Health Care Update

SEPT 2020 ISSUE 8

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IN THIS ISSUE

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Kerri Thomas

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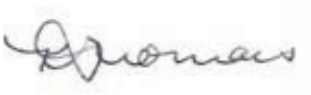
Welcome to the eighth issue of *Health Care Update*. In this issue, we cover several recent developments, including:

- COVID-19, remote working and the healthcare sector
- A hospital update on the Australian Productivity Commission's 2020 report on Government Services and what the data tells us
- The risks of unqualified practitioners using 3D printing prosthetics medical technology
- The Queensland Pharmacist Prescribing Drug Trial and potential issues for insurers related to pharmacists' expanded scope of practice, and
- The call for submissions on the impact of COVID-19 from the Aged Care Royal Commission.

We also take you through a number of legal developments affecting healthcare practitioners, clinics and insurers in various states across the country.

If there are any topics you would like us to cover, please send me an email at *kerri.thomas@sparke.com.au*. On behalf of the team, I hope you enjoy this issue.



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COVID-19, REMOTE WORKING AND THE HEALTHCARE SECTOR

Written by Jehan Mata, Special Counsel, located in Melbourne, and Edward Osborne, Special Counsel, located in Sydney

Coronavirus (**COVID-19**) has resulted in rapid changes to the way workplaces operate, and our healthcare providers are no exception to this. As the use of remote-access technology becomes more widespread, healthcare providers may become more vulnerable to cyber-attacks, which may in turn lead to privacy-compliance issues and service interruptions. It also presents other risks for providers, including the potential for litigation due to misdiagnosis or changes to communication methods.

Virtual-care limitations and risks

In response to COVID-19 and limitations around in-person consultations, the Medicare Benefits Scheme (**MBS**) was recently expanded to allow for an increase in telehealth consultations, meaning that virtual care will no longer be limited to patients in rural settings.

One of the key limitations in conducting virtual examinations is the ability of the patient to access the appropriate technology. Many patients now required to use telehealth facilities are elderly and immuno-compromised. Unfortunately, older patients often do not have smartphones, adequate internet connections, or the ability to navigate the technology. This may discourage practitioners or patients from engaging in telehealth appointments.

The inability to perform a physical examination also provides a major challenge for practitioners. Virtual assessments likely increase the chance of misdiagnosis, which is arguably the greatest liability risk telehealth presents. To ensure practitioners adequately discharge their duty of care, it is imperative that they inform patients of the limitations in making diagnoses and recommending treatment if the patient is seen remotely.

The difficulties performing remote assessments may prompt health practitioners to make alternative and provisional diagnoses, with follow-up advice to patients to arrange an in-person visit to an office for lab tests and a physical examination.

The widespread use of telehealth may also lead to performance or conduct-related complaints to the Australian Health Practitioner Regulation Agency (**AHPRA**). As noted earlier, there is an increased risk of misdiagnosis associated with virtual examinations, and such issues are often referred to the regulator for investigation. Communicating and building rapport with patients can be particularly challenging at times, which could increase complaints made to AHPRA. Accordingly, practitioners should take care to maintain accurate and up-to-date records and consultation notes, as this may assist in protecting practitioners from exposure or from disciplinary action should future claims arise.

Privacy and cybersecurity considerations

On 31 July 2020 the Office of the Australian Information Commissioner (**OAIC**) released its half-yearly notifiable data-breach report, revealing 518 data breaches were notified to it in the six-month period to 30 June 2020. The healthcare sector featured heavily, making up 22% of all such notifications. In fact, since OAIC reporting started in 2018, the healthcare sector has

consistently notified more data breaches than any other sector.

Two days after the release of the notifiable data-breach report, the Australian Cyber Security Centre (**ACSC**) advised of a significant increase in targeted ransomware campaigns against healthcare providers, which include a data-stealing component.

Then, on 6 August 2020 the Commonwealth Government released its 2020 Cybersecurity Strategy (**Cybersecurity Strategy**), which, among other things, recognised the criticality of the healthcare sector, and the importance of mitigating cyber risk and maintaining strong privacy safeguards in it.

Privacy and cybersecurity in the healthcare sector are nothing new; healthcare records often contain highly sensitive information, so are attractive to cyber criminals and insider misuse, and otherwise subject to elevated privacy-protection obligations.

So, what can healthcare providers do to improve their privacy and cybersecurity posture?

On the governance front, our proactive clients will have established or be working on establishing:

- an appreciation of the intersection between cybersecurity and privacy and, in relation to the latter, a plan to comply with the Australian Privacy Principles or other relevant statutory privacy frameworks
- an understanding about how data is processed, and the privacy and confidentiality interests of stakeholders served or affected by them
- privacy and cybersecurity risk assessments, allowing them to prioritise and act on identified risks
- a privacy and cybersecurity governance framework, and granular controls for understanding and managing their risk-management priorities
- a plan to communicate the importance of privacy and cybersecurity to stakeholders, and how they deal with each, and
- appropriate data safeguards.

While we generally do not provide technology-focused cybersecurity advice, there are several freely-available resources that can serve as a good starting point. One such resource is the ACSC's website where you can find details about the "Essential Eight"—a series of baseline cybersecurity mitigation strategies to fend off such attacks in the future.

Embracing technology increases availability of medical services

Despite the ongoing challenges of COVID-19 and remote working practices within the healthcare sector, the increased use of technology to connect with patients and otherwise streamline their care helps the availability of medical services to, for example, people in remote and rural areas.

Understanding the risks associated with more reliance on technology and mitigating against them can seem daunting. However, ensuring business continuity—and limiting the likelihood of data loss, liability or regulator intervention—are strong motivators for a proactive compliance approach.

Acknowledgement: Brydee Hodgson, Lawyer, Paul Scopacasa, Lawyer and Deborah Placidi, Paralegal

Photo by Janews.

PUBLIC HOSPITALS UPDATE– WHAT'S THE DATA TELLING US?

Written by Mark Sainsbury, Partner, and
Alex Mitchell, Law Clerk, both located in Brisbane

Sentinel event data and reporting

The Australian Productivity Commission's 2020 report on Government Services details a national increase in sentinel events in public hospitals from 65 in 2016-17 to 80 in 2017-18.

Sentinel events are defined as reported adverse events that occur because of system and process deficiencies and result in the death of, or serious harm to, a patient. Within the context of the Commission's report, core sentinel events include procedures involving the wrong patient or body part, inpatient suicide, retained instruments after surgery, and serious medication errors. Essentially, sentinel events comprise the majority of avoidable mortalities in hospitals.

In Queensland public hospitals, 11 sentinel events were reported from approximately 1.5 million

hospital stays. This number is almost double the six sentinel events reported in 2016-17. Notably:

- inpatient suicide doubled from two cases in 2016-17 to four cases in 2017-18
- likewise, medication error leading to the death of a patient doubled to four cases in 2017-18
- retained instruments after surgery remained consistent with figures from 2016-17, with two reported cases, and
- one case of maternal death associated with pregnancy, birth, or the puerperium had one reported case in 2017-18, against nil reported the year prior.

What does this mean for public hospitals and their insurers?

While these figures seem alarming, the Commission advises that, "changes in the number of sentinel events reported over time do not necessarily mean that Australian public hospitals have become more or less safe, but might reflect improvements in incident reporting mechanisms, organisational cultural change, and/or an increasing number of hospital admissions".

It is worth noting that the number of sentinel events reported in Queensland from 2016-17 was markedly lower than prior years. To this end, the number of sentinel events in 2017-18 represent the "average" total of reported events when compared to the data from 2013 to 2018.

In April 2020, the Australian Commission on Safety and Quality in Health Care revised the list of core sentinel events to include the use of physical or mechanical restraint and the use of an incorrectly positioned oro- or naso-gastric tube, resulting in serious harm or death. The amendments also removed reporting requirements for maternal death and intravascular gas embolism as sentinel events. It will be interesting to observe the effect of these revisions to future reporting of the provision of health services in public hospitals.

COVID related abuse and response

On 15 May 2020, Queensland's Chief Medical Officer made a Direction that, for the duration of the COVID-19 pandemic emergency, any person who intentionally coughs, sneezes, or spits at a public official or worker (or threatens to do so) may be fined $1,334 and may also face criminal charges.

In further support of the Chief Medical Officer's Direction, the Queensland Parliament passed the *Justice and Other Legislation (COVID-19 Emergency Response) Amendment Bill 2020* (Qld) (**Bill**) on 21 May 2020.

Relevantly, Part 13 of the Bill inserts a new Chapter 18B into the *Police Powers and Responsibilities Act 2000* (Qld) to provide a legislative framework for the circumstances in which a police officer may apply to the Children's Court or a magistrate for a COVID-19 test order. From 25 May 2020, an application may be made against a person who has been arrested for an assault offence under the *Criminal Code 1899* (Qld) and, in the suspected commission of that offence, the person wilfully coughs, spits, or sneezes at another person. Examples may include a hospital inpatient who spits in a nurse's face or a person who spits on a police officer while being arrested. If the order is granted by the court the alleged offender must submit to a doctor or nurse for the taking of a respiratory tract sample, which will then be tested for COVID-19.

These tests will allow victims to obtain medical confirmation as to whether the alleged offender is carrying the COVID-19 virus and may have transmitted it to the victim.

Unfortunately, medical and emergency response authorities are already reporting an increase in COVID-related abuse of employees, including spitting on staff working in hospital emergency departments.

3D PRINTING PROSTHETICS MEDICAL TECHNOLOGY–RISKS AND REWARDS

Written by Jehan Mata, Special Counsel, located in Melbourne

The last decade has seen significant developments in 3D printing of limb prostheses. Here we discuss the current status of the prosthetic and orthotic industry in Australia, the perceived advantages and disadvantages of the method, concerns within the medical community, and the potential causes of action that may result if errors are made or if there are deficiencies in the end product.

What method is involved?

The method of creating the prosthesis involves joining material to make objects from data and building it up, layer by layer. The method has caused concern within the medical profession because those undertaking the construction do not have medical qualifications and there is no supervisory body to keep the manufacturers accountable.

Who regulates the prosthetic industry?

In Australia, the prosthetic industry is self-regulated by the Australian Orthotic Prosthetic Association (**the Association**), and although this means it is not subject to government registration or licensing, the Association has established standards, codes and guidelines. Membership to the Association is voluntary but individuals applying to become a member must meet qualification and residential requirements. Since membership is voluntary, not all individuals undertaking 3D printing are required to be a member; recent statistics show that only 80% of orthotists and prosthetists are members of the Association.

What are the advantages and disadvantages of the technique?

The main advantage of the technique is that the final product can be produced at reduced cost and in a timely manner, allowing greater accessibility to such products and rapid design improvements and customisation. 3D printing of prosthetic limbs is particularly attractive for children, as the prosthesis can mould to a child's development needs.

Despite the advantages of the 3D printing method, experts are increasingly worried about prosthetics being made by people without medical qualifications.

Currently a large global community is printing prosthetics, consisting of individuals from a wide professional background, including teachers, engineers, occupational therapists, students, professors, designers and artists, as well as parents and families. The creation of devices by unqualified persons creates risks arising from ill-fitting devices, which can cause people to fall and suffer injuries, as well as blisters, pressure sores and consequential infections. The technology has been described as being "disruptive" due to the small-scale product development, which circumvents the expertise and checks that usually operate in established manufacturing of consumer products.

What causes of action may arise?

When complications occur, we expect to see an increase in claims for negligence, breach of contract and breach of the Australian Consumer Law.

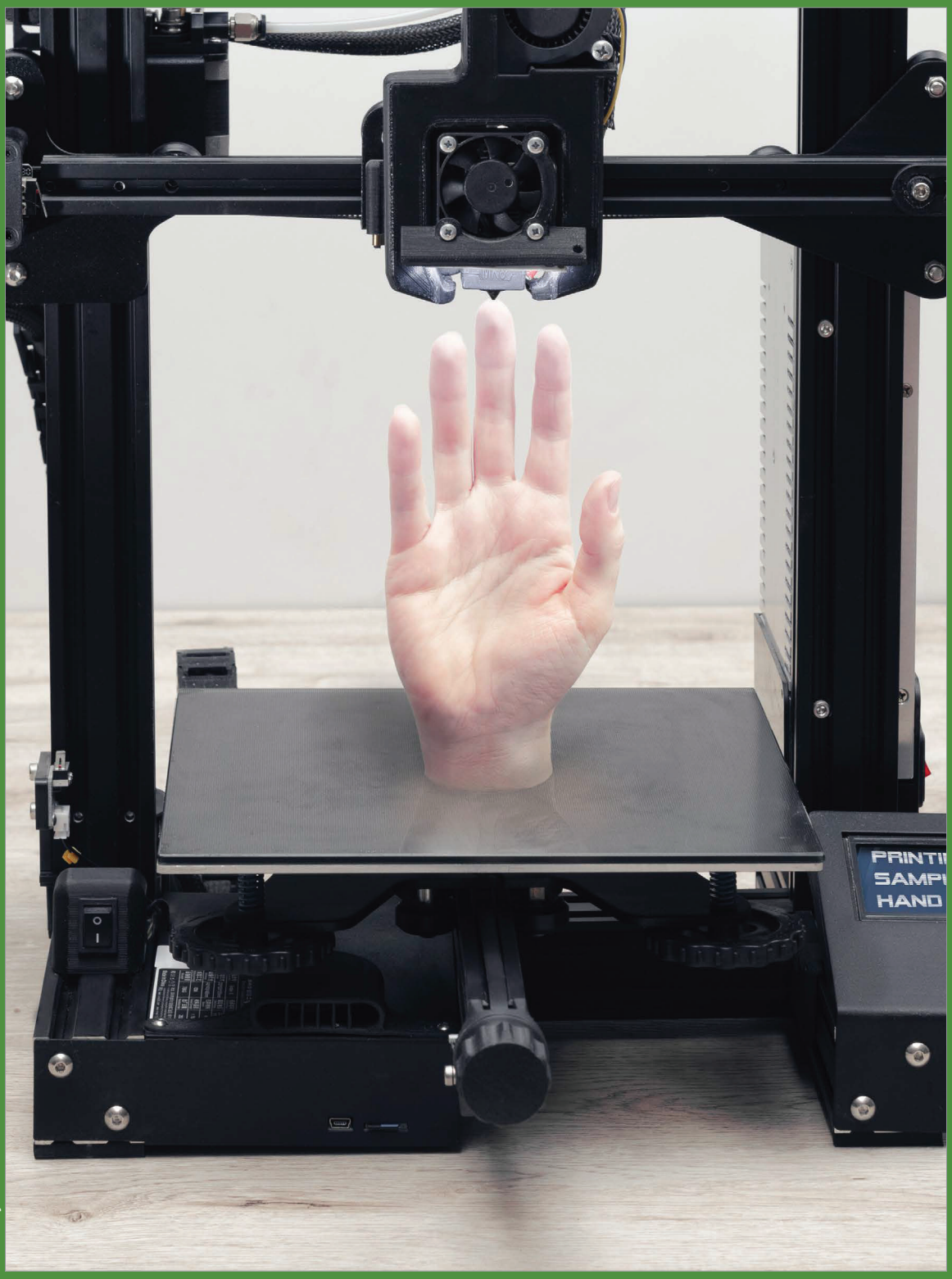

Photo by Malikov Aleksandr.

The Australian Consumer Law

Schedule 2 of the *Competition and Consumer Act 2010* (Cth) (**Australian Consumer Law**) applies to the supply of goods or services "in trade or commerce".

Given the nature of the 3D prosthetic limb printing industry, various organisations are providing the products for free and as a measure of goodwill. Given the products are being provided without charge, it is unlikely Australian Consumer Law would apply because the products were not supplied in trade or commerce, that is, for a fee.

Even if the prosthetic limb is supplied in trade or commerce, forensic problems could arise due to the lengthy manufacturing chain involved in 3D prosthetic limb printing. The manufacturing chain includes manufacturers of the printers, producers of raw printing materials, digital designers of Computer Aided Design or CAD files (data files similar to architectural blueprints) and producers of the 3D printed products. This long manufacturing chain will inevitably result in the joinder of multiple parties, which in turn will result in expensive litigation.

Negligence

In order to establish liability, a claimant would need to prove that the defendant did not exercise reasonable care to prevent harm to that claimant. Liability could rest with suppliers of raw materials or the users of the 3D printing machines who print the defective products. For instance, the manufacturers of the product will more likely bear the primary responsibility for defective products if they create the risk or fail to warn users of a known defect. Liability may also arise if suppliers fail to issue proper warnings about the proper fitting and use of the device for example.

Breach of contract

If an agreement or contract is entered concerning the printing of 3D prosthetic limbs then claims may arise concerning the reliability of the product, which has been communicated to the users when taking possession of the product. However, in the case of products supplied for free, it may be difficult to determine that a contract exists, as no consideration (in this case, payment) has been provided.

We have observed that suppliers and manufacturers of 3D printed prosthesis limbs have attempted to minimise their liability by using waivers. Some companies are requesting that clients sign waivers to the effect that the supplier has not given warranty about any of the designs and do not guarantee they are fit for particular purposes, and that no representations have been made concerning the devices. However, we query whether such attempts to limit liability would succeed, particularly when the supplier is required to accept responsibility by law.

Our view

The lack of regulation around this rapidly developing industry is a cause for concern. Without appropriate training and qualifications, ill-fitting and inappropriate devices may be supplied, which ultimately may cause personal injury. Lawmakers are yet to implement recommendations regarding how Australian Consumer Law can be modified to properly address industries involved in new forms of technology, and the potential adverse impact such products can have on the end-users—who are typically patients in an already compromised position.

Acknowledgement: Brydee Hodgson, Lawyer and Deborah Placidi, Paralegal

THE IMPORTANCE OF WORKING WITH REGULATORS

Mukonoweshuro v Occupational Therapy Board of Australia [2020] NSWCATOD 11

Written by Mark Doepel, Partner, and
Steven Canton, Senior Associate, both located in Sydney

This recent NSW case relates to Mr Mukonoweshuro, an occupational therapist practicing first in Queensland and then in New South Wales. Mr Mukonoweshuro had been subject to licencing restrictions by the Occupational Therapy Board of Australia (**the Board**) because of his transition from being an overseas practitioner.

Where appropriate, the Board also acted through the Occupational Therapy Council of Australia (**the Council**), the accredited authority to assess overseas-trained occupational therapists for eligibility to practice in Australia.

In Australia, the primary role of boards and councils is to protect the health and safety of the public. This case highlights the importance of practitioners working with boards and councils to ensure that any risks are overcome and that professional bodies can be satisfied of the training and skill of practitioners.

When practitioners find themselves before boards and councils, conceding that further work is required can often be perceived by practitioners as an unfavourable option as opposed to the instinctive desire to justify prior actions. However, as seen in this case, taking such action including appealing to Tribunals, can ultimately be to a practitioner's detriment.

Case background

Having worked as an occupation therapist in Zimbabwe between 2009 and 2014, Mr Mukonoweshuro travelled to Australia in 2014. On 29 August 2014, the Board registered Mr Mukonoweshuro on the basis that he would only work under supervision with an approved practitioner.

In January 2017 to August 2017, Mr Mukonoweshuro practiced under Category 2 "indirect" supervision with Ms Mills at River Healthcare. However, at the end of the supervisory period questions were raised about the authenticity and accuracy of the supervision report (including by Ms Mills).

On 15 September 2017, the Council notified Mr Mukonoweshuro that it had decided not to issue him with a "practical competition" certificate, but rather recommended he undertake a further 12 months of supervision to "assist [you] in gaining the competence required".

In November 2017, Mr Mukonoweshuro appealed the Council's decision to an Independent Appeal Panel (**the Panel**). On 29 January 2018, the Council notified Mr Mukonoweshuro that the appeal had been unsuccessful. The Panel stated that he had not provided sufficient material to demonstrate that he met the "required criteria".

The Panel found that the documentation submitted by Mr Mukonoweshuro did not contain information as to appropriate occupational therapy treatment or targeted intervention tailored to the needs of individual clients; and failed to demonstrate an understanding of the role of occupational

therapists in an aged care setting. The Panel noted that it was difficult to determine from the submitted documentation whether, as claimed by Mr Mukonoweshuro, he had undertaken the requisite "CPD activity" (paragraph 36 of the judgment).

From January 2018 to May 2018, Mr Mukonoweshuro worked under the supervision of Mr Gaidies. In May 2018, that supervision was cancelled after Mr Mukonoweshuro failed to provide requested supervision reports and logbooks.

August 2018 Application

A further application was submitted, which led to a 23 August 2018 notification by the Board that supervisory conditions were being reinstated for a further 12 months.

However, in September 2018, Mr Mukonoweshuro again failed to provide the requested supervisory logs and progress reports and by 3 October 2018, his supervisory practice arrangements had been cancelled by the Board.

In November 2018, Mr Mukonoweshuro then started a position with Tamworth-based rehabilitation consultant RehabCo. He then sought approval and a change of circumstances allowing him to upgrade from Level 2 indirect supervision to Level 4 minimal general oversight. After requesting further information on 4 February 2019, Mr Mukonoweshuro's supervision was approved but only with Level 2 supervision.

Mr Mukonoweshuro sought a review of that decision on 11 February 2019. After further review, on 2 May 2019 the Board declined to remove the subject conditions indicating that Mr Mukonoweshuro had not complied with his previous conditions or supplied appropriate materials.

Appeal to the Tribunal

Subsequently, in June 2019, Mr Mukonoweshuro sought to appeal to the NSW Civil and Administrative Tribunal (**Tribunal**) seeking a grant of his general registration. In particular, Mr Mukonoweshuro sought to challenge the August 2018 decision to reimpose supervisory conditions for a further 12 months.

Mr Mukonoweshuro argued that:

a) he successfully completed six months' supervised practice with Ms Mills

b) he demonstrated competence to practice at Level 4 supervision

c) all relevant reports were submitted by him where appropriate, and where supervisors failed to provide information, he should not be penalised, and

d) his experience and qualifications meant that the more stringent Level 2 supervision was not appropriate.

The matter proceeded to a hearing on 23 September 2019 and 14 October 2019, with a decision handed down in 31 January 2020. Amongst other reasons, the Tribunal found that Mr Mukonoweshuro had not provided sufficient evidence to show that he had met the supervisory conditions. Furthermore, the Tribunal held that the appeal had not been made at the appropriate time (which was within 28 days of the August 2019 application) and so it could not proceed.

Ultimately the Tribunal made orders confirming the Board's decision.

Why the approach matters

This case highlights the importance of working with boards to overcome issues, as opposed to challenging their decisions. In this case, Mr Mukonoweshuro had multiple opportunities from 2017 to August 2018, and then subsequently, to work with the Board to provide logs and reports and to overcome the need for supervision. However, the constant challenges and failures to provide materials ultimately led to Mr Mukonoweshuro's outcome. Now, nearly two years since the August 2018 decision, he finds himself needing to fulfil a further 12 months of supervision.

In Australia, the primary role of boards and councils is to protect the health and safety of the public. This case highlights the importance of practitioners working with boards and councils to ensure that any risks are overcome and that professional bodies can be satisfied of the training and skill of practitioners.

Photo by Prostock-studio.

Photo by Elvira Koneva.

UPDATES FROM QLD, WA, SA, NSW AND VIC

QUEENSLAND

Pharmacist Prescribing Drug Trial

In a rare show of bipartisan support, the Queensland Government has greenlit a state-wide trial to allow pharmacists to prescribe and dispense low-risk emergency and once-off repeat prescriptions of the contraceptive pill and antibiotics for urinary tract infections (**UTIs**). The trial proposes to make better use of community pharmacy resources, improve access for Queenslanders in regional areas, and create a model for other Australian jurisdictions.

Pharmacists have traditionally acted as a final safety barrier to ensure that doctors' prescriptions do not adversely interact with other drugs, have been prescribed in the correct dosage, and that patients have been appropriately counselled regarding their use. However, the scope of their practice has continued to grow following the authorisation of trained pharmacists to administer vaccines to adults and recently, to 16- and 17-year olds without parental consent.

The Pharmacy Guild of Australia and the Pharmaceutical Society of Australia have supported the move, which will see pharmacists practising to their full scope.

Objections

The Royal Australian College of General Practitioners (**RACGP**) and the Australian Medical Association (**AMA**) have strongly opposed the trial, arguing that the risk to patient safety outweighs the convenience of prescribing pharmacists.

Their objections include:

- pharmacists do not have the requisite medical training
- the absence of clinical examination or investigation may cause non-UTI conditions, such as sexually transmitted infections, to remain undiagnosed
- there is a risk of increased community resistance to antibiotics, which may encourage the creation of "super bugs"
- pharmacists may not have complete access to patient records
- pharmacists may have a financial interest in prescribing medications for business purposes in a retail environment, and
- assuming the role of both prescribing and dispensing removes the "checks and balances" on medications, which will increase the likelihood of human error.

As an alternative, the AMA has expressed support for the inclusion of non-dispensing pharmacists working in general practice. Even for low-risk scripts, their position is that the difference between prescriber and dispenser ensures patient safety.

This comes after the UK's largest pharmacist organisation and indemnity provider, the Pharmacists' Defence Association (**Association**), warned that several serious incidents of unsafe practice have been linked to independent pharmacist prescribers in general practices. The Association noted specifically the instances of pharmacists prescribing for walk-in patients in circumstances where a diagnosis was required and without reference to the patient's clinical records.

However, a 2018 study published in the Canadian Pharmacists' Journal found that pharmacists were doing a better job of following the prescribing algorithms for non-complicated UTIs when compared to doctors.[1]

1 Nathan P. Beahm et al, 'Outcomes of Urinary Tract Infection Management by Pharmacists (RxOUTMAP): A study of pharmacist prescribing and care in patients with uncomplicated urinary tract infections in the community' (2018) 151(5) Canadian Pharmacists Journal 305.

The Pharmacy Board of Australia has stated that any gaps in competencies following the roll-out could be addressed through professional development programs, which would be a standard requirement for pharmacists to maintain their general registration.

What does this mean for pharmacists and their insurers?

The expansion of the pharmacist role naturally comes with increased risk and therefore exposure to professional liability claims. The warnings raised by the Pharmacists' Defence Association in the UK will not go unnoticed by local and international insurers of Australian pharmacist schemes.

However, the trial is limited to low risk, once-off repeat prescriptions and will be conducted within a regulatory framework. Therefore, the associated risks should be capable of identification and mitigation.

It would be prudent for pharmacists in the trial and the on-risk insurers to review the professional indemnity cover to ensure it does, in fact, cover the expanded scope of practice.

COVID-19 impact

As at the time of preparing this article, the Queensland Government had not set a start date for the trial.

However, the development of the COVID-19 pandemic has caused the Government to hastily broaden Queensland drug dispensing protocol to expand the range of "emergency medication" items pharmacists can dispense without the need for accompanying general practitioner prescriptions. It is also envisaged that this will include any COVID-19 vaccine, which is eventually rolled out.

Once again, insurers will be required to adapt to any such developments and, potentially, be compelled to cover any new risks emerging from any expanded scope of practice.

Written by Mark Sainsbury, Partner, and Alex Mitchell, Law Clerk, both located in Brisbane

WESTERN AUSTRALIA

Causation arising out of a loss of chance—*Chester v WA Country Health Service* [2019] WADC 152

This claim brought by the Plaintiff against the WA Country Health Service in the District Court of Western Australia, alleged that the Defendant breached its duty of care by incorrectly reporting his left shoulder injury as a subluxation, rather than a dislocation, of his left acromioclavicular (**AC**) joint. The Plaintiff also alleged that the attending medical officers failed to advise him to seek orthopaedic review to determine the most appropriate form of treatment of his injury.

There was no doubt that the hospital discharge summary provided to the Plaintiff wrongly recorded a radiological finding of an AC joint subluxation instead of a dislocation. It was also clear that the second medical practitioner at the hospital omitted to write in the discharge summary the need for the Plaintiff to seek immediate orthopaedic review.

Court findings

The Court found that on the agreed expert evidence, the Defendant should have referred the Plaintiff for orthopaedic review or recommended he seek orthopaedic advice upon his choice of proceeding to surgery or conservative treatment.

Having established a breach of duty, the question for consideration was whether the Plaintiff could prove it was more probable than not that, had the Defendant referred him for orthopaedic review, the present problems suffered by him would have been avoided.

The expert orthopaedic surgeons were divided as to whether they would have recommended conservative or surgical treatment for the Plaintiff's injury and on the evidence, the Plaintiff failed to prove that surgery was the preferred treatment.

In its commentary, the Court noted a finding that early surgery might have made a difference did not prove causation and the Plaintiff could not argue that his condition would have been less severe if he had proceeded to surgery earlier.

The Court found the Plaintiff had not proved that anything turned on the incorrect description of a subluxation in the discharge summary or that any defect from which he now suffered due to widely accepted conservative treatment would have been avoided in the circumstances.

Key takeaway

This decision confirms that a plaintiff must establish more than just a mere possibility that present problems could have been avoided and the loss of chance is insufficient.

Written by Laura Bendlin,
Senior Associate, located in Perth

SOUTH AUSTRALIA

Aged Care Royal Commission recommences hearings

The Royal Commission into Aged Care Quality and Safety based in Adelaide suspended hearings in March 2020 due to the COVID-19 pandemic amid concern for those required to attend the public hearings in the aged care sector.

On 14 May 2020 a media release was issued by the Commission seeking submissions from aged care providers, people receiving care and family members about the impact of the coronavirus on the aged care sector.

On 25 June 2020 amended Letters Patent were issued by the Attorney General, giving the Commissioners an extension of time to complete their final report, from the previous deadline of 12 November 2020, to 26 February 2021.

The Royal Commission has recently recommenced hearings, holding a virtual hearing in July on the topic of allied, oral and mental health. Since then, hearings have been heard on the following further topics:

a. the impacts of COVID-19

b. accommodation in aged care

c. home care

d. funding, financing and prudential regulation

As at the date of this publication, the Commissioners have not announced the topics of future hearings.

We look forward to continuing to work with our clients impacted by the Commission activity and will keep you updated on further developments over the coming months.

Written by Lani Carter,
Senior Associate, located in Adelaide

NEW SOUTH WALES

The hidden cost of COVID-19

One of the less appreciated repercussions of COVID-19 has been how it has put significant strain on general practitioners and medical clinics. Pre-COVID-19, Australian general practitioners were the first "port of call" for any health concerns and routine health management such as prescriptions or blood tests.

However, visits to general practitioners have fallen significantly in light of COVID-19. This has been due to the need to isolate persons with cold and flu like symptoms, as well as due to a wider fear of contracting COVID-19 from another patient at a medical practice.

However, what is generally unappreciated is that a medical clinic, or general practitioner, is a business, just like any other, with fixed costs. As such, while patient numbers have dramatically decreased, so has revenue, and that puts significant strain on clinics and practitioners financially.

That in turn, can have significant negative impacts on the medical industry and local communities. With fewer general practitioners available, it makes it difficult for patients to get the care they need. It is foreseeable that some of those patients might simply escalate their complaints to hospital emergency departments—putting additional strain on an already struggling system. Similarly, some patients may simply choose to leave minor illnesses unattended. However, if those illnesses worsen, what might have been a simple fix could be significant and again diverting precious resources from hospitals.

Accordingly, COVID-19 is disrupting Australia's system of local general practitioners, and that could have long-term hidden impacts on when and how Australians seek healthcare.

Cases involving minors—when are interim payments appropriate?

Medical negligence cases involving minors, and especially cases involving newborn babies, can often drag on for years. This is because it often impossible to know the extent of injuries, and whether they will have a small or drastic impact upon the injured person, until they develop and mature. In some cases, that can mean that cases involving babies are "frozen" in the Court system for 18 years until they reach the age of maturity.

In such cases, one potential limitation is that plaintiffs are often unable to access monies that are likely to be awarded in a later judgment or settlement. That is often the case even where such monies are inevitable, such as where liability has been admitted—and the parties are simply waiting to know the extent of injuries. In those cases, that money would be of great benefit to an injured party, as it would facilitate them obtaining medical and rehabilitation costs over what could be a significant period of time.

In order to address that limitation, plaintiffs can bring an action for "interim payments" under s 82 of the *Civil Procedure Act*. The matter of *Tripovich v South Eastern Local Health District* is a timely example of how that procedure was utilised to the Plaintiff's benefit.

Case highlights

In July 2017, medical negligence proceedings were brought on behalf of Alexis, a baby girl, against South Eastern Local Health District. It was alleged that during Alexis' delivery, the Health District's hospital and staff failed to exercise an appropriate level of care and skill, failed to perform early interventions during the birth, and ultimately that their negligence caused Alexis to suffer hypoxic brain damage and multiple disabilities during the delivery. Liability was admitted.

On 11 December 2019, the Plaintiff sought an order from the Court seeking a payment of interim damages in the sum of $75,000 pursuant to s 82 of the *Civil Procedure Act 2005* (NSW). The Plaintiff's claim for interim damages was supported by a number of expert reports addressing liability issues comprising of midwifery, obstetric, neo-natal, paediatric neurology and paediatric neuropsychology opinions.

Further, there was also evidence that speech pathology, occupational therapy, and adaptive living skills assistance, would be of assistance at this stage of Alexis' development, particularly in light of problems with schooling.

In making its decision, the Court was persuaded that s 82 could be applied as it is limited to cases where:

1. the Defendant has admitted liability
2. the Plaintiff has obtained judgment against the Defendant for damages to assessed, or
3. if the proceedings went to trial, the Plaintiff would obtain judgment for substantial damages against the Defendant.

Further, the amount sought was $75,000 and the Court was satisfied that any future Court-approved settlement or judgment would be well in excess of that amount.

Timely reminder

Accordingly, this case is a timely reminder that even though cases involving minors can be postponed over several years whilst damages are settled, that does not mean that minors must go without treatment. Interim payments can be obtained, where appropriate, in order to ensure that minors have access to the funds they require to continue with their medical treatment and rehabilitation.

All update articles for NSW written by Mark Doepel, Partner, and Steven Canton, Senior Associate, both located in Sydney

VICTORIA

Case Note: Peninsula Health—Risks of discharging patients without a diagnosis

The recent decision in *Boxell v Peninsula Health* [2019] VSC 830 (17 December 2019) provides a cautionary tale for emergency departments, which discharge patients without a diagnosis.

Ronald Boxell, 47 years of age, experienced chest pain on 6 October 2013. Mr Boxell was subsequently taken by ambulance to Frankston Hospital at around 6:40 am. No cause was found for Mr Boxell's pain, and he was discharged around 3:40 pm without a diagnosis being made. The following day, Mr Boxell died at home as a result of acute aortic dissection (**AD**), a rare condition found in approximately one in 10,000 emergency presentations. Proceedings were commenced in the Supreme Court by Mr Boxell's wife and children (**Plaintiffs)** against Peninsula Health.

The Plaintiffs alleged that Peninsula Health was negligent in failing to exclude AD as a possible cause of Mr Boxell's symptoms. Peninsula Health argued that AD was considered a possible cause of the pain but was excluded given Mr Boxell's presenting history. Its key defence was that it had acted in a manner widely accepted as competent professional practice (as set out in s 59(1) of the *Wrongs Act* 1958 (Vic)).

Justice Keogh's findings

Justice Keogh found in favour of the Plaintiffs, finding that Peninsula Health was negligent in failing to consider AD as a possible diagnosis and by failing to perform a CT aortogram (**CTA**), which is a definitive investigation for AD.

Justice Keogh's decision guides how practitioners, particularly in emergency departments, should conduct themselves to avoid liability.

1. First, concerning whether the Senior Emergency Consultant, Dr Martin Jackson (**Dr Jackson**) had considered AD as a diagnosis, Justice Keogh rejected Peninsula Health's evidence in those instances where it differed from the hospital notes. Dr Jackson submitted that, in accordance with his standard practice, he confidently excluded AD and the need for a CTA based on the absence of common symptoms and the fact Mr Boxell's pain was subsiding. However, he made no reference to considering the need for AD, nor was this process of exclusion referred to in his clinical notes. Without any contemporaneous notes to corroborate Dr Jackson's oral evidence, and noting that his answers, particularly in cross examination, were often discursive or expressed in terms of "what would have happened" or "usual practice", Justice Keogh was not persuaded that Dr Jackson did consider AD as a likely cause of the pain.
2. Second, His Honour concluded it was not reasonable emergency practice to discharge Mr Boxell without a diagnosis and without performing a CTA to confirm or exclude AD. He specifically noted the following:
    a. Justice Keogh commented that when a patient presents with chest pain, emergency physicians must consider a list of possible diagnoses, including AD, to confirm or exclude immediately life-threatening causes. Mr Boxell's history of pain, including severe sudden onset of central chest pain described as "sharp", aligned squarely with known presenting symptoms of AD. Further, Mr Boxell presented with known risk factors for AD, including hypertension and a history of smoking.

b. Justice Keogh also reported that, in relying on the absence of classical symptoms of AD, the Defendant paid no consideration to the variability of AD symptoms or that the disorder often mimics other more common disorders. His Honour also considered that the lethal nature of AD should have been considered and provided further justification to perform a CTA.

c. He accepted the expert evidence that there was a need for "ongoing clinical curiosity" as to the cause for the sudden, severe chest pain.

Power of record-keeping versus oral evidence

This decision highlights the need for practitioners to keep comprehensive and accurate notes, given the Court's reluctance to accept Dr Jackson's oral evidence that he had acted in accordance with his standard practice, when it was not supported by the clinical records. Further, this case signals that practitioners may need to modify and expand their diagnostic pathways to confirm or exclude rare and lethal conditions before discharging patients.

It also provides insight into how courts may approach the argument so often relied upon by defendants, that their practice aligned with "competent professional practice" as determined by their peers. The decision also highlights the need for defendants, when relying on this defence to ensure that the evidence adduced is capable of showing that the practice in question **did** align with competent professional practice.

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