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Electronic care plans and medicolegal liability

Background

Government policy encourages the use of care plans in general practice, and developments in information technology have the potential to facilitate their use via a shared electronic care plan. Sharing a comprehensive set of patient data raises privacy issues and questions about the nature and extent of potential liability.

Method

A round table discussion was held with participants purposively selected for expertise in their fields.

Results

Consensus stressed the privacy dangers inherent in the creation of a shared electronic care plan accessible by multiple treating professionals and a private sector intermediary information technology provider, and the difficulties in ensuring appropriate informed consent is provided by patients.

Discussion

As the use of shared electronic care plans increases in Australia, new legal and ethical issues may emerge which need to be understood and addressed if general practitioners and other healthcare team members are to be able to participate with confidence.

Keywords: doctor-patient relations; communication; patient care planning; medicolegal/jurisprudence; consent

Government policy encourages the use of care plans, especially in the treatment of chronic illness.¹ Care plans differ from ordinary patient records generated by medical practitioners in that they are a separate, additional document which sets out a treatment plan.

Traditionally, when a care plan was generated, paper copies were handed to the patient and communicated to other healthcare providers, usually via fax. However, developments in information technology (IT) have the potential to automate this process using a shared electronic care plan (SECP).

A SECP differs from a traditional care plan in that it is a living document that exists independently of the patient record systems of the various health providers involved in a patient's treatment, and is accessible at any point in time by each of them. One example is the Chronic Disease Management Network project (CDM-Net) that piloted the use of a broadband system operated by a private sector intermediary to facilitate care plan development and electronic transmission to members of a patient's care team.² General practitioners draft a personalised care plan on a template securely accessed through the internet. Nominated care team members review the plan and comment before it is finalised and printed for the patient. The plan is generally reviewed 6–12 months later, with further opportunities for input from the healthcare team members.

Legally, team members are required to exercise the skill of ordinarily skilled professionals within the same profession when carrying out their work.³ Care plans create legal issues because they create new mechanisms for shared responsibility for patient treatment and because they document a treatment plan which may provide evidence of negligence to the extent that it results in suboptimal treatment. The

nature and extent of a care team member's potential liability is unclear should a patient suffer adverse consequences as a result of their treatment (or failures in their treatment).

In addition, for a SECP, the sharing of a comprehensive set of patient data between involved health professionals and the necessary disclosure of that information to an IT intermediary for processing raises important privacy issues. These issues need clarification if GPs are to participate in SECPs.

Providing guidance to health practitioners requires consideration of legal and ethical issues. There is no legal precedent that specifically addresses the responsibilities of practitioners regarding the use of SECPs, although the issues of liability have received consideration in the context of multidisciplinary cancer care.⁴ There is a need to comply with collection, use and disclosure limitation principles in privacy legislation⁵ and it is important to ensure informed consent regarding the sharing of patient information between treating professionals.^{6,7} Australian and other common law courts have determined that care plans must be suitable in all circumstances,⁸ that the duty of care owed to patients extends to making reasonable attempts to contact patients for follow up of abnormal test results and some referrals to specialists,^{9–11} and that doctors may share responsibility for errors arising from failures in communication.¹²

Method

A 2 hour roundtable discussion was held at Monash University (Victoria) in May 2009 to discuss two broad topics: the interests of patients, particularly privacy, and other medicolegal issues including the legal status of the care plan record.

Participants were purposively selected for their expertise: a lawyer with health sector experience, a medical ethicist, a GP who has been closely involved

with general practice organisations, an academic GP, and research team members. The discussion was recorded and transcribed verbatim. Data were analysed using thematic analysis, independently by two investigators. Differences of opinion were discussed until agreement was reached.^{13–15}

Ethics approval was obtained from the Monash University Standing Committee on Ethics in Research Involving Humans (SCERH CF09/0511:2009000194).

Results

Central to the discussion was the need to ensure the best interests of patients, and to minimise the potential for privacy breaches and other medicolegal risks. Based on this roundtable discussion, a set of consensus recommendations (Table 1) was developed to guide GPs regarding SECP arrangements.

The interests of the patients, such as privacy

Participants questioned whether it is in the interest of patients to share so much of their personal information and if patients would have difficulty understanding the ramifications of sharing the considerable health information that is stored in a GP's computer, 'So once you're on the system, you're really, in a sense, exposing your information, or sharing that information with everyone.' (Participant 5)

Shared electronic care plans involve a shift away from the current gatekeeper arrangement, where GPs control information ensuring it is not distributed contrary to the patient's interests and expectations; 'It is a movement away from the GP as the hub, where information is referred out and reported back to the GP who can put a fence around the information, where it is parcelled out a bit at a time to the appropriate people, that's the fundamental flaw with it.' (Participant 2)

Participants argued against universal availability of all information in the interests of systems efficiency, because that might significantly undermine patient care. Another concern was that shared health information could extend beyond the care team, for example companies 'accidentally putting up on their website, identifiable patient information, it's happened recently.' (Participant 6)

Other issues raised included security, commercial access by private businesses, storage by a private sector organisation, and compelled access to the SECP record by others such as employers, who could require patients to give consent to such access, 'Then there's the question about commercial access by private institutes to patient data, I think that is critically important and the trend is worrying; stamp it out.' (Participant 4)

Informed consent was critically defined as time bound and it was deemed inappropriate to envisage a generalised form of consent, 'Informed consent can only ever be about what is asked at that time,

that time and that space, and it's usually around a procedure or an activity; global informed consent, in fact that's something you just can't do.' (Participant 2) It was also felt that, 'The whole issue of informed patient consent is being railed through, being basically ignored, so I think the risks are enormous.' (Participant 2) Detailed explanation is required before consent could be appropriately informed.

The medicolegal status of the care plan record

General practitioners need to consider the legal status and ramifications of care plans – more than a reminding checklist, they are a legal document that may be used to establish negligence on the part of a member or members of the care team. 'Most GPs would not see this document as a legal document in the way it is usually described that would prove in a court of law whether they were negligent or not... these legal complexities are being alluded to, and it is sort of mirroring the transition of the medical record being an aide to memoir to being a legally important document.' (Participant 2)

There is considerable uncertainty about who owns the care plan document, who is responsible for ensuring that it is complied with, who is responsible if the plan is inappropriate and the uncertain legal status of care plan documents, 'If we assume that a care plan has a certain legal status, then it has to be legally defensible.' (Participant 2)

Medicolegal liability for failure to follow up

Participants debated whether clearer documentation of a planned course of action increases potential liability for failure to follow up, 'If we recommend a course of action then we are obliged to follow up that course of action, and the more that we document a planned course of action, it would seem that the more you are obligated to follow up that everything's done.' (Participant 2)

While electronic systems have the potential to generate reminders, they also risk system breakdowns and IT provider mistakes, either directly (such as a programming problem or data entry error) or indirectly (such as allowing scope for others to hack into the system). Contracts have a potential role in allocating responsibility, 'Who wears the blame for what, and how does that relate to insurers,' (Participant 6) although

Table 1. Consensus recommendations for GPs regarding SECP arrangements

- Understand the privacy issues involved in creating and sharing a comprehensive record of a patient's health status and treatment
- Limit the information in the shared care plan to that which is relevant and appropriate for the patient's treatment under the plan
- Ensure patients are aware of the nature and extent of the information that is disclosed and who will have access to it and obtain fully informed consent to sharing of this information
- Enable patients to retain some control over the information contained in their care plan including its disclosure to new health team members
- Use a template for the care plan that reflects best practice management for the condition/s it is designed to treat. Review this regularly to ensure currency
- Clearly articulate the nature of the contractual relationship between the parties to the care plan and the mutual responsibilities of members of the care team, the IT provider and patients in relation to the patient's treatment under that plan
- Be clear to what extent you can rely on the care plan and when to refer to your own practice records in ensuring appropriate patient treatment
- Ensure team members all have a clear understanding of the nature and extent of their duty to follow up and recall patients independent of any prompts provided by a SECP
- When reviewing the care plan or including a new team member, ensure the plan is current, fits with best practice and renew the informed consent process as this is time and context specific

participants were unsure, 'How successfully such a contract can protect against liability.' (Participant 6) Thus, it was felt important 'To try to define who has legal responsibility, liability in case of court action...' (Participant 4)

Discussion and recommendations

The discussions highlighted three key areas:

- privacy safeguards and measures
- ensuring care plans reflect best practice, and
- clarifying the rights and responsibilities of participants.

Privacy safeguards

The round table highlighted the privacy dangers inherent in the creation of a SECP and the difficulties in ensuring appropriate informed consent. In order to comply with privacy and health records legislation^{16,17} patients must be fully informed and understand three matters:

- what information is being shared – in this case patient health information from the GP's records, negotiated management goals and additions from other team members
- with whom it is being shared – with members of an identified care team and IT provider/s
- for what purpose it is being shared – to create an individualised care plan to guide management by all team members.

The information must then be used and disclosed consistently with what patients are told. The real difficulty in complying is in ensuring that patients fully understand the nature and extent of the information sharing that takes place. According to the specific circumstances, including age, mental capacity of the patient and the amount of information held about the patient, this may require extensive explanation. It may also require ensuring patients are aware of what further information is included in the SECP and that patients are able to exercise control regarding this additional information.

In addition to these legal obligations, treating professionals have ethical duties to act in the best interests of their patients. These duties include ensuring that patient consent to participation is fully informed and that appropriate steps are taken to restrict the unnecessary sharing of information that may cause harm to the interests of patients if disclosed.

Ensuring that the care plan reflects best practice

Patients are entitled to expect that care plans that provide the underlying basis of their treatment reflect best practice and are updated appropriately to ensure currency. Treatment of a patient in accordance with an inappropriate care plan may give rise to potential liability for negligence.

Clarifying mutual responsibilities and obligations

The fact that a team care arrangement is used for patient treatment may create ambiguity about the mutual responsibilities of care team members, and the extent to which each is entitled to rely on the SECP and information recorded in it as a basis for patient treatment. Therefore, documentation that spells out the nature of the contractual relationship between the parties to the care plan, including IT providers, is vital as well as the mutual responsibilities and obligations of those involved. Responsibilities for the follow up or recall of patients must be clear, particularly the extent to which members of the care team can appropriately rely on the electronic system to generate necessary prompts.

Conclusion

As a consequence of SECPs becoming more prevalent in Australia, new legal and ethical issues may emerge that need to be understood and addressed if GPs and other team members are to be able to participate with confidence. Measures to ensure privacy receives appropriate protection in the context of informed consent, that SECPs reflect best practice and that the mutual rights and responsibilities of participants are clearly documented, may provide a useful way forward in addressing legitimate concerns.

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