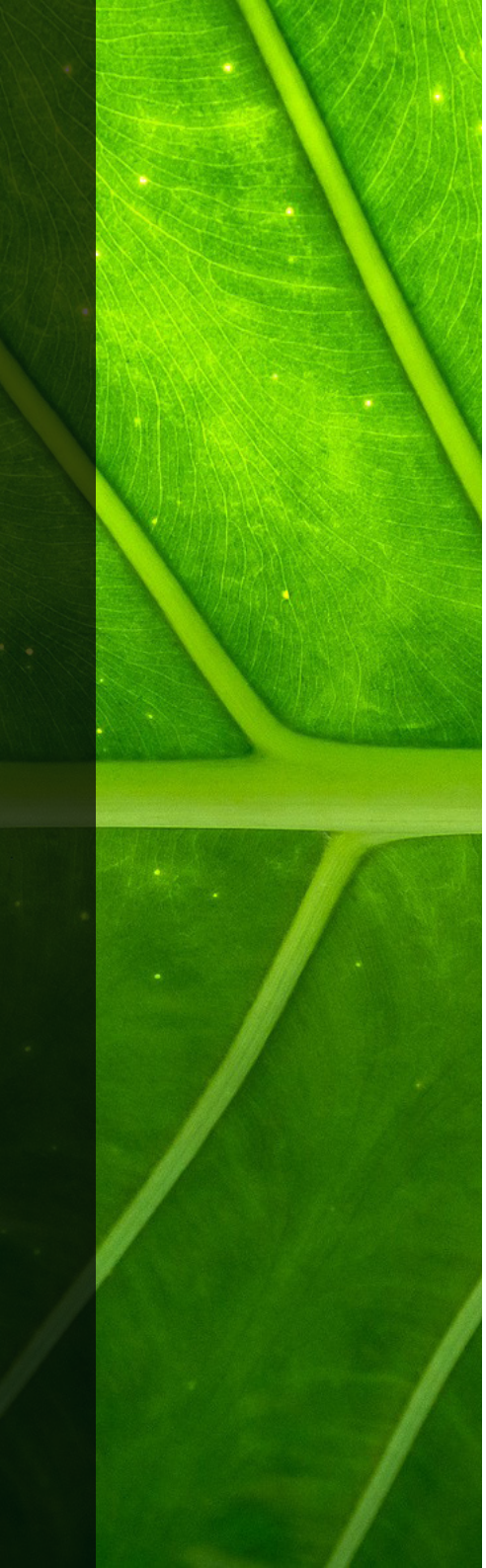
HICKSONS
LAWYERS

HICKSONS 2018 HEALTH LAW FORUM WRAP UP

Creating Sustainable Value

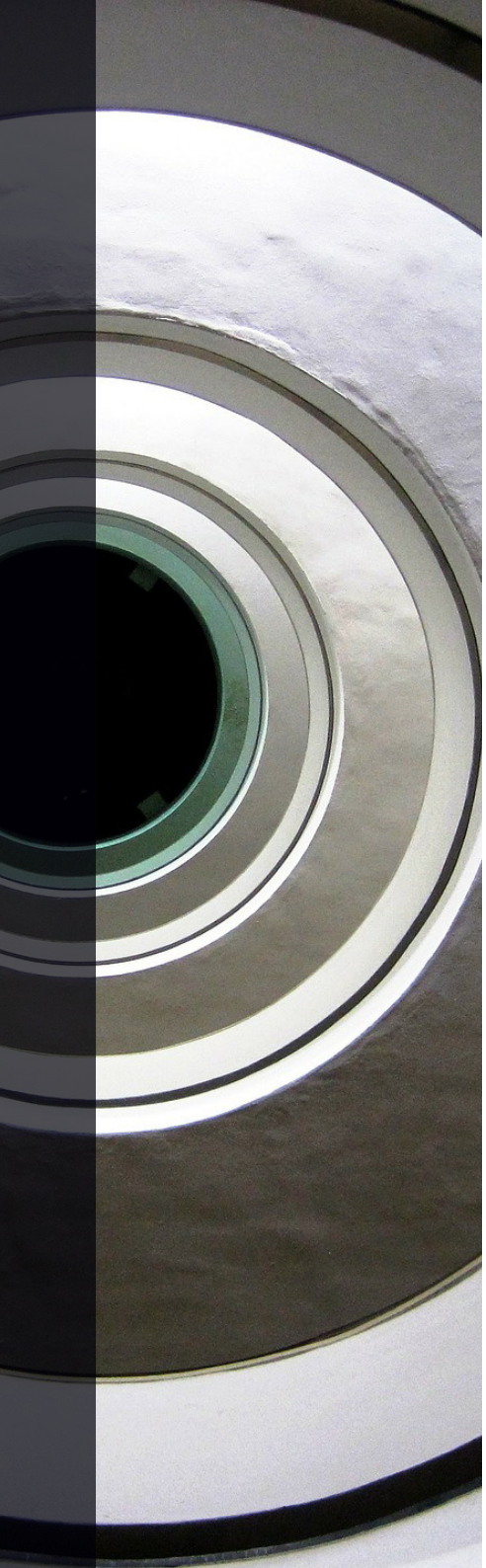


INTRODUCTION

On 18 September 2018 we were delighted to host our annual Health Law Forum. The Forum is designed to provide those working in the health care sector with a series of presentations from eminent speakers that address both legal issues and challenges facing the health sector generally.

This year we were fortunate to secure four highly regarded speakers being Richard Sergi, Barrister, Greenway Chambers; A/Prof Samuel Harvey, Head, Workplace Mental Health Research Program, Black Dog Institute, UNSW Medicine; Dr Carmel Harrington, Managing Director, Sleep for Health, and Research Fellow, Children's Hospital Westmead; and Professor Clifford Hughes AO, President, International Society for Quality in Health Care, and Professor of Patient Safety and Clinical Quality, Macquarie University.

This wrap up provides a short summary of each of the speaker's presentations. Should you require any further information please do not hesitate to contact us.



HOW SHOULD CLINICIANS AND HOSPITALS RESPOND TO THE EXISTING LEGALLY UNCERTAIN APPROACH TO 'COMPETENT PROFESSIONAL PRACTICE'?

Richard Sergi

Barrister, Greenway Chambers

Richard Sergi discussed the operation of section 5O of the Civil Liability Act 2002 (NSW) ('the Act') in light of the current case law. Section 5O provides that a professional is not liable in negligence in the event that they acted in a manner that (at the time the service was provided), was widely accepted in Australia by peer professional opinion as competent professional practice.

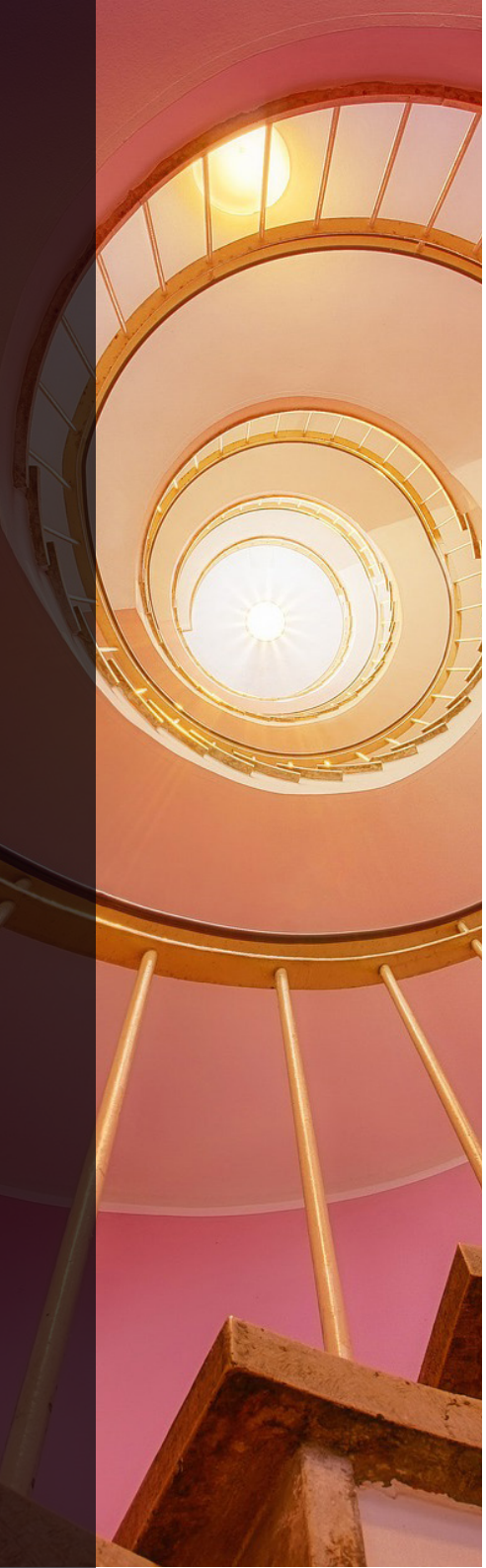
The modern common law of negligence in Australia was overhauled following the decision of *Rogers v Whitaker* (1992) 175 CLR 479. In that matter the High Court took the approach that it was a matter for the courts, not the medical profession, to decide whether a professional had breached the relevant standard of care. This was a significant deviation from the '*Bolam* principle' which was widely accepted in England. The House of Lords in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 determined liability on the basis of what the medical profession (not the court) considered to be the standard of proper professional practice.S5O modifies the Bolam principle and was enacted following the Ipp review.

Section 5O applies to determine the relevant standard of care when considering if there has been a breach of duty, it is not a defence. In relation to what constitutes a 'practice' so far as s5O is concerned, there are dissenting judicial views. In *McKenna v Hunter & New England Local Health District* [2013] NSWCA 476, Macfarlan JA pointed out that s 5O is premised on the defendant doctor demonstrating that the doctor conformed with "a practice that was in existence at the time the medical service was provided" and secondly, that the "practice was widely although not necessarily universally accepted by peer professional opinion as competent professional practice"

This emphasis on the existence of a 'practice' contraindicates there simply being a widespread view among peers that what the professional did in the circumstances constituted 'competent professional practice.' The significance of the need for a 'practice' per se is that in unusual situations there may well be no relevant 'practice' in existence that the professional can rely upon for the purpose of satisfying the provision.

Often in the course of carrying out one's profession there can be many features of providing care which are unique or unusual such that it cannot be said that the conduct of the professional was consistent with 'a practice' of that profession. If Macfarlan JA's approach is accepted as being correct then in such cases the professional will not be able to avail themselves of s5O.

In *Sparks v Hobson* [2018] NSWCA 29 Basten JA says the phrase 'competent professional practice' is intended to cover the whole gamut of professional services provided by a practitioner whether or not the particular circumstances have arisen sufficiently often to result in an established practice.



In that same matter Simpson JA stated that whilst she was bound by *McKenna* she expressed concern regarding the result of a narrow interpretation of the phrase 'a practice.' Her Honour's rationale for preferring Basten JA's approach was on the basis of her understanding that the task of the court is not to evaluate the merits of the competing views but to determine whether, as a factual matter, the service had the acceptance of peer opinion, even if other peer opinion was different.

On 13 April 2018 the Court of Appeal handed down the decision in *South Western Sydney Local Health District v Gould* [2018] NSWCA 69. In *Gould* the Court of Appeal considered s 5O(2) which stipulates that peer professional opinion cannot be relied on if the court considers the opinion to be irrational. The trial judge had rejected expert opinion of a microbiologist and a hand surgeon on the basis both were 'irrational' within the meaning of section 5O(2). Their Honours on appeal noted that expert opinion cannot be rejected on the basis it is 'irrational' merely because it does not articulate the reasoning process leading to conclusions of opinions set out in the report. Whilst this may be grounds for an objection as to the admissibility of the report, it is not a basis for finding the report is irrational.

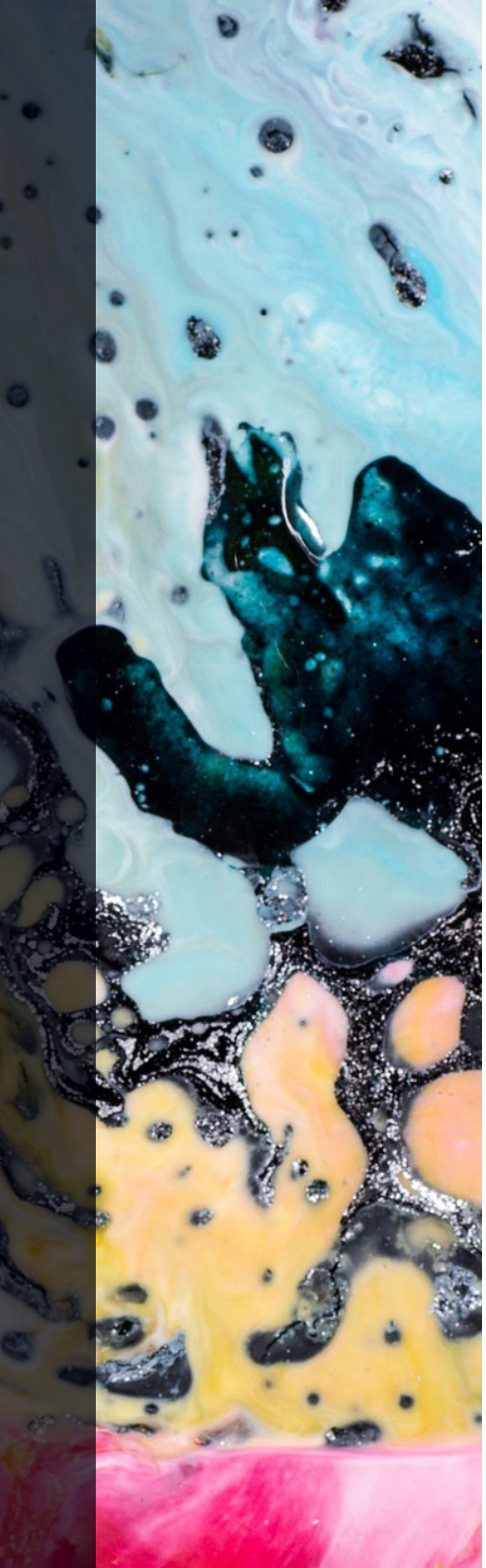
Leeming JA also noted that the question of what is a standard professional practice throughout Australia is, in some cases, a question of fact. In *Gould* the evidence of the treating surgeon as to the antibiotic regime used by him was entirely factual.

When pleadings s 5O it is prudent to sufficiently articulate the manner of practice being relied upon to invoke the section. For the abundance of caution and whilst there remains a degree of uncertainty as to the precise meaning of 'a practice' it is preferable to plead the manner in which the defendant says they acted accorded with a practice in existence at that time and the facts which are relied upon to establish that practice.

While there is presently no formulaic approach available in terms of successfully establishing the requirements of s5O, there are some propositions which are helpful. Chiefly, it is not sufficient for a peer expert to baldly state the practice engaged in was widely accepted as competent professional practice. It is imperative to engage with the facts giving rise to the allegation of negligence. Basten JA helpfully observed in *Sparks* that an expert's evidence will more readily be accepted if they have grappled with conflicting views in a reasoned manner.

We are amid a current climate where there are irreconcilable views as to the correct interpretation of section 5O. Whilst on 14 September 2018 there was an application in *Sparks v Hobson* [2018] NSWCA 29 seeking special leave from the High Court to consider this issue, the application was refused on the basis that the matter was not an appropriate vehicle to deal with the issue. As a result, we can expect that it will be at least another 2 to 3 years before the current state of the law in relation to s5O is considered by the High Court. Until that time the view of Macfarlan JA of the need to establish a particular 'practice' will prevail.

To watch Richard Sergi's presentation click here.



HOW DOES WORK CAUSE OUR MENTAL HEALTH TO FLAT LINE AND HOW DO WE RESUSCITATE?

A/Prof Samuel Harvey

Head, Workplace Mental Health Research Program, Black Dog Institute, UNSW Medicine

Associate Professor Harvey's presentation focused on the mental health of clinicians by considering his evidence-based approach to improving the mental health of workers. His current research had touched upon issues with respect to workplace trauma, including the occupational outcome of those suffering from mental disorder, predictors of sickness absence and workplace based interventions for both the prevention and treatment of mental illness.

Between 2001 and 2014 there was no increase in common mental disorder ("CMD") symptoms in the Australian working age population, however, AP Harvey did not consider a lack of an epidemic was an indication that there is no problem which needed to be addressed. The Australian Bureau of Statistics had recorded 15,000 working age individuals suffered from depression and anxiety, with the main work related factors impacting on mental health, being stress and sickness.

The Whitehall II Study was a UK study which involved taking a national birth cohort study of 6,870 working individuals, which had recorded very detailed information about the first 50 years of those individuals' lives and used that information to examine the link between job strain and CMD. The study concluded that there was a very clear association between work stress and the subsequent development of CMD. Work related risk factors for mental health problems included the imbalance in workers' control of their workplace, occupational uncertainty and lack of value and respect in the workplace. The study led to the national (UK) Health Safety and Environment management approach that required a stress audit of workers.

AP Harvey suggested a better approach than stress audits was to change those factors which had the greatest impact on psychosocial welfare. Research has clearly shown that debriefing following a traumatic event does not assist and can in fact exacerbate a psychological condition. Further, pre-employment screening had also been shown to be of little or no value. However, leaders in a business can have a key role to play in creating mentally healthy workplaces as they are in a position to change work based mental health risk factors and are able to promote an atmosphere that encourages early help seeking.

In support of that argument he referred to a case study with NSW Fire and Rescue Service which involved managers undergoing a 4 hour training program consisting of role plays aimed at giving them confidence to deal with stress and mental health issues amongst staff. A follow up study of the staff of those managers who were part of the intervention group revealed an 18% reduction in absence due to work related sickness and a more proactive approach to dealing with mental health issues.

AP Harvey's team has also released the "Headgear" app

which was introduced in the construction industry aimed predominately at men to address mental health in that industry. The program involved a 30 day challenge with short tasks to be performed each day. Workers were encouraged to complete the course, even if they missed a day. Approximately 2,200 workers participated in the program's initial trial. A 3 month follow up showed a significant decline in mental health issues at work for those who had undertaken the course.

In research involving the mental health of junior medical doctors ("JMO"), the results identified that 30% of JMOs had elevated depressive symptoms and were at risk of suicide. That was of particular concern because of the ready access doctors have to a means of lethality. The top three risk factors for JMOs were sleep deprivation, responsibility at work and fear of making mistakes. An analysis of the results indicated that 46% of CMD in JMOs could be prevented through the elimination of conflict between the demand of study, career and personal responsibility and 28% of CMD could be prevented in JMOs if the stress of sleep deprivation was removed. A JMO wellbeing and support plan for the prevention of mental illness would involve restricting working hours to under 55 hours per week and ensuring the JMOs had satisfactory sleep and a work life balance.

In his closing remarks, Associate Professor Harvey noted that mental health has become the leading cause of long term work incapacity and evidence based research on work place intervention had shown it to play a crucial role in prevention and promotion of recovery from mental ill health.

To watch A/Prof Samuel Harvey's presentation click here.

SLEEP - #1 STRATEGY FOR OPTIMAL WELLBEING AND PERFORMANCE

HICKSONS LAWYERS

Dr Carmel Harrington

Managing Director, Sleep for Health.
Research Fellow, Children's Hospital Westmead

Dr Carmel Harrington, the Managing Director of 'Sleep for Health' and Research Fellow at Children's Hospital Westmead, presented on the importance of sleep as it relates to optimal wellbeing and performance.

The misguided attitude that 'sleep is for the weak' is one that has been popularised over the past 15 – 20 years, and yet studies have shown that lacking sleep can lead to significant adverse outcomes such as being twice as likely to have diabetes, thrice as likely to have dementia, and five times as likely to have depression. The detrimental effects of sleep deprivation extend beyond the increased likelihood of being diagnosed with particular health conditions, with cognitive characteristics such as attention span, distractibility, impulse control, working memory, cognitive flexibility, and risk-taking also being negatively affected.

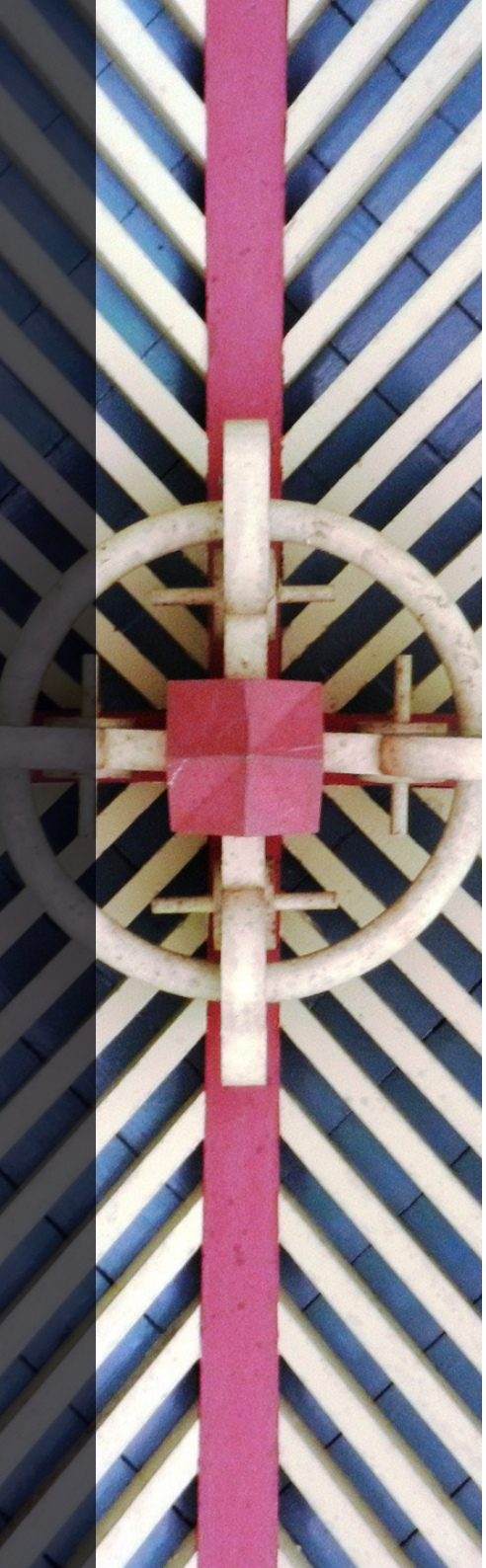
This was demonstrated in a 2017 study by Maric et al which showed that most students who had regular sleep were initially risk adverse but following a period of sleep restriction (7 nights of 5 hours of sleep per night) 80% moved towards risk-taking behaviours. The study found that sleep restriction significantly increased risk-taking, with subjective ratings indicating the students were unaware of the increase in their risk-taking behavior.

Impaired judgement is similarly noticeable in people suffering from chronic sleep deprivation, with these people being unable to accurately assess their cognitive performance or degree of sleepiness. A 2003 study by Van Dongen et al revealed that individuals with acute sleep deprivation (no sleep for 2 nights) and individuals with chronic sleep deprivation (up to 6 hours of sleep per night for 14 nights) both showed the same deficits in performance. Whilst there may be a difference in the degree of sleepiness, chronic and acute sleep deprivation both result in significant deficits to neurocognitive ability, including decreases in psychomotor vigilance, working memory and cognitive process performance.

Sleep deprivation can lead to significant consequences when considering the cognitive and non-technical skills required in surgical practice, with Arzalier-Daret (2018) concluding that sleep deprivation impairs a Resident's medical management of life-threatening situations.

Furthermore, whilst conventional wisdom dictates that sleep is a time where the body shuts down, Dr Harrington highlighted that sleep is in fact an active process during which functions that cannot be done whilst a person is awake, take place.

A 2013 study by Drummond, SP et al, found that the brain of someone who had slept for 7 hours and 15 minutes was notably more active in terms of being able to undertake complex thinking, than the brain of someone who had slept for 6 hours. Additionally, it was demonstrated by Belenky (2003) that those who sleep less had slower decision-making and were more

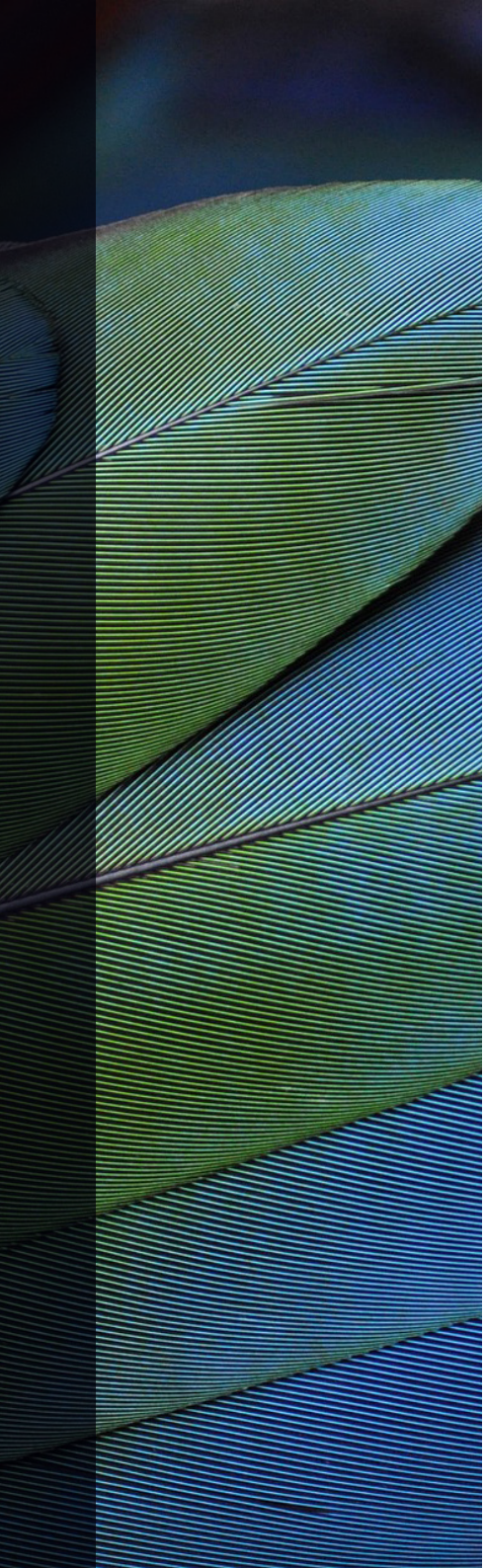


prone to making more mistakes.

Dr Harrington provided practical advice on improving sleep habits. This included:

- getting up at the same time every day,
- exercising for at least 20 minutes per day but not within 3 hours of bedtime,
- eating whole foods,
- not having caffeine after midday,
- not having alcohol (or at least restricting intake and not within 3 hours of bedtime);
- not sleeping during the day (with the exception of a 20 minute powernap at around 3pm)
- not having a big meal within 3 hours of bedtime.

Dr Harrington further advised that we should evenly divide our day between work, sleep, and other activities and warned against sacrificing time allocated to sleep time, even in the face of a busy schedule.



"CANDOR" OR "DUTY OF CANDOUR" - CAN YOU SPOT THE DIFFERENCE?

HICKSONS LAWYERS

Professor Clifford Hughes AO

President, International Society for Quality in Health Care. Professor of Patient Safety and Clinical Quality, Macquarie University

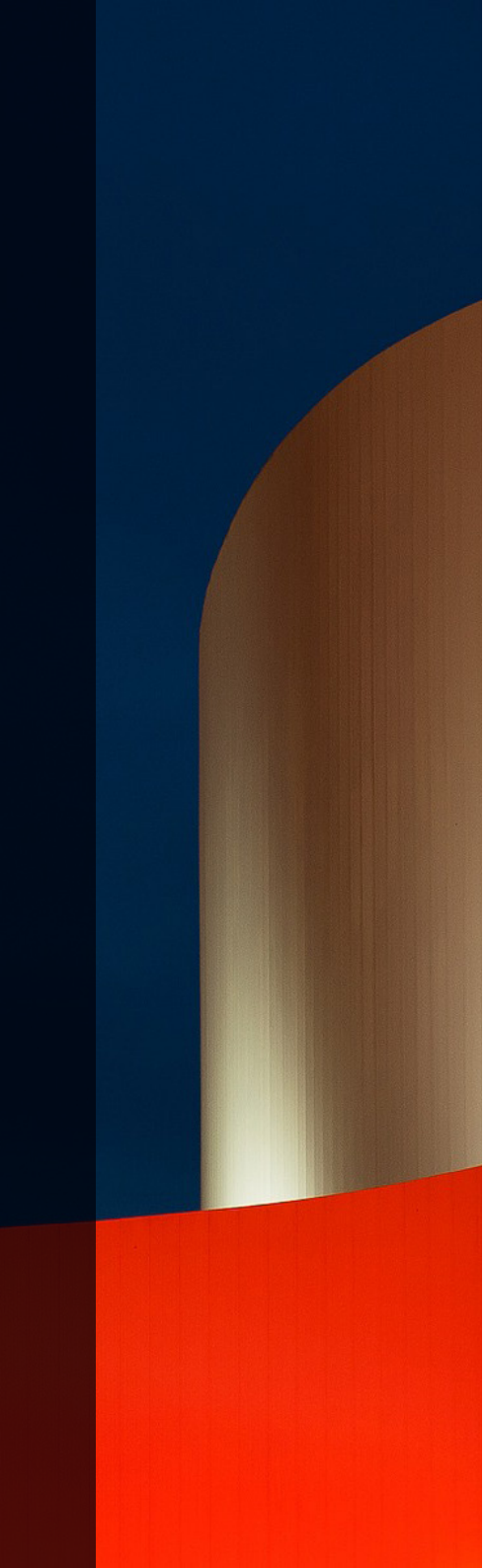
Prof Hughes' presentation was focused on the duty of candour or being honest and truthful in providing health services and in particular dealing with adverse incidents in hospitals. He reminded us the importance of being truthful in our communication with our clients and patients when things went wrong in healthcare or in professional practice. Patients and clients expect candour in our professional dealings and we tend to forget that healthcare and the legal system are about people not programs and products. There is a letter 'u' in the word duty and candour. Together we can make a difference to their experience in dealing with adverse events by being honest and truthful about it.

Prof Hughes considered the approach taken by the UK and the US when dealing with adverse events in healthcare. They are now adopting a more candid and open approach rather than 'closing up the shop' in fear of legal proceedings when dealing with adverse events in hospital settings. Saying sorry can go a long way in incident management. However, whilst the UK and the US were trying to achieve the same goal, they had gone about it in completely different ways. The UK have taken what he described was a bureaucratic approach by introducing a range of regulations. The US on the other hand were taking an educative approach, encouraging clinicians to be patient focused.

He highlighted the challenges in health with health professionals not listening to their patients. He provided examples of incidents where patients died in hospital settings due to lack of compassionate care and staff not listening to patients. One example was the story of Carol Hermelgem's daughter who had skin rash which was misdiagnosed as viral illness by her GP and the hospital. She died shortly afterwards from meningococcal disease. Further Prof Hughes made an interesting comparison between the reaction of people in a village (villagers) to an individual to that by hospital staff to a patient in a hospital. In his experience, villagers notice their changes in their 'neighbours' more so than hospitals notice changes in their patients.

In Australia we are moving away from patient centred care towards patient based care, which is more about listening to the patients and the people we serve. It's about the patient, their family and the care for which we are building a health care system. Prof Hughes emphasised that in moving towards a more candid patient based care, we need strong professional leadership with clear strategy in driving the change. Above all we need to listen to the patients and people we serve. If we can do that we will build a better system.

To watch Professor Clifford Hughes AO's presentation click here.



For further information or if you did not receive an invitation to this year's event and wish to receive an invitation to our next Health Law Forum, please contact:

Karen Kumar
PARTNER

T 02 9293 5452
E karen.kumar
@hicksons.com.au

Cameron Leaver
PARTNER

T 02 9293 5421
E cameron.leaver
@hicksons.com.au

To keep up to date with the latest legal learnings:

Subscribe to our blog - www.hicksons.com.au/insight-news

Download our app from the Apple or Google Play store by searching: Hicksons

Follow us on LinkedIn by searching: Hicksons