

COLLABORATIVE HEALTH CARE INITIATIVES: THE MEDICO-LEGAL ISSUES

PROFESSOR MOIRA PATERSON *

Technology offers the potential for collaborative treatment of chronic diseases involving clinical partnerships between multiple health care providers based on web-based care plans. However, collaborative regimes may increase the potential for the for medical negligence suits. Possible issues that can arise include responsibility for ensuring the appropriateness of any care plan, the accuracy, security and continued integrity of any information entered in the system and responsibilities to follow up patients. These issues are discussed in the context of a Victorian initiative to establish a broadband-based network of health services for monitoring and supporting care management of diabetes.

A new development recently trialled in the Barwon Region of Victoria, the CDM-Net (Chronic Disease Management Network) project,¹ involves the use of a shared electronic care plan as a basis for the multidisciplinary treatment patients with a chronic health condition. This paper explores the medico-legal issues raised by projects of this type.

Background

A key driver for this new concept is the large and growing cost burden of chronic disease in Australia. This is expected to grow significantly in line with the aging of the population and increasing prevalence of shared chronic disease risk factors such as overweight and obesity, poor nutrition and physical inactivity. Current projections suggest that health care expenditure for cancer, cardiovascular disease and diabetes will nearly triple from A\$14.4 billion in 2002/03 to A\$41.3 billion in 2032/33.²

The Australian government sees multidisciplinary care as a part of the solution to this problem. In 1999, it introduced General Practitioner (GP) rebates for enhanced primary care multidisciplinary care planning, requiring collaboration between GPs, other providers and patients with chronic illnesses.

Subsequently, in 2005, it added GP Management Plans (GPMPs) and Team Care Arrangements (TCAs). GPMPs are used for patients with a chronic illness who would benefit from structured care while TCAs are intended for patients with complex care needs, require collaboration among providers, and allow patients to claim rebates for allied health and dental care. According to Medicare statistics in 2005–06 GPs prepared more than 645,000 GPMPs and almost 300,000 multidisciplinary care plans (EPCs and TCAs).³

At the same time, the Australian government has also focused on e-health strategies. In 2005 it created the National E-Health Transition Authority (NEHTA) which has recently issued a discussion paper on a proposed unique health identifier.

A more recent development involves the use of shared electronic healthcare plans. An example is provided by the CDM-Net project⁴ which has trialled the use of IT in the context of a collaborative treatment model for chronic health disease – in this case, diabetes. In essence, it involves the use of a secure collaborative web-based service to create, share, track, monitor, and manage collaborative care plans.

The system collects and shares a range of health information about each patient, including medications and immunisations, and inactive as well as currently active health problems. This information comes from a variety of sources, including the GP's clinical desktop, other members of the care team, the patient themselves, some hospitals and emergency services, and some pathology laboratories.

The system uses standardised templates to create draft care plans and care plan reviews (GPMP and TCA) for approval by the GP. It also continuously monitors health parameters of patients, such as blood glucose levels and medications and is designed to assist them in adhering to their care plans by sending them reminders and alerts via SMS.

Medico-legal issues raised

The shared electronic care plan model raises a number of important privacy and medico-legal issues that need to be considered and addressed if GPs and others are to have confidence in using the model.

Privacy

The privacy issues relate to the fact that a shared electronic care plan model involves a much higher level of sharing of information than might normally take place in the context of a team care arrangement.

Limitations in the software currently used by GPs currently require downloading of the totality of the information stored on the GPs computer system and it is up to the GP to take active measures to avoid specific information being downloaded. Information which may be potentially problematic would include information about terminations, sexually transmitted diseases and mental health issues.

While patients have to give their consent to participate, there are some difficult issues concerning the reality of informed consent given that patients may be unaware of what information is held or of its significance if disclosed.

Information sharing may also raise additional security issues, especially in an electronic context. It is therefore important to ensure that there are security measures

in place appropriate to the sensitivity of medical records and also to address the issue of third party access on the part of any information technology provider.

Other medico-legal issues

Negligence issues may also arise due to the use of a shared treatment plan and reliance on an IT-based system of communication and patient management.

These fall into four broad groups: factors deriving from the use of a system of treatment based on a computer-generated care plan; issues of miscommunication; issues of shared responsibility; and duties to recall and follow up patients.

Suitability of care plans

A care plan sets out a proposed schedule of treatment and may provide an additional document which may be used by the patient in litigation.

A recent decision of the Victoria Court of Appeal in *Hookey v Paterno*⁵ makes clear that treatment plans must not only accord with what a respectable body of other professional opinion says was appropriate to offer but must also be appropriate in light of the particular circumstances of the patient.

Arguably therefore, in the case of a care plan generated using a standardised template it is important both to ensure that the template is based on current best practice and also that it allows sufficient flexibility to address the specific needs of individual patients.

Reliance on care plans

A further issue relates to what extent the care plan can, or should, be relied upon as a sole basis for treatment. This may depend on which team member is using it. If a team member is involved in patient's treatment only in the context of the care team (eg a podiatrist who is involved in the treatment of patient only in respect of the symptoms of their diabetes), then reliance on the plan may be appropriate. However, the position would be quite different for a GP who is involved in other aspects of a patient's treatment also.

In this regard it is relevant to consider the case of *O'Shea v Sullivan and Macquarie Pathology*.⁶ Although this was not concerned with care plan, it illustrates the dangers of incorrect reliance on a single source of information. What happened in this case was that the doctor relied on false negative screening result as a basis for not carrying out further urgent investigation of a patient with unexplained symptoms of post-coital bleeding. Although it was accepted that the laboratory had been negligent in misinterpreting the patient's cervical smear, the Court concluded that the doctor had also been negligent in relying totally on the results, particularly in the light of evidence that there could be up to a 20% possibility of a false negative result.

Arguably, a similar line of reasoning could be raised in relation to inappropriate reliance on a care plan document as a basis for care. This relates to the issue of abdication of responsibility discussed below.

Liability for miscommunication

Another issue that may arise can be described as the illusion of communication. So, for example, a member of the care team may enter data into the system and then assume that this is sufficient when there may be reasons why that data is not in fact viewed and acted upon by others in a sufficiently timely manner. That may be due to errors, such as errors in entering data or system error, or because any design limitations are insufficiently understood. For example, a team member may assume that any new data input into the system is immediately drawn to the attention of the GP when in fact the system is designed to bring it the GP's attention only when he or she next reviews the patient's file.

The available case law on liability for miscommunication relates to issues such as illegibility of handwriting, but it suggests that both parties to the miscommunication may share liability. For example, in the case of *Prendergast v Sam and Dee Ltd*⁷ a GP was found 25% responsible when a pharmacist misread his script for Amoxil and dispensed a dose some fifty times the permitted daily maximum.

Abdication of responsibility

Another important issue relates to inappropriate delegation of duties. Who is responsible for ensuring that a patient receives appropriate treatment in accordance with their care plan or that the plan is varied where it is found to be inappropriate?

There is always a danger when several different people are involved that they may incorrectly abdicate their duties on the basis that someone else is responsible. Once again, liability may be allocated between team members if something goes wrong.

It is therefore vital for someone – most logically, the GP – to have overall responsibility and for each team member to have a very clear idea about their specific responsibilities.

Duties of recall and follow up

The final issue relates to duties in respect of recalls and following up of patients. This is an area where there seems to be some confusion as to what standards are expected and how far the duty extends. It is therefore instructive to review the three key Australian cases that shed light on this issue.

In 1996, in the case of *Kalokerinos v Burnett*,⁸ the New South Wales Court of Appeal upheld judgment against a doctor who failed to follow up on a patient's failure to attend an appointment with a gynaecologist to investigate prolonged vaginal

bleeding. When the patient's cancer was later discovered, it was too late for a hysterectomy and she required radical radiation which resulted in serious side effects. The Court held that the doctor's failure to refer her to a specialist in another town when he found that she was unable to make arrangement to travel to Tamworth constituted negligence. In finding against Dr Kalokerinos, the Court accepted evidence by the patient that she would have attended the appointment had she been adequately informed of the potential consequences of not attending. However, it found that the patient has partially responsible for the outcome because she continued to ignore the vaginal bleeding for quite a long period despite knowing that it could be a potential symptom of cancer. It therefore reduced damages by 20%.

The South Australian case of *Kite v Malycha*⁹ concerned the duty of a surgeon to follow up on a pathology report in relation to a needle biopsy of his patient's breast. The report indicated the specimen was highly suspicious of an underlying carcinoma. However, it was not seen or followed up on by Dr Malycha and Mrs Kite was not followed up when she failed to attend her next appointment. As a result, the cancer had spread to other parts of Mrs Kite's body before the lump was ultimately removed. The Court awarded Mrs Kite and her husband over A\$500,000 damages and concluded that, on the balance of probabilities, the cancer would either have been cured or Mrs Kite would have had a much greater life expectancy had she received appropriate treatment immediately following the biopsy.

In finding against Dr Malycha the Court commented that he should have recorded the biopsy procedure in his notes and should have made some inquiry to find out had happened to the report. Furthermore he should at least have become aware of the absent report when Mrs Kite missed her next appointment.

The Court did not find any contributory negligence on the part of Mrs Kite due to the failure to counsel her about the potential significance of the test. In reaching this conclusion Justice Perry commented that as follows.

In general terms, Mrs Kite owed a duty to exercise reasonable care for her own safety and well being. But her conduct must be judged in the light of the circumstances as a whole. Mr Malycha concedes that he reassured her as to her condition when she saw him on 2 December 1994. Very likely his reassurance would have led her to believe that a follow-up consultation was not so important as it might otherwise have been. As I have said, irrespective of whether she rang up about it, she was entitled to assume that if the outcome of the testing of the biopsy gave cause for concern, she would be informed. No doubt she would then have sought further advice.

A similar approach was taken by the New South Wales Court of Appeal the following year in *Tai v Hatzistavrou*.¹⁰ In this case the doctor had ordered tests to exclude the possibility of cancer. However, there were delays and errors by hospital staff in

arranging for the tests. Once again, neither the doctor nor the patient followed up on them. As a consequence, the cancer had spread to other parts of her body before a test was ultimately carried out.

The Court of Appeal upheld the decision of the Supreme Court finding Dr Tai liable for negligence. In his judgement Priestley JA commented that:

If the doctor thinks it necessary, even for only prudential reasons, that the patient should submit to a particular surgical procedure, then the doctor has a continuing duty to advise the patient to submit to the surgical procedure, so long as the doctor/patient relationship is on foot.

There was no finding of contributory negligence because the patient was not counselled about the need to have the procedure.

To summarise briefly, each of these cases depended very much on its individual facts but there some key themes that emerge:

1. The key issue is whether the doctor acted reasonably in the circumstances and what is reasonable must take into account the fact that patients do not always do as they are told.
2. The extent to which a patient understands the significance of what is at issue is also very important – in other words, there needs to be sufficient communication to ensure that the patient understands what it at stake.
3. What is reasonable will also be affected by the ease with which a follow-up system could be implemented.

It is arguable that an electronic system able to generate reminders can serve a valuable role in avoiding liability for failures to follow up or recall patients. However, there is also a danger that it may create additional expectations and therefore affect the judgment of what is reasonable in the circumstances.

In *Kite v Malycha* the fact that a patient expected to be contacted in the event of an adverse report was sufficient to exclude any liability on her part. There may therefore be a danger that patients who are aware that system can generate reminders will have reasonable expectation that this will always be the case.

There is also a risk that team members may rely on it inappropriately and be liable if a patient suffers adverse consequences because of it. This may be because the system is not designed to generate all of the reminders required or because something goes wrong such as an entry error or some technical problem.

Conclusion

Having then identified these issues, what is necessary is to devise strategies that minimise the potential risk to an acceptable level.

Most of this comes down to putting in place appropriate protocols which are reviewed regularly to ensure that they meet current best practice, to negotiate and clearly outline mutual responsibilities and obligations and to have a clear understanding of what can realistically be expected of such a system and how it fits in with a patient's overall care. The problem, however, is how to achieve this. Ultimately this comes down to an issue of time – spending time to ensure that each team member fully understands the system and not simply how to operate it and time with patients to ensure that they also have a realistic understanding of it.

* Associate Professor Moira Paterson, Faculty of Law, Monash University.

¹ The CDM-Net project was funded by the Department of Broadband, Communications and the Digital Economy under its Clever Networks program. Project partners are the Victorian Department of Innovation, Industry and Regional Development, Victorian Department of Human Services, Multimedia Victoria, CSIRO e-Health Research Centre, IBM, Intel, Cisco Systems, Global Health, Monash, Deakin and Victoria Universities, Barwon Health, Diabetes Australia (Victoria) and the GP Association of Geelong. The author has provided legal consultancy services for that project.

² Goss J 2008. *Projection of Australian health care expenditure by disease, 2003 to 2033*. Cat. no. HWE43. Canberra: AIH.

³ Medicare Australia. Medicare Benefits Schedule item statistics reports.
http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml

⁵ [2009] VSCA 48.

⁶ (1992) ATPR (Digest) 46-124; (1994) *Aust Torts Reports* 81-273.

⁷ *London Times*, 14 March 1989.

⁸ Unreported, NSW Court of Appeal, 30 January 1996. See: Gerber Paul: 'Kalokerinos Case: More Sinned Against than Sinning?' (1997) 4 *Journal of Law and Medicine* 322.

⁹ (1998) 71 SASR 321.

¹⁰ *Tai v Hatzistavrou* (Unreported, New South Wales Court of Appeal, 25 August 1999) (followed in *Giurelli v Girgis* (1980) 24 SASR 264; (1980) 86 LSJS 25). John Devereux, 'Tai v Hatzistavrou' (2001) 8 *Journal of Law and Medicine*, 377-378.