



HEALTH LAW BULLETIN

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Australian Law Reform Commission Privacy report

The Australian Law Reform Commission's recently launched report on the Privacy Act 1988 (Cth), *For Your Information: Australian Privacy Law and Practice* (ALRC 108), highlights the heavy privacy obligations on health services providers who operate in the current privacy law framework. The report identifies future challenges for the industry with the movement towards electronic health information systems and makes various recommendations for reform of the privacy laws in order to provide a more practically workable model for the health industry.

The Current Regulatory Framework - Health Information & the Privacy (Health Information) Regulations

The ALRC notes that its general recommendation for greater national consistency in the handling of personal information is particularly compelling in the area of health information, where in jurisdictions such as NSW, Victoria and the ACT, various pieces of overlapping and inconsistent health privacy legislation apply to private sector health providers.

For example, private sector health providers in New South Wales are regulated by both the Health Privacy Principles (HPPs) in the New South Wales *Health Records and Information Privacy Act*, as well as the National Privacy Principles (NPPs) contained in the Privacy Act. These privacy principles are not identical, and in certain respects, impose different standards.

This causes significant difficulties in the health industry where individuals regularly move between public and private sector health service providers, public and private sector providers operate side by side, and health information may be subject to two

different sets of privacy principles at the same time.

The ALRC makes the following key recommendations in response to these issues:

- An intergovernmental agreement should be developed between the Australian Government and the States and Territories in relation to the handling of personal information. This agreement should establish a cooperative scheme and States and Territories would be required to enact legislation adopting model Unified Privacy Principles¹ which consolidate the IPPs and NPPs.
- The *Privacy Act* should be amended to provide that the Act is intended to apply to the exclusion of State and Territory laws dealing specifically with the handling of personal information by the private sector. In particular, the following State or Territory laws would be excluded to the extent that they apply to private sector organisations: *Health Records and Information Privacy Act 2002* (NSW); *Health Records Act 2001* (Vic); and the *Health Records (Privacy and Access) Act 1997* (ACT).
- Privacy principles that deal specifically with the handling of health information should be set out in new *Privacy (Health Information) Regulations*, and health information should be regulated by the general provisions of the Privacy Act, the model UPPs and the *Privacy (Health Information) Regulations*.²

Electronic Health Information Systems

In the current technological age, the movement toward collecting health information in electronic health



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information systems has considerable privacy implications and provides new challenges for health services providers. The ALRC report concludes that whilst there is no need for specific legislative control to regulate these systems, the Privacy Act must be amended and updated to account for these changes. However, if the Government's proposal for national shared electronic health records is established, the ALRC recommends that this be based on specific enabling legislation.³

Government Response - Future Implications for Health Services Providers

On 11 August 2008, Senator John Faulkner, Special Minister of State, advised that the Government would be considering the extensive recommendations in two stages, and the recommendations relating to the unified privacy principles (UPPs) and health reporting regulations would be examined in the first stage.⁴

A full copy of the ALRC's report is available at www.alrc.gov.au

Written by Dawnie Lam, Solicitor

¹ Recommendation 3-4

² Recommendation 60-1

³ Recommendation 61-1

⁴ http://www.smos.gov.au/media/2008/mr_262008_joint.html

Special Commission of Inquiry into NSW Public Hospitals releases its first report

On 31 July 2008, the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals released its First Report. The Report deals with the circumstances surrounding the appointment of Dr Graeme Reeves (the so-called "Butcher of Bega") as a VMO obstetrician and gynaecologist by the former Southern Area Health Service.

Although the appointment of Dr Reeves was not specifically within the Commission's terms of reference, the Special Commissioner, Peter Garling SC, has been hearing evidence and submissions about all aspects of acute care in NSW, including obstetrics. Moreover, his terms of reference require him to inquire into and report on "any systemic or institutional issues in the delivery of acute care services in NSW public hospitals raised in submissions". The First Report contains a detailed review of the NSW Health policies and practices relating to the recruitment of Visiting Medical Practitioners at the time of Dr Reeves' appointment.

Dr Reeves had practised as a specialist obstetrician and gynaecologist for many years prior to coming to the attention of the NSW Medical Board in 1997. At that time, following a hearing of a Professional Standards Committee, the Board placed a condition on his registration requiring

him to cease the clinical practice of obstetrics. Dr Reeves was also placed on the Board's "impairment" program which required, among other things, that his health be regularly monitored by a Board-appointed psychiatrist.

In February 2002, Dr Reeves applied to the Southern Area Health Service for appointment as a VMO obstetrician

not learn until November 2002 that he was not registered to practise obstetrics. He was required to give an undertaking that he would no longer provide any obstetric services, but was permitted to continue practising gynaecology. When Dr Reeves breached his undertaking by continuing to perform obstetrics, his appointment with the Southern Area Health Service was terminated.

"The Southern Area Health Service could not have expected the level of defiance Dr Reeves showed in continuing to practise obstetrics."

and gynaecologist to work at Bega and Pambula Hospitals. He provided the Area Health Service with a copy of a letter from the NSW Medical Board that referred to Dr Reeves' obligations under the Board's impairment program, but made no mention of the fact that he had conditional registration that did not permit him to practise obstetrics. Dr Reeves concealed this fact from the Area Health Service in what Mr Garling describes in his report as an act of "intentional and calculated dishonesty."

The Southern Area Health Service appointed Dr Reeves as a VMO obstetrician and gynaecologist, and did

In his first report, Mr Garling identifies deficiencies in the NSW Health and Southern Area Health Service policies in place in 2002 which contributed to the failure on the part of the Area Health Service to ascertain that Dr Reeves had conditional registration prior to his appointment. In particular, there was no requirement for independent verification of an applicant's registration status with the Medical Board, nor any requirement to check the applicant's past performance and disciplinary history and provide the Appointments Committee with a written record of a structured referee check.



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The report notes that a number of these deficiencies have since been rectified in current NSW Health policies. The NSW Medical Board has also changed its procedures, and now provides on-line access to its registration database to enable confirmation of any conditions placed on a doctor's registration.

The report is also critical of the Southern Area Health Service for failing to take adequate steps to prevent Dr Reeves from continuing to practise obstetrics after November 2002 when his conditional registration came to light. However, Mr Garling concedes that the senior managers within the Area Health Service could not have expected the "level of defiance" Dr Reeves showed in continuing to practise obstetrics contrary to the specific direction given to him and his express undertaking.

The Special Commission is due to submit its Final Report by 30 November 2008.

Written by Julie Hamblin, Partner

Pharmacists and franchising

In view of the large number of pharmacies operating under franchise arrangements, a case currently on appeal to the High Court may have important consequences for the pharmacy profession.

The case of *Master of Education Services Pty Ltd v Ketchell*, decided in the Supreme Court of New South Wales last year, emphasised the importance of making full disclosure to franchisees. In this case the franchisor's failure to obtain written confirmation that the franchisee had read and understood the Disclosure Document and Franchise Agreement resulted in termination of the agreement. Consequently, all fees outstanding under the Franchise Agreement, such as the management and royalty fee, did not

have to be paid to the franchisor. This decision has significant repercussions for pharmacy franchisors and franchisees, requiring a vigilant approach to disclosure in order to ensure the agreement remains enforceable.

The decision has since been the subject of an appeal to the High Court. The decision which is expected to be handed down in the next few months will be of great consequence for Australian franchise law and will shape the interpretation of the Franchising Code of Conduct. We will keep you posted of any further progress with this case and its implications for both franchisors and franchisees.

Written by Robert Gardini, Partner

Accessing funds in the current market environment

The health sector has not been immune to the bearish stock market this calendar year. The share market continues to be volatile, making equity fund raising more difficult and uncertain. For some, their share price has declined to a level where equity funding is perceived as too expensive. However, debt funding is not easily available either, with banks having tightened their lending criteria. In such conditions, some have considered underwritten rights issues, dividend reinvestment plans or alternative funding, such as mezzanine finance or convertible notes.

Recent and proposed changes in the law are designed to make the equity fundraising process more efficient. This may reduce the time and cost of completing transactions.

Rights issue now possible without a prospectus

A rights issue offers existing shareholders a right to subscribe for new securities. Since the right is granted to existing shareholders, companies may prefer this form of equity funding particularly when they perceive their share price as "low", because their existing shareholders are given the opportunity to benefit from the "low" issue price. Last year, the law was changed to allow qualifying listed companies to conduct a rights issue without a prospectus. This may shorten the preparation time and reduce the overall cost of conducting a rights issue. Listed companies now commonly issue a letter of offer setting out the terms of the rights issue, together with a "cleansing statement", which confirms

their compliance with the continuous disclosure obligations without exemption.

Proposed changes to permit listed companies to raise a larger percentage of capital without specific shareholder approval

In its current form, ASX Listing Rule 7.1 prevents a listed entity from issuing or agreeing to issue more than 15% extra capital within a 12 month period without the prior approval of shareholders specific to that capital raising. The ASX proposes to amend Listing Rule 7.1 to allow companies with a market capitalisation of less than \$100 million to obtain a yearly general shareholder mandate at their AGM to issue up to 25% extra capital within 12 months of the AGM.



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The need for companies to convene a shareholders' meeting to seek specific approval to issue more than 15% extra capital is a time consuming and often costly process. In particular, it restricts the ability of smaller listed entities to move quickly on a deal, placing them at a competitive disadvantage to unlisted entities that do not need specific shareholder approval and larger organisations who will be able to raise larger amounts of money under the 15% cap without the need for the approval of their shareholders.

We understand that the ASX is currently waiting for ASIC's feedback on the proposal. HWL Ebsworth will keep you informed of any developments.

Written by Grant Hummel, Partner

Aged care update

Amendments to the Aged Care Act 1997 (Cth)

The *Aged Care Act 1997 (Cth)* ('Act') was amended by the *Aged Care Amendment (2008 Measures No. 1) Act 2008*, which came into operation on 20 March 2008. This Amendment Act implements the changes to the *Aged Care Act* accommodation subsidies and resident accommodation fees that were announced in the 2007 Federal Budget.

It amends the Act to simplify the fees and charges paid by residents as well as the accommodation supplements paid by the Government for residents who cannot fully meet their own accommodation costs. Higher levels of accommodation payments will be phased in to support the provision of quality accommodation.

There are also amendments to the provisions governing income tested fees. Currently, self-funded retirees pay higher income tested fees because nearly all of their income is counted under the income

test. However, pension income is currently not counted under the income test. This results in self-funded retirees paying more than part-pensioners of similar means. The amendments create a new income test that treats all people in the same way and treats all income the same.

There are three important safeguards that will ensure that residents are protected and that the changes do not adversely affect existing residents.

1. a resident's accommodation charge will continue to be determined based on assessable assets at the time of entry to care and remain fixed until they are discharged;
2. the Government will continue to place a cap on accommodation charges; and
3. residents with unrealisable assets will continue to be able to apply for hardship assistance if they cannot afford to pay their charges.

The changes also:

- a. broaden eligibility for community care grants for providers of Community Aged Care Packages and extend eligibility to Extended Aged Care at Home providers;
- b. extend the operation of aged care legislation to the Territory of Christmas Island and the Territory of Cocos (Keeling) Islands; and
- c. make technical amendments to improve consistency and clarity in the Aged Care Act.

The amendments were implemented as a part of the Labor party's policy to solve the "*blame game*" in health. The Labor party are attempting to eradicate the problem created by a lack of aged care beds which in turn places pressure on public hospitals.

Boost to Funding

The Labor party released a statement on 21 June 2008 that nursing homes across Australia will benefit from new funding worth more than \$8.7 million to encourage homes to use improved evidence-based clinical care.

Minister for Ageing, Mrs Justine Elliot, said more than \$8.7 million would be provided in the round – part of the Australian Government's \$21.6 million over four years Encouraging Best Practice in Residential Aged Care (EBPRAC) program.

The funding round will target areas including:

- wound management;
- incontinence management;
- behaviour management;
- infection control; and
- palliative care.

The Australian government also announced on 3 July 2008 that Commonwealth staff will begin a number of reviews of funding claims made by aged care providers to ensure Australian government financial payments are matching the level of care for the nation's 170,000 people living in nursing homes.

This review was officially announced by the Treasurer in the May 13 budget as result of data for the July 1, 2007 to March 31, 2008 period, which covers part of the previous Government and the Rudd Labor Government.

The data from the Office of Aged Care Quality and Compliance within the Department of Health and Ageing shows 37 per cent of claims upon examination had to be downgraded by Department of Health and Ageing assessors.

Written by Mick Patrick, Solicitor and William Slack, Paralegal



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Amendments to the NSW Medical Practice Act introduce compulsory reporting of doctors for sexual misconduct, substance abuse and incompetent clinical practice

The *Medical Practice Amendment Act 2008* has introduced strict reporting requirements for doctors who have reason to believe one of their colleagues is practising medicine unsafely.

The amendments introduce the concept of “reportable misconduct”. A doctor commits reportable misconduct if he or she:

- practises medicine while intoxicated by drugs or alcohol;
- practises medicine in a manner that constitutes a flagrant departure from accepted standards of professional practice or competence and risks harm to some other person; or
- engages in sexual misconduct in connection with the practice of medicine.

A doctor who believes, or ought reasonably to believe, that another doctor has committed reportable misconduct must report the conduct to the NSW Medical Board as soon as practicable. The report will be dealt with by the Board in the same way as any other complaint against a medical practitioner.

A failure to report a colleague to the Board under this provision may constitute unsatisfactory professional conduct or professional misconduct under Act, exposing any doctor who does not submit a report to the risk of disciplinary action. The Act further provides that any report made in good faith does not constitute a breach of professional etiquette or ethics and cannot result in liability for defamation or malicious prosecution.

While it is clearly desirable to encourage doctors to come forward if they believe one of their colleagues is not practising medicine safely or appropriately, the new reporting requirements are extremely onerous and may be uncertain in their

application. It is not clear, for example, what level of suspicion or evidence is required before a doctor should “reasonably believe” that a colleague is committing reportable misconduct. It is also difficult to know what constitutes a “flagrant departure” from accepted professional practice.

There is also a concern that the new provisions will encourage a culture of individual blame within the health system at exactly the time that advocates of better quality and safety measures are

trying to focus on systems improvements rather than individual performance.

However, given the recent concerns about the cases of Dr Patel and Dr Reeves, there was clearly a political imperative to introduce tighter regulatory procedures for identifying and disciplining doctors who do not adhere to appropriate professional standards.

Written by Julie Hamblin, Partner

Case Note: Peer evidence as to competent medical practice

New South Wales Supreme Court, Court of Appeal - 26 November 2007

Dobler v Halverson & ors

How is rational peer professional practice defined? Is section 50 of the *Civil Liability Act 2002* (NSW) the standard of care or a defence? The New South Wales Court of Appeal considered these questions in a doctor’s appeal from a first-instance loss-of-a-chance decision.

Facts

Mr Kurt Halverson sustained severe hypoxic brain damage following a cardiac arrest at age 18 – he was then diagnosed with long QT syndrome (LQTS). Mr Halverson claimed his general practitioner (the “doctor”) was negligent because he failed to refer him for an ECG after episodes of syncope (i.e. brief loss of consciousness), caused by LQTS, and that he would have been diagnosed and treated if an ECG had been performed. In December 2006, McClellan J (the trial judge) found in favour of the Halverson family.

Damages were agreed between the parties, prior to the decision, in the amounts of \$8,086,000 for Mr Halverson, \$550,000 for his father, \$150,000 for his mother, and \$11,500 for his sister.

The doctor filed an appeal against the findings and sought a re-hearing. The doctor submitted that the trial judge erred in his application of section 50 of the *Civil Liability Act*, his preference of the plaintiffs’ expert evidence, and in determining causation.

Decision

The appeal was unanimously dismissed. The lead judgment was written by Giles JA.

Section 50 of the *Civil Liability Act*

Section 50 provides that liability in negligence is not incurred by a professional, if at the time the



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professional service was provided, the professional acted in a manner widely accepted by peer professional opinion as competent medical practice that is in no way irrational.

Until this decision it was assumed section 5O set out the “test” for the relevant standard of care (competent peer professional practice) and therefore liability. It was not considered to operate as a defence.

The Court considered the origins of section 5O in addressing the appeal, beginning with the *Bolam* principle that “where a doctor acts in accordance with a practice accepted by a responsible body of medical opinion, even though there may be varying practices, a doctor is not negligent”.

Australian courts did not fully endorse *Bolam*, and in the *Bolitho* decision a modified version of the Bolam principle was developed. Bolitho clarified that it was not for professional bodies or peers to determine the standard of care, but for the Court, with reference to the guidance of professional bodies and peers. In addition, it fell to the Court to determine if any practice or standard of care was, in fact, rational. The High Court decision in *Rogers v Whittaker* affirmed Bolitho.

These common law decisions are relevant, as section 5O, on the Ipp Committee’s recommendation, codified the Bolam principle and incorporated aspects of *Bolitho* and *Rogers v Whittaker*.

The doctor’s submission that section 5O did not operate as a defence but merely set out the standard of care, was rejected. Giles JA stated that:

section 5O may end up operating so as to determine the defendant’s standard of care, but the standard of care would be determined by the Court with guidance from evidence of acceptable professional practice.

Based on the standard of care found by the Court, “unless it is established by the defendant that he/she had acted in accordance with widely accepted, rational, peer professional practice” he/she will have been negligent. The standard of care is established by the Court, not the plaintiff. It is for the plaintiff to show that the defendant’s conduct was below that standard (and therefore negligent). Section 5O then gives the defendant the opportunity to rely on rational peer professional practice to negate an allegation that his/her conduct was below the standard. As section 5O operates in this manner, it is a defence.

Giles JA indicated that if section 5O was not a defence, the absurd result would be that the plaintiff would need to identify and negate professional practices favourable to the defendant.

It was also submitted that the trial judge made an error of law by taking a narrow view of competent professional practice. Giles JA stated that the submission mistook the trial judge’s reasons, as “it must be asked whether the manner [in which the professional acted] was widely accepted by peer professional opinion as competent practice”. As the trial judge was answering this question, and not defining professional practice, the submission was rejected. It is relevant to note that the opinion of all the defendants’ experts was resoundingly rejected. It was found, at first instance, and confirmed on appeal, that their opinions arose from inappropriate factual assumptions that had been provided to each.

Causation – Loss of chance

The doctor also appealed on the basis that the trial judge failed to use commonsense, and the evidence as a whole, to determine causation. Giles JA noted that the trial judge contrasted the difficulties between legal responsibility and scientific certainty. He confirmed the standard of legal proof was appropriate. Referring to the trial judge’s finding

that there was a 65 per cent chance of diagnosing Mr Halverson’s condition and avoiding damage, Giles JA affirmed that causation had been determined on the balance of probabilities, which was appropriate in this case.

Implications

This decision confirms that the professional standard of care as identified in section 5O of the Civil Liability Act can only operate as a defence. It was previously thought that a return to a modified *Bolam* standard of care narrowed the opportunities where a professional’s standard of care would be found negligent. Now that it is known to be a defence, the strength of the test is weakened. This decision has arguably returned to the broader assessments of professional liability, akin to *Bolam* and *Bolitho*.

Defendants should focus on establishing that they acted in accordance with rational peer professional practice, recognising that this is a defence, and should plead section 5O in any defence prepared.

In cases where there is a lost chance, the standard of proof is “on the balance of probabilities”, where scientific certainty is not possible. It is for the Court to determine, on the balance of probabilities, the chance, its value, and its loss.

Written by Kerrie Chambers, Partner and Lorinda Hokin, Lawyer



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Proposed changes to general requirements for labelling of medicines

The Therapeutic Goods Administration (TGA) has issued a proposed Therapeutic Goods Order No. 79 “General requirements for the labels for medicines” (TGO 79) to supersede existing TGO 69. A guidance document to accompany draft TGO 79 is also proposed, to provide information about how the new order will take effect in practice.

Drafts of TGO 79 and the guidance document were made available by the Therapeutic Goods Committee for review and comment by stakeholders. Consultation closed on 29 February 2008 and further comment from the TGA is awaited.

The draft TGO 79 includes a two year transition period for labelling to comply with the amended provisions. This transition period would commence upon TGO 79 being entered onto the Federal Register of Legislative Instruments.

The changes

TGO No. 69 “General requirements for labels for medicines” currently sets out the requirements in Australia for medicine labelling.

One material difference between TGO 69 and TGO 79 appears to be an inference that patient safety may be improved by declaring on the label or in a package insert excipients in medicines which are known to cause serious adverse reactions. If there is insufficient space on the label (and the medicine is included in schedule 4 or schedule 8 of the Poisons Standard), the excipients can be declared on a package insert. Column 2 of Schedule 1 of draft TGO 79 also specifies other information to be given on labels or inserts in some cases.

The guidance document to TGO 79 states that:

“Prescription medicines require excipient declarations on the label, or if there is insufficient space

on the container or primary pack label, then declaration may be in a package insert. Use of MIMS, PP Guide or Consumer Medicine Information (CMI) which is not supplied in the packet for excipient declarations for prescription medicines is no longer an acceptable alternative.”

It is apparent however from a reading of part 9(1) of draft TGO 79 that the label on a container and primary pack must only include an ingredient which is an excipient, if that ingredient is referred to in column 1 of schedule 1 of draft TGO 79. This list is in general terms the same as the list of ingredients in the existing TGO 69, however it is broader in that it includes additional items such as crustacea, egg, fish, milk, sesame seeds and soya beans.

TGO 79 will involve a change for both:

- a. healthcare professionals, as this medical information will be more accessible; and
- b. sponsors, as costs will increase.

Implications

If a medicine contains any excipient on the list in Column 1 of Schedule 1 of TGO 79, and the ingredient must therefore be declared, some practical implications may need to be considered:

- a. The option to supply a package insert will not be available to products which are only supplied in a bottle and are not contained in a carton.

- b. It will no longer be sufficient for such specific ingredient information to be supplied by way of MIMS, PP Guide or CMI. These means have been used to provide labelling information other than on a bottle, and outside of a carton.
- c. The additional labelling requirements for excipients will be more user-friendly for healthcare professionals administering medicines and will arguably improve safety.
- d. However, the requirement is likely to increase the cost of the goods due to an increase in sponsor’s costs. Some practical implications for sponsors to consider include:
 - i. sponsors will need to incur the costs of printing additional information on containers or primary package labels, or printing package inserts and placing those inserts in the carton;
 - ii. greater logistical effort will be required to ensure that labels on containers, primary packs or package inserts are updated when changes to information occur. Inventories will be needed to ensure sponsors are aware of which versions of leaflets are on which batches of product, or in which cartons.

Written by Ashley Holland, Partner



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Windfall for medical insurers in medical malpractice cases

In most circumstances where a worker's injury gives rise to a tortious liability on the part of a third party, the workers compensation insurer has the right to recover compensation payments from that third party, pursuant to Section 151Z of the *Workers Compensation Act 1987 (NSW)*, or similar statutory provisions in other States.

The situation is different, however, where a worker sustains an injury which is then complicated or aggravated by medical treatment received. There have been a series of Court of Appeal decisions which have found that in those circumstances, Section 151Z does not operate to allow the workers compensation insurer to recover the payments made.

In *Hood Constructions Pty Limited v Nicholas* [1987] 9 NSWLR 60, a worker sustained an injury in the course of his employment and was paid compensation

were to be reduced to take account of the compensation payments already received. In *Rooty Hill Medical Centre Pty Limited v Gunther* [2002] NSWCA 60, a worker sustained an injury in the course of his employment and as a consequence of negligent medical treatment, sustained a further injury for which workers compensation was paid. He sued the medical centre where the treatment had been given seeking common law damages.

The Court of Appeal confirmed that Section 151Z of the *Workers Compensation Act* did not apply and the plaintiff's damages had to be reduced to give effect to the overriding intention of parliament that a worker should not be entitled to both compensation and damages. The Court stated it could only prevent the worker retaining both compensation and damages, by reducing his damages by the amount of compensation which had

Per quod servitium amisit

Attempts have been made by workers compensation insurers to rely on the principle of *per quod servitium amisit*, which is a claim by an employer for damages for the loss of services of a worker. The claim is brought in the name of the employer, pursuant to the insurer's right of subrogation. The principle states that where a person who is rendering a service under a contract of service, sustains injury through the negligence of a third party, which prevents him from continuing to render that service, the employer may recover compensation from the wrongdoer for the damage sustained from that loss of service. (See *Commonwealth v Quince* [1944] 68 CLR 227).

It is arguable that this principle cannot be relied on by an employer or workers compensation insurer seeking recovery

“Medical negligence insurers get the benefit of the plaintiff’s workers compensation entitlements, and have no obligation to reimburse the workers compensation insurer for any increased exposure.”

pursuant to the *Workers Compensation Act*. The worker required surgery and as a consequence of the negligence of the treating doctor, suffered an additional injury. In the course of proceedings for damages against the doctor, the worker sought a declaration that payments made to him pursuant to the *Workers Compensation Act*, were not repayable pursuant to Section 151Z.

The Court stated that the injury caused by the medical treatment was not “*an injury for which compensation is payable*” within the meaning of Section 151Z, notwithstanding the fact that the surgery was undertaken to remedy an injury sustained in the course of employment. The Court went on to find that the worker's damages against the doctor

been paid and which could be paid in the future.

The practical consequence of this line of authorities is that medical negligence insurers get the benefit of the plaintiff's workers compensation entitlements because common law damages are reduced accordingly. Moreover, they have no obligation to reimburse the workers compensation insurer for any increased exposure it may have as a result of negligent medical treatment provided.

Actions

There are a number of cases where the workers compensation insurer has sought to avoid the operation of the above decisions, by relying on other common law remedies.

of additional workers compensation payable as a result of negligent medical treatment. This is because it has been suggested that the existence of a special statutory right of recovery under Section 151Z excludes any alternative common law claims for recovery of workers compensation payments. (See *Sydney City Council v Bosnich* [1968] 3NSWLR 725 and *GIO Australia Limited v Robson & Anor* [1997] 42 NSWLR 439.)

Alleged Breach of Duty owed by the Medical Provider to the Employer

Workers compensation insurers have also sought to bring a claim against the medical provider alleging a breach of a duty by the medical provider to



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take reasonable care to avoid causing economic harm to the employer.

The decision of the Victorian Court of Appeal in *Scott v. Bowyer & Anor* (1998) 1 VR 207 involved a claim for recovery of worker's compensation payments by an employer against the driver of a motor vehicle which had injured the employee. The Court dealt with the issue as to whether the driver of the vehicle owed a duty to the employer not to cause economic loss, being the worker's compensation payments made by its insurer. The Court held there was no such duty, because there was no relationship of proximity between the relevant class of act or omission and relevant kind of damage.

The Court also concluded that payments were not recoverable, as the worker's compensation legislation was exhaustive, in the sense that it afforded a remedy which was the exclusive remedy. In coming to that conclusion, the Court referred to and relied upon the decision of Sugerman AP in *Sydney City Council v Bosnich*.

The Victorian decision was followed by Grove J in *Ulan Coalmines Pty Limited v Hunter Area Health Service & Anor* [1999] NSWSC 664. That case involved a claim for recovery of worker's compensation payments made following supervening negligence by the hospital in its treatment of a work injury.

Grove J stated that the plaintiff could only obtain damages for a breach of duty owing to it and not for a breach of duty to another. Relying on the decision of *Scott v Bowyer*, Grove J found that there was no right of recovery by the insurer.

Section 74(1) Trade Practices Act 1974

This section provides that in every contract for the supply of services by a corporation to a consumer in the course of a business, there is an implied warranty

that the services will be rendered with due care and skill and that any materials supplied in connexion with those services will be reasonably fit for the purpose for which they are supplied.

It is unlikely that this section will provide a remedy for the employer or workers compensation insurer against a negligent hospital or health professional in most circumstances, because of the doubt as to whether the employer or workers compensation insurer is a contracting party for the provision of the medical treatment and hence, a consumer within the meaning of the section.

Conclusion

It is clear that on the current state of the law, medical negligence insurers are the beneficiaries of a windfall where

medical negligence occurs in the course of treatment for a compensable work injury. The Court will reduce the amount of damages payable in respect of the medical negligence by the amount of compensation which has already been received and by the amount which the plaintiff is likely to receive in the future. Expert evidence from a workers compensation lawyer is required to quantify the amounts of compensation which would be likely to be received by the worker in the future.

Alternative common law claims may be difficult to establish due to the absence of a duty of care or a contractual relationship between the employer or workers compensation insurer and the medical provider.

Written by Neroli Martin, Consultant

Protecting root cause analysis in NSW private health facilities

How do we learn from, and prevent further, adverse outcomes in health care? A helpful and much used tool has been a root cause analysis (RCA). Most Australian States have in place legislation to facilitate an RCA although some apply only to public hospitals.

At present, RCAs conducted at NSW private health facilities are not afforded privilege or protection from disclosure, for example, under subpoena by a patient making a claim. This absence of adequate protection for the participants has hindered transparency and arguably weakened the process and quality of the RCA report.

When it comes into force, the NSW Private Health Facilities Act 2007 (the Act) will mirror, in private facilities, the root cause analysis process and protections that currently exist in public hospitals. Those who have been involved in the public hospital RCA will appreciate the benefits

afforded by this protection. Moreover the formalisation of the process enables participants to understand their role better, as well as the outcomes and consequences of the investigation.

The new Act requires private facilities to create RCA teams if a "reportable incident" occurs. Although this is not yet defined under the Act, it is likely to adopt the definition in the NSW Health policy directive: "Reportable Incident Definition under section 20L of the Health Administration Act." http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_634.pdf. Under the directive, a reportable incident is one with serious or major clinical consequences (as defined) which has a frequent or likely chance of recurrence.

Under the new legislation, an RCA team in a private health facility must focus on systemic change and is not permitted to investigate the competence of an



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individual. However, this does not prevent the team identifying incidents which involve concerns about individual conduct. If the team considers the incident might involve professional misconduct or unsatisfactory professional conduct, or indicate that a person suffers from an impairment, they must notify the licensee of the facility and the chair of the Medical Advisory Board. If the incident involves unsatisfactory professional performance that does not reach the level of possible professional misconduct or unsatisfactory professional conduct, the team has a discretion to make a notification.

When conducting the investigation, the team must abide by the rules of natural justice. In general, the rules of natural justice include informing affected persons about the investigation and giving them a reasonable opportunity to respond to any adverse comment, and considering the response; making reasonable enquires and ensuring any findings are based on sound reasoning and relevant evidence; acting fairly and without bias; and investigating without undue delay.

At the end of the process, the team must provide a written report describing the incident, the reasons they think it occurred and any recommendations for changes to practice or procedure. The Director-General of NSW Health receives the report. In the absence of consent, the report must not name an individual who provided or received health services, and, so far as is practicable, should not contain information that would permit an individual to be identified. The report cannot be used as evidence in any proceedings to show that a practice or procedure was careless or inadequate.

Members of the RCA team must not disclose any information they obtain as part of the investigation, except to exercise their functions and provide a report. A member cannot be compelled, in any forum, to disclose information or produce documents which they hold solely because of their role in

the RCA team. Team members also have protection from defamation for statements made in writing or orally as part of the RCA process.

The new NSW Act encourages full and frank participation by creating a confidential RCA investigation process. While the focus is on systemic change, the team can notify concerns about individual health professionals to be investigated

elsewhere, if necessary. Some facilities may choose to disclose the final RCA report as part of an open disclosure policy and we note that NSW public hospitals have adopted this practice.

The Act is likely to come into force later this year.

Written by Meghan Magnusson,
Senior Associate

Case Note: Court of Appeal reversal on domestic assistance threshold under Civil Liability Act

Claims for domestic assistance

Since *Geaghan v D'Aubert* it has been accepted that section 15(3) of the Civil Liability Act (CLA) was to be interpreted as imposing a threshold before voluntary domestic assistance could be awarded, requiring both:

- an intensity of need of six hours per week or more, and
- a duration of six months or more

Harrison v Melham

Now in the case of *Harrison v Melham* a special five judge bench of the New South Wales Court of Appeal has overruled both *Geaghan v D'Aubert* and *RTA v McGregor* (which was to the same effect).

The Court of Appeal by a 4:1 majority has now ruled that section 15(3) of the CLA is to be interpreted as a preclusion which applies only if both limbs, (i.e. less than six hours per week intensity and less than six months duration) are satisfied.

If a plaintiff establishes a need for voluntary domestic assistance which endures for six months or more, whatever its intensity (e.g. half an hour per week) he is entitled to damages for it. Similarly, if a plaintiff establishes a need for voluntary domestic assistance that is

of six hours or more per week intensity, he is entitled to damages for it even if it endures only for one week.

The practical utility of either limb of what we must now call a preclusion rather than a threshold, is in my view reduced to virtually nil. I believe the legislature needs to urgently amend section 15(3) to restore its operation as imposing a two limb threshold. The legislature already has a template to achieve this in the form of section 15B(2)(c), which effects a partial restoration of *Sullivan v Gordon* damages.

As section 15B(2)(c) operates as a threshold requiring both six hours per week and six months, the distinction between a need for assistance in performing personal domestic activities and a lost ability to care for or assist dependants may become vitally important. Are cooking dinner, cleaning the pool and mowing the lawn (as examples) actions performed as personal domestic activities, or to care for one's dependants?

The only bright spot for insurers in this decision, is the court's ruling that the duration preclusion cannot be overcome by aggregating a series of lesser periods.

Written by William Wade, Special Counsel



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New procedures for Medical Negligence Claims in the NSW Supreme Court

On 31 March 2008, a new practice note commenced in the professional negligence list of the Supreme Court of New South Wales. The practice note applies to all proceedings on foot as at 31 March 2008, and matters commenced in or transferred to the list after that date.

The most significant changes concern the preparation and giving of expert evidence in claims for personal injury and the steps required in advance of a hearing. This will have a particular impact on expert evidence in medical negligence claims. The practice note assumes the standard orders will be made but does give the Court discretion to make different orders where appropriate.

The major features of the practice notes are as follows:

Expert Evidence

- Where more than one expert is to give evidence on an issue:
 - (a) all experts will give evidence concurrently;
 - (b) prior to hearing, experts must confer and produce a report indicating areas of agreement and disagreement.
- Unless otherwise ordered, the parties must jointly brief a single expert in relation to each head of damage claimed (but limited to a total of 3 experts on damages in most cases). This single expert rule requires that:
 - (a) the parties agree to a single expert within 14 days of the order and apply to the Court for directions if they cannot do so;
 - (b) the parties agree on to put to the expert and method of briefing the expert within a further 14 days, and apply to the Court if they cannot do so;
 - (c) the expert provide a report within 21 days of being briefed, or within the time agreed when initially approached for a report;
 - (d) within 14 days of receiving report any party can put a maximum of 10 questions to an expert;
 - (e) the expert report may be tendered at trial by any party.

Preparation for Hearing

- The practice note sets out numerous steps each party must take prior to hearing. These include that:
 - (a) all factual evidence must be given by way of statements, exchanged in advance of the hearing;
 - (b) the plaintiff must prepare a chronology to which defendants indicate facts which are agreed and facts which are in dispute;
 - (c) the plaintiff must prepare a list of questions for trial judge to which defendants indicate that which is agreed and that which they wish to challenge;
 - (d) the parties must prepare joint and individual tender bundles, with indexes to individual bundles exchanged in advance of the hearing.

While the changes to the practice note are clearly aimed at limiting the time and expense associated with preparation of expert evidence, there may be considerable practical difficulties in securing agreement on the choice of and briefing materials for single experts. The new orders for preparation for hearing will increase the costs of proceeding to trial. However, they do enable each party to understand clearly the case they are to meet, which may facilitate resolution in advance of a hearing.

Written by Meghan Magnusson, Senior Associate



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IVF donors to lose anonymity under new legislation in New South Wales

With the passage through New South Wales Parliament of the *Assisted Reproductive Technology Act 2007*, New South Wales has now become one of only a small number of jurisdictions worldwide to have legislation dealing comprehensively with assisted reproduction. The NSW legislation (passed in late 2007 but yet to come into force) establishes a detailed regulatory framework for the use of gametes and embryos in assisted reproduction technology (ART) procedures, covering issues such as consent, counselling, record-keeping and post-mortem use.

A key objective of the legislation is to ensure that children born from donated gametes (semen or eggs) or embryos will be able, once they turn 18, to learn the identity of their biological parents. To facilitate this, the Act establishes a Central ART Donor Register which will hold identifying information about donors and recipients and their children, and make this information available to certain limited classes of people in accordance with the legislation.

Before the passage of the *Assisted Reproductive Technology Act*, ART providers were subject to self-regulation through the Code of Practice of the Reproductive Technology Advisory Committee of the Fertility Society of Australia, but there was limited and piecemeal statutory regulation in NSW. Semen donation was regulated by the *Human Tissue Act 1983* in a similar fashion to blood donation, sometimes with anomalous consequences, and research on human embryos was regulated by both Commonwealth and State legislation. The possible application of the *Anti-Discrimination Act 1977* to ART procedures, particularly in relation to treatment for single women or same sex couples, was a source of uncertainty and concern for providers.

On the question of whether children born from ART procedures should have the right to know the identity of their biological parents, the practice has differed between providers. Some have required donors to consent in advance to the disclosure of their identity to any children born from their gametes or embryos. However, given the shortage of available donors, others have been reluctant to require consent to disclosure from donors for fear this will further reduce the number of people willing to donate.

The new legislation makes it clear that it will not be possible in the future for the donors of gametes and embryos to remain anonymous. Although much

gametes or embryos already in storage, or where a couple wishes to use the same semen donor again so that their existing child or children have a sibling from the same father.

Importantly, the Act contains a new limit to the number of families that can be created from the gametes of a single donor. ART providers are not permitted to provide treatment using a donated gamete if it will result in offspring of the donor being born to more than five women, including the donor and any current or former spouse of the donor. This is significantly more restrictive than the existing Code of Practice, which permits up to ten families to be created using the gametes of one donor.

The new Act endorses the principle that children born from ART procedures should be able to know who their biological parents are.

of the detail of the new requirements will be contained in regulations to the Act, which are yet to be released, the legislation imposes an obligation on ART providers to notify the Central ART Donor Register of ART procedures performed using donated gametes and embryos, and to provide identifying information about both donors and recipients. In addition to permitting children born from these procedures to know the identity of their biological parents, the Register is also intended to allow the adult offspring of a donor to learn the identity of other children of the donor, provided those children also consent.

These obligations will apply to all ART procedures carried out after the Act comes into force, even if the gametes or embryos used were donated earlier. It is possible that the regulations will allow different transitional arrangements for

The Act also lays down strict requirements for information provision and consent in relation to all ART procedures, whether or not they involve donated gametes or embryos. Gametes cannot be used if they have been stored for more than five years, and can only be used strictly in accordance with the gamete provider's consent. Donors are therefore able to stipulate by whom they wish their gametes to be used, and could, for example, direct that their gametes not be used to treat single women or same sex couples. Directed donations of this kind may previously have fallen foul of the *Anti-Discrimination Act*.

On the vexed issue of post-mortem use of stored gametes or embryos, the Act provides that a gamete cannot be used after the death of the gamete provider unless the gamete provider has consented to the use of the gamete after his or



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her death and the woman receiving treatment using the gamete is aware of the death of the gamete provider and still consents to the treatment.

The Act regulates a number of other aspects of ART treatment, including provisions to the following effect:

- commercial surrogacy is prohibited;
- all surrogacy agreements are void, and therefore unenforceable;
- gametes and embryos can be exported from NSW, but only with the consent of the gamete provider;
- the importation of gametes and embryos into NSW is permitted as long as the other requirements of the legislation, such as those relating to consent and record-keeping, are complied with;
- new infection control standards for ART providers may be prescribed by the regulations.

For practical purposes, a key consequence of the new legislation for ART providers will be the need to ensure they have rigorous consent and record-keeping procedures so they can demonstrate compliance with the regulatory requirements. While most ART providers have been well attuned to the importance of obtaining full and informed consent from both donors and recipients, there is now an added importance to maintaining comprehensive and accurate records at all stages of ART treatment.

By establishing such a detailed regulatory framework for ART treatment, including the obligations to provide information to the Central ART Donor Register, NSW Parliament has given a clear signal that it wishes to be involved in the oversight of this area of medical practice. It has also given strong endorsement to the principle that children born from ART procedures should be able to know who their biological parents are. It remains to

be seen whether this will be a significant disincentive for future donors.

Written by Julie Hamblin, Partner

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