Health Care Update

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IN THIS ISSUE

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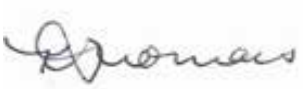
Welcome to the ninth issue of the Health Care Update. As Australia and the rest of the world navigate the COVID-19 pandemic, the health industry has been at the heart of it all, experiencing new opportunities and challenges of historic proportions. In particular, the acceleration of digitisation has inspired innovation and transformation, while also increasing instances of cyber breach. Easing of restrictions has led to questions around the legality of vaccination policies in the workplace, and complaints made to AHPRA regarding access to, and quality of, healthcare provided by practitioners is on the rise. In this issue, we cover these recent and current developments, including:

- evolution of the digital Health industry and associated cyber breaches
- mandatory vaccination policies in Australia
- analysis of the AHPRA framework for dealing with vexatious complaints
- data security in the context of Health Information, and
- a story of a new health tech company helping clinics and practitioners thrive.

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

We hope you have found this issue informative and useful. If there are any topics you would like us to cover in the future, please contact Kerri Thomas.



Kerri Thomas,
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THE CYBER SUPERSPREADER - MOVE OVER COVID, THERE IS A NEW VIRUS IN TOWN AND IT'S HERE TO STAY

Authors: Partner Mark Doepel and Special Counsel Jehan Mata

In March 2020, there was a tremendous shift as consumers and providers looked for ways to safely deliver healthcare electronically during the pandemic. In May 2021, 17% of services were delivered virtually and it is expected that digital health will continue to be used to deliver care. That said, the virtual platform is not novel and the shift to digital health was underway prior to the pandemic. Unfortunately, the transformation in the health industry is not the only change we have seen during the pandemic. There's also been a surge in cyber-attacks on the health sector as cyber-criminals take advantage of the pandemic.

The Australian Cyber Security Centre (ACSC) has reported an

increase of about 85% of cyber security incident reports

in 2020 as compared to 2019.

Reports of these attacks came from both health care professionals and customers who fell victim to data breaches and health related scams. This article discusses the current trends, the threats that the medical industry is facing, and the steps required to remain vigilant and safe.

Digitalisation and pre-pandemic changes to health sector

Many industries, including the health sector, have made a significant move to digitalisation in the last two years. Australia has adopted advanced technology during the pandemic, allowing practitioners to deliver healthcare—in the large part—safely to Australians.

My Health Record was introduced in 2012 to provide a platform to store a digital copy of personal medical information within an online national database. It allows consumers to manage their medical record, add additional information and share their record with multiple practitioners with the aim of providing seamless, safe and efficient care.

By 2016, the My Health Record service had

2.6 million users

which is nearly 10% of Australia's current population.

Another service introduced in May 2013 was myGov, which provide Australians with one secure platform to access a range of services. This integrated Federal Government database saves time, paper, personnel and has a long-term lower expenditure. These are just a couple of examples of moves within Australia to a more digitalised healthcare system prior to COVID-19.

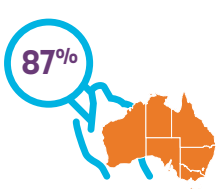
Health sector since the pandemic

When the virus hit, the healthcare system was placed under immense pressure to deal with this unprecedented and evolving landscape. As a result, the government fast-tracked its plans to provide secure platforms, such as telemedicine for medical professionals. To augment these changes, Medicare also made additions to its list of reimbursable covered services, so as to allow practitioners to be remunerated for providing care virtually until 31 December 2021.

These changes to the Medicare Benefits Schedule (MBS) have assisted in the provision of continuous and coordinated healthcare and high-quality practices. More than four million health and medical services have now been delivered to more than three million patients through MBS telehealth items.

In the United States, telehealth usage has increased 38 times from the pre COVID-19 baseline.

In just April 2020, the **application of telehealth was 78 times higher** than in February 2020.



Similarly, Australians have been responsive to telehealth, with **87%** of consumers reporting an interest in continuing to use telehealth if Medicare funds it.

Medical practitioners also hope that the current funding arrangements will remain. At the time of publication, the government has yet to comment on whether MBS telehealth items will become a permanent feature.

Cyber-attacks and ransomware

As telehealth becomes an increasingly important element in the provision of health services, so too does the increased risk of cyber-attacks and ransomware. Consequently, cyber-attacks and security breaches have become an extreme concern as cybercriminals take advantage of the pandemic environment. The health industry has been a lucrative target for cybercriminals, as personal information is in high demand on the dark web. These cyber-attacks can result in patient information being accessed, leading to possible identity theft, data extortion, reputational harm and other damage. Security breaches can cause significant financial loss and possible legal liability.

Therefore, it is vital for businesses and individuals to be alert as cybercriminals continue to evolve their craft.

An increase in phishing attacks are occurring, noting that **91% of cyber-attacks** begin with a phishing email.

The increase of email related breaches in the health sector has been overwhelming, especially in smaller businesses, with 59% reporting phishing attacks. Cybercriminals target small businesses because they don't always have the financial ability to invest in advanced technology or provide cyber training to their staff. Sixty per cent of people also report working in distracting environments, with 73% of employees making more mistakes due to general fatigue experienced during the pandemic.

Against this backdrop, businesses and individuals need to be hyper-vigilant to reduce the risk and impact of a cyber-attack. In a recent case, a pharmacy staff member clicked on an email thinking it was from a supplier and within minutes all PCs were locked with an accompanying ransomware demand. The pharmacy could not dispense or trade. Fortunately, the business IT provider already had precautions in place and had backed up the pharmacy's data. These precautions allowed the pharmacy to continue trading within 24 hours of the cyber-attack. However, this did not stop the business from incurring financial loss and reputational damage. This case highlights the importance of creating a culture of cyber-awareness and adopting good security practices as part of day to day activities.

At their worst, these attacks can be a threat to patients' wellbeing and lives. The United Kingdom's National Health System hospitals suffered a ransomware attack in 2017, forcing them to delay treatment plans and reroute incoming ambulances as they lost access to the hospitals' information systems. These attacks impede hospital operations and put the health and welfare of patients at risk, making clear that a new level of caution is essential to reduce the risk of attack. Refer to our recent article Ransomware - Show me the money: should we or shouldn't we that explores legalities of Ransomeware.

Practitioners' duty

All healthcare providers have a professional and legal obligation to protect their patients' health information. Creating and maintaining information security practices is a critical professional and legal obligation when using digital health systems. The *Healthcare Identifiers Act 2010* requires reasonable steps to be taken to protect healthcare identifiers from misuse, loss, modification, disclosure and unauthorised access. The *Privacy Act 1988* (Cth) outlines the privacy responsibilities with which healthcare providers must comply in managing health and personal information. Noncompliance with healthcare provider requirements can result in civil penalties and/or imprisonment. The Department of Health published a checklist for telehealth services to help healthcare providers maintain privacy and confidentiality whilst using technology-based consultations. The list below sets out some ways practitioners can provide safe and effective health services via telehealth whilst maintaining confidentiality:

- Assess whether telehealth is safe and clinically appropriate for the patient and whether a physical examination is required to provide better care.
- Configure and establish web conferences and phone calls securely.
- Identify yourself and confirm the identity of the patient. Be aware of unidentified participants and surroundings.
- Ensure protection of patient's privacy and their rights to confidentiality, particularly if working from home.
- Maintain clear and accurate health records of consultations.

Benefits of digital health

Digital health in combination with good practice and safety measures provides significant benefits to the Australian economy. The digitalisation of medical data enables high quality healthcare, which include:

- responsive and sustainable healthcare
- prevention before treatment, as digital health aid patients to self-manage their conditions through regular monitoring and tracking of symptoms
- avoiding hospital admissions
- reducing time spent in waiting rooms
- fewer adverse drug events
- less duplication of tests
- fewer medical errors
- improved coordination of care for people with chronic and complex conditions
- better-informed treatment decisions, and
- expanding the reach of healthcare professionals.

Healthcare also contributes 5% to global greenhouse gas emissions. The use of digital health reduces the dependence on paper-based communication, which lowers healthcare's carbon footprint.

Studies show that an increase in **digital health over the past six years has resulted in a decrease in greenhouse gas emissions**. So not only does digital health provide efficiencies and enhance healthcare, it is also good for the planet.

Necessary precaution and safety measures

With every benefit comes a risk. The surge in cyber-attacks and ransomware means that a new level of vigilance is required, and appropriate measures are necessary. It is highly recommended that businesses obtain cyber insurance, as part of a suite of policies. Ultimately, it is important to understand that cyber-attacks cannot be prevented; nevertheless, we can reduce the impact they have on us. This is achieved by backing up data, updating systems regularly, staff training and creating a self-awareness culture.

Takeaway

Change is and was inevitable, and the digitalisation of healthcare was already on its way. The pandemic has certainly accelerated the process and has seen the government introduce technology almost a decade earlier than planned. However, the health industry's exposure to attack is still high and it is everyone's responsibility to be proactive and remain vigilant to ensure a sustainable and safe transition to digital health. Ultimately, prevention is better than cure and ongoing vigilance and resilience will assist the industry moving into a more digitised world.

AN ANALYSIS OF THE AHPRA FRAMEWORK FOR DEALING WITH VEXATIOUS COMPLAINTS

Author: Partner Mark Sainsbury

Background

Since the inception of the COVID pandemic situation, medical defence organisations, insurers and regulatory bodies (such as AHPRA) have been dealing with an increased number of enquiries from health care practitioners and complaints from health care consumers relating to access to health care and quality of health care services.

As those of us working in the health care arena will appreciate, many complaints lack merit, are misconceived, misunderstood, or are merely the way in which an unhappy client chooses to voice their concerns. Whilst these complaints may be easily dealt with or ultimately dismissed by a regulator, they are usually genuine complaints about concerns held by the health care recipient.

A different and less common type of complaint is a **vexatious complaint** where the complainant has a different (and more sinister) motivation for making the complaint.

AHPRA vexatious complaint framework

When managing and responding to AHPRA complaints on behalf of practitioners, it is worth bearing in mind that a regime exists within AHPRA for dealing with vexatious complaints.

AHPRA developed the framework for its claims managers and investigating officers to use when attempting to identify and deal with vexatious notifications (view framework). This framework was borne out of a 2017 study conducted by the Centre for Health Policy within the Melbourne School of Population and Global Health at the University of Melbourne.

The Centre for Health Policy study (view report) looked at a broad range of industry regulators—from telecommunications regulators to crime stoppers to health and medical regulators. In brief, the study found that there was a large proportion of complaints that were alleged to be vexatious (generally by the respondent or their solicitors). However, the number of genuinely vexatious complaints was concluded to be around 1% of all complaints received.

Whilst low in number, vexatious complaints have a significant impact that is demonstrated by the disproportionate amount of time required for agencies to handle those complaints and the adverse impact upon the practitioners who are subject to those complaints.

The study concluded that it was inherently difficult to identify vexatious complaints and the process involved to determine:

- the veracity of the complaint, and
- the intent of the complainant.

When trying to define what it considered to be a vexatious complaint, the study authors referenced the legal meaning of a vexatious complaint that relates to the motivation of the person causing an event. The study went on to determine various factors that may contribute to vexatious complaints and AHPRA has adopted these factors into its framework to assist its managers to identify potential vexatious complaints.

The study noted that the most serious of vexatious complaints were those commenced by a professional complainant in the same industry as the practitioner target of the complaint, wherein those complaints were calculated and were likely to be driven by the desire for professional gain in a competitive professional environment. Conversely, vexatious complaints by lay complainants are more likely to be driven by unmet needs in a flawed complaints system.

The findings of the study concluded that such complaints are not made in good faith and should not receive the benefit of good faith provisions as found in s 237 of the National Law.

The framework adopted by AHPRA reflects a number of findings from the Centre for Health Policy study.

AHPRA have elected not to adopt a definitive meaning for a vexatious notification but describe it within the framework document as: a vexatious notification is a notification without substance, made with an intent to cause distress, detriment or harassment to the practitioner named in the notification.

AHPRA acknowledges the balance that must be struck between the extreme impact a vexatious complaint can have on a recipient practitioner whilst being mindful of not deterring genuine complaints by readily labelling such complaints as vexatious.

AHPRA advises its employees of the following indications to look out for when assessing a potentially vexatious notification:

- whether a notifier has an historical pattern of making notifications about the same practitioner
- whether the notifier has engaged in organised, strategic, calculated behaviour
- if personal gain or revenge appears to be involved
- the notification format and content
- a notifier's behaviour when interacting with AHPRA, and
- relationship between practitioner and the notifier.

Vexatious complaint consequences

If AHPRA considers a complaint made by one practitioner against another practitioner and qualifies as vexatious, they will ask the relevant Board to initiate an own-motion investigation into the conduct of the practitioner that made the complaint. If vexatious behaviour is determined by the Board, regulatory action will very likely be taken against the practitioner complainant.

AHPRA also refer to the codes of conduct that apply for the various National Boards, making it clear that health practitioners should not make vexatious complaints about other health practitioners. Therefore, a practitioner would be found to be in breach of the relevant code of conduct if it was determined they had made a vexatious complaint. The National Law contains good faith provisions (see s 237) that protect people who make a notification in good faith from being held liable in civil action or defamation. The AHPRA framework confirms that these provisions should not be applied to afford protection to those persons (including practitioner complainants) found to be making a vexatious complaint.

If AHPRA or a Board elected to investigate a practitioner complainant for an alleged vexatious complaint, that practitioner may seek cover under their medical negligence professional indemnity policy for assistance to defend the regulatory action.

Insurers would need to consider whether such a claim would come within the scope of the insuring clause or any "inquiries" extension or endorsement in circumstances where the inquiry may not arise out of health care services provided by the insured. Further, exclusion clauses (such as a "Dishonest or Wilful Act" exclusion) may also impact the extent of any cover available. It is also feasible that defamation proceedings may be launched by one practitioner against another in response to a vexatious complaint or, potentially, by a practitioner against the regulator if allegations of a vexatious complaint are raised within the AHPRA framework. Once again, such a complaint or claim may result in a practitioner seeking cover under any relevant insurance policy.

Takeaways

Whilst vexatious complaints are rare, AHPRA has recognised the significant impact these can have on practitioners and regulator resources more broadly and have adopted a framework to identify and manage such complaints.

Insurers, claims managers and appointed lawyers acting for practitioners in response to complaints should refer to the framework when assessing whether a complaint might be vexatious and should be reported to AHPRA. The framework may also be relevant for insurers if a practitioner insured seeks cover in response to an allegation that the practitioner has made a vexatious complaint.

MANDATORY VACCINATION – AN ONGOING COMPLEX ISSUE FOR EMPLOYERS

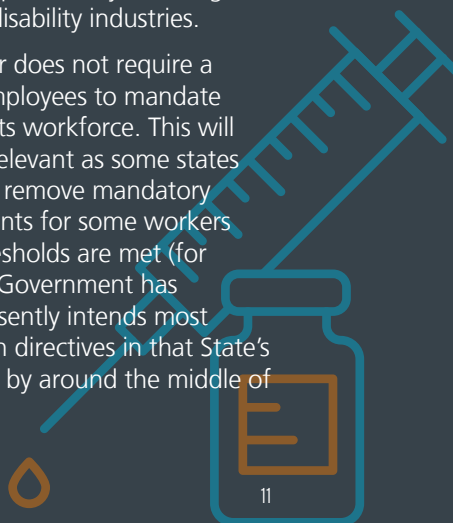
Authors: Partners Jackson Inglis and Sam Jackson, Lawyer Ashley Sherr

Vaccination for COVID-19, and particularly mandatory vaccination, is a hot topic in the workplace that is constantly evolving. Currently, there is a great deal of complexity for employers, particularly for those that operate across multiple states/territories or multiple industries. These complexities arise largely because:

1. each of the states/territories has a different regime of public health directions or public health orders (collectively, **PHOs**) regulating what parts of employers' workforces are required to be vaccinated for COVID-19 in order to continue working at certain locations lawfully. These differences are particularly stark between the "COVID-free" states and territories (i.e. NT, WA, SA, Tas and Qld) and the states with ongoing outbreaks that are existing in "COVID-normal" (e.g. ACT, Vic, NSW) and will continue to evolve as COVID-free areas shift towards a COVID-normal strategy as and when borders open up and remain open.
2. the PHOs are constantly changing based on a variety of factors including the status of domestic and international borders, the vaccination level of the population and the size of any outbreak (including the presence of the Delta variant or more recently, the Omicron variant).
3. the rights of employers to enforce mandatory vaccination, absent a PHO, is contingent, in part, on the location of the particular employee and the nature of any outbreaks in that location. Given the status of COVID outbreaks can change very dramatically in a very short period of time and the starkly different circumstances in each state and territory, this creates an element of uncertainty around employers' lawful rights on this issue.

As a result, the legal landscape on whether and how an employer can mandate vaccination amongst its workers is difficult to predict. Notwithstanding this unpredictability, the following general guidance about mandatory vaccination remains true across the country:

1. In circumstances where a PHO requires a worker to be vaccinated to perform work lawfully, it is generally lawful for an employer to mandate vaccination (subject to appropriate exceptions). Employers are generally required to enforce the requirements of those PHOs or face significant criminal consequences such as significant fines. At the time of this publication, all states and territories have PHOs in place, which require vaccination for COVID-19 for at least part of the workforce in that state or territory, particularly in the aged care, healthcare and disability industries.
2. However, an employer does not require a PHO to apply to its employees to mandate vaccination amongst its workforce. This will become increasingly relevant as some states and territories start to remove mandatory vaccination requirements for some workers when vaccination thresholds are met (for example, in NSW the Government has announced that it presently intends most mandatory vaccination directives in that State's PHOs will be removed by around the middle of December).



3. The implementation of a mandatory vaccination requirement for employees may be a reasonably practicable control measure for minimising the risk of COVID-19 in the workplace, if reasonably practicable, and can therefore assist an employer or person conducting a business or undertaking (**PCBU**) to meet its obligations under occupational health and safety/work health and safety (**WHS**) legislation.
4. An employer implementing a mandatory vaccination requirement without a PHO applying must ensure that it complies with any duty to consult it has under WHS legislation and any applicable industrial instrument (e.g. modern award, enterprise agreement). A failure to comply with consultation obligations can mean that an employer's mandatory vaccination requirement is not reasonable and therefore is not legally enforceable. This was recently considered in the case of *CFMMEU & Anor v Mt Arthur Coal*. We published Keep your coal: mandatory vaccination still lawful and reasonable; but consultation is key that explores the implications of this decision in more detail.
5. Employers operating in certain industries have an elevated risk profile related to COVID-19 due to the vulnerability of customers, patients or others who workers may come in close contact with. For example, in the healthcare industry, the close proximity generally required for the administration of healthcare and the increased vulnerability of patients to significant complications associated with COVID-19, mean that imposing mandatory vaccination is far more likely to be considered a reasonably practicable control measure. This is particularly so given the comprehensive evidence that vaccination for COVID-19 is a proven and effective measure for controlling the risks associated with the spread of COVID-19.

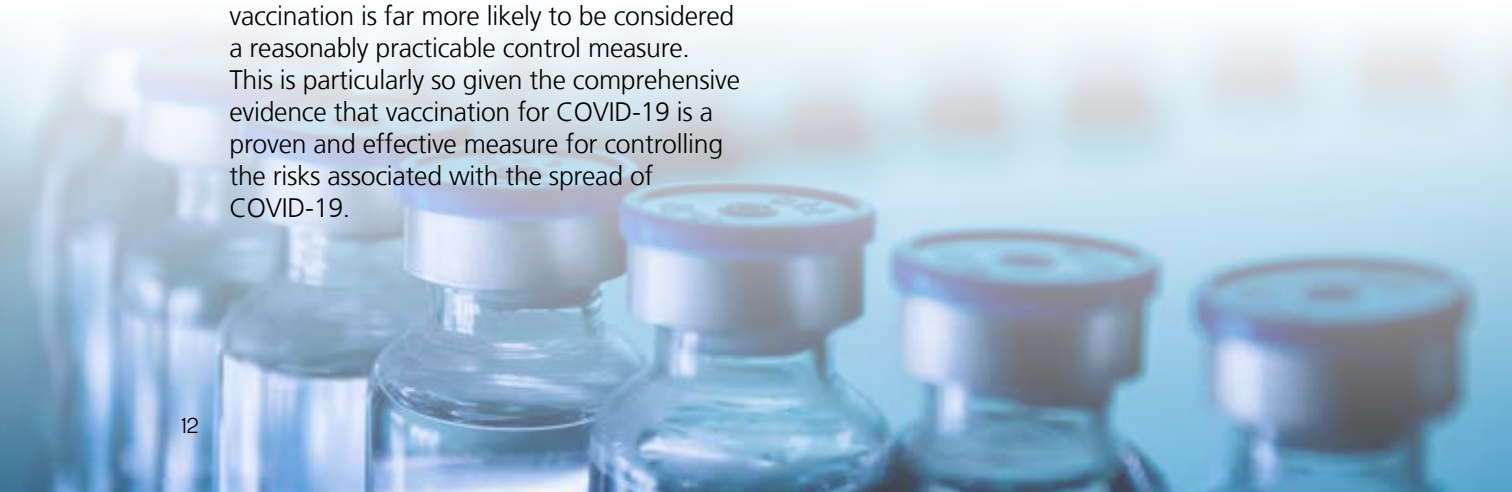
The Sparke Helmore Workplace team has been assisting employers and PCBUs across Australia in managing issues related to COVID-19, including:

- advising clients on how to manage employees who refuse to be vaccinated for COVID-19
- navigating compliance with PHOs in each state/territory, including determining which (if any) apply to all or parts of a business and its workforce
- developing and implementing policies requiring vaccination for COVID-19 separate to the requirements in PHOs
- acting on behalf of employers in relation to claims brought by employees dismissed due to non-compliance with a direction to be vaccinated for COVID-19, and
- advising employers or PCBUs in relation to their compliance with WHS obligations related to vaccinated and unvaccinated workforces and emerging from COVID-19 lockdowns generally.

Our SA team also recently published an article, Mandatory Vaccination Policies in South Australia on the current rules around mandatory vaccination in South Australia.

If you have any questions, please don't hesitate to contact Partner Jackson Inglis and Partner Sam Jackson.

[Disclaimer: As circumstances in respect of mandatory vaccinations in Australia are changing frequently, the article above needs to be read in context as at the date of publication.]



DATA SECURITY IN CONTEXT: HEALTH INFORMATION VIDEO

Author: Partner Dalvin Chien

Over the last few months, the Sparke Helmore Intellectual Property & Technology (**IPT**) team has rolled out a video series on Data Security. The series touches upon a number of key data security topics such as Personal Information, Health Information, the Consumer Data Right, and Data Breaches. The videos are short, informal, and shot in a Q&A format. They are intended to be easily digestible, with the aim of further educating those who do not deal with data security on a day-to-day basis, or who may want a refresher on a particular aspect of data security that may be relevant to their business.

The third video in this series—"**Data Security in context: Health Information**"—focuses on the regulation of Health Information, the potential impact of upcoming law reforms on the protection of Health Information and, in light of the COVID-19 pandemic, the privacy concerns posed by the use of QR codes for COVID-19 contact tracing. These topics will only become more important as we look towards the future of privacy regulation and how this may impact the collection, use, storage and disclosure of Health Information.

It is also important to consider the potential ramifications of unauthorised access or disclosure of Health Information when we look at the recent trend of employers requiring employees to provide evidence of their vaccination status. The other videos in the series provide helpful background knowledge as it relates to Personal Information (of which Health Information is a subset), the Consumer Data Right (which, while not directly impacting the health sector at present, is expected to be expanded to a number of industries in the coming years) and finally Data Breaches (relevant to any organisation that holds data relating to individuals). Needless to say, the information provided in these videos should be of interest to healthcare professionals, health facilities, medical defence organisations and insurers offering cover in the healthcare and life sciences industries.

To view the Data Security Series, visit www.sparke.com.au/ipt.

If you have any questions about the content of this series, or data security more generally, please get in touch with your Sparke Helmore contact, or feel free to reach out directly to Dalvin Chien, Partner in the IPT Practice at Dalvin.Chien@sparke.com.au.

BRAD VINNING'S EXECUTIVE STORIES PODCAST: TALKING WITH CEO OF CUBIKO, CHRIS SMEED

Author: Partner Brad Vinning

In this "Executive Stories" podcast, Partner Brad Vinning from our Corporate & Commercial team interviews Chris Smeed, Founder of Cubiko, a company that has developed unique software for medical practices that import and transform data from multiple sources to fuel powerful metrics and dashboards. The software captures the data and transforms it into timely, accurate, easy-to-understand dashboards that provide meaningful insights into the practice with the primary aim of allowing the practitioner to focus on providing healthcare services whilst maximising the economic benefits. Chris offers an interesting perspective around the latest developments in clinic software.

LISTEN TO PODCAST

UPDATES - NATIONAL, QLD, VIC, WA, ACT

NATIONAL

COSMETIC SURGERY CHECKS AND BALANCES – A JOINT REVIEW BY AHPRA AND THE MEDICAL BOARD OF AUSTRALIA

Authors: Partner Mark Doepel, Senior Associate Steven Canton

Introduction

On 30 November 2021, AHPRA and the Medical Board of Australia (**Medical Board**) announced a joint review into cosmetic surgery checks and balances. The review will be led by Mr Andrew Broad, the retiring Queensland Health Ombudsman and we anticipate consultation will begin in early 2022, with the final report released by mid-2022.

The review is significant because it has the potential to cause amendments to the *Health Practitioner Regulation National Law* (**National Law**), create a precedent for the rapid development of the health industry, affect the manner and environment in which health professionals practice, and restrict the use of the term "cosmetic surgeon", which to date is not a protected title, and can be used by any surgeon.

It appears the review will focus on:

- strengthening risk-based regulation of practitioners in the industry
- regulatory actions to better protect the public, and
- the role of state and territory health authorities in regulating and licensing facilities.[1]

So how did we arrive at the point where such a significant review was required? This article considers some of the key concerns that have emerged over the last decade leading to this joint review.

The introduction of the *Health Practitioner Regulation National Law*

The lack of regulation around cosmetic surgery is a long-standing issue. In October 1999, the NSW Government received The Cosmetic Surgery Report[2], which noted that medical practitioners performing cosmetic procedures included plastic surgeons, cosmetic surgeons, cosmetic physicians, general practitioners,

1 *Ahrpa and Medical Board announce review of cosmetic surgery checks and balances, 30 November 2021*
2 *The Cosmetic Surgery Report*, Report to the NSW Minister for Health, October 1999

dermatologists, ophthalmologists (eye surgeons), otolaryngologists (ear, nose and throat specialists) and, to a lesser extent, oral and maxillofacial surgeons.

Despite this, when the National Law was introduced in 2009, it was limited in its introduction of "protected titles"—titles only used by certain persons registered with particular professions with the necessary skill and training to obtain a registration. This issue was compounded by the Medical Board of Australia's standard, which failed to include any specialist title around "cosmetic surgeon".[3] As a result, any practitioner could potentially use a derivation of "cosmetic professional".

Slow development towards new guidelines

Since the National Law was introduced there's been growing concern that the law lacks adequate protection for both patients and practitioners related to cosmetic medicine. In 2011, the NSW *Cosmetic Medical And Surgical Procedures, A National Framework – Final Report*[4] noting the need for a national framework around the procedures themselves, how those procedures are promoted, the practitioners who perform those procedures, the patients to whom they are performed, and the place or facilities in which they are performed.

In 2013, the Queensland Health Quality and Complaints Commission released a report on cosmetic surgery complaints, noting that there were fewer safeguards in the area of cosmetic surgery than other areas of medicine.

In 2014, Mr Kim Snowball published the *Independent Review of the National Registration and Accreditation Scheme for health professions*, an in-depth review of the way practitioners become accredited and the use of protected titles. However, the review deferred consideration of cosmetic issues to the Medical Board.

In 2015, the Medical Board then issued a Public Consultation Paper that provided different options on how to proceed, including maintaining the status quo, educating the public and publishing explicit guidelines articulating the Medical Board's expectations.

Following the consultation process, in October 2016, the Medical Board introduced the *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* outlining a series of protections, such as:

- a seven-day cooling off period before major procedures
- a three-month cooling off period before major procedures for under 18s, and mandatory evaluations by psychologists, psychiatrists, or GPs
- a seven-day cooling off period before minor procedures for under 18s, and mandatory evaluations by psychologists, psychiatrists, or GPs
- the treating medical practitioner is to take explicit responsibility for post-operative patient care, including emergency facilities when sedation, anaesthesia or analgia is used
- a mandatory consultation before prescribing schedule 4 cosmetic injectables, and
- detailed written information about costs.[5]

3 Medical Board of Australia - List of specialties, fields of specialty practice, and related specialist titles
4 *Cosmetic Medical and Surgical Procedures, A National Framework Final Report*, Australian Health Ministers' Conference 2011
5 *Medical Board issues guidelines on cosmetic medical and surgical procedures, 9 May 2016*

Too little too late?

Despite the introduction of these changes, the cosmetic industry continued to be negatively represented in the media for poor standards and adverse events. Notably, on 30 August 2017, Ms Jean Huang (**Ms Huang**) passed away when a breast filler procedure at the Medi Beauty Clinic in Chippendale resulted in significant complications.

This led to a significant NSW-based review and in May 2018, the NSW parliament passed the *Health Legislation Amendment Act (No 2) 2018*, introducing tougher penalties including a fine of $55,000 if high-risk procedures or treatments, such as a breast augmentation, are performed in an unlicensed facility.

In July 2018, COAG (Council of Australian Governments) also published its *Regulation of Australia's health professions: keeping the National Law up to date and fit for purpose* consultation paper querying whether the titles "surgeon" and "cosmetic surgeon" ought to be restricted. It was subsequently agreed in October 2019, that the title "surgeon" should be restricted, although how this should occur is still unresolved.

Further media attention

In July and September 2021, the Senate Community Affairs References Committee held public hearings into, amongst other matters, the current standards for registration, and the role of AHPRA and other relevant organisations in addressing concerns about the practice and conduct of health practitioners.

Then, on 26 October 2021, ABC's Four Corners aired a joint ABC, Sydney Morning Herald, and The Age exposé entitled "Cosmetic Cowboys: The unregulated world of cosmetic surgery".[6] The program and subsequent newspaper articles focused on what it saw as deficiencies with the cosmetic surgery industry and with some of its practitioners. This has now sparked the upcoming joint AHPRA and Medical Board external review.

What next?

Given the media scrutiny following significant adverse outcomes like that of Ms Huang, the Senate hearings, and now the joint review underway, we could see significant reforms to the cosmetic industry impacting health professionals and their patients. But what those changes are and how quickly they become law remains to be seen.

6 ABC Four Corners, Cosmetic Cowboys, 26 October 2021

QUEENSLAND

COURTS CONSIDER WHAT CONSTITUTES MATERIAL FACTS TO EXTEND LIMITATION PERIOD

Authors: Partner Mark Sainsbury, Paralegal Emma Frylink

Two recent decisions in Queensland involved claimants trying to commence personal injury claims outside of the limitation period. In both cases, the court examined what constitutes material facts of a decisive character in order to extend the limitation period, with the outcome differing between the cases.

Case 1: *Wilson v Mackay Hospital and Health Service* [2021] QSC 178

Facts

The Applicant, Ellie Wilson (**Ms Wilson**), sought an extension of the limitation period under s 31 of the *Limitation of Actions Act* to bring a personal injury claim. When Ms Wilson was three years old, her sister (who was two years old) sought treatment at Mackay Hospital. The sister was discharged but continued to deteriorate and passed away whilst enroute back to the Hospital. Ms Wilson suffered psychiatric injury (**PTSD**) as a consequence of these events. She was working part-time and had not received indication that she would be unable to obtain full-time employment as a consequence of her PTSD.

Findings

On 8 March 2021, Dr New (psychiatrist) diagnosed her as having a "Class 2 impairment". Upon receiving this diagnosis, Ms Wilson had *material facts of a decisive character* within her means of knowledge: being, the extent of her PTSD and the impact of this on her ability to work fulltime. The Court accepted that Ms Wilson satisfied the "material facts" test and her application to proceed with a claim against Mackay Hospital was successful.

Case 2: *Magarey v Sunshine Coast Hospital and Health Service (Nambour Hospital)* [2021] QSC 240

Facts

The Applicant, Jesse Magarey (**Ms Magarey**), also sought an extension of the limitation period under s 31 to commence a personal injury claim. She injured her right ankle descending a ladder in May 2013 and, on advice from a doctor at Nambour Hospital, she underwent three surgeries on her ankle between 2015 and 2016. In 2017 she developed an infection of the bone. She then had four further surgeries before having a below knee amputation in 2018. She engaged lawyers in 2017 who obtained medical opinions in 2020.

Findings

A medical report providing a favourable opinion as to liability would constitute a *material fact of a decisive character* to form the basis of an extension of limitation period under s 31. However, the application was denied on the basis that she did not take reasonable steps to follow up her lawyers to ensure that her claim was being progressed. The Applicant failed to discharge the onus that the material fact was not within her *means of knowledge* before the relevant date for the purposes of extending the limitation period under s 31.

Accordingly, Ms Magarey was prevented from commencing a personal injury claim against the Hospital. The Court noted that Ms Magarey's solicitors could be exposed to a professional negligence action if her inability to proceed with the claim was caused by their delay.

What distinguished these cases is the actions the claimant took to inform themselves: whether they took reasonable steps to ensure the material facts were within their means of knowledge.

The important take home for insurers, MDO's and health facilities is the longtail nature of medical malpractice claims and cover. Even when a limitation date is safely passed, it does not mean a potential claimant is without options to proceed with a civil action. If these circumstances arise, the claimant's "means of knowledge" should generally be put to proof at a hearing of the s 31 application.

VICTORIA

BRIEFING EXPERTS – A VICTORIAN CASE STUDY: *BEHAN V MELBOURNE HEALTH* [2021] VCC 44 (5 FEBRUARY 2021)

Authors: Partner Kerri Thomas, Special Counsel Jehan Mata, Lawyer Noor Klank

A recent Victorian County Court decision is a cautionary lesson about how to approach letters of instruction.

Ms Behan (**the Plaintiff**) sought orders from the Court for Melbourne Health (**the Defendant**) the Defendant to produce statements, conference notes or records of interview, which formed the basis of assumptions contained in the letter of instruction sent to the Defendant's expert witness. Although such material is usually privileged, the Plaintiff argued that privilege was waived at the time of service of the expert report, which set out detailed instructions provided by the Defendant's solicitors that were based on discussions with two witnesses who were involved in the Plaintiff's rehabilitation. The Court referred to important principles to consider in determining whether a party has waived privilege based on the phrasing of the letter of instruction sent to an expert witness.

Background

The Plaintiff suffered an above knee amputation of her left leg in 1996. In mid-2011, she underwent another surgery and was referred to Melbourne Health for rehabilitation. The Plaintiff's treatment was initially under the care of Ms Langford, a physiotherapist, but she was later referred to Mr Offerman, an exercise physiologist, to help with her rehabilitation program. On 14 February 2012, the Plaintiff fell heavily as she attempted to get onto and/or operate an exercise bike. The Plaintiff claimed that her fall occurred due to the negligence of the Defendant for failing to properly assist her during rehabilitation.

During litigation, the Defendant's legal representatives sent a letter of instruction to Mr Wayne Dite, an exercise physiologist, which summarised the Plaintiff's interactions with Ms Langford and Mr Offerman, allegedly based on their clinical notes. The letter also set out Ms Langford and Mr Offerman's experience, details of their interactions with the Plaintiff, a detailed description of the incident and their opinions regarding the cause of the accident.

Issue

The Plaintiff argued that the Defendant had waived privilege based on s 122(2) of the *Evidence Act 2008* (Vic) for "knowingly and voluntarily disclos[ing] the substance of the [privileged material]…". "Voluntary" is interpreted to mean something other than under the compulsion of law. The issue for the Court to determine was whether the Defendant set out information retrieved from Ms Langford and Mr Offerman in the letter of instruction, which constituted a knowing and voluntary disclosure of their evidence.

Decision

Whether there has been knowing and voluntary disclosure

The Defendant's lawyers letter to Mr Dite used words such as "*Ms Langford/Mr Offerman's instructions are that…*", which appeared to be a deliberate intention to disclose to Mr Dite that both witnesses' recollection was tenacious and could be trusted. The letter further outlined that Mr Offerman had never had a patient fall from an exercise bike and that "*nothing could have been done to prevent this accident*". His Honour formed the view that the phrasing was intended to provide Mr Dite with the witnesses' opinions on the incident. His Honour Judge Pillay found that this was anathema to the basis of a letter of instruction, as what Mr Dite was tasked to do was formulate an opinion regarding how the incident likely occurred, based on his expertise and the available facts. Therefore, his Honour questioned the intention behind the phrasing of the letter and considered it to be a deliberate attempt to reinforce the Defendant's position.

Whether the references to Ms Langford and Mr Offerman's instructions amount to a disclosure of their evidence

His Honour concluded that the information contained in the letter provided information from Ms Langford and Mr Offerman, which went beyond a description of the factual circumstances leading to the incident. His Honour observed that courts have long found that "*simple references in correspondence to the overall opinion of Counsel*" amounts to a waiver of privilege. Thus, the Court held in favour of the Plaintiff and ordered that the statements, records of interview and notes of conference in relation to Ms Langford and Mr Offerman be produced by the Defendant.

Takeaway

This case is a cautionary reminder to remain vigilant when briefing experts. It is always tempting to try to sway experts based on instructions obtained by lawyers during conference with witnesses, but this jeopardises the strength of the experts' ultimate opinion and certainly jeopardises the ability to maintain privilege over material, irrespective of whether it was the solicitors' intention to waive any such privilege.

WESTERN AUSTRALIA

ASSESSMENT OF DAMAGES IN WRONGFUL BIRTH ACTIONS

Authors: Partner Chris Rimmer and Special Counsel Sascha Gore

The Western Australian District Court decision of *O'Loughlin v McCallum* (2021) WADC 77 delivered on 9 August 2021 provided observations on the assessment of damages for wrongful birth, specifically considering new law about the costs of raising a child where both parents are solely in receipt of Centrelink benefits with no derived income from wages.

Background

On 11 June 2014, the first Plaintiff (**Ms O'Loughlin**) gave birth to BK. The second Plaintiff (**Mr Smith**), is BK's father. Five years earlier Ms O'Loughlin accepted the advice of the Defendant (**Dr McCallum**), her treating obstetrician at Kalgoorlie Hospital, and consented to him performing a sterilisation procedure, subsequent to the birth of her sixth child via caesarean section, which was not successful.

General damages

In providing an assessment of general damages in the sum of $22,000 ($45,000 reduced by the deductible of $23,000 prescribed by the *Civil Liability Act*) Flynn DCJ reviewed the infrequent published decisions of wrongful birth claims with an award for general damages. A specific issue raised by Ms O'Loughlin's claim was whether the impact upon Ms O'Loughlin of the 2019 internet publication of her District Court action against Dr McCallum should be taken into account when assessing general damages as there had been social media criticism of a plaintiff claiming the costs of an "unwanted child". Flynn DCJ considered that at law Dr McCallum had not caused this particular harm suffered by Ms O'Loughlin, it was not appropriate for the scope of Dr McCallum's liability to extend to harm arising from the internet comments, and the liability of the medical practitioner did not extend to every manifestation of harm, notwithstanding factual causation was established.

Loss of earning capacity

As to the claim for loss of earning capacity, Flynn DCJ acknowledged that Ms O'Loughlin was aged 35, had no vocational qualifications and no experience of paid employment. She had a history of assault convictions (which she denied, but this was overcome by the Defendant producing a certificate pursuant to s 23 of the *Evidence Act WA*) and her involvement in the criminal justice process before the birth of BK limited her employment prospects. Based on Ms O'Loughlin's expressed preference to commence employment in the retail sector, his Honour stated that it was appropriate to have regard to the relevant rates of pay in the *Fair Work Act* with a casual employee paid at $24.30 per hour. Despite providing this precise calculation as an assumed basis for the quantification for economic loss, no further details were provided. Instead, Flynn DCJ awarded a global sum of $20,000 (including interest) for the loss of earnings in the period August 2015 to June 2020.

Centrelink payments

The most significant aspect of the trial was whether the payments from Centrelink that Ms O'Loughlin and Mr Smith received as a result of the birth of BK should offset any entitlement at common law associated with the costs of raising BK. Flynn DCJ acknowledged that in *Cattanach v Melchior* the majority of the High Court held that there is no reason in principle or policy to deny damages in the amount of costs of raising a child who is born after a negligently performed sterilisation procedure. The Defendant adduced expert actuarial evidence from Mr Plover of Cumpston Sarjeant to support his submission that it is appropriate for government assistance to be set off against any claim for the costs of raising BK. Mr Plover's evidence was relied upon such that the net present value of government assistance provided to Ms O'Loughlin and Mr Smith on account of BK exceeded the net present value of the estimated costs of raising BK.

Findings

Flynn DCJ confirmed that the precise question of whether a family tax benefit paid or payable under the *Family Assistance Act* must be brought into question when calculating the costs of raising a child had not been the subject of judicial analysis. However, the principles of law to be applied to answer the question had been much discussed. In the case of a social security benefit the deciding consideration is not whether the benefit to which the injured person is entitled was received because of the tort, but rather the character of the benefit, which is determined by the intent associated with the payment of the benefit.

To ascertain this intent, Flynn DCJ referred to the legislative intent. His Honour concluded that the context of the *Family Assistance Act* and the nature of the family tax benefit suggested an overall legislative purpose to assist a carer, and not in substitution of the cost of raising a child. Highlighting that Mr Plover relied upon publications from the National Centre for Social Economic Modelling (**NATSEM**) to estimate the average costs of raising a child that took into account certain variables, including the level of household income and family size, Flynn DCJ stated that it was appropriate to consider the findings of NATSEM but also expenditure constraints and economies of scale that reduced the marginal costs of raising each subsequent child. On the NATSEM findings his Honour assessed the past costs of raising BK in the sum of $25,115, with pre-judgement interest on the amount in the sum of $5,274, and the future costs until his 18th birthday at $52,957.

ACT

HEALTH NEGLIGENCE CLAIMS AND THE HUMAN RIGHTS COMMISSION

Authors: Partner Catherine Power and Senior Associate Cindy Lim

In 2005, the ACT established the Human Rights Commission (the Commission). Among a range of other functions, the Commission was established to provide an accessible, independent process for the resolution of complaints about health services.

There is limited publicly available information about the Commission's operation in the early years, however since 2014, the Commission has seen a year-on-year increase in complaints to the Health Services Commissioner. In the 2019/20 financial year, 574 health services complaints were received.

While most would consider it uncontroversial for services provided by doctors and hospitals to be captured under "health service", the Commission adopts a far wider definition, which includes any service "provided in the ACT to someone for the purpose of assessing, recording, maintaining or improving the physical, mental or emotional health, comfort or wellbeing of the service user". This broad definition means we continue to see increasing referrals of matters involving a range of service providers from those in highly regulated industries (such as optometrists) as well as those in largely unregulated industries (such as beauty therapists).

Threshold of professional negligence

Unlike common law, the threshold for a complaint is not negligence. The complainant needs only to allege the service was not provided "appropriately". There is no guidance given for what may cause a service to fall short of being appropriate. However, beyond complaints about the adequacy or quality of treatment provided, we note the Commission has also considered complaints about communications with the complainant, record keeping processes and advertising practices.

On the face of it, such complaints may not meet the threshold of professional negligence, and therefore care should be taken by insurers to consider whether the wording of their policies provides coverage for such complaints.

Where the complaint does potentially raise an allegation of professional negligence, the Commission's conciliation process provides a unique opportunity for insurers to bring about an early resolution of that claim.

In 2019/20 the Commission boasted a successful closure rate of 79% of complaints within 250 days, something which is rarely (if ever) achievable within the ACT common law claims process.

Conciliation

The conciliation process is confidential, and communications and documents exchanged during it are not admissible should the matter ultimately become litigated. This is critical to the willingness of parties to engage in meaningful discussions about the complaint and for disputes to be satisfactorily resolved often through non-financial avenues, such as an acknowledgement of the issues raised by the complainant, an apology or statement of regret. Conciliation also provides an opportunity for parties to negotiate a financial outcome and common law release without going down the path of litigation.

The upward trend of health services complaints to the Commission is one we anticipate will continue in the near future. While the informality of the Commission's complaints management process can feel like unfamiliar territory to lawyers and insurers alike who practise in the common law litigation space, there are obvious cost and claim management benefits (and few drawbacks) to actively engaging in the process where it is available.

Example of a complaint to the Commission

In 2019, Sparke Helmore was instructed on behalf of a beauty therapist. A former customer had complained about laser treatment, which she thought had caused permanent scarring. The parties participated in the Commission's conciliation process in which the complainant was provided the opportunity to give feedback on her experience. Based on that feedback, and without admission, the beauty therapist undertook to review their communication and consent procedures. Subject to a common law release, a very modest financial outcome was agreed. As the claimant was self-represented, there were no legal costs.

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