AMA Victoria's response to A Statutory Duty of Candour: Consultation Paper

8 December 2017

The Australian Medical Association (Victoria)

Introduction

AMA Victoria welcomes the opportunity to provide feedback to the consultation paper, *A Statutory Duty of Candour*.

AMA Victoria provides the following responses to the questions in the consultation paper.

Q1. Do you agree that the statutory duty of candour should apply to the set of health services [regulated by the *Health Services Act 1988*] including private sector organisations?

AMA Victoria believes that the statutory duty of candour should apply to all hospitals, as defined in the paper.

It must be acknowledged that private contractors engaged in public hospitals pose a specific challenge. Similarly, doctors working at private hospitals are contracted to provide their services and may work on an ad-hoc basis at several different private hospitals around Victoria.

AMA Victoria acknowledges the challenge of providing engaging and relevant training on the proposed statutory obligation to all medical staff across a health service, including rotating junior doctors, fractional appointments and visiting medical officers.

Equity in access to education, training and mentoring must be provided to all staff (clinical and non-clinical), including contractors, if an organisation is to satisfy their obligation of candour.

Q2. Which, if any, other healthcare providers should be in scope for the statutory duty of candour?

The statutory duty of candour should apply to health organisations (such as hospitals, day procedure centres, residential aged care facilities) where the services are undertaken by an Australian Health Practitioner Regulation Agency (AHPRA) registered practitioner.

Q3. Do you believe the statutory obligation should apply to individuals instead of, or as well as, organisations?

The statutory duty must not apply to individual clinicians and practitioners but rather to the organisations that manage and oversee the delivery of the care services. AMA Victoria recognises that doctors will often be relied on to discharge such a duty on behalf of hospitals and organisations.

A critical concern for doctors is the threat of disciplinary action, as patients and even other practitioners may view adverse events as evidence of breaches of professional standards. It is unclear how the proposed statutory duty of candour will impact on practitioners' concerns in this regard.

Doctors must be supported to understand how their own professional obligation of open disclosure[1] interacts with a statutory duty of candour and the differences between them. Organisations must have clear policies and procedures about open disclosure and the statutory duty of candour, which should be consistent with existing clinical governance

[1] Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia, 2017.

frameworks, quality and safety policies, professional indemnity requirements and employment obligations.

The Department of Health and Human Services must provide resources and assist organisations to meet any new statutory obligations.

Q4. At what threshold of harm and/or for what type of incidents should the statutory duty of candour apply?

The consultation paper proposes to introduce a statutory duty of candour that requires all hospitals to ensure that any person harmed while receiving care is informed of this fact and apologised to. The paper acknowledges that there is no single accepted definition of 'harm' in the patient safety field.

Acknowledgement of harm and an apology, or expression of regret for the harm endured, are key components of the existing duty of open disclosure. To satisfy the professional obligation of open disclosure, a medical practitioner might offer an apology to a patient for a non-severe unexpected outcome, say arising from the cancellation of planned treatment.

AMA Victoria submits that the legal threshold for triggering a statutory duty of candour must be higher.

In the United Kingdom, the statutory duty of candour is triggered in case of death and severe and moderate harm, which includes prolonged psychological harm.[2]

The consultation paper presents some definitional issues in relation to the 'incidents', 'events' and levels of 'harm' that might trigger the application of the statutory duty of candour.

Definitions of harm and trigger thresholds must be clearly defined to exclude categories of harm arising from reasonably foreseeable outcomes of treatment or failed treatment, the natural course of an illness or condition, or adverse events that do not result in long term harm.

Should a statutory duty of candour be implemented, it should only apply to cases of 'severe harm' causing a prolonged or permanent impact/s on the patient. This can be physical and psychological.

Q5. Should the statutory duty of candour apply to instances of psychological harm as well as physical harm?

As expressed above, AMA Victoria strongly advocates that should a statutory duty of candour be implemented, it should only apply to cases of 'severe harm' causing a prolonged or permanent impact/s on the patient. This can be physical and psychological.

The definition of harm must be specific to exclude courses of treatment that are properly and responsibly undertaken, but which may be 'deemed harmful' by the patient. Exemptions should also be made to the statutory obligation where withholding information would be in the patient's best interest.

[2] Care Quality Commission, Health and Social Care Act 2008 (Regulated Activities): Regulation 20: Duty of candour, 2014.

Q6. Should the statutory duty of candour apply to near misses and/or complications of treatment that result in no harm and/or no lasting harm? Should it apply where the wrong treatment was given or non-evidence-based treatment was given if there is no harm as a result?

The statutory duty of candour should not apply to near misses. Near misses should be captured by the usual process of hospital incident reporting through the Victorian Health Incident Management System (VHIMS).

Complications of treatment that result in no harm and/or no lasting harm should not trigger the statutory obligation of candour.

Q7. Do you agree that there should be provision for 'consumer declared harm' as a trigger for the statutory duty of candour to apply?

AMA Victoria has serious concerns relating to the provision for consumer declared harm.

A provision may be made for consumer declared harm as a trigger for the statutory duty of candour, but only where the harm directly impacts on the patient. As stated above, this should only apply to cases of 'severe harm' causing a prolonged or permanent impact/s on the patient. This can be physical and psychological.

Q8. Which, if any, of the matters [identified in the paper] should be included within the statutory requirements for the duty of candour?

Should a statutory duty of candour be implemented, it should only apply to cases of 'severe harm' causing a prolonged or permanent impact/s on the patient. This can be physical and psychological.

Q9. Are there other matters that should be included within the statutory requirements or encouraged through other means?

Refer answers to Qs 4 to 8.

Q10. Do you agree with the key barriers and enablers identified [in the paper]?

One key barrier is the loose definition of 'incidents', 'events' and levels of 'harm' that might trigger the application of the statutory candour obligation. It is essential that the definitions which activate the duty of candour obligation are specific. AMA Victoria recommends that a definition of harm triggering the statutory duty is directed to those actions that have as their effect a prolonged or permanent impact/s on the patient.

Medical practitioners cite medico-legal risks as moderate to major barriers to open disclosure but also consider that inadequate training and education are key barriers to compliance.[3]

[3] Studdert, D. et al., "Legal aspects of open disclosure II: attitudes of health professionals – findings from a national survey", *Medical Journal of Australia*, 2010; 193 (6): 351-355.

Q11. What are the most important factors to ensure the statutory duty of candour achieves its intended aims?

To ensure that the statutory duty of candour achieves its intended aims, AMA Victoria recommends:

- adopting a definition of 'harm' (and/or 'incidents' and 'events') that is limited to those actions that have as their effect a prolonged or permanent impact/s on the patient;
- education, training and support for hospitals and staff;
- systems for reporting and monitoring compliance should be educative not punitive; and
- statutory protections should indemnify individual practitioners against any disciplinary action or litigation which arises out of statutory candour obligations.

Q12. How can the necessary training best be delivered?

It is crucial that all staff are made aware of their legal obligations and confident of what the process of disclosure entails.

Hospitals should conduct regular training sessions in open disclosure and the statutory duty of candour. Training should be made available to clinical and non-clinical staff members, as well as private contractors.

We acknowledge that apologies and expressions of regret, in most instances, would be delivered by medical practitioners. The central concern for AMA Victoria is that medical practitioners may not necessarily express an apology correctly, particularly in situations of considerable stress and pressure.

Doctors are deeply concerned, that if not worded correctly, an apology or expression of regret could be interpreted as an admission of fault, either systemic (at the organisational level) or individual. Some of the challenges associated with adherence to the proposed statutory obligation are in part a reflection of the tension between informing patients and the perceived risk that disclosure could give rise to a potential (implied) liability.

Training must provide legal clarity on the issue of liability and help medical practitioners and other staff feel more at ease with the process.

AMA Victoria acknowledges the challenge of providing engaging and relevant training to all medical staff across a health service, taking into account factors such as rotating junior doctors, fractional appointments and visiting medical officers. Online training resources should be made available, to facilitate equity in access to training and education modules.

The department should provide an education package to organisations on compliance with the open disclosure framework and proposed statutory duty.

Q13. Do you agree with the support requirements identified [in the paper]? What other actions might be needed?

Refer answer to Q11.

Q14. Is there a need to strengthen Victoria's apology laws?

It is critical to revisit the provisions of the *Wrongs Act (Vic) 1958*, to ensure protection for medical practitioners and other health care workers.

The national open disclosure standards advise health professionals to apologise without admitting fault, in case they open themselves to legal liability.[4]

Victorian apology laws define an apology as 'an expression of sorrow, regret or sympathy', so long as it does not include a clear acknowledgment of 'fault'.[5] (Refer ***Appendix***). Since Victoria expressly excludes statements containing acknowledgment of fault in the definition of an apology, this may well hinder the practice of statutory disclosure.

AMA Victoria recommends that Part IIC (ss.14I-14L) of the *Wrongs Act 1958* (Vic) be amended to expand the definition of apology to include apologies that involve an acknowledgement of responsibility or fault.

If statutory candour disclosure is to become a routine part of medical practice, law reform is needed in the form of stronger protections under Victorian apology laws and to make the protection consistent in respect of apologies under the disclosure standards, the Wrongs Act and the statutory candour obligations.

Q15. Do you think there is merit in including statutory protections for open disclosure alongside the statutory duty of candour?

If a statutory duty of candour is introduced, then statutory protections should be included and be consistent with the strengthened protection under the Wrongs Act (refer to Q14 above).

Individual practitioners should be indemnified against any disciplinary action or litigation which arises out of such candour obligations.

Q16. Is there a need to clarify, in legislation or through supporting materials, the relationship between open disclosure and qualified privilege?

Yes, there is a need to clarify the relationship between open disclosure and qualified privilege.

Qualified privilege protects many registries which have been very successful in the field of surgery in improving outcomes. The Victorian Audit of Surgical Mortality (VASM) is a great example of a registry operating under qualified privilege which allows a full, frank and often robust exchange of views between treating surgeons and assessors.

Identification of patients and individuals concerned would lead to poor engagement with the process and destroy the original intent, which is to feed back information to surgeons on matters which could be improved in their practice.

If qualified privilege is compromised and there is open disclosure of outcomes, this would inevitably lead to a more punitive approach. Surgeons would be less likely to give a frank opinion for fear of starting a process which may lead to the punishment of their colleagues. It may also lead to a reluctance of surgeons to take on higher risk patients.

[4] Australian Commission on Safety and Quality in Health Care, Australian Open Disclosure Framework, 2013.
[5] *Wrongs Act (Vic) 1958*, Part IIC, s.14I

Q17. Are other statutory protections required?

Refer answers to Q14 and Q15.

Q18. How should failures to comply with a statutory duty of candour be identified?

AMA Victoria recommends consulting with Safer Care Victoria on compliance mechanisms to monitor and improve the quality and safety of care delivered in Victorian hospitals.

The Victorian Agency for Health Information should collect data and share information across the health system to prevent avoidable patient harm.

AMA Victoria supports continued engagement of medical practitioners in the Victorian Clinical Council.

It is also essential to strengthen clinical governance mechanisms and AMA Victoria welcomes the opportunity to provide input to the functions of the Board Ministerial Advisory Committee.

Q19. What consequences or sanctions should be available in response to identified breaches of the statutory duty of candour?

AMA Victoria recommends that training and advice is most important in the first instance. Punitive sanctions, against health services, should only be considered for recurrent breaches of duty.

Q20. Are there other issues, not covered in this paper, that should be addressed or considered as part of the introduction of a statutory duty of candour?

No comment.

Appendix

WRONGS ACT 1958

SECT 14I
Definitions
In this Part—

"apology" means an expression of sorrow, regret or sympathy but does not include a clear acknowledgment of fault;

"civil proceeding" includes—
(a) a proceeding before a tribunal; and
(b) a proceeding under an Act regulating the practice or conduct of a profession or occupation; and
(c) a proceeding of a Royal Commission, whether established under the **Inquiries Act 2014** or under the prerogative of the Crown; and
(d) a proceeding of a Board of Inquiry or Formal Review established under the **Inquiries Act 2014**.

"injury" means personal or bodily injury and includes—
(a) pre-natal injury; and
(b) psychological or psychiatric injury; and
(c) disease; and
(d) aggravation, acceleration or recurrence of an injury or disease.

SECT 14J
Apology not admission of liability
(1) In a civil proceeding where the death or injury of a person is in issue or is relevant to an issue of fact or law, an apology does not constitute—
(a) an admission of liability for the death or injury; or
(b) an admission of unprofessional conduct, carelessness, incompetence or unsatisfactory professional performance, however expressed, for the purposes of any Act regulating the practice or conduct of a profession or occupation.
(2) Subsection (1) applies whether the apology—
(a) is made orally or in writing; or
(b) is made before or after the civil proceeding was in contemplation or commenced.
(3) Nothing in this section affects the admissibility of a statement with respect to a fact in issue or tending to establish a fact in issue.

SECT 14K
Reduction or waiver of fees

(1) In a civil proceeding where the death or injury of a person is in issue or is relevant to an issue of fact or law and it is alleged that the death or injury occurred as a consequence of the provision of a service, a reduction or waiver of the fees payable for the service or a related service does not constitute—
  (a) an admission of liability for the death or injury; or
  (b) an admission of unprofessional conduct, carelessness, incompetence or unsatisfactory professional performance, however expressed, for the purposes of any Act regulating the practice or conduct of a profession or occupation.

(2) Subsection (1) applies whether the reduction or waiver of fees—
  (a) is made orally or in writing; or
  (b) is made before or after the civil proceeding was in contemplation or commenced.

(3) Nothing in this section affects the admissibility of a statement with respect to a fact in issue or tending to establish a fact in issue.

SECT 14L
Application

This Part applies to an apology or reduction or waiver of fees made on or after the commencement of section 6 of the *Wrongs and Other Acts (Public Liability Insurance Reform) Act 2002.*