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Medico-legal issues

Rural Collaborative Practice Project

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Table of contents

Introduction	1
The purpose of this manual	1
The Australian legal system	2
Adverse events in Australian hospitals	3
Medico-legal claims in Australian hospitals	4
Other potential consequences of adverse events	5
The nurse as a professional	5
The law of negligence	8
Introduction	8
The elements of an action in negligence.....	8
The existence of a duty of care	8
The standard of care	9
Breach of duty.....	10
Injury and causation.....	11
Foreseeability.....	11
Damages.....	11
Negligence vs incompetence and culpability.....	11
Vicarious liability.....	13
Non-delegable duty of care	14
Applying the law of negligence to the Project	16
Will advancing my clinical practice increase my medico-legal risk?.....	16
How can I manage my medico-legal risk if I provide telephone advice to patients?.....	17
What do I do if I advise a patient to stay for observation, but they refuse?	18
Do I have a duty of care to a violent or aggressive patient?.....	19
Are GPs always obliged to respond to an emergency?.....	20
Am I always obliged to respond to an emergency, even if I don't feel confident?	21
Working as a team - what if I don't agree with the doctor's orders?	23
Working as a team - what if the doctor won't respond to a call for assistance?	25
Working as a team - who is liable for poor outcomes?.....	26
Working as a team - can I 'cover' myself by calling the doctor?	27
Working as a team - can I admit my own patients?.....	29
What is the status of guidelines and related documents?	30
What if the guidelines are wrong? Who will be liable?	33
How can I develop my skills safely?.....	35
Other risk management issues	36
Obtaining valid consent to treatment.....	36
Keeping accurate and contemporaneous records.....	38
Retaining medical records.....	40
Ensuring privacy and confidentiality	40
Credentiaing and defining scope of clinical practice	42
Open Disclosure.....	43
Incident reporting	44
Root cause analysis.....	45
Insurance for VMO services.....	46

Purchasing additional indemnity cover	47
Other consequences of adverse events	48
Complaints to the hospital or health service	48
Complaints to the Health Services Commissioner	48
Coronial Investigations	49
Health care professional regulatory bodies	51
<i>Health Professions Registration Act 2005</i>	51
Statutory obligations of health care professionals	52
Introduction	52
<i>Road Safety Act 1986</i>	52
<i>Health Act 1958</i>	52
<i>Children, Youth and Families Act 2005</i>	53
<i>Drugs, Poisons and Controlled Substances Act 1981</i>	53
<i>Drugs, Poisons and Controlled Substances Regulations 2006</i>	53
Conclusion	56

Introduction

Demands on rural health care professionals are increasing. Shortages of skilled registered nurses and General Practitioners ('GPs') in rural areas mean that health care professionals need to work together more effectively in order to provide sustainable high quality care for their communities.

The Rural Collaborative Practice Project ('the Project') has been established to test a new model of collaborative practice between GPs and registered nurses who provide emergency care in rural hospitals and health services. The Project involves introducing the Primary Clinical Care Manual ('PCCM') into selected hospitals and health services in rural Victoria. The PCCM has been developed and is maintained by the Queensland Government (Queensland Health) and contains guidelines for the management of patients with low acuity to high acuity presentations. Introduction of the PCCM will provide a basis for GPs and registered nurses who provide emergency care in rural hospitals and health services to support each other within a defined clinical framework.

Bass Coast Regional Health, Cann Valley Bush Nursing Centre, Mansfield District Hospital, Omeo District Health and Stawell Regional Health will be the first Victorian pilot sites for the implementation of the PCCM and the associated Rural and Isolated Practice Registered Nurse training program ('RIPRN'). All pilot sites are rural hospitals and health services that rely on local GPs to provide medical support to their emergency services.

The Project will facilitate introduction of a new model of emergency care that allows GPs and registered nurses working in rural areas to work collaboratively and flexibly and involves strategies to reduce the workload of on-call GPs and advance the clinical practice of registered nurses to support their management of emergency presentations.

The purpose of this manual

Some participants in the Project have raised questions about the medico-legal implications of advancing the clinical practice of registered nurses and of a more collaborative, team-based model of care. Some are concerned that their potential liability may be greater if things go wrong; others are unsure about who bears legal responsibility for the care of the patient; and all are interested in how medico-legal risk is best managed.

The provision of emergency care is known to be a relatively higher risk area of practice with respect to medico-legal claims, but it is neither clear nor inevitable that advancing the clinical practice of registered nurses who provide emergency care in rural hospitals and health services will result in a corresponding increase in their medico-legal risk.

The manual recognises that medico-legal risk is a reality for all health care professionals, but that if it is understood and managed well it can be controlled. Registered nurses who provide emergency care in rural hospitals and health services will be supported to provide care of an appropriate standard. The tools and supports provided through the Project to registered nurses and other health care professionals are designed to support safe practice and reduce medico-legal risk in rural emergency care. The provision of training (through RIPRN); clinical guidelines (through PCCM); and support for GPs, nurses, hospitals and health services to collaborate and agree on their roles and how they will manage emergency presentations all are expected to

assist significantly with the management of medico-legal risk. In particular, the skills-based application of clinical guidelines and improved documentation and communication which are supported by the Project are key risk management tools.

The manual outlines some of the legal issues that participants in the pilot programme have raised. It focuses primarily on the law of negligence and explains the elements of negligence, the ways in which health care professionals can be liable for negligent acts and the potential impact of a more collaborative model of care and/or of advancing the clinical practice of registered nurses in rural hospitals and health services.

The Australian legal system

The legal system in Australia is based on legislation and common law.

Legislation forms the framework of the law and exists in 2 forms:

- statutes, or Acts; these are made by Parliament, both at Commonwealth and State levels; and
- delegated or subordinate legislation, made under the Acts (i.e. regulations, rules); these are made by individuals or bodies authorised to do so by Parliament.

Legislation has supremacy over common law. There is a plethora of legislation which is relevant to health care professionals, some of which will be discussed in this manual.

Common law is essentially judge-made law (case law) and is used to interpret common legal principles as well as legislation. Case law creates a precedent in the law so findings of the court will be influenced by similar cases previously decided. The precedent effect of case law can cross different jurisdictions, so for example the finding in an English case may have bearing on a similar Australian case.

The law is fluid, and ever changing. Particularly in the field of medical law, where the law must keep pace with scientific and socio-political developments, new cases will always be presenting before the courts. Although it can be difficult to predict with any certainty what decision a court will make when faced with a novel situation, there are some common principles that apply to the law of negligence which, when understood, provide a sound basis for managing medico-legal risk.

Adverse events in Australian hospitals

In the Quality in Australian Health Care Study, an adverse event was defined as:

'An unintended injury or complication which results in disability, death or prolongation of hospital stay and is caused by health care management rather than the patient's disease'.¹

Modern health care is complex and risky and there is a known and significant incidence of adverse events. According to the former Australian Council for Safety and Quality in Health Care, the rate of adverse events in Australian hospitals is likely to be 10%, with the highest incidence of harm occurring as a result of medication errors, infections, transfusion of blood and blood products, patient falls and pressure ulcers.²

A proportion of patients die or suffer permanent serious injury as a result of adverse events in Australian hospitals and health services. The Australian health care system is focusing, increasingly, on detecting, investigating, managing and preventing reoccurrence of adverse events.

Most commentators recognise that even the best health care professionals can (and do) make mistakes:

"It is important to recognise that human error is inevitable for even the best-trained and best-qualified healthcare providers."³

The primary concern for most health care professionals when a patient is harmed is the personal consequences for the patient and their carers. Dealing with serious adverse events can be a very challenging issue for those who are committed to curing, not harming, patients. Increasingly, the health care system is recognising that health care professionals require significant personal and professional support at such times.

In recent years through initiatives such as Root Cause Analysis and Mortality and Morbidity Committees, hospitals and health services have become more transparent in their management of adverse events, allowing the circumstances of the event to be fully investigated and actions to be taken to stop similar events reoccurring in the future. This approach recognises the systems basis of clinical risk and is consistent with contemporary knowledge about the causes and prevention of adverse events. It is important that health care professionals participate in and cooperate with efforts to make our systems for the delivery of care safer.

¹ Wilson RM, Runciman WB, Gibberd RW, et al. The Quality in Australian Health Care Study. *Med J Aust* 1995; 163: 458-471

² Australian Council for Safety and Quality in Health Care. Adverse events rates fact sheet. Accessed on 9 September 2007 at [http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/6A2AB719D72945A4CA2571C5001E5610/\\$File/advrsefact.pdf](http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/6A2AB719D72945A4CA2571C5001E5610/$File/advrsefact.pdf)

³ Wilson RM, Harrison B, Gibberd RW, Hamilton JD. An analysis of the causes of adverse events from the Quality in Australian Health Care Study. *Med J Aust* 1999; 170: 411-415

Medico-legal claims in Australian hospitals

If a mistake occurs that results in significant harm or ongoing disability, a claim of negligence may be made (see the discussion on the law of negligence commencing on page 8 of this manual). It follows that all health care professionals, including those who are highly motivated and competent, may at some stage in their career face an allegation that they have been negligent.

The risk of a successful claim of negligence is not limited to high complexity care - errors leading to successful claims of negligence have been reported frequently in low complexity settings. For example, failing to properly supervise a patient who is assessed to be at risk of falling may have serious permanent consequences for the patient giving rise to a successful claim in negligence.

Nevertheless, the likelihood that an individual patient will claim damages as a consequence of an adverse health care event remains low in Australia.

Public sector medico-legal claims during 2004/05 across Australia showed the following patterns:⁴

- the three most frequently recorded clinical service contexts associated with medical indemnity claims were obstetrics (1,141 claims; 18% of all claims), accident and emergency (940 claims; 15%) and general surgery (721; 11%);
- obstetrics only (715 claims), emergency medicine (610 claims) and general surgery (489 claims) were the most commonly recorded specialties of clinicians involved in incidents that gave rise to claims. Nurses were the primary clinicians involved in 361 claims;
- data on primary incident/allegation type show that medical or surgical procedures (2,163 claims; 34% of all claims) were most commonly recorded in medical indemnity claims, followed by diagnosis (1,324; 21%) and treatment (947; 15%); and
- the majority of claims arose from events that occurred in major cities (4,407 claims; 68%); 1,930 claims (30%) arose from incidents that occurred in regional areas, and 91 claims (1.4%) arose from incidents that occurred in remote areas. This pattern most probably reflects the concentration of medical services in Australia in metropolitan areas.

Although traditionally the majority of claims of negligence have been directed against medical practitioners and/or hospitals, nurses are exposed to medico-legal risk. Nurses played the most prominent role in the events that gave rise to 361 of a total of 6,453 reported medico-legal incidents in Australian public hospitals in 2004-05 - approximately 6% of total incidents.⁵ They are, however, rarely named as defendants in litigation. It is usually a nurse's employer hospital or health service which is named as the defendant in an action in negligence.

⁴ AIHW (Australian Institute of Health and Welfare) 2006. Medical indemnity national data collection, public sector 2004–05. AIHW cat. no. HSE 42. Canberra: AIHW.

⁵ Incidents giving rise to actual or potential medico-legal claims.

Other potential consequences of adverse events

Apart from an action in negligence, there are several other avenues through which the management of a patient by a nurse may be scrutinised. The main ones are:

- complaints to the hospital or health service;
- complaints to the Health Services Commissioner;
- a Coroner's investigation; and
- an investigation by a health care professional regulatory body.

The following sections of this manual explore issues relevant to claims of negligence. Later in the manual, we present information about complaints processes, Coronial investigations and investigations by professional registration bodies such as the Nurses Board of Victoria. We also present information about risk management and statutory obligations of health care professionals.

The nurse as a professional

Registered nurses are professionals in their own right and always have carried individual responsibility for the consequences of the care they provide.

The Code of Ethics for Nurses in Australia, produced by the Australian Nursing and Midwifery Council, states as follows:

"As morally autonomous professionals, nurses are accountable for their clinical decision making and legal obligations for the provision of safe and competent nursing care."

It is part of the nurse's responsibility to recognise when a certain activity may be beyond his or her authorised practice or competency, and this in itself constitutes a professional judgment for which he or she is accountable, as is the decision as to who is the most appropriate person to call for assistance. This concept has been endorsed by the Nurses' Board of Victoria⁶.

The nurse's independent professional responsibility has been confirmed in various court cases. For example, in *John James Memorial Hospital Ltd v Keys* a doctor admitted a patient to hospital for the management of her sciatic pain. The possible side effects of the medication prescribed included confusion and drowsiness. The patient experienced two falls in the hospital when she attempted to mobilize without supervision. At trial the doctor was held liable for not informing the nurse, who had left the patient unattended, of the possible side effects of the medication. However, the Court of Appeal considered that the failure of the doctor to communicate this risk to the nurse was irrelevant as the patient's disorientation '*was a condition foreseeable by any trained person who had knowledge of [the plaintiff's] medication regime*'. Hence the nurse could not escape liability simply because she was not instructed adequately by

⁶ Guidelines: Scope of Nursing & Midwifery Practice. Nurses Board of Victoria.

the doctor, and the hospital was found to be vicariously liable (for an explanation of vicarious liability, see the discussion commencing on page 13 of this manual).⁷

A nurse is accountable for his or her practice, therefore, to the patient and to the hospital or health service. Just because a nurse calls a doctor or seeks the assistance of another person does not mean this accountability is diluted; to the contrary, a nurse's accountability encompasses any decision to call on a doctor, or any other member of the clinical team, for advice and/or assistance.

Similarly, the NSW Industrial Relations Court considered that a sole nurse practitioner, although employed by a health service and subject to its protocols and procedures, had a 'direct and personal responsibility' to follow the procedures expected of her, and that apart from not following the protocols, the nurse also 'failed to follow her own methodology'⁸. It was considered that the health service was entitled to 'rely on the expertise and competency' of the nurse and to expect that her duties would be attended to. As to the respective responsibilities of the nurse and the hospital in relation to the protocol, the Court said⁹:

'The applicant [nurse] and respondent [health service] were provided with copies of these protocols and each party understood that the Department's protocols were to be followed. It cannot be asserted that because the respondent failed to take time to draw the Department's protocols and clerical standards to the attention of the applicant that there was a failure on the part of the respondent, bearing in mind the level at which the applicant was employed to perform her duties.'

The Court rejected the nurse's argument that she could be excused for her failure to meet the appropriate standards because she was never counselled or warned about such standards by the health service. The Court noted that the nurse had been entrusted with the safety of her patients and that this trust had been betrayed; the standard of professional care provided by her was not the best that she could have provided. The Court went on to say¹⁰:

'The applicant [nurse] accepted that not only was she responsible for providing a clinical service which was absolutely fundamental to the health and well being of women who used that service, but she was responsible for providing such clinical service at an advanced level of nursing practice, [involving] an advanced level of knowledge, of initiative of responsibility.. and therefore of course accountability.'

In a recent investigation by the New Zealand Health and Disability Commissioner¹¹, it was found that while the nurses in question undertook a series of 'technical tasks' (e.g. taking

⁷ *John James Memorial Hospital Ltd v Keys* (1999) FCA 678

⁸ *Ison v Northern Rivers Area Health Service* 03/03/1997 IRCt (NSW) 44/97

⁹ *Ison v Northern Rivers Area Health Service* 03/03/1997 IRCt (NSW) 44/97

¹⁰ *Ison v Northern Rivers Area Health Service* 03/03/1997 IRCt (NSW) 44/97

¹¹ A Report by the Health and Disability Commissioner (Case 05HDC07285). New Zealand.

temperature), they did not apply any critical thinking¹², make any assessments of the patient's condition, or exercise any clinical decision-making, and they did not apply basic nursing skills in assessing the health of the patient. In this case, an elderly lady at a rest home sustained a skin tear which ultimately resulted in septicaemia and death; it was found that the nurses had failed in their assessment of the patient by not considering the possibility of infection earlier. It was considered that the nurses ought to have been aware that a normal temperature did not preclude infections in elderly patients, and that this was *'fundamental knowledge that would be reasonably expected of a registered nurse working with older adults'*, so that the nurses' failure to make any further assessment of the patient fell below professional standards.

It was considered that it is the responsibility of registered nurses working in an aged care facility to have the appropriate knowledge, education and skill relating to the care of older adults. It was said that registered nurses *'should apply a degree of critical thinking to any given situation'*. Good nursing practice was considered not to have been followed in that:

- the doctor was not called when the signs and symptoms warranted it;
- the notes from the previous shift were not read;
- there was poor documentation and documentation added after the patient was discharged; and
- the patient was not assessed in a way which would be expected of a registered nurse.

These cases demonstrate that registered nurses are expected to exercise their own judgment and their conduct is expected to meet the reasonable standard of a registered nurse. Registered nurses remain independently accountable for their actions and decisions.

¹² The Australian Nursing and Midwifery Council (ANMC) defines *Critical Thinking and Analysis* as follows: "Relates to self-appraisal, professional development and the value of evidence and research for practice. Reflecting on practice, feelings and beliefs and the consequences of these for individuals/groups is an important professional benchmark." See ANMC Registered Nurse Competency Standards (accessed on 11 November 2007 at http://www.anmc.org.au/docs/Competency_standards_RN.pdf).

The law of negligence

Introduction

The most common ground on which a health professional, hospital or health service might be sued via court proceedings is negligence. Negligence is a type of civil (as opposed to criminal) wrongdoing (i.e. a 'tort').

A person who is injured as a result of health care that he or she has received may be entitled to monetary compensation (damages) if it can be proven, on the balance of probabilities, that the health care professional who provided the care was negligent.

Before we examine issues of particular interest to participants in the Project, it will be helpful to review the basic principles of the law of negligence. We will then apply those principles to the specific circumstances of the Project.

The elements of an action in negligence

As noted above, adverse outcomes in health care are not uncommon. Even if a health care professional has made a mistake, it can be very difficult for a patient to establish that the professional has been negligent. All of the following elements of negligence need to be proven before damages can be awarded:

- 1 There was a duty of care owed by the health care professional to the person.
- 2 There was a breach of that duty of care.
- 3 There was an injury which was caused by the breach in the duty of care.
- 4 The injury was reasonably foreseeable as a result of the breach.

Proof on the balance of probabilities requires a patient to establish that in the circumstances it was more likely than not that negligence occurred. This is a lower standard of proof than applies in criminal cases, where the prosecution must prove the case beyond reasonable doubt.

The existence of a duty of care

A patient who has been harmed must establish that the health care professional owed them a duty of care. Whether a duty of care exists will in part depend on whether there is considered to have been an assumption of responsibility and/or the nature of the relationship between the parties.

In most cases involving health care provision, in particular those relevant to the Project, the existence of a duty will be obvious. For example, a nurse who is rostered to duty in an urgent care centre clearly owes a duty of care to a patient who presents to the centre requiring urgent attention.

There are instances, however, where it may not be clear whether a duty of care was owed, so the question becomes: what is the scope of the duty of care?

The circumstances in which the courts are willing to find that a duty of care exists are expanding. This is said to be in line with increasing consumer awareness and expectations,

technological advances, and trends in other jurisdictions. For instance, a doctor has been held to owe a duty of care to the partner of his patient, whom he had never seen, for failing to diagnose his patient's HIV infection and counsel his patient to be tested for the virus.¹³ Another doctor has been found to owe a duty of care to the parents of his patient who alleged that they incurred travel costs to obtain treatment for their daughter overseas as a result of the doctor not informing them of a clinical trial which was locally available.¹⁴

Later in this manual we will consider issues relevant to the Project such as the responsibility of a GP to provide telephone advice or attend a patient at the request of a nurse. Underpinning these issues are questions about the scope of the duty of care of the GP and of the nurse.

The standard of care

The duty owed to a patient by a health care professional is to exercise reasonable care. Falling below the expected standard of care amounts to a breach of duty. This duty extends to all the ways in which a health care professional is called upon to exercise his or her skill and judgment, and includes examination, diagnosis, treatment and provision of information and advice.

The standard of care in Victoria has now been defined in the *Wrongs Act 1958* so that a '*professional is not negligent in providing a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by a significant number of respected practitioners in the field (peer professional opinion) as competent professional practice in the circumstances*'.¹⁵ The standard expected is that of an ordinary skilled person exercising and professing to have that special skill.¹⁶ All other states (but not the Northern Territory) have similar statutory provisions.

If there are differing peer professional opinions which are widely accepted by a number of respected practitioners in the field, one or more of these opinions may be relied on; peer professional opinion does not have to be *universally* accepted to be considered widely accepted.

If reputable guidelines or standards exist that are relevant to a particular clinical situation, they are likely to be referred to by a court as evidence of the accepted standard of care. Guidelines cannot be followed blindly, however, and all clinicians remain accountable for their clinical judgement. The status of guidelines and related documents is explained in more detail later in this manual.

Health care professionals generally will be judged, therefore, against the standards of care accepted by their peers. 'Peer professional opinion' cannot be relied on, however, if the court determines that the opinion is unreasonable - it is expected that this would only occur in rare

¹³ *BT v Oei* [1999] NSWSC 1082

¹⁴ *McCann v Buck* [2001] WASCA 78

¹⁵ Section 59 *Wrongs Act 1958*

¹⁶ This means that a person '*need not possess the highest expert skill at the risk of being found negligent it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.*': *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 at 121

circumstances, for example when a court is satisfied that there is no logical basis to support a body of expert opinion.

Breach of duty

A breach of the duty of care occurs when there is a departure from the standard described above.

Some of the ways in which health care professionals have been found to breach their duty of care include:

- failing to treat (adequately or at all);
- failing to diagnose;
- failing to advise or warn a patient of material risks associated with treatment;
- not keeping up to date with the current state of knowledge;
- failing to refer to a specialist where appropriate;
- failing to adopt recognised precautions;
- failing to attend or examine;
- failing to diagnose a condition (where a reasonably competent practitioner would not have so failed);
- technical error in treatment;
- failure to communicate with other professionals; and
- poor delegation.

A court does not consider the motivation of the health care professional, in particular whether a health care professional did his or her best to take care, or acted according to his or her best judgment. The assessment of the standard of care is purely objective - was the care provided reasonable in the circumstances?

The health professional's conduct is measured against a reasonable health professional in respect of the specific task adopted, and not against his or her own specific level of competency or experience.¹⁷

A departure from common practice may provide evidence of negligence, but it is not conclusive of itself. The ultimate test is that of reasonableness, in the context of the circumstances.

¹⁷ *Wilsher v Essex Area Health Authority* [1986] All ER 801

Injury and causation

In order for negligence to be established, it must be shown that an injury occurred which resulted from the breach of duty. The injury may be physical or psychiatric harm or economic loss.

The basic test is whether, 'but for' the negligence, would the injury have occurred?; if the injury would have occurred anyway, liability will not be proven.

Foreseeability

The final essential element in negligence claim is that the injury or loss which was suffered was reasonably foreseeable, meaning that a reasonable person would have realised that it was possible the breach could result in that particular injury or loss.

Damages

The result of a successful negligence claim is that the injured person receives monetary compensation, called damages.

A person may recover damages to compensate for any financial loss resulting from the injury ('special damages'), but in order to recover damages for 'pain and suffering' ('general damages') the person must demonstrate that he or she has sustained a 'significant injury' within the meaning of the *Wrongs Act 1958*.

A person will have a 'significant injury' only if he or she can prove a physical injury which comprises at least 5% permanent impairment of the whole body where the injury is physical, or 10% permanent impairment of the whole body where the injury is psychiatric.¹⁸ A person cannot claim general damages for psychiatric injury, however, if it is secondary to a physical injury.¹⁹

If the person does not have a significant injury they will be confined to a claim for economic loss only, which generally will include past and future medical expenses, the cost of any services or equipment required, loss of earnings and earning capacity and the cost of attendant care.

Negligence vs incompetence and culpability

Negligence does not mean that a health care professional is incompetent or morally culpable.

The risk of adverse events in health care is well documented and it is widely accepted that even the most highly trained and competent health care professionals will make mistakes at times.

The challenge for hospitals and health services is to design their systems of care so that they do not depend solely for their safety on the ability of the health care professionals that they engage to perform perfectly, every time.

Mistakes will occur even within the best systems and some mistakes will lead to foreseeable harm to patients, exposing the health care professional and/or the hospital or health service to a

¹⁸ *Wrongs Act 1958*, section 28LB, 28LE, 28LF

¹⁹ *Wrongs Act 1958*, section 28LJ

claim of negligence. A finding of negligence merely means that in the particular circumstances, on the balance of probabilities, the act or omission of the health care professional departed from what was acceptable peer practice, or was considered by the court to be unreasonable practice.

Further, not every mistake will amount to negligence. There can be differences in professional opinion, and mistakes can be made even though a health care professional exercised their skill to the required standard.

Most cases are settled out of court. Less than 5% of cases proceed to judgment. Any payment made to a plaintiff to discontinue their case is usually made with a denial of liability. It is generally cheaper and less risky to dispose of a claim this way, since court hearings are costly, stressful and unpredictable. Simply because a case is settled in this matter does not mean that negligence is proved or admitted.

Negligence, therefore, is a legal concept that in almost all circumstances does not imply moral culpability. Only in extremely rare cases might a health care professional be found to be culpable, and that will be in circumstances where their behaviour amounted to recklessness. A health care professional in these circumstances may be found guilty of criminal or culpable negligence if it is proved beyond reasonable doubt (as opposed to the balance of probabilities, which is the usual test for negligence) that they acted with reckless indifference to the welfare of a person. A finding of criminal negligence implies moral culpability and must be distinguished from the tort of negligence, discussed above.

Finally, while accountability is key, it is a separate and distinct concept from culpability. Accountability means every health care professional must be able to take responsibility and explain and/or justify their actions. All health care professionals, at all levels, are professionally responsible for maintaining their competence and performance and limiting their scope of clinical practice accordingly.

It is important that health care professionals are provided with appropriate support so that they can practice safely. This should include the approval and implementation of policies, procedures and guidelines that clearly define the expectations and scope of duty of health care professionals, as provided for in the Project.

Vicarious liability

The law provides that an employer is vicariously liable for the conduct of an employee. That means that an employer is liable for the negligence of an employee.

The underlying principle of vicarious liability is that the hospital or health service, as an employer, will be liable for the conduct of its employee or servant if the conduct is within the employee's or servant's authority, whether it is in the form of an act which he or she is employed to perform or an act which is incidental to that employment.²⁰

This means that if a patient is treated negligently by a nurse or nurses at a hospital or health service, the patient need only sue the hospital or health service. There is nothing preventing the patient suing the nurse but it is rare for a patient to do so. Usually, a patient will sue the hospital/health service and it is the hospital/health service (or its insurer) which pays the damages award. If the patient sues the hospital/health service and/or the nurse individually, the nurse usually is entitled to insurance under the hospital's insurance policy. In Victoria, the Victorian Managed Insurance Authority ('VMIA') provides the insurance for all public hospitals and health services and the insurance policy specifically covers those clinicians who are employees of the public hospital or health service whilst treating the hospital's or health service's patients.

Not only are hospitals and health services vicariously liable for the conduct of their employed nurses, they are also vicariously liable for the conduct of their employed doctors.

A Visiting Medical Officer ('VMO') generally is an independent contractor rather than an employee of the hospital or health service. VMOs are engaged by the hospital or health service to provide medical services for public patients, usually with associated rights of private practice. This means that generally as a matter of law, a hospital or health service will not be vicariously liable for the acts and omissions of VMOs.²¹

The hospital or health service may, however, be liable under the principles of non-delegable duty of care (discussed below). Further, in practice, the treatment of *public* patients by VMOs is covered under the VMIA's Medical Insurance Policy, provided the treatment rendered was provided by the VMO to a public patient of the hospital/health service or was referred to the VMO from the emergency department for ongoing care following discharge from the hospital/health service. A VMO is also covered under this policy if he or she refers a patient, as a public patient, to the hospital's or health service's elective surgery waiting list.²²

²⁰ *Deatons Pty v Flew* (1949) 79 CLR 370, at p378 (Latham CJ)

²¹ Note that the title 'VMO' is not necessarily in itself conclusive and it is possible that a court may find, in the circumstances, that a hospital is vicariously liable for the acts and omissions of a VMO nevertheless. It has been said that *'the problem is to be solved by looking at the evidence in this case to ascertain what it is capable of showing as to the relationship between the hospital and the doctor, however they may be described. That evidence consists in the account of their activities within the hospital, their use of, and compliance with, hospital forms and routine, and the operation of by-laws'* *Albrighton v Royal Prince Alfred Hospital* [1980] 2NSWLR 542.

²² Clause 2, Medical Indemnity Insurance Policy, VMIA

Non-delegable duty of care

In some circumstances a hospital or health service will be found liable for the negligence of a nurse, doctor or other health care professional even though that nurse, doctor or other health care professional is not an employee of the hospital or health service. This arises in circumstances where the hospital or health service owes the patient a non-delegable duty of care. A non-delegable duty of care may arise in an emergency or an elective situation.

In the context of provision of care by a hospital or health service, a non-delegable duty of care is a legal duty of a hospital or health service owed directly to the patient which cannot be divested by delegation. In those circumstances, the hospital or health service will be liable for the breach of duty by any health care professional, whether or not they are an employee.

It is a duty which, because of the particular nature of the relationship between the hospital/health service and the patient, cannot be delegated to the health care professional who provides the care. The duty remains at all times with the hospital/health service.

It has been said by the courts that the scope of the non-delegable duty of care depends on the scope and nature of medical services which the hospital or health service has undertaken to supply. If a hospital or health service accepts a patient who approaches it, thereby undertaking to make available all the skills and devices which it is reasonably able to deploy, it is responsible for ensuring that treatment or advice is given with proper care, and this duty cannot be divested by delegation.²³

For example, a non-delegable duty of care was held to exist in *Albrighton v Royal Prince Alfred Hospital* so that the hospital was liable for the negligence of its honorary medical officers because the hospital in that case was regarded as undertaking to provide reasonable care for all the needs of the plaintiff, who had approached the hospital directly for treatment, and whom it had admitted. The court held that:

'Whatever legal duties were imposed upon those who treated, diagnosed or cared for her needs from time to time, there was an overriding and continuing duty upon the hospital as an organization'.²⁴

This means that a hospital or health service owes a non-delegable duty to ensure that the treatment which it undertakes to provide to a patient is performed with reasonable care.

A non-delegable duty of care may apply, therefore, when a patient approaches a hospital for emergency care and is treated by a doctor in a private capacity and a Medicare benefit is claimed for the treatment.

This non-delegable duty does not extend to treatment performed by a doctor who is not an employee of the hospital or health service, however, where the patient *directly approaches* that doctor and pays separately for his or her services, even though such treatment is performed at the hospital or health service. In this situation the hospital/health service merely provides facilities, nursing and other ancillary services and therefore is only liable if one of the facilities or services it provides is responsible for the injury.

²³ *Ellis v Wallsend District Hospital* (1989) NSWLR 553

²⁴ *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542

Therefore it is a question of fact as to whether the hospital or health service functions merely as a platform from which a health care professional treats a patient, or whether it functions as a place where a person in need of treatment goes to receive treatment. Only in the latter situation will the hospital or health service be found to have a non-delegable duty to the patient. Factors which may be taken into account to determine whether the treatment undertaken is within the scope of the hospital's or health service's non-delegable duty of care include the circumstances of the patient's admission, the arrangements (if any) regarding control by the hospital or health service of the doctor's work, matters of remuneration and the doctor's obligation to work.²⁵

Yet not every aspect of patient care will be considered to be associated with a non-delegable duty. For instance, it has been held that a surgeon, operating on a patient in a private capacity, did not owe that patient a non-delegable duty of care such that he was liable for the failure of theatre staff employed by the hospital to keep a proper count of sponges used in surgery.²⁶ Therefore while a non-delegable duty of care can be held to exist, the courts can still limit the scope of this duty.

As with any other duty of care, hospitals, health services and health care professionals can manage their risks where a non-delegable duty of care exists. Standard risk management approaches apply:

- work as a team;
- work within their approved scope of practice and in accordance with accepted professional standards;
- comply with clinical guidelines or protocols that are appropriate and applicable to the clinical situation;
- document comprehensively; and
- seek assistance when necessary.

²⁵ *John James Memorial Hospital Limited v Keys* (1999) FCA 678

²⁶ *Elliot v Bickerstaff* [1999] NSWCA 453

Applying the law of negligence to the Project

In this section we address various issues that have been raised by Project participants, applying the principles of negligence that have been explained in the previous section.

Will advancing my clinical practice increase my medico-legal risk?

Key points

Registered nurses who provide emergency care in rural hospitals and health services already assume a degree of medico-legal risk.

The actual medico-legal impact of advancing the clinical practice of registered nurses who provide emergency care in rural hospitals and health services may not be known with certainty for some years. It is possible but not inevitable that there will be some increase in medico-legal risk.

Medico-legal risks can be managed, however, and risk management needs to be practised actively. The tools and support provided through the Project will assist in the management of medico-legal risk in this situation.

Registered nurses who provide emergency care in Victorian rural hospitals and health services who work within their approved role and responsibilities will be fully insured for any damages that are awarded in the event of a successful action in negligence against them.

The Nurses Board of Victoria recognises that a nurse's clinical practice may include areas of practice that 'have not previously been within the realm of nursing or midwifery practice and have traditionally been the responsibility of other health professionals'.²⁷

The implementation of the PCCM means that registered nurses may assume greater clinical responsibility for the management of patients with acute or emergency presentations. They also will have access to tools and other supports to limit their medico-legal risk.

If a patient alleges negligence against a registered nurse who has provided emergency care in a rural hospital or health service and the case is heard in court, the court will consider professional opinion about what would be expected of an ordinary skilled registered nurse practising in that setting. For example, a court may well find that an ordinary skilled registered nurse working in a rural setting would be expected to have basic skills in assessment, resuscitation and stabilisation of patients.

It should be noted that in almost all circumstances nurses will be protected from any personal financial burden if a claim against them is successful - the financial burden of nurses' legal liability ultimately will be borne by the hospital or health service which employs them, under the principles of vicarious liability and non-delegable duty.

²⁷ *Guidelines: Scope of Nursing and Midwifery Practice*. Nurses Board of Victoria.

How can I manage my medico-legal risk if I provide telephone advice to patients?

Key points

The provision of telephone advice to patients is a very important service to communities in rural and remote areas. It is subject to the same principles of negligence as the provision of face-to-face advice.

Registered nurses should take care to ensure that they communicate well, understand the patient's symptoms, work within their approved role and responsibilities and in accordance with their training and experience and document the key aspects of the discussion and the advice that is provided.

The Project creates a good opportunity for registered nurses, general practitioners, hospitals and health services to work together to agree policies and protocols for the provision of telephone advice.

This issue relates to advice given by a health care professional over the telephone to a patient, in circumstances where he or she does not actually see the patient.

The provision of telephone advice to patients in rural and remote areas is a very important and valued service. It should be done competently, carefully and within a nurse's approved role and responsibilities.

A nurse providing emergency care in a rural area would be expected to provide such advice in accordance with the standard of an ordinary skilled registered nurse practising in that setting.

While it may be tempting to advise all patients to come to the hospital or health service as a risk management strategy (to 'cover' the nurse and protect him or her from medico-legal risk) this may not be in a patient's overall best interests.

The principles of negligence apply in this situation in the same way they apply to the provision of face-to-face advice. The courts have recognised that negligent and/or misleading advice and opinion can ground liability in negligence and that where the information giver ought to have known that the recipient of the information would rely on that information, there is a duty to take reasonable care that the information is correct.²⁸

A nurse providing emergency care in a rural setting should assume that a patient who seeks telephone advice is likely to rely on that advice. The fact that there is no formal triage process will not alter the duty of care that is owed to the patient and/or the other health care professional.

A registered nurse providing emergency care in a rural setting can limit their medico-legal risk in this situation by:

- ensuring that they are fully informed about the patient's condition;
- ensuring that they do not provide advice in areas in which they are not trained and/or experienced;

²⁸ *L Shaddock & Associates Pty Ltd v Parramatta City Council* [1981] 50 CLR 225

- following standard practice;
- documenting the key aspects of the conversation including the patient's symptoms, the patient's response to specific questions and the advice given;
- always advising the patient to seek further advice or present for review if their condition changes; and
- over time, working with their colleagues and the hospital or health service to review best practice and document policies and procedures for the provision of telephone advice.

What do I do if I advise a patient to stay for observation, but they refuse?

Key points

In most circumstances, a patient cannot be forced to stay against their will, but they need to be advised very clearly of the risks that they are assuming by refusing to stay.

Make all reasonable efforts to make it possible for patients to stay, and document the key points of the discussion with them about why it is important for them to stay.

Sometimes it is good practice to advise a patient to stay for observation or for review by another health care professional.

While generally a health care professional cannot force a patient to stay against his or her will (to do so would expose them to liability for false imprisonment), it has been held that a nurse was negligent for failing to advise a patient to remain at a hospital.²⁹ There are exceptions to the rule that a patient cannot be forced to stay to receive treatment. For instance, a mentally ill patient may be admitted as an involuntary patient under the *Mental Health Act 1986*. A medical practitioner should be consulted if this situation appears to apply. In addition, if a patient is considered to be incompetent, then their consent will be considered to not be withheld validly - the issue of consent and competence is discussed later in this manual.

If a competent patient refuses to stay, the risks of leaving against advice should be explained clearly and the nature of the advice and the patient's refusal should be documented in the medical record. The patient should be asked to sign the medical record confirming their refusal, but this cannot be enforced.

²⁹ *Wang v Sydney Area Health Service* [2000] NSWSC 515. The hospital was vicariously liable for the nurse's negligence. Even a medical receptionist has been held to owe a duty of care to a patient (e.g. in prioritising an appointment for a patient): *Alexander v Heise* [2001] NSWCA 422

Do I have a duty of care to a violent or aggressive patient?

Key points

Victoria's *Occupational Health and Safety Act 2004* requires employers to take reasonably practicable steps to maintain a safe environment for patients and staff in which patients can be offered treatment in accordance with the duty of care that is owed to them. If violence or aggression cannot be controlled so as to provide a safe working environment, however, the health service's duty to staff takes precedence over its duty of care for patients. The statutory duty of care is high and a breach leads to a potential penalty or conviction.

Health care professionals and health services must work together to develop strategies to prevent and manage the risk of occupational violence. The focus needs to be on proactively reducing risks at the source.

Violence against health care professionals is increasing in frequency and is a particular risk in the emergency setting. The *Occupational Health and Safety Act 2004* requires :

- an employer, so far as is reasonably practicable, to provide and maintain for its employees a working environment that is safe and without risks to health;
- that persons other than employees of the employer are not exposed to risks to their health or safety arising from the conduct of the undertaking of the employer;
- an employee, while at work, to:
 - take reasonable care for his or her own health and safety; and
 - take reasonable care for the health and safety of persons who may be affected by the employee's acts or omissions at a workplace; and
 - co-operate with his or her employer with respect to any action taken by the employer to comply with a requirement imposed by or under the Act or the regulations.

This means that health services have a non-delegable duty to take reasonable steps to provide a safe place and a safe process of work for everyone on site, including visitors, patients, sub-contractors and a sub-contractor's employees. This duty is not diminished by the duty of care that is owed to patients. In the New South Wales context, the Industrial Relations Commission has made the following statement:

"There can be no doubt that in a situation where the choices facing the defendant are physical intervention in order to ensure that a patient is restrained from hurting others and a risk to the health, welfare or safety of employees, if such steps are not taken, the absolute obligations imposed upon the defendant by s.15 of the Act, require that safety of employees be preferred.

No matter how dedicated to patient welfare a nurse or other employee might be, it is inconsistent with the requirements of the Act, that the defendant permit them to be subject to physical assault, or indeed repeated physical assault, by

patients who are not restrained from harming others. Employment on such a basis is not permitted by the Act."³⁰

Strategies to minimise occupational violence in the health care setting include improving environmental design; reducing risk through administrative controls (e.g. adoption of 'zero tolerance' policies); and training staff to identify and manage situations in which violence is likely to escalate. A safe place of work is paramount. Zero tolerance policies generally provide for the restraint of violent patients in uncontrolled circumstances and the refusal of non-emergency treatment where violence is unable to be managed effectively.

Health services must develop comprehensive policies and programs that balance the need to protect staff against the duty to provide health care to patients. They also need to be proactive and oversee implementation of those policies and programs so that all reasonably practicable steps are taken to reduce risks at the workplace.

Are GPs always obliged to respond to an emergency?

For example, would it be 'reasonable' to expect that a GP would know how to deliver a baby if a woman presented unexpectedly in second stage labour? Should GPs be expected at least to stabilise and to transfer the patient to a more appropriate level of service? What if the GP does not have appropriate insurance cover?

Key points

While the law is somewhat unclear, we believe that a GP who is approached in a professional context should respond to an emergency. A failure to respond could be found to be unreasonable in the circumstances and amount to a breach of the GP's duty of care.

The question of insurance cover is a serious one for the GP, but would not be considered by the courts in deciding whether or not the GP had been negligent in the circumstances.

It may be implied that by accepting a position or role at a hospital or health service a GP assumes a duty of care towards a person in need of emergency assistance.

Otherwise the traditional rule has been that a medical practitioner is entitled not to treat a person who seeks treatment (there is no duty to rescue). This rule was challenged, however, by the case of *Lowns v Woods*, in which it was found that in the circumstances of that case a GP did owe a duty to respond to a call to assist a person who was not his patient.³¹

We believe that a GP who is approached in a professional context should respond to an emergency and a failure to respond could be found to be unreasonable in the circumstances and amount to a breach of the GP's duty of care.³²

³⁰ WorkCover Authority of New South Wales (Inspector Pompili) v Central Sydney Area Health Service [2002] NSWIRComm 44 (18 March 2002) at paras 89 and 90.

³¹ *Lowns v Woods* (1996) Aust Torts reports 81-376

³² *Lowns v Woods* (1996) Aust Torts reports 81-376

The next question is what standard of care the GP would be judged against. The answer is: that of a reasonable GP. It would be reasonable to expect any trained GP to be able to stabilise and transfer a patient to a more appropriate level of service. Further, it would be reasonable to expect a GP to know how to deliver a baby and to perform other basic emergency procedures.

The issue of GPs not being indemnified for undertaking emergency procedures outside their usual scope of practice is a serious one and should be raised by GPs with their indemnity insurance providers. Most insurance policies for doctors cover this eventuality. Where a health care professional is employed by a public hospital or health service and is acting within their scope of employment, the principle of vicarious liability will apply and the employee health care professional will be fully indemnified for any damages that are awarded in the event of a successful action in negligence against them. The Rural General Practitioners Medical Indemnity Insurance Policy provided by the VMIA also does not exclude procedures. If a GP has alternative cover, then they will need to look at the coverage offered by their indemnity insurer.

It should also be noted that any person (including a health care professional) who provides assistance, advice or care to another person in relation to an emergency in which the person expects no money or financial award for providing the assistance, is not liable in any civil proceedings for any injury caused to the patient.³³

Am I always obliged to respond to an emergency, even if I don't feel confident?

Key points

Again, while the law is somewhat unclear, we believe that a hospital or health service (and the health care professionals employed by it) should respond to an emergency. A failure to respond could be found to be unreasonable in the circumstances and amount to a breach of the duty of care.

In circumstances where a patient presents to a hospital or health service, the law is not altogether clear as to whether the hospital/health service and/or clinicians at the hospital/health service can refuse to respond, even if emergency hours are limited.

While the English courts have recognised a duty to treat in an emergency ward³⁴ it is uncertain which way Australian courts will go. It has been suggested that, if a hospital *offers* emergency services, then this creates an expectation or reliance that these services will be provided such as to create a duty of care.³⁵ However, at the same time it has been recognised by the courts that any duty owed by a public authority, such as a hospital, is only a duty to give proper consideration as to whether to exercise that power, and not to actually exercise it.³⁶

³³ *Wrongs Act* 1958 Section 32B

³⁴ *Barnett v Chelsea and Kensington Hospital Management Committee* [1961] 1 QB 428 (QBD)

³⁵ Skene L. *Law & Medical Practice. Rights, Duties, Claims & Defences*. 2nd Edition 2004 at 73

³⁶ *Sutherland Shire Council v Heyman* (1985) 157 CLR 424 per Mason J

This is not a question that can be answered conclusively, as there have been no cases to point.³⁷

In any event, the confidence or specific capability of a clinician is not relevant to the standard of care they owe to the patient. An inexperienced clinician who undertakes a specific procedure will be held to the same standard of care as a competent clinician; it is the act, not the actor, which must meet the standard.³⁸ Inexperience is not a defence, so that the standard of care expected of a junior clinician is the same as that expected of a more experienced clinician: *'the law requires the trainee or learner to be judged by the same standard as his more experienced colleagues. If it did not, inexperience would frequently be urged as a defence for professional negligence'*.³⁹

If, however, a person is unsure of his or her capability and assistance is sought from someone more experienced, then that standard is met.⁴⁰

That is not to say that every health care professional is expected to be competent in all aspects of practice, but certain areas will be *'part of the standard array of skills and knowledge that the community is entitled to expect of every legally qualified [medical] practitioner'*.⁴¹ While it would be reasonable to consider basic resuscitation, stabilisation and transfer of patients to be part of the 'standard array of skills and knowledge' expected of a registered nurse providing emergency care in a rural hospital or health service, each case will be regarded in the context of the role adopted and the circumstances in which that role is played. It is not possible to define an exhaustive list of all skills that would be expected.

A registered nurse providing emergency care in a rural hospital or health service with limited resources and support would be judged, therefore, against the standard expected of a nurse practising in similar circumstances. Whether a particular skill ought to have been within the competency of that nurse will depend on the particular facts at hand. The nurse would not be expected to practise with the highest skill, but with the ordinary skill of an ordinary competent nurse in the context of rural emergency nursing.⁴²

³⁷ Skene L. *Law & Medical Practice. Rights, Duties, Claims & Defences*. 2nd Edition 2004 at 73

³⁸ *Wilsher v Essex Area Health Authority* [1986] 3 All ER 801

³⁹ *Wilsher v Essex Area Health Authority* [1986] 3 All ER 801 per Glidewell LJ. Although it has recently been suggested by the District Court in Western Australia that a standard of a doctor ought be measured against his or her qualifications or experience, a judgment in a District Court is not binding. Further, this view was based on the dissenting judgment on this point in *Wilsher*, and therefore does not follow the majority decision of the Court of Appeal in that case (which is binding): *Lawson v Minister of Health* [2005] WADC 105

⁴⁰ *Wilsher v Essex Area Health Authority* [1986] 3 All ER 801 per Glidewell LJ

⁴¹ *Krishna v Loustos* [2000] NSWCA 272

⁴² *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 at 121

Working as a team - what if I don't agree with the doctor's orders?

Key points

It is imperative to seek confirmation if an order does not seem appropriate.

Registered nurses have an independent duty of care. A registered nurse who followed an order that the nurse knew, or ought reasonably have known, was incorrect is likely to have breached the expected standard of care.

The care of the patient is the first priority. Health care professionals, hospitals and health services should work together to agree protocols to be followed in the event that there is a disagreement between health care professionals about the appropriate management of a patient.

If a clinician is unsure of, or does not agree, with the orders of another experienced clinician, it is imperative that they seek confirmation of the order.⁴³ A clinician should not allow professional barriers, the hierarchical relationship that often exists in hospitals and health services, or their own desire to appear knowledgeable and competent to prevent them from questioning orders.

The Medical Practitioners Board of Victoria found that the conduct of a junior doctor fell below a reasonable standard when she did not question an intravenous fluid order or clarify her uncertainty about the order with a more senior doctor.⁴⁴ The failure to question led to a neonate being hydrated with 50% dextrose instead of 5% dextrose, resulting in severe brain damage. The Board acknowledged that it would have been difficult for the young doctor to question or challenge a consultant or, to a lesser extent, a registrar regarding an order which she found unusual. However, it determined that:

'The public expects that junior and inexperienced doctors should realise that they must check instructions about which they are uncertain, otherwise a patient's care may be compromised.'

We consider that the same principle would apply to registered nurses who are uncertain about a doctor's orders. In the case discussed above, the nurses did question the order for 50% dextrose, but they questioned it of the junior doctor who confirmed the unusual order. Although outside of the scope of the Board's determination, no criticism was made of the nurses in this case.

The Code of Ethics for Nurses in Australia produced by the Australian Nursing and Midwifery Council, Value Statement number 5 is:

"Nurses fulfil the accountability and responsibility inherent in their roles."

The explanatory statements which accompany this value statement include the following:

⁴³ Medical Practitioners Board of Victoria re Dr Lea Lee Foo [2006] MPBV 15, Dr FGH [2006] MPBV 16, Dr CDE [2006] MPBV 17

⁴⁴ Medical Practitioners Board of Victoria re Dr Lea Lee Foo [2006] MPBV 15, Dr FGH [2006] MPBV 16, Dr CDE [2006] MPBV 17

“Nurses contribute with other health care providers in the provision of comprehensive health care, recognising and respecting the perspective and expertise of each team member.

Nurses have an ethical responsibility to report instances of unsafe and unethical practice. Nurses should support colleagues who appropriately and professionally notify instances of unsafe and unethical practice.”

Registered nurses have an ethical obligation, therefore, supported by the Nurses Board, to report their concerns if they do not agree with doctor’s orders.

If a nurse follows a doctor’s orders which clearly are unreasonable, then the nurse could be liable for the consequences.

Working as a team - what if the doctor won't respond to a call for assistance?

Key points

Doctors place themselves at medico-legal risk if they fail to respond to a reasonable request for assistance.

The nurse should pursue all reasonable efforts to convey the patient's need to the doctor; document the facts; care for the patient to the best of his or her ability and seek to make alternative arrangements for the patient.

The Project is intended to reduce unnecessary calls to GPs, but its success will depend on the team developing trust and confidence in the willingness of team members to respond to legitimate calls for assistance. The Project provides an opportunity for teams to discuss these issues in advance of emergency situations, and agree on a protocol to manage differences.

Presumably, the doctor will have a contractual obligation to the hospital or health service to respond to a nurse's call for assistance. In addition, if he or she does not respond and as a consequence the patient is harmed, then he or she may be found to be negligent.

In one case an obstetrician was found to have breached her duty of care to her private patient by failing to attend when notified of signs of foetal distress by the nurse.⁴⁵ In another case a doctor who was called by a nurse in relation to a patient who presented to the emergency department was found to be negligent for not coming in to see the patient, although it was accepted in this case that there are circumstances when a doctor need not be called for example if the patient '*has a small cut which the nurse can perfectly well dress herself*'.⁴⁶

What should a nurse do if the doctor refuses to come in, despite having been requested to do so? If a nurse believes that the doctor ought come in, and the nurse has explained all the facts, conveyed his or her observations, and the reasons why he or she believes the doctor should come in, and the doctor still refuses to do so, then this should be documented carefully in the notes, including all the information provided by the nurse to the doctor and the advice of the doctor. The nurse should then proceed to manage the patient to the best of his or her own abilities and explore other alternatives, such as calling another doctor, transferring the patient to another facility, contacting a regional health service for assistance or calling '000'.

It is recommended that hospitals/health services and relevant health care professionals agree and implement protocols to address situations where there is a disagreement about patient management between clinical staff. Such protocols could include seeking a second opinion or reporting the disagreement to the Director of Medical Services. They could also consider what to do in the case of an emergency, and who to appoint as a team leader. In cases where a patient requires urgent assistance, a quick dispute resolutions system is essential.

⁴⁵ *Ballard v Cox* [2006] NSWSC 252

⁴⁶ *Barnett v Chelsea and Kensington Hospital Management Committee* [1968] 1 All ER 1068

Hospitals and health services also should consider putting into place mechanisms by which health care professionals are able to report their concerns regarding the professional conduct of their colleagues, so that issues can be resolved constructively.

Working as a team - who is liable for poor outcomes?

Key points

Both the GP and the nurse will be judged according to the principles of negligence - did they owe the patient a duty of care; did they provide a reasonable standard of care including through the GP's decision to delegate responsibility for the care; if not, did foreseeable harm ensue?

Case study

'A patient presents with a lower limb injury that meets the Ottawa criteria and fits our guidelines as agreed to by our GPs for an x-ray. The GP is notified of this (in accordance with the hospital's protocol and in particular to comply with Medicare requirements). The x-ray shows a small fracture which is stable and in alignment. The GP sees the x-ray on his computer in rooms or at home. He advises that the nurse can apply a plaster. In six weeks time when the plaster is removed it is discovered that the patient has a contracture due to incorrect application of plaster. Who is responsible or accountable in this situation?'

The medical practitioner may be in breach of his or her duty of care if it was unreasonable to delegate the task to the particular nurse (if he or she lacked experience or competence) or if the plaster or procedure which he or she instructed the nurse to perform was inappropriate

The Medical Practitioners Board of Victoria made a finding of unprofessional conduct against a medical practitioner who had not supervised treatments administered by a nurse, in particular for failing to take any or adequate steps to ensure those treatments were appropriate in the circumstances, to ensure that the treatments were being properly and/or appropriately administered by the nurse and to monitor the nurse's performance of treatments adequately or at all.⁴⁷

In another case in which the Medical Practitioner's Board of Victoria considered whether a medical practitioner had inappropriately delegated a task to a more junior doctor, the Board gave consideration to the matters to be taken into account when delegating a task to another. These included⁴⁸:

- the task to be delegated;
- the relevant experience of the delegator and the delegate;

⁴⁷ Medical Practitioners Board of Victoria re Dr Warwick Lorne Greville [2004] MPBV 2

⁴⁸ Medical Practitioners Board of Victoria re Dr DDD [2002] MPBV 24

- the knowledge of the delegator of the delegate's experience and competence and ability to perform the task;
- the willingness of the delegate to perform the task;
- measures for the delegate to consult with the delegator in relation to any follow-up procedures or concerns;
- the other options open to the delegator, e.g. whether to perform the function him or herself or to seek another person to whom to delegate the task; and
- the precise circumstances of each party, e.g. whether one of them was at the end of a long shift, tired or under pressure.

If the delegation is deemed appropriate, the negligence will be regarded to be that of the nurse and the hospital or health service will be vicariously liable.

Working as a team - can I 'cover' myself by calling the doctor?

Key points

To date, case law suggests that it is unlikely a nurse will be held negligent if he or she acts on the advice of a doctor, even if that advice turns out to be negligent.

It is arguable, however, that the scope of the nurse's duty these days is greater than in traditional roles. In modern day circumstances, courts may be more reluctant to consider that a nurse is exonerated merely by calling a doctor.

In addition, professionalism requires that registered nurses assume appropriate responsibility and accountability for clinical decisions within a reasonable scope of nursing practice. Appropriate assumption of responsibility goes to the heart of professionalism. The key to the success of the Project, and to the management of medico-legal risk, is to ensure that referrals are made when clinically appropriate rather than simply for medico-legal risk management purposes.

Registered nurses are expected to exercise their own judgment and their conduct is expected to meet the reasonable standard of a nurse. Registered nurses remain independently accountable for their actions and decisions.

There is no obligation to call a doctor if, on the facts on the case, it was reasonable to decide not to.⁴⁹ If the situation is within the competence of the nurse then it is appropriate that the nurse assumes responsibility for the decision, which may be made in his or her own professional judgment, so that it is not always necessary to call a doctor.⁵⁰

If, however, circumstances are such that a doctor ought to have been called but was not, a nurse could be found to be liable. For instance in the case of an at-risk labour, a nurse was

⁴⁹ *Alexander v Heise* [2001] NSWCA 422

⁵⁰ *Fiek v Nurses Board of Victoria (Occupational and Business Regulation)* [2006] VCAT 1968

found to be in breach of her duty for not calling the doctor when there were continuing signs of foetal distress (the hospital was vicariously liable).⁵¹

In some circumstances a nurse might be considered to have discharged his or her duty by calling upon a doctor.⁵² To date, case law suggests that it is unlikely a nurse will be held negligent if he or she acts on the advice of a doctor, even if that advice turns out to be negligent. In an old English case, a nurse called the on-call doctor from the emergency department, who refused to come in but instead instructed the nurse to advise the patient to see his own doctor. The patient subsequently died and the doctor was held to be liable, but the nurse was considered to have discharged her duty calling the doctor.⁵³

It is arguable, however, that the scope of the nurse's duty these days is greater than in traditional roles. In modern circumstances, courts may be more reluctant to consider that a nurse is exonerated merely by calling a doctor.

A nurse is expected to exercise his or her own critical thinking and judgment at all times, and a telephone call to a doctor may not necessarily 'dilute' a nurse's duty. For example, if the instructions provided by a medical officer are so unreasonable that no reasonable nurse would have followed them unquestioningly, or if the nurse misconstrued those instructions, then a nurse would not be protected from liability by simply acting on the advice of a medical officer.

A nurse who contacts a doctor for advice also has a responsibility to assess the clinical situation competently and advise the doctor accordingly. Failure to undertake a reasonable assessment and/or to advise the doctor of relevant clinical issues discovered during that assessment may constitute a breach of the expected standard of care.

Even if a nurse acts on 'doctors orders', he or she has an independent duty of care to the patient. If registered nurses assume certain responsibilities, they need to ensure that they have adequate skills and experience. The Nurses Board of Victoria confirms that nurses are *'expected to function within the limits of their education and competence and to consult or refer where necessary.'*⁵⁴

The key to the success of the Project, and to the management of medico-legal risk, is to ensure that referrals are made when they are clinically appropriate rather than simply for medico-legal risk management purposes. If an activity is beyond the scope of training or competence of a nurse, he or she is responsible for initiating a consultation with, or referral to, other members of the team such as a medical officer. If, however, a nurse is confident to undertake activities which are within his or her approved role and responsibilities, he or she should feel empowered and supported to do so without unnecessary referrals. The adoption of the team approach in itself should reduce the risk of adverse events. It is said that *'[j]udgements are made in a*

⁵¹ *Ballard v Cox* [2006] NSWSC 252

⁵² *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 All ER 1068

⁵³ *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 All ER 1068

⁵⁴ *Guidelines: Scope of Nursing & Midwifery Practice*. Nurses Board of Victoria.

collaborative way, through consultation and negotiation with other members of the health care team'.⁵⁵

Good risk management requires careful documentation of the facts that are conveyed in such conversations and the advice that is provided.

Working as a team - can I admit my own patients?

Key points

Traditionally, patients have been admitted to public hospitals and health services under the care of medical practitioners rather than registered nurses. While the Department of Human Services has an administrative requirement for patients to be admitted under the authority of a medical practitioner, there does not appear to be a legal basis for such a requirement. Short stay units would be an appropriate means by which patients can be monitored and observed overnight without requiring a formal admission by a medical practitioner.

The view that registered nurses cannot admit patients stems from the data reporting requirements of all hospitals and health services to the Department of Human Services ('DHS'). It does not appear to be a specific legal requirement.

For admissions to be reported accurately to the DHS, they must be authorised by a medical practitioner.

If the main concern is being able to keep a patient under observation overnight in circumstances where the nurse is neither comfortable to send the patient home nor to call the doctor, the solution may be, as already practiced in some hospitals and health services, to create a short stay unit within or adjacent to emergency department and to apply short stay observation unit pathways.

Short stay units 'are designated areas, commonly located adjacent to emergency departments, that accommodate patients who require a brief period of observation or therapy. They have been developed as an extension of emergency services, providing continued patient management to better define diagnoses, and to reduce costs and inappropriate admissions and discharges. The ultimate goal is to improve the quality of medical care through extended observation and treatment, while reducing inappropriate admissions and healthcare costs.'⁵⁶

Short stay units would be an appropriate means by which patients can be monitored and observed overnight without requiring a formal admission by a doctor.

⁵⁵ *Guidelines: Scope of Nursing & Midwifery Practice.* Nurses Board of Victoria.

⁵⁶ Daly S et al. Short-stay units and observation medicine: a systematic review. *MJA* 2003; 178 (11): 559-563

What is the status of guidelines and related documents?

Key points

Clinical guidelines may be good evidence of the accepted standard of care - a failure to comply with guidelines in relevant circumstances, without a good reason, with resulting harm to the patient may expose a health care professional to an action in negligence.

On the other hand, guidelines cannot be followed blindly. All clinicians remain accountable for their clinical judgement.

The PCCM is a comprehensive manual of primary care guidelines which forms the basis for the Project. These guidelines provide significant decision-making support for registered nurses and doctors participating in the Project.

As with professional codes, up-to-date clinical guidelines may provide persuasive evidence as to whether reasonable care was exercised, by reflecting common and accepted practice, particularly if they are evidence-based and reflect a consensus view of experts as to the proper standards which should be followed.

The Nurses Board and the National Health and Medical Research Council have both endorsed the role of guidelines and policies to support staff.^{57 58} The desirability of protocols has been endorsed in certain medical matters, particularly in emergency situations,⁵⁹ for example:

- the Medical Board imposed a requirement on a doctor to produce written guidelines, amongst other things, for delegation of treatments to, and supervision of treatments by, nursing staff.⁶⁰
- a triage nurse was found not to have breached her duty of care in categorising a patient according to 'Mental Health Triage Guidelines for Emergency Departments', endorsed by an expert. It was considered that the presentation of the patient was in accordance with the guidelines, as was his categorization.⁶¹
- two nurses were found to be negligent for making an incorrect count of the sponges used in surgery, such that a surgical sponge was left inside the patient's body. It was established in evidence that there were well recognised guidelines which were to be followed in all operating theatres ('ACORN' standard for counting of sponges, swabs, instruments and needles). The hospital had adopted these guidelines and adequately instructed its staff in relation to them, so it was suggested at trial that the hospital was not negligent in this regard. The nurses were found to have been negligent, however,

⁵⁷ *Guidelines: Scope of Nursing & Midwifery Practice*. Nurses Board of Victoria.

⁵⁸ NHMRC. *A guide to development, implementation and evaluation of clinical practice guidelines*. Endorsed 16 November 1998.

⁵⁹ *Vissenga v Medical Practitioners Board of Victoria* [2005] VCAT 1044

⁶⁰ *Medical Practitioners Board of Victoria re Dr Warwick Lorne Greville* [2004] MPBV 2

⁶¹ *Warner v State of Queensland* [2006] NSWSC 593

for not following the guidelines, which the court accepted as a standard of what ought to have been done.⁶²

- a sole nurse practitioner, who had not followed protocols, alleged her employment was unlawfully terminated. The Industrial Relations Court accepted that the protocols ought to have been followed by the nurse, and that as a sole practitioner it was expected that she 'would be capable of applying all relevant regulations and requirements pertaining to the particular profession'.⁶³ This formed an important part of the basis for the Court's decision that the nurse's employment had not been terminated unlawfully.

It is important to remember, however, that:

- while guidelines can provide evidence as to what constitutes reasonable practice, they cannot replace expert evidence;
- a finding of negligence is not precluded merely because a medical practitioner acts in 'accordance with the usual and customary practices'.⁶⁴ Ultimately the court will decide what was a reasonable standard of care; and
- guidelines may be departed from if there is an alternative method supported by expert opinion.⁶⁵ It may in fact be reasonable in the circumstances for a clinician to depart from guidelines, for instance, if the guidelines were known to be out-of-date, or if an alternate treatment was considered appropriate for that particular patient.⁶⁶

Guidelines are not to be used without discretion, since *'the exercise of professional responsibilities requires independent judgements to be made and each practitioner is responsible for his/her own actions'*.⁶⁷ In one case where emergency circumstances called for a doctor to order that a protocol be followed, which consequently resulted in treatment which was not appropriate in the particular patient (even though the pre-requisites of the protocol existed) a doctor was found to be guilty of unprofessional conduct before the Medical Board. This finding was reversed by the Victorian Civil and Administrative Tribunal ('VCAT'), however, although VCAT acknowledged that the doctor made an error of judgement in directing that the protocol be followed (and considered that he at least should have made an appropriate alteration to the protocol). VCAT took into account in reversing the Board's finding the fact that the circumstances were stressful and required a prompt decision; there was a clear perception

⁶² *Langley v Gladore Pty Ltd (In Liquidation)* (1997) Aust Tort reports 81-448

⁶³ *Ison v Northern Rivers Area Health Service* 03/03/1997 IRCt (NSW) 44/97

⁶⁴ *Albrighton v Royal Prince Alfred Hospital* [1980]2 NSWLR 542

⁶⁵ *Vernon v Bloomsbury Health Authority* [1995] 6 Med LR. In this case the Court endorsed expert opinion that to prescribe doses of gentamicin was proper, and not negligent, even though it was higher than those recommended by manufacturers, which were considered to be conservative and erring on the side of caution.

⁶⁶ *Cranley v Medical Board of Western Australia* (Sup Ct WA) [1992] 3 MLR 94-113

⁶⁷ *Vissenga v Medical Practitioners Board of Victoria* [2004] VCAT 1044

that it was not desirable to depart from the protocol; it was desirable to have a protocol in anticipated emergency situations; and it was desirable that protocols should generally be followed in those anticipated emergency situations.⁶⁸

A clinician who departs from guidelines and demonstrates a lack of understanding of the principles may be held liable. In another case before the Medical Practitioners Board, a doctor who departed from antibiotic guidelines was thought to have shown 'a fundamental lack of understanding of basic pharmacokinetics and antimicrobial principles' and was found to have engaged in unprofessional conduct. A condition was consequently imposed on him that he not use antibiotics other than with strict adherence to the current edition of the Antibiotic Guidelines.⁶⁹

Therefore, whether it was reasonable to follow guidelines, or in the alternative to depart from them, and ultimately whether a clinician acted reasonably, i.e. in accordance with peer professional opinion, will depend on the facts of each individual case. Guidelines generally should be flexible and clinicians are required to use their discretion when applying them to individual care. They should be updated regularly and contain a statement making clear that they are not mandatory or prescriptive regardless of the circumstances.

Hospital and health service staff should be reminded that guidelines/protocols/policies do not abrogate their responsibility to apply clinical judgment, but that a decision to deviate from a guideline that details current accepted good practice must be justifiable and may be subject to scrutiny by the courts.

A clinical guideline, protocol or standing order that provides for a clinical intervention in specific circumstances should never be so prescriptive as to disallow any clinical discretion in appropriate circumstances. Hospitals and health services should review their clinical guidelines, in conjunction with their health care professionals, to ensure that they provide for flexible application in appropriate circumstances.

The PCCM is anticipated to be a very useful resource for registered nurses who provide emergency care in rural hospitals and health services. As with all guidelines, however, it will benefit from continuous monitoring of its adequacy and currency. If health care professionals participating in the Project conclude that the PCCM does not apply in a particular circumstance, they should document fully the reasons for their conclusions. In addition, they should undertake peer-based review of, and provide feedback through the Project about, all situations in which the clinical guidelines are deviated from or appear to be inappropriate. The focus should be on whether deviation from the guidelines was appropriate in the circumstances and/or whether revision of the guidelines to take account of emerging circumstances needs to be considered.

It also should be noted that if drug therapy protocols (e.g. Standing Orders or Health Management Protocols) in the PCCM are used as the authority for administering a drug, they must be followed without deviation.

⁶⁸ *Vissenga v Medical Practitioners Board of Victoria* [2005] VCAT 1044

⁶⁹ *Medical Practitioners Board of Victoria re Nicholas Sevdalis* [2001] MPBV 15

What if the guidelines are wrong? Who will be liable?

Key points

A clinician cannot rely on incorrect guidelines as a defence to an inadequate standard of care.

Hospitals, health services and clinicians should work collaboratively to ensure guidelines are current, comprehensive and practical in their application. The effectiveness of guidelines should be monitored and evaluated.

If a clinician follows clinical guidelines which are inaccurate, liability is likely ultimately to lie with the clinician because guidelines cannot be used without discretion; indeed it has been held that it is not a defence that clinical judgment was marred by guidelines.⁷⁰

In an American decision⁷¹ it was alleged that a policy was applied in a manner which affected the exercise of a doctor's medical judgment who, against this judgment, applied the policy in discharging a patient earlier than he otherwise would have done. The court decided that it was the doctor who made the decision that the plaintiff ought to be discharged, and the maker of the policy did not override the doctor's judgment; indeed it had been given no opportunity to do so. It was held, therefore, that there could be no cause of action against the maker of the policy.

Whether or not the author of guidelines would be liable depends on whether a duty of care is owed to the clinician who relies on them, and whether it was reasonable for the clinician to rely on them in the circumstances. If so, a clinician may be entitled to contribution from the author of the guidelines.

Normally, the general distribution of information does not incur liability as a duty cannot be owed to the world at large. However, if hospital/health service protocols and procedures are produced with the intention and knowledge that health care professionals will rely on them, and these guidelines are being implemented specifically, the hospital/health service almost certainly will be deemed to owe a duty of care, although there are no specific cases on point.

In a commercial context, it has been held that if the author of a statement which may be in general circulation knows that the statement would be communicated to an identifiable class of people who would rely on it, particularly *'in connection with a particular transaction for the purpose of deciding whether to enter into that transaction'*, then there may be a duty of care owed by the author of the statement.⁷² By analogy, a hospital or health service, in producing protocols and policies specifically for its staff, and in circulating the PCCM, is doing so with the knowledge and intention that its staff will rely on them, particularly if staff members are being instructed specifically to rely on them.

⁷⁰ *Wickline v State* 228 Cal Rptr 661 (Cal. App. 2 Dist 1986)

⁷¹ *Wickline v State* 228 Cal Rptr 661 (Cal. App. 2 Dist 1986)

⁷² *Caparo Industries v Dickman* [1990] 1 All ER 568

In the American decision discussed above⁷³, the Court noted that the author of a policy could be held accountable 'when medically inappropriate decisions result from defects in the design or implementation' of the policy. It also said, however, that that 'the physician who complies without protest' with the policy, 'when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care.' The Court said that the medical practitioner could not use the maker of the policy as a scapegoat.

A clinician cannot abdicate from his or her duty of care by relying on guidelines, therefore, and it will be no defence to an action in negligence to say that he or she relied on them. Whether a clinician ought to have known that policies were not current is not as relevant as whether he or she applied the policies with discretion.

In a recent decision by the Health and Disability Commissioner in New Zealand a rest home (where the nurses looked after the patient), was considered to have lacked clinical leadership and mechanisms for monitoring the clinical policies and procedures and quality systems. It failed to have in place a formal education programme for staff and failed to have appropriate clinical monitoring and supervision of the quality management system.⁷⁴ It was considered that while the rest home had a quality plan, there were few mechanisms in place to ensure the plan materialised into action.

Institutions have a responsibility to ensure proper mechanisms are in place to implement guidelines and monitor their effectiveness.

⁷³ *Wickline v State* 228 Cal Rptr 661 (Cal. App. 2 Dist 1986)

⁷⁴ A Report by the Health and Disability Commissioner (Case 05HDC07285). New Zealand.

How can I develop my skills safely?

Key points

The principles of negligence apply to registered nurses who are learning new skills within the scope of their employment.

A registered nurse should not attempt a procedure or health care intervention without supervision unless he or she has developed the necessary competence through theoretical and practical application and is authorised by the hospital or health service to work within an appropriate scope of practice.

Hospitals and health services have a responsibility to implement effective training programs and processes for credentialling and defining the scope of registered nurses' clinical practice.

Student nurses will be indemnified by the hospital's or health service's insurer provided that they are 'a student and/or practitioner of a University, College of Advanced Education or like institution appointed to a health service or organisation' insured by the Victorian Managed Insurance Authority and whilst providing health care services to patients of such health service or organisation.⁷⁵

Under the policy of insurance, however, it is the obligation of the hospital to exercise reasonable care to ensure that trainee nurses only act under the supervision of suitably experienced and registered nurses.⁷⁶

Employee nurses working within the scope of their employment also will be indemnified under the hospital's or health service's policy of insurance. Those nurses will be learning continuously and from time to time there will be opportunities to advance their clinical practice through the introduction of new procedures and other interventions.

Hospitals and health services should ensure that adequate training and supervision, by appropriately experienced health care professionals, are provided to registered nurses who are learning new procedures or health care interventions. In addition, they should ensure that they have comprehensive policies and procedures for credentialling and defining the scope of clinical practice of all clinicians, so that there are defined pathways via which health care professionals can acquire and safely apply new skills.

⁷⁵ Clause 5, Medical Indemnity Insurance Policy, VMIA

⁷⁶ Clause 4.5.4, Medical Indemnity Insurance Policy, VMIA

Other risk management issues

Obtaining valid consent to treatment

Underlying the requirement of consent to health care treatment is the paramount consideration that a person has the right to make decisions about his or her life.

Consent essentially makes an unlawful act lawful. If there is no consent at all, then any treatment, or in theory any kind of touching of a patient at all, will amount to a trespass. Informing the patient in 'broad terms' of the procedure will avoid liability in trespass.⁷⁷

Failure to gain a valid consent to health care also can result in an action in negligence. In the past two decades, many successful actions in negligence have been grounded in a failure to warn patients about the material risks of procedures.

If a patient consents, but says later that they were not fully informed of the risks of the procedure (and had they been so informed they would not have had the procedure), then the relevant health care professional could be liable in negligence. A breach of the duty to inform will be considered to have occurred only if the person was not informed of the 'material risks' of the procedure, i.e. those risks to which a reasonable person in the patient's position would be likely to attach significance, or a risk to which the medical practitioner is or should be reasonably aware that that *particular* patient, if warned of that risk, would be likely to attach significance.⁷⁸

Consent must be relevant (i.e. it must cover the procedure undertaken) and it must be free and voluntary. It is imperative, when obtaining consent, that the person from whom consent is being taken is competent, otherwise the consent may not be considered to be valid.

Consent may be express or implied. Signing a consent form for a procedure is an example of express consent for that procedure. Attending a doctor for a check up will represent implied consent to a medical examination. An admission to a hospital or health service does not, however, necessarily constitute implied consent to treatment.

Consent may be oral or written. It is important, however, to be aware that consent forms are not conclusive evidence that the patient consented, although their role is important in providing evidence that the consent process was undertaken. The consent form will not be adequate if a patient signs it without being adequately informed.

Consent can be withdrawn at any time.

There are some circumstances in which consent need not necessarily be obtained, for example in an emergency where the patient is not competent to consent and there is no person available who can consent on his or her behalf.

⁷⁷ *Rogers v Whitaker* (1992) 109 ALR 625

⁷⁸ *Rogers v Whitaker* (1992) 109 ALR 625

If a patient is incompetent, he or she lacks the capacity to understand the general nature and effect of the proposed procedure or treatment or of communicating the consent or refusal. Competency may fluctuate, and may be affected by drugs or pain. Psychiatric illness does not necessarily mean a person is incompetent. Each person must be assessed individually and there always should be a presumption of competence. The assessment of competence can be conducted by a registered nurse or a GP. If a nurse is unsure about a patient's competence, it would be reasonable to seek a second opinion if time permits. The nature of the assessment undertaken and the reasons for a conclusion of incompetence should be documented thoroughly.

In the case of emergencies, there must be a serious and imminent threat to life or physical or mental health, requiring immediate treatment, for treatment to be lawfully undertaken without consent. If a person previously has refused specific treatment when he or she was competent, the emergency exception may not apply. An example is a Jehovah's Witness who has clearly expressed his or her wish not to have a blood transfusion. The previous refusal, however, must cover the circumstances at hand.

In the case of children, consent to treatment should be obtained from a parent or guardian. If parents refuse treatment for a child which a health care professional considers to be in the child's best interests, an application may be made to the Court who can authorise a procedure to be undertaken, despite the parents' refusal. It is not necessary to apply for a Court order in the case of blood transfusions, however, which under the *Human Tissue Act* 1982 can be administered to a child even if the parents refuse consent, if the risk to the child is life-threatening.⁷⁹

Older children who have not yet reached the age of 18 may be able to consent if they demonstrate sufficient maturity and have 'sufficient understanding and intelligence to understand fully what is proposed'.⁸⁰ Generally, children 16 years and over demonstrate such a capacity. Whether a young person's consent is acceptable also depends on the type of procedure in question.⁸¹ A health care professional's legal position will be strengthened if parental consent also is obtained in these circumstances, but a mature minor also has a right to confidentiality and privacy which can preclude discussing the issues with the young person's parents.

Parental consent may override a young person's refusal of treatment.⁸²

The key thing to remember is that obtaining consent is a process, and not just a piece of paper. It requires an open and frank discussion between the health care professional and the patient, ensuring the patient understands and is informed of matters which would be of significance to him or her. There are no rules, and every process must be tailored to the individual patient. The patient must be given the opportunity to ask questions and, if possible, time to consider and digest the information.

⁷⁹ Section 24

⁸⁰ *Gillick v West Norfolk AHA* [1986] AC 112 (HL) at 189

⁸¹ For example, *Marion's Case* (1992) 175 CLR 218

⁸² *Re R (a minor) (wardship: medical treatment)* [1991] 4 All ER b177 (CA)

Examples of the type of information that a patient should be given include:

- the likely diagnosis, and certainty of this diagnosis;
- the likely nature of the illness and outcomes if treatment is not undertaken;
- the recommended treatment and any alternative options;
- likely outcome of treatment;
- any risks and side effects associated with treatment;
- what the patient can do to facilitate the treatment and things he or she must avoid;
- the costs involved and likely effect on work capacity; and
- the right the patient has to make his or her own decisions and the withdraw consent at any stage.

Keeping accurate and contemporaneous records

Not only is there a legal duty to make records⁸³, accurate and contemporaneous record keeping is imperative in risk management to:

- ensure that patient care is accurately mapped, so that continuity of care and accountability is maintained. Every observation, decision and communication should be recorded accurately and contemporaneously to reduce the risk of error or miscommunication, and therefore to reduce the risk of adverse events; and
- provide documentary evidence should a complaint, claim or investigation ever be made.

It is important, therefore, that notes are clear, legible and dated accurately, and if possible the time is noted. Specific timing of events often can be a crucial point in litigation, particularly in relation to causation. The author of the note should always write their name legibly as well as signing it. If an investigation or claim arises, it is important to be able to identify the key witnesses to the case easily.

All elements of the decision making process should be documented clearly and contemporaneously. An adequate history and examination, the rationale for any treatment administered, details of the treatment, monitoring of the response to treatment, the treatment plan and the diagnosis which supports the treatment plan must be recorded.⁸⁴

When obtaining or giving advice over the telephone, it is important to document the date and time the call is made, the name of the person to whom the call is made, the information

⁸³ *Kite v Malycha* (1998) 71 SASR 321; the court held that a doctor owed a duty to record that he had performed a particular investigation in the notes.

⁸⁴ Medical Practitioners Board of Victoria, re. Dr John Chun-Tsang Lai [2003] MPBV 30

provided to that person and the advice provided by the person. Any discussion should always be documented carefully.

The importance that contemporaneous records can provide in terms of evidentiary weight is observed in two Queensland cases. In one of these cases, a single contemporaneous note provided evidence of a conversation between the defendant doctor and the plaintiff and was sufficient to defeat a claim.⁸⁵ In another case, a well-documented record of the history and examination of a plaintiff patient was found to be inconsistent with the plaintiff's memory of the events. Thorough contemporaneous notes assisted in convincing the judge as to the doctor's version of events.⁸⁶ Hence, contemporaneous records are given sound evidentiary weight by the courts – 'good records, good defence'.

The Medical Practitioners Board of Victoria considers that the maintenance of proper medical records is essential. The Board confirms that they serve to refresh the memory of the treating practitioner, and provide a record of important examination findings or diagnostic testing, so other parties have a proper basis for assessing and treating patients. Not keeping accurate records puts patients at risk of harm.⁸⁷ Further, in the current climate where health care professionals are more accountable, records assist a health care professional to later justify and explain their management.

The Health and Disability Commissioner in New Zealand found that nurses had breached their standard of care by not keeping adequate records of a patient's progress.⁸⁸ It was said that progress notes were necessary to provide a clinical overview which can assist other health professionals in implementing or reviewing a patient's ongoing management. One particular nurse was found to have breached her duty by not keeping notes contemporaneously; she had added a note about the patient's condition retrospectively, after she heard that the patient's condition had deteriorated. It was considered that the entry constituted essential information about the patient's condition, and that by not recording her observations at the time, the nurse did not provide timely information to other staff taking over the patient's care.

If a record is made following the event, then it must be clearly identified as retrospective, with the time and date of making the note indicated.⁸⁹ Records should never be amended retrospectively.

⁸⁵ *Tonks v Glasson*, unreported. Brisbane District Court OIaint No 3177 of 1997, Senior Judge Trafford-Walker, 5 May 1999

⁸⁶ *McIntosh v Hazel* [2003] QSC 076

⁸⁷ Medical Practitioners Board of Victoria, re. Dr John Chun-Tsang Lai [2003] MPBV 30

⁸⁸ A Report by the Health and Disability Commissioner, New Zealand. Case 05HDC07285.

⁸⁹ Medical Practitioners Board of Victoria re. Dr Lea Lee Foo [2006] MPBV 15, Dr FGH [2006] MPBV 16, Dr CDE [2006] MPBV 17

Retaining medical records

The importance of record keeping has already been discussed. For how long should these records be kept?

Under the *Limitation of Actions Act* 1958 proceedings must be brought either within three years from when the patient became aware that they had an injury caused by the negligence of a health care professional, or 12 years from the date of the alleged negligent act, whichever is first to occur. There are however exceptions which may extend the limitation period. For example, if a person is under a disability at the time the injury occurred such that they are unable to pursue their legal rights, time is suspended whilst the patient is under the disability. There are also provisions in the Act for the Court to exercise its discretion to extend time in certain circumstances.

In a perfect world health care records should be kept forever.⁹⁰ This is expensive, however, and poses practical difficulties with storage. It has been suggested that the most practical approach would be to have records which may be 'stale' reviewed by a medical practitioner who can make a decision to store them in a secondary or tertiary storage or allow them to be safely destroyed.⁹¹

Ensuring privacy and confidentiality

Health care professionals have a duty to protect the privacy and confidentiality of patients.

A patient's right to privacy is protected by the *Privacy Act* 1988 at the Commonwealth level, and by the *Health Services Act* 1988 and the *Health Records Act* 2001 at the State level.

Essentially, under the legislation, personal information must not be collected unless it is necessary for the purpose for which it is collected. Prior to its collection, the person from whom the information is collected must be informed, or be aware, of the reason for the collection of the information and parties to whom the information might be disclosed. The information collected must also be relevant and up to date and not be unreasonably intrusive.

Information can only be collected with consent; an exception is where the person is not competent to consent (or consent cannot practicably be obtained).

The legislation also imposes obligations of confidentiality, so that a person's information cannot be disclosed for any purpose other than the primary purpose that it was collected except in certain circumstances, for example:

- for related purposes;
- with the person's consent;
- where required or authorised by law;

⁹⁰ Note that under section 29 of the *Administration and Probate Act* 1958, the estate of a deceased person can sue on any cause of action vested in the deceased person.

⁹¹ Niselle P. *Managing Risk in Medical Practice*. (1999) 7(2) JLM 130

- where the person is not competent to consent and it is not reasonable practicable to obtain proxy consent;
- information is to be provided to the persons' immediate family members, the person is not able to consent and is not known to have previously objected;
- the person from whom the information is dead and is not known to have previously objected;
- for funding, monitoring, improving, or evaluating health services, training staff, research or statistical purposes;
- to lessen or prevent a serious risk to the individual or the public; and
- to defend legal proceedings and in law enforcement.

Audit of records for quality or training purposes generally is considered to fall within the permitted purposes of monitoring, improving, or evaluating health services or training. Appropriate arrangements to ensure confidentiality should be implemented and hospitals and health services may elect to seek endorsement by their ethics committee if external assessors are to be used for this purpose.

In addition to the statutory obligations, there also is a duty imposed by common law for health care professionals to maintain the confidentiality of their patients' information, and a wrongful breach of confidentiality could form the basis for a claim in negligence, if such a breach resulted in a significant injury for the patient.

At common law, similar exceptions apply to the duty to maintain confidentiality. One common scenario which will be faced by health care professionals, especially in emergency departments, is in the provision of information to relatives of the patient. A health care professional should be satisfied that a patient does not object to his or her information being provided to a relative. An exemption would be if information needs to be urgently conveyed, for instance when a patient is urgently admitted. A health care professional must not disclose any information to a patient's relatives if a patient specifically asks the health care professional not to do so.

A patient's information may be disclosed to other health care professionals involved in the care of the patient, so a nurse may convey a patient's relevant information to a doctor, or vice versa, when the other health care professional is involved in the current care of the patient, unless the patient has requested that information is held in confidence.

There are also instances where the law actually requires a breach of confidentiality; some of these are discussed below.

Credentiailling and defining scope of clinical practice

'Credentiailling refers to the formal process used to verify the qualifications, experience and professional standing and other relevant professional attributes of [health care professionals] for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health services within specific organisational environments. Defining the scope of clinical practice follows on from credentiailling and involves delineating the extent of an [individual's] clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability, and the needs and capability of the organisation to support the [health care professional's] scope of clinical practice'.⁹²

Credentiailling is an important risk management tool. It assists in ensuring that approval granted by the hospital or health service to health care professionals to perform certain procedures are within their experience and competence, therefore minimising the risk of adverse events. Indeed the lessons learnt from various major inquiries into clinical governance failures in acute hospitals, serve as a salutary reminder of the possible consequences of not having effective systems in place for credentiailling and defining the scope of practice of health care professionals.

The concept that the hospital or health service may be liable for the conduct of its VMOs has already been discussed. Further, it has been established, in the United States, that where a patient is injured as a result of a doctor's incompetence, the hospital or health service can be found liable for the negligent granting of privileges.⁹³ We are of the view that particularly in the implementation of the PCCM, in which registered nurses are taking on greater responsibilities, an effective credentiailling system should be implemented in respect of all health care professionals, and not restricted to VMOs, to ensure a consistently high quality of patient care.⁹⁴

The process of credentiailling and defining the scope of clinical practice of health care professionals should be carried out in accordance with principles of procedural fairness. The process should be structured and routine, formalised and carefully documented. The process has been recommended to include the appointment of a properly constituted committee with carefully prepared terms of reference, the strict observation of confidentiality and the exposure of all medical staff to the same process. It has also been recommended that regular

⁹² Australian Council for Safety and Quality in Health Care. *Standard for Credentiailling and Defining the Scope of Clinical Practice. A national standard for credentiailling and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals.* July 2004. Available at [http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/A0E19BFE6489F6E1CA2571C70008A86A/\\$File/credenti.pdf](http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/A0E19BFE6489F6E1CA2571C70008A86A/$File/credenti.pdf)

⁹³ *Darling v Charleston Community Hospital* 383 US 946 (1966). Liability is now limited somewhat by US legislation which protects hospitals from liability in these circumstances provided there is compliance with certain minimum standards of credentiailling: *Health Care Quality Improvement Act* 1986, 42 USC 11101-11152

⁹⁴ It has been suggested that in certain circumstances, a hospital could be directly liable if it failed to provide properly qualified and competent medical staff: *Wilsher v Essex Area Health Authority* [1986] All ER 801

applications ought to be made for the definition of scope of practice with a special review if necessary if there are complaints or concerns about performance.⁹⁵

Proper systems and policies ought to be put in place in respect of the process of credentialling and defining scope of practice, in order to minimise the risk of litigation from disgruntled practitioners who are denied rights and privileges resulting from the process.

The concept of credentialling has been endorsed by the Australian Competition Tribunal.⁹⁶ It said that:

'...The credentialling process not only involves an examination of the skills and qualifications of the practitioner, but is directed to:

- (a) ensuring that practitioners with suitable experience are placed in suitable positions within the hospital;
- (b) ensuring that practitioners provide clinical services appropriate to the particular role of the facility;
- (c) ensuring that the hospital has available to it the necessary range of clinical services including relevant specialities and sub-specialities to perform its particular role; and
- (d) facilitating the hospital's requirement to manage clinical and other services to ensure their proper coordination and delivery to patients in a clinically effective manner.'

Credentialling and defining scope of practice play an important role in assuring high quality care and, therefore, in preventing adverse events. Yet the practical implementation of effective credentialling and scope of practice systems is not without its problems, some of which can be addressed by applying proper systems and policies to ensure the process is conducted fairly and uniformly.

Open Disclosure

It has been suggested that if a patient is provided with a full and frank explanation and a sincere apology when something has gone wrong, it is more likely that they will accept that a human mistake has been made. Attempts to cover up mistakes are thought to increase the risk of litigation.⁹⁷

Open disclosure refers to the frank and open discussion of events that lead to harm to a person while receiving health care. The essential elements of open disclosure include:

- frank discussion, which must be honest, open, and occur immediately;
- an acknowledgement that an adverse event has occurred;

⁹⁵ Appelbee L. *Hospital Credentialling: Identifying and Managing the Risks*. (2000 8 (1) JLM 112. Citing LL Wilson. *Credentialling of Hospital Medical Staff* (1997) 17 J Qual Clin Practice 187 at 187

⁹⁶ *Re Australian Competition and Consumer Commission By Australian Association of Pathology Practices Inc* (2004) 206 ALR 271

⁹⁷ Nisselle, P. *Managing Risk in Medical Practice*. JLM Vol 7. November 1999.

- an expression of regret;
- recognition of the reasonable expectations of the patient;
- a factual explanation of what happened;
- the provision of known clinical facts;
- discussion of the potential consequences and of ongoing care;
- explanation of the steps being taken to manage the event;
- explanation of the measures being taken to prevent recurrence;
- an indication that an investigation is being, or will be undertaken to determine what happened and to prevent recurrence, an agreement to provide feedback on the investigation where possible.

Open disclosure, however, does not mean an admission of liability, even if an apology is made. Health care professionals should be trained to speak openly and frankly with patients without making an admission of liability. Open disclosure should never include any statement or agreement as to who is liable for the harm caused. Just because an adverse event occurs does not mean the test for negligence is satisfied.

The former Australian Council for Safety and Quality in Healthcare released an 'Open Disclosure Standard': '*A National Standard for Open Communication in Public and Private Hospitals, Following an Adverse Event in Health Care*'.⁹⁸ The purpose of the standard is to promote a clear and consistent approach to the concept of open disclosure. It has been adopted and/or trialled by a number of health services in Victoria. Health care professionals should ensure that they are familiar with the policy adopted by their health service with respect to open disclosure.

Incident reporting

Any adverse event that occurs in the hospital or health service should be documented carefully at the time it occurs and reported through the hospital's or health service's reporting systems. Reporting assists hospitals and health services to review and remedy the causes of adverse events, and enables them to comply with the notification requirements of their insurance policy.

The DHS requires hospitals and health services to report 'Sentinel Events' within 3 working days of the event occurring. The Sentinel Events which must be reported include:

- procedures involving wrong patient or body part;
- suicide in an inpatient unit;
- retained instruments or other material after surgery requiring re-operation or further surgical procedure;

⁹⁸ <http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/former-pubs-archive-disclosure-progress>

- intravascular gas embolism resulting in death or neurological damage;
- haemolytic blood transfusion reaction resulting from ABO incompatibility;
- medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs;
- maternal death or serious morbidity associated with labour or delivery;
- infant discharged to wrong family; and
- other catastrophic event.

Root cause analysis

One way of preventing the reoccurrence of adverse events is by root cause analysis ('RCA') on high risk, high impact events, so that the factors which cause these events are identified. The focus of RCA should be on the analysis of systems and processes, not individuals. The outcomes of RCA can be used to decide what can be done to detect failures in the system, to find solutions to address these failures and to prevent the same adverse incident from occurring again.

Further details on the RCA process can be found on the Victorian Government website.⁹⁹ It is vitally important that the RCA process is conducted and documented carefully to avoid generating unnecessary medico-legal risk. Health care professionals should not conduct RCAs unless they have received specific training. Key risk management strategies relating to documentation of the RCAs include:

- remember – documentation may become available to the patient;
- restrict documentation to clinical facts which have been verified, as far as is possible, as accurate;
- don't attribute blame or make defamatory statements;
- don't record opinions (other than expert opinion supported by evidence);
- maintain communication with the health service's insurer and seek legal opinion when necessary; and
- investigation reports should not contain any identifying information.

⁹⁹ <http://www.health.vic.gov.au/clinrisk/sentinel/rca.htm>

Insurance for VMO services

Under the VMIA's medical indemnity insurance policy, VMIA indemnifies the hospital/health service and its employees whilst providing health care services to patients of the hospital/health service.

VMIA also indemnifies persons for whose conduct the hospital or health service is liable at law whilst providing health care services to public patients of the hospital or health service.¹⁰⁰ This means that VMOs who may not be employees of the hospital or health service, are covered whilst providing health care services to public patients of the hospital or health service so long as those health services were delivered in circumstances in which the hospital or health service would be held liable at law for the conduct of the VMO. This will apply in most situations in which a VMO is treating a public patient at the hospital or health service. In those circumstances the hospital or health service owes a non-delegable duty of care to the patient and would be liable at law for the VMO's negligence.

If the VMO treats the patient as a private patient and not in the capacity as an employee of the hospital or health service, then VMIA will not indemnify the VMO for any liability arising. There are however some exceptions. The first is where a VMO who is treating a patient privately refers the patient to a public hospital/health service elective surgery waiting list. The VMO will be indemnified by VMIA to the extent that any legal liability arises in respect of the placement of that patient on the waiting list. Secondly, if a VMO, whilst consulting with a private patient obtains the patient's consent to a procedure and refers the patient to a public hospital or health service to have the procedure as a public patient, then the VMO will be indemnified for any claims against the VMO that arise from the information or lack of information about the procedure or risks associated with it given by the VMO to the patient at the time of obtaining the patient's consent to the procedure. This is contingent upon the VMO having admitting rights to the public hospital or health service to which the patient is referred.¹⁰¹

Rural GPs also may be individually indemnified by the VMIA under a policy of insurance. The Rural General Practitioners Medical Indemnity Insurance Policy also includes cover for employees of the insured GP, and medical practitioners if the medical practitioner is, at the time of the health care incident giving rise to the claim, a registered medical practitioner and an employee of the insured GP, and was providing health care services as a locum of the insured GP. Under the policy of insurance, the insured GP must ensure that only registered nurses are employed and/or engaged in the capacity as nurses.¹⁰² Trainee nurses, Division 2 registered nurses and nurse assistants must act only under the supervision of suitably experienced registered nurses.¹⁰³

¹⁰⁰ Clause 2, Medical Indemnity Insurance Policy, VMIA

¹⁰¹ Clause 2, Medical Indemnity Insurance Policy, VMIA

¹⁰² Clause 4.9.3, Rural General Practitioners Medical Indemnity Insurance Policy, VMIA

¹⁰³ Clause 4.9.4, Rural General Practitioners Medical Indemnity Insurance Policy, VMIA

Insurance for nurses

Registered nurses employed by public hospitals and health services are indemnified by VMIA with respect to any claims against them arising out of the care provided by them to a patient of the hospital or health service.¹⁰⁴

If a registered nurse, employed by a medical practice, provides emergency triage and responses from the hospital or health service, it is arguable that the hospital or health service is liable for that nurse's conduct under its non-delegable duty of care and that the nurse is entitled to be indemnified under the VMIA's medical indemnity insurance policy.

Purchasing additional indemnity cover

Health care professionals should consider their insurance needs in respect to their own individual circumstances and making an informed decision about whether they wish to purchase additional insurance.

The VMIA's insurance policy is comprehensive and covers most situations in which a claim may arise, particularly in circumstances where the health professional is acting in his or her capacity as an employee.

Whilst the VMIA insurance policy indemnifies health care professionals for claims that may be made against them, and for the legal costs of defending the claim, VMIA is not obliged to pay for the legal representation of a health care professional when a claim is not involved. For instance, VMIA is not obliged to fund legal representation of a hospital or health service or a health professional at a Coroner's Inquest. VMIA sometimes gratuitously pays for their legal representation; however they are not obliged to. Equally, VMIA is not obliged to fund the legal representation of a health professional at a disciplinary proceeding, although has on occasions been known to gratuitously do so.

There also is an unlikely possibility that a hospital or health service will dispute its vicarious liability. This could occur if the hospital or health service considered that an employee acted outside the scope of his or her employment.

Finally, the VMIA is entitled to decline indemnity if it has not been promptly notified by the hospital or health service of a claim or potential claim (to the extent of loss caused to VMIA by virtue of failure to give notice).¹⁰⁵

¹⁰⁴ Victorian Public Healthcare Program, Insurance Manual for Victorian Public Hospitals

¹⁰⁵ Clause 4.4, Medical Indemnity Insurance Policy, VMIA

Other consequences of adverse events

Complaints to the hospital or health service

A disgruntled patient or relative may make a complaint to the hospital or health service. The Health Services Commissioner encourages patients to raise their complaints with the relevant health care provider as a first step.

Complaints should be handled efficiently and openly - often, a person who has a complaint will be satisfied if they feel that they are being taken seriously and their complaint is being addressed properly by the hospital or health service.

It is imperative that any complaint made to a hospital or health service, or any Freedom of Information application made where there may be an underlying complaint, is reported to the VMIA immediately, as the VMIA has a right to refuse indemnity if such reports are not made promptly.

Complaints to the Health Services Commissioner

One way a person may make a complaint about a health services provider is to the Health Services Commissioner, who effectively adopts the role of a 'health ombudsman'. This position is established under the *Health Services (Conciliation & Review) Act 1987*. Any patient or representative of the patient may make a complaint. The grounds for complaint are also set out in the Act and may include allegations that a health service provider acted 'unreasonably' by providing or not providing a health service, or in the manner it provided the health service, or in not properly investigating or taking proper action on a complaint made to it.

The Health Services Commission must investigate any complaint made which falls within the legislation and can facilitate resolution by a process called conciliation (i.e. co-operation), or alternatively conduct a formal investigation of the complaint. The Health Services Commission may refer a complaint to the relevant health care professionals board.

The complaint process is free of charge. It is impartial and confidential, and participation in the process is on a voluntary basis. Open discussion is encouraged, so that all parties can be asked to give their point of view.

While the complaint process can function as an alternative to legal proceedings, it does not replace or preclude them so that anyone who makes a complaint to the Health Services Commissioner is still entitled to commence court proceedings. The main role of the Health Services Commissioner is to provide a cheap, simple and relatively fast way to resolve complaints.

The possible outcomes of a complaint to the Health Services Commissioner include an explanation (or the provision of more detailed information) of the treatment or medical condition, an open forum of discussion to have concerns aired and discussed face-to-face, an apology, a change to the system or procedures in order to prevent a similar incident from occurring, the provision of remedial treatment, or financial compensation.

Coronial Investigations

The purpose of a Coroner's Inquest is to determine the manner and cause of a person's death. The function of the Coroner is to ensure all 'reportable deaths' are investigated. The *Coroner's Act 1985* defines a 'reportable death' as a death that:

- appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury;
- occurs during anaesthetic;
- occurs as a result of an anaesthetic and is not due to natural causes;
- involves a person who immediately before their death was a person held in care; and/or
- involves a patient within the meaning of the Mental Health Act 1986.

The *Coroners Act* provides that a doctor present at or after a death must report the death as soon as possible to the Coroner if:

- the death is a 'reportable death';
- the doctor does not view the body;
- the doctor is unable to determine the cause of death; and/or
- no doctor attended the person within 14 days before the death and the doctor who is present is unable to determine the cause of death from the deceased's immediate medical history.

The *Coroners Act* also requires a person who has reasonable grounds to believe that a reportable death has not been reported to report it as soon as possible to a coroner or the officer in charge of a police station.

Because a death has been reported does not mean an inquest will be held. Generally Coroners have discretion to initiate an inquest except where the legislation states an inquest is mandatory.

Generally, investigations are undertaken by the police on behalf of the Coroner. The Coroner's assistant gathers information including autopsy reports, witness statements and possibly independent expert opinion to prepare an inquest brief. If approached by the police, a health care professional witness should advise that they will draft a statement and forward it at a later date. Health care professional should avoid making statements without assistance, particularly verbal statements, even if pressed by the police to do so.

Although not obliged to provide statements, generally it is recommended that health care professional witnesses do so with the assistance of a legal advisor, unless they wish to take advantage of the rule against self incrimination (which entitles a person to refuse to answer a question or produce a document if the answer would tend to expose that person to criminal proceedings, a civil or administrative penalty or fine and, less commonly, to forfeiture of an existing right).

If the Coroner decides to conduct an inquest a date will be set once the investigation is complete and statements have been obtained. The health care professional and/or his or her legal advisor should examine the inquest brief prior to the inquest. A person with a 'sufficient interest' may appear or (with the leave of the Coroner) be represented by a lawyer. They may be examined and cross examine other witnesses.

If a statement has been provided to the Coroner, then a health care professional witness may be called to give evidence at the inquest. If a witness will not give evidence voluntarily, then the Coroner may summon a person to attend as a witness or to produce any documents or other materials, and order a witness to answer questions. If a person to whom a summons is issued does not appear, the Coroner may issue a warrant to apprehend the person.

The Coroner is required to examine witnesses on oath or affirmation. Witnesses may refuse to answer a question on the grounds of self incrimination. The Coroner is not bound by the rules of evidence and has a broad discretion to conduct a proceeding. However, in practice, a coronial inquest resembles a civil trial. A health care professional witness will be asked to read out his or her statement, to confirm the statement is correct and if any amendments or clarification are required. Counsel for other parties may then cross examine the witness. The witness may then be re-examined by his or her own Counsel to clarify matters that arose during cross-examination.

Following the investigation, the Coroner must find, if possible:

- the identity of the deceased
- how death occurred; and
- the cause of death.

The Coroner may comment on any matter connected with the death including public health or safety. The Coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence. The Coroner has a wide discretion to provide the finding to the following:

- Director of Public Prosecution
- disciplinary tribunals
- professional bodies; and
- the Department of Human Services.

The Coroner may make recommendations to any minister or public statutory authority on any matter connected with a death which a Coroner investigated, including public health or safety.

Health care professional regulatory bodies

Health Professions Registration Act 2005

On 1 July 2007 the *Health Professions Registration Act 2005* ('the Health Professions Act') came into force as an omnibus Act to unify the system of registration for health care professionals, as well as to create a common system of registration for investigations and hearings in relation to professional performance, professional conduct and the ability of registered health care professionals to practise.

'Responsible Boards' include those boards established under each of the 11 different health care professional Acts, such as the *Medical Practice Act 1994* and *Nurses Act 1993*, which have now all been repealed and replaced by the Health Professions Act.

The Health Professions Act also provides for the registration of students, however this is at the responsible board's discretion and so far the Nurses Board has decided not to proceed with student registration.

Some of the functions of responsible boards under this Act include approving courses of study that provide qualifications; regulating the standards of practice; investigating professional conduct, professional performance or the ability to practice; issuing and publishing codes for the guidance of registered health care professionals as to standards recommended by the responsible board relating to the provision of health services and professional performance; and initiating, promoting, supporting, funding or participating in programmes that the responsible board considers will improve health care professionals' ability to practise.

The Health Professions Act introduces revised definitions of 'professional misconduct' and 'unprofessional conduct' and introduces a common system for making complaints ('notifications'). This is covered under section 42 of this Act, and applies to registered students as well as registered health care professionals. It provides that a person may notify the responsible board of concerns in relation to the conduct, performance, health, behaviour or character of a health care professional or a health care professional student.

Hearings may be held by professional standards panel or health panel appointed by the relevant board on behalf of the responsible board following an investigation. The matter may be referred to VCAT if it raises serious concerns about a health care professional's professional performance, conduct or ability.

Statutory obligations of health care professionals

Introduction

Some legislation imposes obligations on health care professionals.

A breach of statutory obligations usually imposes a fine, termed in penalty units. One penalty unit is currently equivalent to \$110.12.

Statutory fines are not covered by the VMIA's policy of insurance for public hospitals and as such will be payable by the individual health care professional in breach of the law.¹⁰⁶

The following are some examples of statutory obligations.

Road Safety Act 1986

Under the *Road Safety Act 1986* if a patient over the age of 15 presents for treatment following a motor vehicle accident, whether or not he or she was the driver, he or she must allow a medical practitioner to perform a blood alcohol test.¹⁰⁷ This is a circumstance where consent of the patient is not required. The medical practitioner must report the results of these tests (with or without the patient's consent). Note that this Act only authorises medical practitioners to take blood samples, although a nurse may do so if he or she receives approval in writing from the Director of the Victorian Institute of Forensic Medicine. This is an individual approval and the Director must be of the opinion that the person has the appropriate qualifications, training and experience to take the sample.

Health Act 1958

Section 127 of the *Health Act 1958* requires that a registered medical practitioner must not carry out or authorise the carrying out of a HIV test unless the registered medical practitioner has given, or is satisfied that the person requesting the test has been given, information about the medical and social consequences of the test. If the test is positive then that person must not be advised of the results of the test except by and in the presence of a registered medical practitioner or a person of a prescribed class.¹⁰⁸

The penalty is 10 penalty units.

¹⁰⁶ Clause 3.4, Medical Indemnity Insurance Policy, VMIA

¹⁰⁷ Section 56

¹⁰⁸ *Health (Infectious Diseases) Regulations 2001*, r 16:

- 'For the purposes of section 127 of the Act, a person of a prescribed class is -
- (a) a person who at the commencement of these Regulations has had experience for at least 2 years in counselling in relation to the Human Immunodeficiency Virus antibody test; or
 - (b) a person who has successfully completed a course approved by the Secretary in pre-test and post-test counselling in relation to the Human Immunodeficiency Virus antibody test.'

Children, Youth and Families Act 2005

Section 184 of the *Children, Youth and Families Act 2005* makes it mandatory for a nurse or medical practitioner to report any reasonable suspicion of child abuse or abandonment to the DHS.

The penalty for not doing so is 10 penalty units. However, it is a defence to this charge if the nurse or medical practitioner honestly and reasonably believed that the concern had already been reported by another person.

Drugs, Poisons and Controlled Substances Act 1981

The *Drugs, Poisons and Controlled Substances Act 1981*, amongst other things, regulates the supply, prescription, administration and storage of certain categories of drugs. Different types of drugs are classified under different Schedules contained in the Commonwealth 'Standard for the Uniform Scheduling of Drugs and Poisons' referred to in the Act.

Schedule 4 poisons are prescription only medicines, for example cardiovascular drugs, antibiotics, nitrous oxide and many others.

Schedule 8 poisons are drugs with stricter legislative controls, for example cocaine, morphine, pethidine, oxycodone, methadone, hydromorphone, flunitrazepam, fentanyl, ketamine. Schedule 9 poisons are also drugs of abuse.

A nurse, other than a nurse who is endorsed on the Register as a nurse practitioner, is not authorised to supply any Schedule 4 or 8 poisons, which means he or she cannot supply a patient with medication from the hospital or health service ward stock. Other than a nurse practitioner, only a pharmacist or medical practitioner can do this.

Some examples of this Act which may be relevant to emergency presentations are as follows.

Section 33 requires a nurse practitioner or a medical practitioner who has reason to believe that a patient is a drug-dependent person to report this to the DHS.

Section 35 prohibits a medical practitioner or nurse practitioner to administer, supply or prescribe a Schedule 8 or 9 poison to a patient who they believe is a drug-dependent person unless they hold a permit issued by the Secretary. It also prohibits a nurse or medical practitioner to administer, supply or prescribe these poisons for a continuous period greater than 8 weeks without a permit. The penalty for breaching either of these prohibitions is 100 penalty units.

A health care professional who does not comply with the Act or Regulations may also face disciplinary action before the relevant Board and a finding of unprofessional conduct.¹⁰⁹

Drugs, Poisons and Controlled Substances Regulations 2006

The *Drugs, Poisons and Controlled Substances Regulations 2006* is a statutory instrument to the *Drugs, Poisons and Controlled Substances Act 1981*. It regulates, amongst other things, the supply, prescription and administration of drugs, poisons and controlled substances by health professionals, amongst other people. It contains restrictions and obligations which must

¹⁰⁹ Medical Practitioners Board of Victoria, Re Robert Geza Padanyi [2006] MPBV 13

be complied with; persons who fail to comply with these restrictions and obligations will incur a fine.

A nurse, other than a nurse practitioner, is not authorised to prescribe schedule 4 and schedule 8 poisons. However, nurses are authorised to possess S4 and S8 poisons for administration purposes.

A Health Services Permit will have been issued to the hospital or health service. This authorises the hospital or health service to possess Schedule 4 and Schedule 8 poisons for the provision of health services and imposes certain conditions, including conditions which specify what health professional is authorised to administer Schedule 4 and Schedule 8 poisons. The authorisation to generate the standing orders described above will be contained in the Health Services Permit.

Under the *Drugs, Poisons and Controlled Substances Regulations* 2006 a nurse can only administer Schedule 4 or 8 poisons if he or she acts on or in accordance with¹¹⁰:

- the written instruction of a medical practitioner;
- the oral instruction of a medical practitioner if, in the opinion of the medical practitioner an emergency exists (e.g. telephone orders);
- the written transcription of emergency oral instructions by the nurse who received those instructions;
- the directions for use on a container supplies by a medical practitioner or pharmacist (e.g. the administration of a person's own lawfully prescribed medication);
- standing orders (in specified emergency situations) where approval to generate standing orders had been given via the conditions on the hospital's or health service's Health Services Permit.

The penalty for breach is 100 penalty points.

Registered nurses also should check whether any hospital or health service protocols are in place which authorise them to administer specified unscheduled medications, or schedule 2 or schedule 3 poisons. This is a matter of hospital or health service policy.¹¹¹

Regulations 8(2) and 9(2) in Division 2 of the *Drugs, Poisons and Controlled Substances Regulations* 2006 prohibit the administration, prescription, sale or supply of Schedule 4 poisons by a medical practitioner or nurse practitioner unless:

- that poison is for the medical treatment of a person under his or her care; and
- he or she has taken all 'reasonable steps' to ensure a therapeutic need exists for that drug or poison.

¹¹⁰ *Drugs, Poisons and Controlled Substances Regulations* 2006, Regulation 47

¹¹¹ *Key Requirements for Nurses in Acute Care Facilities*. http://www.health.vic.gov.au/dpu/downloads/summary_for_nurses_acutecare.pdf

The penalty for a breach of this regulation is 100 penalty units.

'Reasonable steps' to ensure a therapeutic need exists for that drug or poison would include the following:¹¹²

- taking a medical and medication history;
- examining the patient;
- taking into account the presenting symptoms or described condition;
- taking into consideration any past or current drug therapy;
- taking into account any signs of misuse or abuse of medicines/drugs;
- considering the suitability of the substance to be prescribed or administered for the treatment of the presenting symptoms or described condition;
- considering the potential for the misuse or abuse of the substance to be prescribed or administered;
- confirming the patient's story by contacting purported previous prescribers or supplier.

The concern raised is that this regulation may restrict the giving of phone orders by a doctor 'for a patient who is not his or her patient and who has presented to the ED for treatment' - for example, where antibiotics are required and a nurse obtains a phone order from the duty doctor who is not the child's regular GP, and the duty doctor orders an antibiotic for the child but does not come and see the child.

There is no definition of the term 'under his or her care' in the Act or the Regulations, and it is really a matter of how this should be interpreted. Arguably, a duty doctor assumes the care of any patient who presents for emergency services when he or she is called upon to give advice; certainly at law, he or she will be deemed to owe a duty of care to those patients. Indeed, the practice of providing telephone orders occurs in any large hospital or health service where there is a ward medical officer attending patients after hours who are not under his or her ongoing care.

The Victorian Government has provided the following examples of what would be considered unacceptable practice:

- anabolic steroids for bodybuilding purposes or to enhance sporting performance;
- stimulants merely to enhance wakefulness in long distance drivers;
- for persons who are not under their care, e.g. a person resident in another country who has not consulted the doctor in question.¹¹³

¹¹² *Guide to the Drugs, Poisons and Controlled Substances Regulations 2006* at <http://www.health.vic.gov.au/dpu/downloads/guide-dpusr-06.pdf>

¹¹³ <http://www.health.vic.gov.au/dpu/downloads/reqmed.pdf>

It would seem, therefore, that the purpose of these regulations is to prohibit prescription of medicines for non-medical reasons, and prescription of medications to people whose care the doctor has not actually been involved with. In the context of emergency presentations where the duty doctor is called, the doctor has been consulted, albeit by the nurse, and therefore is involved in the patient's care. It is unlikely that the regulation was intended to restrict the prescription of medications to circumstances where there is an *ongoing* relationship between the doctor and patient. The practice to be adopted in relation to the provision of emergency services, and indeed already widely adopted in many hospitals and health services, is unlikely to be considered to be in breach of this regulation.

A more difficult problem is found in regulation 47, which provides that Schedule 4 and 8 poisons may be administered by a nurse on the oral instructions of a registered medical practitioner if an emergency exists. The Regulations do not define 'emergency' and one argument is that presentations such as ear infections do not represent emergencies (in that they are not a serious and imminent threat to life or health) which would justify oral orders under the regulations. However, to apply a narrow definition of 'emergency' would defeat the purpose of the pilot, which aims to reduce demands on rural doctors. It could be argued that any patient who presents for an emergency service, particularly after hours, may be regarded as an emergency, in a broad sense of the word.

It must be emphasised that Regulation 47(4) requires a medical practitioner who has issued oral instructions for a nurse to administer a Schedule 4 or 8 poison to, as soon as practicable, confirm those oral instructions in writing and include them or provide them for inclusion in the treatment records of the person concerned. The penalty for failing to do so is 100 penalty points.

Conclusion

This manual has outlined some of the main legal issues that are anticipated to arise out of the pilot, and has addressed specific concerns raised by participants.

It must be emphasised that the law is fluid and ever-changing, particularly in relation to medical issues, so legal outcomes can be unpredictable and definitive answers or solutions cannot always be offered. This manual sets out basic principles which can be considered, however, if problems are encountered.

If you would like to discuss any issues in further detail, or have any other questions or concerns, please do not hesitate to contact Dr Heather Wellington or Dr Melanie Tan at DLA Phillips Fox on 9274 5000.