognition of this, the OAIC has recently released a comprehensive Guide to Health Privacy. In the Guide, the OAIC provides advice to health service providers on the *Privacy Act 1988* (Cth), including in relation to the collection, use and disclosure of personal information and sensitive information. The Act requires health service providers to establish, implement and maintain coherent and robust privacy practices. In the Guide, the OAIC recommends that health service providers implement eight practical steps to assist them in complying with the Act. Further information is located here. The Guide is a positive Government initiative and can be used by health service providers to lower the risk of claims being made for a breach and/or interference with an individual's privacy, a breach of confidentiality or an allegation of negligence.

We would like to acknowledge the contribution of Brydee Hodgson and Lauren Connolly to this article.

LIFE-THREATENING ILLNESSES AND THE LITIGATION PROCESS

Written by Mark Doepel, Partner, based in Sydney

The Greek philosopher Sextus Empiricus once wrote that the wheels of justice turn slowly, but grind exceedingly fine. This adage remains true in the modern litigation process where proceedings can take years. While delays are frustrating, for most litigants that does not pose a significant challenge. But what about plaintiffs with injuries so severe that they are life-threatening? For these plaintiffs, delays can have significant impacts upon their case.

One area where we are seeing an increase in plaintiffs with a terminal illness is in misdiagnosis. The recent rise relates to patients who have claimed damages for missed treatment opportunities, organ damage due to failure to diagnose infections, and the impacts of malignant cancers due to failed biopsies.

The recent example of an alleged misdiagnosis of a melanoma in *Coote v Kelly; Northam v Kelly* [2017] NSWCA 192 (*Coote*) considers the challenges that arise in cases with plaintiffs with a terminal illness as well as the significant impact on the success of an action and on the award for damages that the management of those difficulties can have.

Background

On 3 September 2009, Mr Coote went to his general practitioner, Dr Kelly, for treatment of a painful lesion on the sole of his foot. Dr Kelly diagnosed the lesion as a plantar wart and treated it with cryotherapy over the next 17 months. Between this time and March 2011, three other doctors also assessed Mr Coote and confirmed that diagnosis of a plantar wart.

However, in early March 2011, Dr Hiddins noticed a pigment change in the colour of the wart, which led him to perform a biopsy. The biopsy revealed acral lentiginous melanoma (ALM) which, by this time, had already metastasised. Mr Coote died 14 months later in May 2012.

Litigation

Initially, upon learning of the misdiagnosis, Mr Coote commenced proceedings against Dr Kelly for the negligent failure to diagnose the ALM. Mr Kelly's evidence was given "on commission", being by video, in case he passed away before the hearing. His evidence

was that the lesion had a dark spot since the time of the initial consultation. That evidence was contradicted by the evidence of the medical practitioners. However, it was accepted by the Court. As such, the Court held that there was a breach of Dr Kelly's duty of care to Mr Coote for failing to obtain an initial biopsy.

That said, in order to establish negligence, a plaintiff must prove a breach of the duty of care and that the breach caused some loss. In this case, the Plaintiff was unable to prove that it was likely that he would have survived if he had been diagnosed earlier. As such, the Court found there was no negligence.

The case was appealed multiple times, leading to four trials over the course of five years. Mr Coote only survived to learn the results in the first trial. The subsequent trials and their appeal were brought by his wife and executor, Mrs Coote, who also brought an action for compensation to relatives. In the 2017 appeal to the NSW Supreme Court, Court of Appeal, the Court dismissed the appeal and upheld the original decision that there was no negligence.

Challenges faced

Coote is an example of some of the challenges that face plaintiffs with a terminal illness but there are many more, for example:

Giving evidence—with the possibility that they will not live until trial, plaintiffs often have to find other ways to give evidence. In *Coote*, that was by way of "commission" (by way of video evidence). It is also not uncommon for evidence to be taken from hospital rooms if a plaintiff's health deteriorates. However, one of the dangers of this is that key issues in the case may not yet have become apparent. As such, it might be difficult for plaintiffs to give evidence on all relevant issues.

Obtaining evidence—cases involving failed diagnoses often require evidence to be adduced from years earlier—that was Mr Coote's presentation at the first appointment with his GP. It also often requires a re-examination of a biopsy taken years earlier. There can be difficulties in obtaining evidence that might have been destroyed as well as issues with fading memories of those persons involved, all of which can make obtaining evidence difficult.

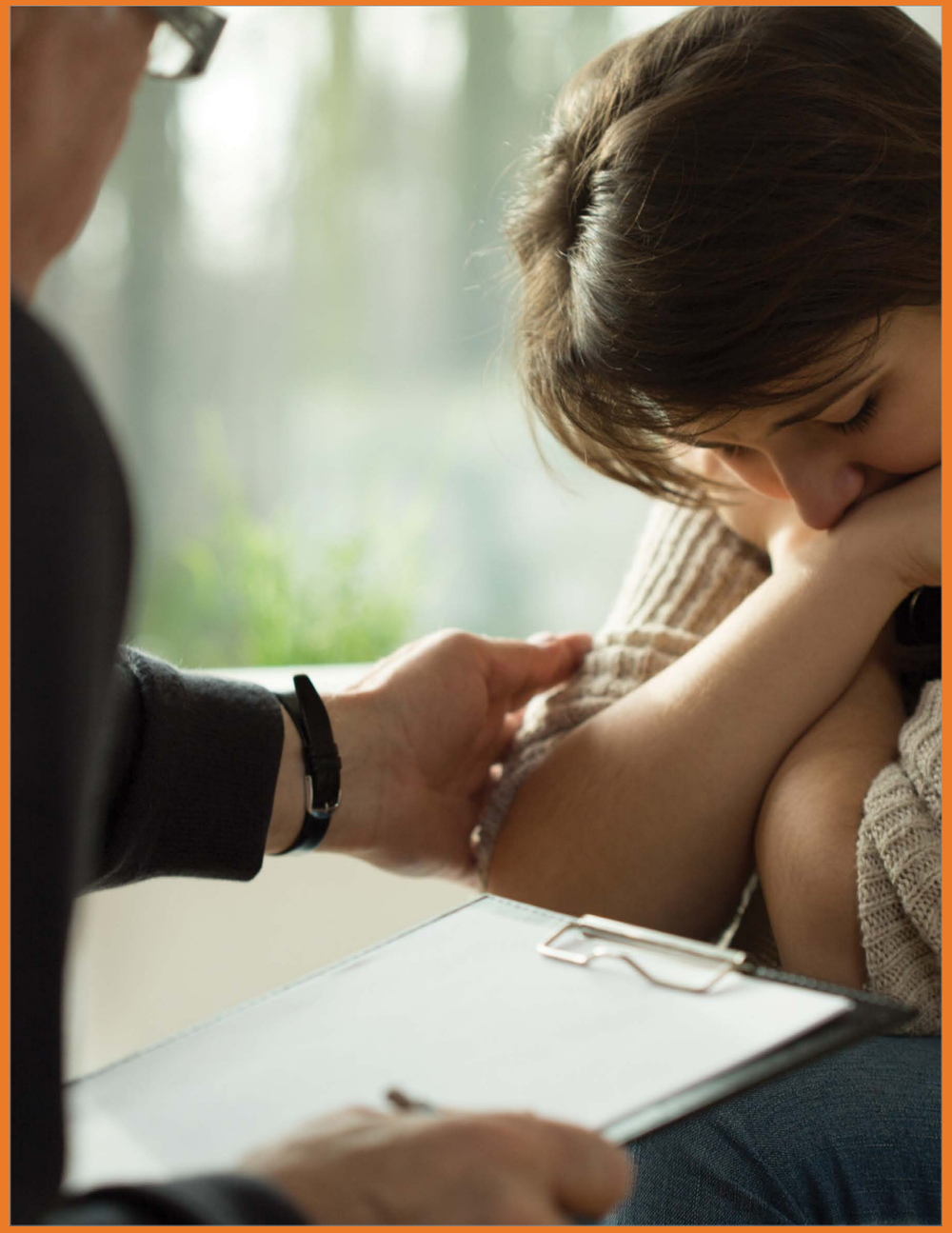
Expedited trial—where plaintiffs are terminally ill, decisions often have to be made on whether or not to expedite proceedings to ensure the judgment is obtained quickly. However, it can also compromise the quality of proceedings if evidence cannot be obtained in time and if issues can't be fully investigated.

Impact on plaintiff's damages—the threat of death can have a detrimental impact on an award of damages. When plaintiffs die, this creates a bar to damages for things such as future medical expenses and attendant care. Such awards might have otherwise been significant.

Associated proceedings—the families of patients with a terminal illness may often bring associated claims for either "nervous shock" (i.e. the shock and trauma of what has occurred) or "compensation to relatives" (for the economic loss that flows from losing a family member). Managing the main proceedings and these associated proceedings can create organisational and temporal difficulties.

Emotional burden—although these challenges relate to practical difficulties, it is important to remember that litigation is stressful and a source of great angst. The emotional burden on people, who are already extremely vulnerable, should not be underestimated.

We would like to acknowledge the contribution of Steven Canton to this article.



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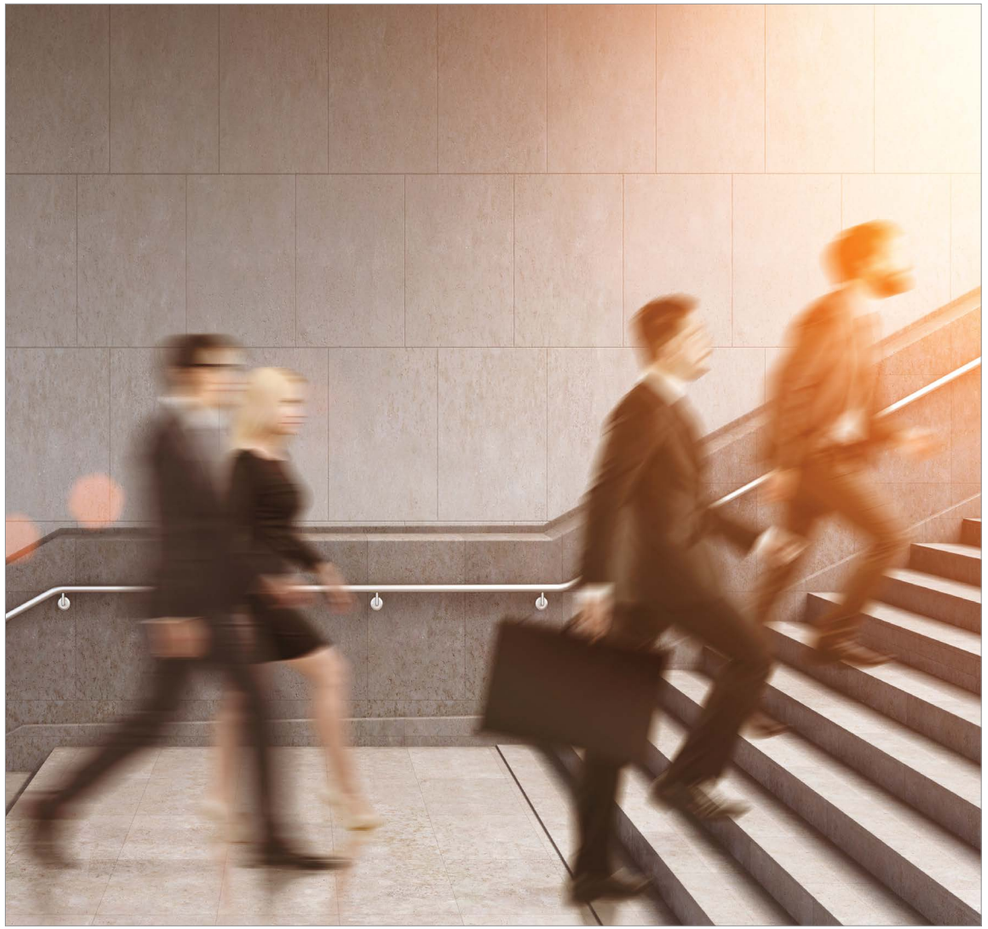

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THE RISE AND RISE OF DEFAMATION CLAIMS

Written by Mark Sainsbury,
Partner, based in Brisbane

Generally speaking, there has been an increasing number of defamation claims brought by individuals against other individuals, associations or incorporated entities—and it is certainly something we have seen reflected in the health care industry, particularly given the growing reliance on digital communication.

Our observations are reflected in recent analysis of defamation claims undertaken by the Centre for Media Transition and the New South Wales Council of Attorneys-General.

Some of the trends highlighted in these publications include:

- the number of defamation claims being decided by trial remains fairly consistent over the past decade, however, the mode of alleged defamatory imputations is progressively reflecting the use of digital technology in society
- of the 189 cases decided between 2013 and 2017, more than 50% related to Google search results, social media posts, emails, tweets or other methods of digital communication, and
- there is an increasing number of claims by private individuals against non-traditional media companies that publish digital content or maintain sites that allow for reviews or public commentary.

We have seen several high profile claims against traditional media entities brought by actors Rebel Wilson and Geoffrey Rush as well as the Wagner family's claim against radio personality Alan Jones. The media scrutiny of these claims and resulting damages awards has no doubt increased general public awareness of defamation actions.

More recently, the decision in the New South Wales Supreme Court of *Voller v Nationwide News & Ors* [2019] NSWSC 766 (*Voller*) has enlivened discussion of what it means to be a publisher of defamatory material in circumstances where the claim arose from third party comments on public Facebook pages under the control of defendant corporations. In *Voller*, the Court determined that by the Defendants providing a public forum for comment over which they exercised supervisory control, the Defendants were not merely a conduit of the defamatory comments.

This decision raises concerns for any media—or other entities that manage websites of this nature—that allow unfiltered public comment. Obligations flowing from control of these sites may ultimately require the content to be supervised and censored to prevent potential defamatory comments being published.

How does this affect the health care industry?

It can reasonably be assumed that the health care industry will also be subject to increasing rates of defamation claims and, in particular, those arising from digital commentary.

HealthEngine, a medical appointment and review website, has recently been the subject of prosecution by the Australian Competition and Consumer Commission for editing or failing to publish negative patient reviews of medical practitioners.

It is worth considering the alternative scenario whereby HealthEngine may publish adverse and potentially fraudulent reviews from patients about medical practitioners and subsequently find itself as a defendant in a defamation claim pleaded pursuant to the Voller decision. Of course, HealthEngine has also faced scrutiny over its perceived claim farming activities, where it provided contact details to plaintiff solicitors of users who may have potential personal injury claims. It is clear from this example that an entity in HealthEngine's position is required to balance multiple competing interests.

We have also recently seen the successful defamation claim brought by a plastic surgeon (Dr Tavakoli) against a patient who posted malicious comments on a Google review site regarding procedures carried out by the surgeon in *Tavakoli v Imisides* (No 4) [2019] NSWSC 717. The Court determined that the posts carried false and defamatory imputations that negatively

impacted the surgeon's reputation and business, awarding general damages and aggravated damages of $530,000 against the patient Defendant.

There have also been several cases relating to alleged defamation by registration boards regarding the publication of conditions placed on health care providers. In the decision of *Nyoni v Pharmacy Board of Australia* (No 6) [2018] FCA 526, the Federal Court held that the publication of certain registration conditions on the Australian Health Practitioner Regulation Agency's website was indeed defamatory of the Plaintiff because the conditions had a tendency to lower the esteem in which the practitioner was held.

However, the claim was defeated by the *Defamation Act 2005* (NSW) defence of absolute privilege available to the Board. While this defence is ordinarily applied to parliament or other public forums, the Court determined that a registration board held the requisite quasi-judicial character to access the defence. This decision was reinforced in a defamation claim against the Nursing and Midwifery Council of New South Wales. Given these decisions, it is reasonable to anticipate defamation claims increasing between individual practitioners, registration boards, professional colleges, clinics or hospitals, in particular where digital communication platforms are involved.

What happens after a defamation claim is made?

In circumstances where an individual clinician or clinic is sued for defamation, a claim on a policy of insurance will almost certainly follow. Consequently, issues of indemnity under the relevant policy need to be carefully considered by insurers of risk and by legal advisors.

In our experience:

- professional indemnity medical malpractice policies often expressly cover defamation
- general liability policies may include defamation within the scope of personal injury cover or by way of endorsement
- cover may be qualified by a requirement for the insured, upon reasonable request of the insurer, to issue an apology or retraction and if such publication is refused by the insured, indemnity can cease from the point of refusal
- cover can be excluded for statements made before the commencement of the period of cover and will usually be excluded where statements were made when knowingly false, and
- consideration should be given to whether insuring clause terms, such as "insured's business" and "occurrence", are genuinely satisfied in the circumstances of the defamation claim.

If indemnity is granted to an insured and solicitors appointed, the onerous task of defending a defamation claim commences. Defamation claims often arise from longstanding disputes between individuals. Therefore, obtaining sufficient factual evidence from a defendant individual in relation to the dispute can be quite difficult and lawyers seldom receive the full story.

This is problematic in circumstances where a defence needs to be thorough and well particularised to rely on any Defamation Act defences. Accordingly, claims that may result in modest damages awards can be extremely time consuming and therefore costly to defend if the matter cannot be resolved in the early stages. In fact, legal costs will almost certainly exceed damages awards in the majority of defamation claims.

However, it's not easy to obtain agreement from an insured to publish an apology. If an insured unreasonably refuses to issue an apology and therefore prevents claim settlement, insurers need to carefully consider their options under the policy to cease cover (with or without a payment under the policy to the insured) so the insured can then continue to defend the claim in its own right.

Insurers must be aware of the extent of defamation cover available in their policies and relevant exclusions. Insurers and legal advisors should try to resolve these claims at an early stage to avoid a protracted dispute and significant legal fees.

We would like to acknowledge the contribution of Alex Mitchell to this article.

It can reasonably be assumed that the health care industry will also be subject to increasing rates of defamation claims and, in particular, those arising from digital commentary.

Photo by Rawpixel.

VOLUNTARY EUTHANASIA– WHERE ARE WE NOW?

Written by Kerri Thomas, Partner, and Jehan Mata, Special Counsel, based in Melbourne

Victoria's landmark voluntary euthanasia laws have now come into effect, meaning that Victorians may utilise the assistance of a medical practitioner in dying. This is a significant moment for the Australian health care sector; however it is imperative that health practitioners and lawyers are familiar with the relevant eligibility criteria and required process set out in the *Voluntary Assisted Dying Act 2017* (Vic).

Criteria

An individual must meet the following strict criteria to be eligible to make a request under the Act:

- be aged over 18 years
- be an Australian citizen/permanent resident
- be a resident in Victoria
- have lived in Victoria for at least 12 months before making the request
- be capable of making the decision (capable of understanding the gravity and irreversibility of the decision)
- been diagnosed with a disease, illness or medical condition that is terminal and will cause death within six months, and
- the condition causes suffering that cannot be relieved in a manner the person considers tolerable.

If a person has a neurodegenerative condition, such as motor neurone disease or Alzheimer's disease, and has a life expectancy of less than 12 months, the person may also be eligible under the Act. The person, however, will still need to be deemed capable of making the decision to end their life.

A person will not be eligible for access to voluntary assisted dying if they have a mental illness only.

As a request cannot be made on someone else's behalf—including by a guardian or Power of Attorney—a person must have independent capacity to make the decision to make a request.

Process

There is also a strictly defined process that needs to be followed before a request may be granted, which is as follows:

- the patient must make an initial request to a registered medical practitioner
- the medical practitioner must respond to the request within seven days, assessing whether the patient is eligible. The medical practitioner must have completed approved assessment training
- if deemed eligible, the medical practitioner must inform the patient of the diagnosis, prognosis and the voluntary assisted dying process
- the medical practitioner must then refer the patient to a co-ordinating medical practitioner for further assessment
- if approved by the co-ordinating practitioner, the patient must then make a written declaration of their wish to access the scheme
- the patient must declare they are making the decision of their own volition, without coercion, and understand the effect of the declaration
- the declaration must be signed in the presence of two witnesses and the co-ordinating medical practitioner
- the witnesses cannot be beneficiaries under the patient's will or involved in providing health services to the patient
- once the written declaration has been made, the patient may make a final request to access the scheme, verbally or otherwise. This request must be made at least one day after the assessment performed by the co-ordinating medical practitioner
- after receiving the final request, the co-ordinating medical practitioner is to complete the final review form and send all the material to the Voluntary Assisted Dying Review Board, established by the Act, and
- the Board then determines whether to grant a permit.

This is an extensive process with very stringent requirements with which medical practitioners must comply when participating in the scheme.

Under the Act, health practitioners are permitted to conscientiously object to participating in the decision making process.

Victoria is the first state to enact this type legislation, and it remains to be seen if other jurisdictions will follow. A bill is currently being considered in Western Australia, while discussions are taking place in other states and territories. Given the controversy surrounding this topic and the strongly held opinions on either side of the debate, we watch with bated breath as to how the law is implemented and what legal issues will result, noting this legislation has the potential to change the landscape of Australian health care forever.

We would like to acknowledge the contribution of Paul Scopacasa to this article.

Photo by Solarseven.

AN EVER-EVOLVING LANDSCAPE: THE RISE IN NON-SURGICAL COSMETIC PROCEDURES

Written by Jehan Mata,
Special Counsel, based in Melbourne

Photo by Rawpixel.

The last decade has seen a dramatic rise in claims being made for physical and psychological injury sustained as a result of non-surgical cosmetic procedures, including the administration of dermal fillers and Botox, vaginal rejuvenation and laser hair removal.

A significant issue we often see in these types of claims is that the individual performing the procedure does not hold medical qualifications. Insurers need to be alert to the type and level of cover they are providing to unqualified individuals who are performing such procedures.

Vaginal rejuvenation and "designer vagina" procedures are recent trends that involve non-surgical cosmetic procedures performed (in most cases) by a beauty therapist to treat vaginal conditions. The procedures include tightening laxity, treating dryness, itching and pain during sexual intercourse, and symptoms associated with menopause and are usually undertaken with an erbium laser (typically used for reducing wrinkles and/or removing tattoos).

The procedure is superficially attractive because the costs are relatively low and the recovery time is marketed as being between two to three days. However, alarmingly no medical qualifications are required to use an erbium laser. While there will be some instances where the individual performing the procedure is a qualified medical practitioner, on many occasions the individual is medically unqualified. In addition, the safety and effectiveness of the erbium laser for vaginal rejuvenation has not been clearly established.

The United States Food and Drug Association (FDA) has warned women and their health care providers of its serious concerns regarding the use of the erbium laser devices for vaginal rejuvenation. The FDA has not reviewed and/or approved erbium laser devices for vaginal rejuvenation.

Despite the FDA approving laser-based devices for treating conditions such as genital warts, it cautions the safety and effectiveness of the devices for vaginal rejuvenation. Furthermore, the FDA notes there have been deceptive health claims being made about the uses of erbium laser devices for vaginal rejuvenation. There have been numerous cases world wide of vaginal burns, scarring, subsequent and ongoing pain during sexual intercourse and recurrent chronic pain. In addition to the physical consequences, there are often secondary psychological and/or psychiatric injuries sustained as a result of the procedure.

In Australia, we have seen the number of claims for non-surgical procedures rise exponentially. The quantum of such claims can be significant, especially when the consequences are chronic. For this reason, before providing cover, it is imperative for insurers to ascertain the details of procedures its prospective insureds are offering and providing to the public. The full extent of the risks involved in vaginal rejuvenation is unknown. Therefore, insurers need to be comfortable with the level of cover they are willing to provide to prospective insureds that will be performing such procedures.

We would like to acknowledge the contribution of Brydee Hodgson to this article.

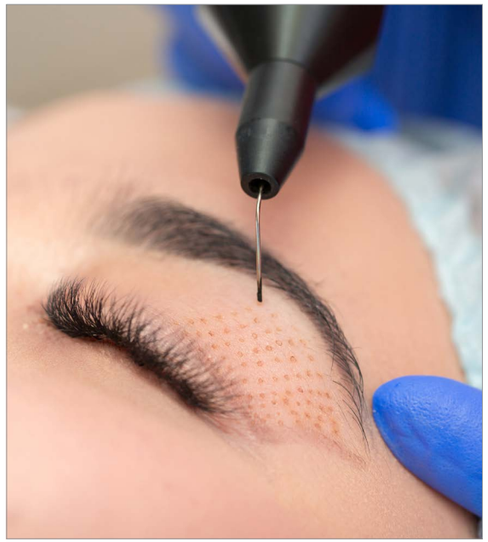

Photo by Vera Larina.

Photo by Elvira Koneva.

UPDATES FROM VICTORIA, SOUTH AUSTRALIA, NSW AND TASMANIA

VICTORIA

Exhaustion in doctors can lead to catastrophic outcomes

Feeling tired? It's critical to manage exhaustion in the workplace as failure to do so can have a detrimental impact on employee wellbeing and expose employers to civil and criminal penalties.

Employers must, so far as is reasonably practicable, provide and maintain safe and healthy work environments for their workers and others impacted by their undertaking, including patients. This includes ensuring that employees are not overworked or exhausted to such an extent that it creates a risk to health or safety.

Failing to pay employees appropriately for all hours worked exposes employers to liability for breaches of applicable awards or enterprise agreements, and therefore the *Fair Work Act 2009* (Cth) (FW Act). Additionally, the National Employment Standards in the FW Act set the maximum weekly hours at 38 hours for full-time employees. Employees may refuse a request or requirement to work unreasonable additional hours, including where doing so may place their health and safety at risk.

Such risks are self-evident in the health industry. Cultural and systemic pressures imposed on doctors are well-known—sleep deprivation is said to be the industry's "Achilles' heel". An audit undertaken by the Australian Medical Association (AMA) in 2016 confirmed that 53% of hospital-based doctors were on rosters that placed them at significant risk of stress and fatigue, and that 40% of trainee doctors felt that job pressure was taking a toll on their mental health, with many fearing they could make a clinical error as a result.

Junior doctors at Sunshine Hospital in Victoria have recently raised alarming rostering requirements, claiming that they often work up to 40 hours' overtime (in addition to their rostered 86-hour fortnights). These claims have prompted the AMA to pursue legal action against the operator of Sunshine Hospital in the Fair Work Commission. While the legal proceeding is still in its preliminary stages, the claims send a clear message to employers to reconsider their rostering requirements to protect staff wellbeing.

In the UK, *R v Bawa-Garba* [2016] EWCA Crim 1841 is illustrative of the dire consequences that can occur if these issues are left unaddressed. In February 2011, Jack Adcock (six years old) was admitted to hospital and later died due to sepsis. An inquest found that his medical care was substandard. Dr Bawa-Garba was charged and convicted with gross negligence manslaughter, and struck off the medical register. She was later reinstated, however, as multiple systemic issues were at play—excessive working hours, staff shortages, IT system failures, inaccessible bedside data and handover deficiencies.

Similarly, in *Brotherston v Royal Perth Hospital* (1995)15 SR (WA) 42a, a patient was awarded substantial damages after suffering permanent brain damage due to negligent medical treatment. Long shifts performed by staff contributed to poor clinical management and their sleep deprivation was likened to being intoxicated.

Claims made by juniors in the medical industry are symbolic of an entrenched culture of overwork. Employers must regulate working hours to ensure a safe working environment for employees, improve clinical outcomes and reduce the risk of liability for non-compliance with their legal obligations.

Written by Sam Jackson, Special Counsel, with assistance from Madeleine Armstrong, Associate

Doctor has registration reinstated after being charged with "stealthing"

A surgeon, charged with rape and sexual assault after he allegedly removed a condom without permission, has succeeded in overturning a suspension of his registration imposed by the Medical Board of Australia. The Victorian Civil and Administrative Tribunal, by way of a majority decision, could not form the reasonable belief that the Board's decision to take immediate action was in the public interest and, therefore, set aside the suspension. This decision has subsequently been affirmed by the Victorian Court of Appeal.

The charges relate to a sexual encounter between the surgeon and another medical practitioner. The medical practitioner alleges he advised the surgeon he would not have sex without a condom, due to concerns about contracting HIV. The surgeon and medical practitioner proceeded to engage in consensual sexual intercourse while using a condom; however, it is alleged the surgeon removed the condom during intercourse without the permission of the medical practitioner. The surgeon was charged with one count of rape and one count of sexual assault. The surgeon denies the allegations and is contesting the charges.

Following an investigation, the Board decided to take immediate action under s 156(1)(e) of the Health Practitioner National Law (the National Law) and suspended the surgeon's registration, deciding that it was in the public interest to do so. The Board concluded that a failure to act on the part of the regulator, when on notice of serious criminal charges, was likely to "erode the public's confidence in the protective function of the regulator and the standards to which the profession is held". The surgeon appealed the decision to the Tribunal.

The Tribunal was constituted by three members, two of whom found that the suspension ought to be set aside, while one member was in dissent. The Tribunal noted there is no assumption that immediate action will be taken where a medical practitioner is charged with a serious criminal offence, noting that this is a discretionary power. The Tribunal provided various examples of serious criminal offences to demonstrate that these ought to be viewed on a spectrum, with differing levels of severity.

While the Tribunal acknowledged these allegations, if proven, were "egregious" and inconsistent with the ethical discharge of a medical practitioner's obligations, the members also referred to a number of public interest factors that supported the surgeon returning to medical practice. These included:

- the presumption of innocence
- the likelihood that the immediate action would be in place for a very significant period of time
- that it would serve the public interest for the surgeon, in whom training and expenditure had been made, to continue to practise, and
- various character references that spoke of his exemplary medical services.

In focusing on the presumption of innocence, and finding that the public would understand the allegations were made against one practitioner and not reflective of the entire profession, the majority did not accept that permitting the surgeon to practice would result in a loss of public confidence in the medical profession and set aside the suspension.

The Board appealed this decision, alleging the Tribunal had made an error on a question of law in making its decision. However, the Victorian Court of Appeal deemed that none of the grounds of legal error were established and dismissed the appeal.

Written by Special Counsel Jehan Mata with assistance from Paul Scopacasa, Lawyer

SOUTH AUSTRALIA

Former midwife found "not guilty" of manslaughter

Former midwife Ms Lisa Barrett was charged with two counts of manslaughter arising from the alleged provision of midwife services to mothers in 2011 and 2012. In each case the babies were born alive, but suffered brain injuries causing them to die shortly after birth.

Ms Barrett was a qualified midwife, but voluntarily surrendered her midwife registration on 28 January 2011 before assisting both mothers with homebirths and referred to herself at the time as a "birth advocate". The Supreme Court found that, notwithstanding that self-appointed title, she had in fact taken on the role of midwife in both births.

On 11 March 2014, in disciplinary proceedings referred by the Nursing and Midwifery Board, the South Australian Health Practitioners Tribunal found that:

- Ms Barrett failed to demonstrate appropriate knowledge, skill and judgement in providing care and advice to expectant mothers
- the standard of care provided by Ms Barrett was substantially below the standard reasonably expected of a midwife, and
- the conduct of Ms Barrett was professional misconduct.

Justice Vanstone noted in the criminal proceedings brought separately in the *Supreme Court (R v BARRETT (No 3)* [2019] SASC 93) that, given the risk factors present in both of the mothers' cases, "[t]he Australian College of Midwives' Guidelines and indeed conventional medical opinion did not sanction a home birth in the circumstances of either Ms Kerr or Ms H".

Justice Vanstone noted that Ms Barrett's conduct had been "less than competent" and "fell short of that of a reasonably competent midwife", however concluded that in neither case had her behaviour been proved beyond reasonable doubt to be grossly or culpably negligent (as the law of manslaughter by criminal negligence requires).

Medical practitioner's indefinite suspension

Earlier this year, Dr Christopher Kwan Chen Lee was suspended by the Health Practitioners Tribunal for six weeks for professional misconduct arising from comments posted in online forums between 9 December 2016 and 10 December 2016 while residing in Tasmania.

The comments were described by the Tribunal as being "racially discriminatory", "disrespectful of women" and had "potential to cause harm to the public". The comments were posted in Dr Lee's own time on Singaporean online forums. Dr Lee had not appreciated his online commentary might impact upon his practice in Australia, despite the fact that he identified himself as a registered medical professional, practising in Australia.

The suspension would have ended on 11 June 2019, however, on 7 June 2019, after considerable public outcry, the Medical Board gave notice that it has suspended Dr Lee's registration indefinitely, effective from 6 June 2019. In its media release, the Board explained that the action was taken in the interests of the protection of the public and to maintain public confidence in the medical profession.

While the Board's decision might not be surprising given the content of Dr Lee's online comments, the Board's decision serves as a reminder that online comments, even when posted outside of work hours, can potentially amount to professional misconduct—particularly where they display a bias inconsistent with the provision of health services to all or have the capacity to bring the profession into disrepute.

ACCC pursues HealthEngine for manipulating patient reviews

On 7 August 2019, the Australian Competition and Consumer Commission (ACCC) commenced proceedings in the Federal Court of Australia alleging for misleading and deceptive conduct by online medical directory and booking platform, HealthEngine. The website publishes reviews and ratings of patient experiences at the medical practices.

The Concise Statement filed by the ACCC alleges that the platform edited reviews submitted by consumers and, when a practice had received significant negative reviews, would display a message asserting that insufficient reviews had been left—thereby misrepresenting the reasons why it did not publish a rating for some health practices.

The ACCC further alleges that the platform provided personal information supplied to it by patients using the platform to third party private health insurance brokers (in return for a fee) without adequately disclosing that this would occur.

The ACCC seeks penalties, declarations and corrective notices as well as orders requiring HealthEngine to contact patients and explain what they need to do to recover control over their information.

At this stage, the platform has not filed a response to the ACCC's claim, but has made a statement noting that the platform had discontinued or overhauled the system before being formally advised of the ACCC investigation.

ACCC chair Rod Sims has warned that "businesses who are not upfront with how they will use consumer data may risk breaching the Australian Consumer Law and face action from the ACCC". These ongoing proceedings serve as a warning to online providers that privacy policies and other agreements hidden from view may not protect the platform if it is found that patient information has been shared without consent.

All update articles for South Australia written by Lani Carter, Senior Associate

NEW SOUTH WALES

HCCC cases address serious boundary issues and sexual assault

The Health Care Complaints Commission (HCCC) continues to bring proceedings against health care professionals who have engaged in boundary violations and sexual assaults. The HCCC takes these complaints particularly seriously given they involve the implication that practitioners have taken advantage of the therapeutic relationship and people who are in their care.

Two recent examples of proceedings for boundary violations include one against a physiotherapist in *Health Care Complaints Commission v Sarkis* [2019] NSWCATOD 134 (*Sarkis*) and one against a psychologist in *HCCC v Stanton* [2019] NSWCATOD 58 (*Stanton*).

Sarkis

The application brought by the HCCC against the physiotherapist alleged boundary violations against three patients. The allegations made in relation to Patients A and B also related to criminal conduct. It had been found in criminal proceedings that the physiotherapist committed an act of indecency against Patient A, by touching her vagina during treatment for hamstrings and shins. Similarly, it had been found that the physiotherapist committed an act of indecency against Patient B, by touching her vagina during treatment for her left knee. Additional acts of indecency were also described in the decision and the Tribunal members judged those allegations as being proven.

The facts involving Patient C were different. It was alleged that the physiotherapist positioned his arms against the patient's genitals during treatment, sent illicit photographs of his genitals to her and ultimately obtained oral sex from Patient C during a treatment session.

The Tribunal found that there was inappropriate behaviour of a sexual nature towards all three patients. As a result, the Tribunal made findings of professional misconduct against the physiotherapist, indicated that if his registration had still been current that it would have been cancelled, and ordered that the practitioner not apply for reregistration for seven years.

Stanton

This application involved a psychologist's treatment of two patients. It was alleged that Patient A had received a massage while partially unclad. Thereafter, the psychologist also sought to schedule a "sensuous and indulgent" massage at the Plaintiff's home or other "quiet" place. When the patient sent a text message indicating that she felt uncomfortable about the massage that had already occurred, the psychologist invited her to meet him in a sauna to discuss her concerns.

Patient B had come to know that her psychologist was on the dating website "Red Hot Pie". This led to them exchanging sexualised text messages and it eventually led to a pre-arranged sexual encounter. The matter was made more complex, as it appears that the psychologist was also engaged in a sexual relationship with Patient B's sister.

The Tribunal at paragraph 60 of its decision found that "…the conduct as proved constitutes a grievous abuse of the therapeutic relationship with Patient A and Patient B, and of the trust placed in psychologists to care for and treat their patients." Similar to *Sarkis*, the Tribunal made a finding of professional misconduct, ordered that it would have cancelled the registration if it was active, and ordered that the practitioner not apply for reregistration for three years.

Fake health news: placenta as a cure

"Fake news" has received a lot of attention in recent years, particularly in the political arena. Fake health news, in the same way, relates to the false, misleading or unproven advertisement of new health fads and "wellness" products that supposedly provide health benefits.

One recent example of this is placentophagy, which involves the ingestion of placentas in pill form. It appears that the placenta is collected after childbirth, steamed or dried, then encapsulated for mothers to re-ingest. The supposed benefits of consuming placenta include treating post-partum depression, replenishing vital nutrients and boosting milk supply.

However, despite these claims, the Therapeutic Goods Administration made an announcement concerning the emerging practice. It warned of the potential risks of placenta consumption and heeded that it is illegal to make or sell unapproved biological products. Similar concerns have also been raised by the Mayo Institute.

New health fads provide challenges for patients, practitioners and government regulators. Patients who adopt these treatments could end up with significant side effects. Dealing with these side effects and competing unorthodox alternative treatments can be difficult for practitioners. Attempting to regulate this conduct is particularly difficult for the Therapeutics Goods Organisation, which has to monitor the availability of products as well as the advertisements and claims made about those products.

All update articles for NSW written by Mark Doepel, Partner, with assistance from Steven Canton, Associate

TASMANIA

Record fine for "holding out"

The Tasmanian Magistrates Court has handed down a record fine of $120,000 under the *Health Practitioner Regulation National Law (Tasmania) Act 2010* (the National Law against former physiotherapist, Mr Michael Sylvester Dempsey, for knowingly holding out or representing to patients that his staff as registered health practitioners—when they were not.

Mr Dempsey plead guilty and was convicted of "holding out" to aged care providers in Tasmania that 11 people employed by his company were registered physiotherapists or occupational therapists, when they in fact came from backgrounds such as hospitality and transport. These people had been engaged by Mr Dempsey's company Libero Healthcare Pty Ltd (now in external administration) in providing pain management services to 78 aged care residents in Tasmania.

AHPRA CEO, Martin Fletcher noted that the decision "highlights the importance of the public and employers checking the online national register of practitioners to make sure services are being provided by a registered health practitioner".

Practitioner's registration details are available at ***www.ahpra.gov.au***

Written by Lani Carter, Senior Associate

sparke HELMORE LAWYERS

Want to know more?

To find out about the ways that we can help you, please contact a member of our Health Care team:

Adelaide

Julie Kinnear
t: +61 8 8415 9823 | e: julie.kinnear@sparke.com.au
Lani Carter
t: +61 8 8415 9873 | e: lani.carter@sparke.com.au

Brisbane

Mark Sainsbury
t: +61 7 3016 5033 | e: mark.sainsbury@sparke.com.au
Andrew Mansfield
t: +61 7 3016 5089 | e: andrew.mansfield@sparke.com.au

Canberra

Catherine Power
t: +61 2 6263 6373 | e: catherine.power@sparke.com.au

Darwin

Colin Davidson
t: +61 8 8963 5687 | e: colin.davidson@sparke.com.au

Melbourne

Kerri Thomas
t: +61 3 9291 2305 | e: kerri.thomas@sparke.com.au
Jehan Mata
t: +61 3 9291 2374 | e: jehan.mata@sparke.com.au

Perth

Piet Jarman
t: +61 8 9492 2277 | e: piet.jarman@sparke.com.au

Sydney

Mark Doepel
t: +61 2 9260 2445 | e: mark.doepel@sparke.com.au
Henry Bourke
t: +61 2 9260 2469 | e: henry.bourke@sparke.com.au