

# Chisholm Health Ethics Bulletin

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## Health Information?

*This article will discuss access to health information and the rise of the Internet as an information provider.*

It is sometimes assumed that the better informed people are, the better their decision making concerning their lives, with the result that the health care system is put to its 'best' possible use. Individual decisions about patient care are complex and require a partnership between health care professional and patient. The health professional should use their own expertise acquired through experience and practice, combined with knowledge gained from research reviews. The patient's own expertise, derived from individual knowledge of *their* experience of illness, (especially if it is a chronic condition) is especially pertinent in making treatment decisions in the light of best practice and current research. It is the responsiveness of both the health professional and the patient to each other, while using appropriate resources that will ensure the 'best' health care decisions for that patient.

### Knowledge and Information

Traditionally, doctors relied almost exclusively on their judgements about their patients' diagnosis and need for treatment. The communication of clinical knowledge about a diagnosis and appropriate treatment was the responsibility of the doctor. The medical system used to be trusted to 'know best' and patients tended to follow doctors' orders without questioning them. Information was not readily available. Even 'the information

"volunteered" by doctors was often sanitised for the patient's perceived benefit.<sup>1</sup> This was a very paternalistic attitude as it did not *respect* or even *recognise* the patient's ability to make an autonomous decision based on their knowing and understanding all the appropriate information. There was a presumption that the patient didn't need to know any more than what the doctor deemed necessary, and that they should be protected from being overburdened with information. This attitude was not malicious by intent; in fact it was probably motivated by the genuine desire to do no harm and to hopefully, do good.

The community is exposed regularly to

*"The enjoyment of later years is enhanced for residents of Rice Village by thoughtfully designed surroundings coupled with the security of ongoing care and spiritual support."*

## FEATURING

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*selected* information on health issues in newspapers and magazines and on radio and television. However, it is not easy for patients and potential patients to access libraries that hold more detailed and specific medical information. In the last 20 years people are demanding more and more information about their condition and possible treatments. In this era of rationing in health care where debates on funding occur almost daily, it is hardly surprising that people want to be more informed so they can be comfortable that they have been offered all the reasonable treatment alternatives.

People expect accountability from health care professionals and the health care system. There are many reasons for this increased demand for information and they may include the following. Firstly, patients are more interested in participating in clinical decisions as they feel that they have a right to determine their future either with, or without treatment. Secondly, advances in biomedical and public health knowledge are so rapid, immense and specialised that no single clinician can keep up with all the new developments. Thirdly, the aging of the population is increasing the demand for health information and support. This is especially pertinent because of the increased prevalence of long standing chronic diseases that can severely affect quality of life. Fourthly, people are increasingly using alternative health practitioners when conventional medicine cannot offer any treatment. Lastly, health prevention and personal responsibility for health is strongly being promoted and supported and this presumes at least a minimal understanding of the effect of risk factors on health.<sup>2</sup>

People who use the health care system have come to be known as clients, consumers and customers. The implication is that there is an expectation of a particular service. For there to be an expectation there must be some knowledge about what is

available, how to access it, and what may be the possible outcomes. These health care users are presumed to be 'in control' and if services are not delivered, or not of an acceptable standard, then someone or something is accountable. The 'patient' of old, implies passivity, someone who would be cared 'for' rather than someone who would demand and expect a service.

### *knowledge and hopefulness go hand in hand*

Although one may presume that there is a link between knowledge acquisition and improved health outcomes it cannot be assumed. The emphasis should not *solely* be placed on the individual to find out all they can and then act accordingly. Inequities in the social system and other restrictions mean that people do not always have the power to make autonomous choices especially when they are sick, in pain, frightened, or anxious. There are, however, other positive reasons for providing patients with information that improves their knowledge about their health. One study investigated the usefulness of a patient library in a suburban practice in Australia.<sup>3</sup> It concluded that research had shown that simply increasing doctor (and patient) knowledge does little to improve patient care, while a *process* that *empowers* patients to take control of their illness and *reinforces* a message presented by their general practitioners may be effective. In the case of cancer patients a growing body of evidence 'suggests that knowledge and hopefulness go hand in hand—patients who desire as much information as possible, both good and bad, are significantly more hopeful than those who prefer minimum information.'<sup>4</sup> In the case of devastating illness when there seems to be no logical explanation for the tragedy, the person and their family may at least feel some sense of control if they are able to seek and accumulate information.

### **The Internet and its Role**

## **as Information Provider**

Information about health and health care comes from a variety of sources. Healthcare professionals, the media, family, friends have all been quite longstanding information sources but it is the Internet which has changed the nature, location and timing of information available. According to Blouin and Brent 'the Internet is an electronic communications network that spans the globe, disseminating information through "world wide web" locations, allowing individuals the freedom to roam and browse through various web sites. Individuals generally may "surf the net" with little or no security access or personal use restrictions.'<sup>5</sup> The sort of health information available on the Internet includes: descriptions of the signs and symptoms of diseases; latest research; treatment options both mainstream and alternative; the personal experiences of those diagnosed with a specific condition or of those caring for such a person; and information about what the health care system can do and how to access it. There are even interactive chat groups where people can communicate instantly with each other about their experiences of illness. Such a variety of sites offer many approaches. 'Surfing the net' for health information is one of the most popular reasons for using the Internet.

It has been suggested that access to information provided on the Internet is likely to improve peoples' sense of control 'as well as their ability to participate actively in health care decisions with potentially better psychological outcomes.'<sup>6</sup> In the Australian context and other such countries where people live in remote areas, lack of access to health information is a problem. The Internet has the potential to solve, or at least reduce, the severity of that problem. There are however, barriers to Internet access that may include cost, illiteracy, language and disability and these need to be addressed. Most

health information on the Internet is text-based and therefore designed for educated, literate and non-disabled audiences.

Not only is information on various aspects of health care readily available on the Internet, it can be *rapidly* acquired without any visits to libraries, community health centres, or doctors' rooms. However, this relatively free access to information poses many concerns as it may be used improperly or in an unintended way and it may even be potentially harmful to the user. There have been reports in the media about people accessing firstly, information about, and then the actual drugs, on the Internet that can have potentially detrimental consequences if taken without professional guidance or recommendation. One author however, suggests that it should be up to the common sense and careful judgement of Internet users to decide what information is valid and reliable rather than it being evaluated prior to posting on the Internet.<sup>7</sup> This suggestion would seem to infer that all users are capable of making these judgements, which with the use of medical jargon and presumed prior knowledge, is not always the case. If information posted on the Internet has the potential to mislead the public it is not alone in its failing. Other forms of public information such as the print media or the broadcast media often over sensationalise an issue or new treatment leaving the consumer without the full information to make a reasoned assessment.

### Quality Assurance on the Internet

The issue of quality assurance for the information posted on the Internet is one which is of the utmost concern as more and more people are becoming reliant on it as their major, or only, source of material. It can be difficult to determine the difference between what is valuable and objectively useful from that which has a political agenda or

which is purely a money making venture. Some specific concerns about the quality of information found on the Internet that may both directly and indirectly adversely affect the quality of patient care include the following. There is a lack of quality review of information content; a lack of peer review; a lack of standardised references or citations in quoting information sources; inadequate listing of all authors, their credentials and importantly their affiliations; and information about devices or drugs consid-

#### *anyone with a computer and a connection to the Internet can be an author, editor and publisher of information*

ered experimental or not yet approved can be posted on the Internet. Basically, anyone with a computer and a connection to the Internet can be an author, editor and publisher of information and they can do so anonymously. The International Committee of Medical Journal Editors in their concern about unsubstantiated and possibly incorrect or harmful information posted on the Internet, have stipulated that the following criteria be included as a minimum: – 'the names of editors, authors, and contributors as well as their affiliations, relevant credentials, and relevant conflicts of interest; documentation and attribution of references and sources of all content; information about copyright; disclosure of site ownership; and disclosure of sponsorship, advertising, and commercial funding.'<sup>8</sup> If these criteria are followed lay people and health care professionals can reasonably judge whether what they are reading is credible, reasonable, or useful and they are enabled to make measured, informed decisions about how to apply this information in the real world.<sup>9</sup>

Another problem with the quality assurance of information posted on the Internet is that Web documents cited today might not be available in the future. Not only would the information be inaccessible but any conclu-

sions drawn from it could not be tested or verified.

### Distinctions

There must however, be a distinction made between quality as an information resource and the quality of knowledge. A high quality Web site on the Internet is one that is ergonomically constructed for ease of navigation for the user. The information needs to be easily located within the site and it may be useful for the site developer to know whether the site is being visited and how often. 'Knowledge, as distinct from information is concerned with questions of truth and validity. Knowledge achieves quality through a complex process of critique, review, and assimilation'<sup>10</sup> as discussed previously. One study in the British Medical Journal<sup>11</sup> found that there was great variability in both the content and validity of medical information provided to the public about caring for a child with a fever. In fact, the researchers found that only a few of the Web pages studied gave complete and accurate information (measured against a sort of 'gold standard' set by the researchers) and they were quite concerned about the consequences of this 'misinformation'.

### Finding the Information

Different search engines on the Internet implement difficult searches in different ways. The choice of terms can dramatically alter the number of results returned. It is doubtful whether a lay person would necessarily know the right search terms to yield the maximum amount of information. This would certainly be true if the information was being sought at a time of stress when either the Internet user or someone close to them was acutely ill, rather than at a time when the search for information was being done just for academic interest. Properly reviewed medical and health journals do put some of their articles 'on line' but to search a data

base such as *Medline* one has to have access through a library or be a subscriber and searching efficiently is a learned skill.

## Conclusion

People are going to seek information to help them understand and cope with an ill health condition. If the information is not forthcoming from healthcare professionals and the healthcare system in general, they will actively seek it elsewhere. This may mean 'surfing the net', self help groups or other means but if these methods are used *in collaboration* with the healthcare professional and the healthcare system, there is more chance that the effects will be of benefit to all parties.

The information obtained from such sources as the Internet, should complement, not replace that gained from the communication between the patient and their doctor. Technology, however, such as the Inter-

net if 'used appropriately can help people increase their knowledge of health, enhance their ability to negotiate the health care system, understand and modify their health risk behaviours, and acquire coping skills and social support.'<sup>12</sup> It would, however, be useful to know the effects of the World Wide Web on clinical practice in the healthcare system and on patient satisfaction before it becomes the only method of information provision.

### ENDNOTES

<sup>1</sup> Patrick J. Pemberton and Jack Goldblatt, 'The Internet and the changing roles of doctors, patients, and families,' *MJA* 169 (1998), 595.

<sup>2</sup> Thomas R. Eng et al., 'Access to Health Information and Support; A Public Highway or a Private Road?' *JAMA* 280/15 (1998), 1371.

<sup>3</sup> Ian Charlton, 'Usefulness of a patient library in a suburban general practice,' *MJA* 167 (1997), 581.

<sup>4</sup> Marion E. Morra, 'Comment on Protocol "Shopping" on the Internet,' *Cancer Practice* 3/5 (1995), 276.

<sup>5</sup> Ann Scott Blouin and Nancy J. Brent,

'Surfing the Internet Access, Use, and Implications,' *Journal of Nursing Administration* 27/No 11 (1997), 12.

<sup>6</sup> Alejandro R. Jadad and Anna Gagliardi, 'Rating Health Information on the Internet: Navigating to Knowledge or to Babel,' *JAMA* 279/8 (1998), 613.

<sup>7</sup> Shannon Bracken, 'Consumer Health Information on the Internet,' *Health Issues* 55 (1998), 11.

<sup>8</sup> Martin B. Van Der Weyden, 'Medical Information and the World Wide Web,' *MJA* 167 (1997), 572.

<sup>9</sup> William M. Silberg et al., 'Assessing, Controlling, and Assuring the Quality of Medical Information on the Internet,' *JAMA* 277/15 (1997), 1244.

<sup>10</sup> Jacqueline C. Wootton, 'The Quality of Information on Women's Health on the Internet,' *Journal of Women's Health* 6/5 (1997), 577.

<sup>11</sup> Piero Impicciatore et al., 'Reliability of health information for the public on the world wide web: systematic survey of advice on managing fever in children at home,' *BMJ* 314 (1997), 1878.

<sup>12</sup> Thomas R. Eng et al., *JAMA* 280/15 (1998), 1374. ✚

Deirdre Fetherstonhaugh

## Rogers v Whitaker, Chappel v Hart and the Evolving Nature of Informed Consent

*The two High Court cases of Rogers v Whitaker and Chappel v Hart have changed the nature of informed consent and send a warning to the medical profession in Australia. As this article shows, patients must be warned of all possible risks of proposed procedures.*

### The Bolam Principle

One of the most contentious areas of medical law in recent years in Australia has been the gradual evolution of the law requiring a doctor to provide a patient with adequate information about a proposed procedure. The rationale behind this is that the patient must be able to make an informed decision and give informed consent about a particular course of action. Unfortunately, as Dix *et al.* point out, the doctrine of informed consent is not applicable 'with any mathematical precision.'<sup>1</sup> Instead, it is 'no more than a recognition of the idea that the decision, either to undergo or forgo a procedure, is ulti-

mately that of the patient him or herself and the patient ought to be provided with sufficient information to allow the consent to be the product of a rational and intelligent process.'<sup>2</sup>

For many years the courts in Australia accepted what was known as the 'Bolam principle', named after the English case of *Bolam*.<sup>3</sup> Essentially, it allowed that if a medical practitioner, in informing a patient about a procedure or in performing that procedure, adhered to what was accepted practice amongst a responsible body of medical opinion, even if not by all, then he or she had fulfilled his or her obligations.

In recent years, however, two cases have gone before the High Court that have changed the Bolam principle for good.

### A New Direction

*Rogers v Whitaker*<sup>4</sup> concerned a plaintiff, Mrs Whitaker, who had surgery on her right eye at the hands of an ophthalmic surgeon. Mrs Whitaker had been blind in her right eye for many years but, at the age of 47, decided to undergo an operation to remove unsightly scar tissue from that eye. Although he told her of some risks, the defendant failed to warn her of the 1 in 14,000 possibil-

ity that 'sympathetic ophthalmia' or blindness might develop in her other eye. Mrs Whitaker had the surgery, blindness developed, and she sued her surgeon.

The case was not concerned with whether the operation was performed negligently. There was no argument that it was performed with due care and skill. Rather, it was concerned with whether the doctor should have informed the patient of the, admittedly very remote, risk of blindness.

The decision of the High Court

***patients should be given all information that they are likely to consider important***

changed the concept of informed consent. Rather than concurring with the surgeon's argument that given the low nature of the risk it was not necessary to inform Mrs Whitaker of the risk and that in not doing so he had acted in accordance with a 'responsible body of medical opinion', the High Court decided that patients should be given all information that *they* are likely to consider important. As the majority of members of the High Court said, 'The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk would be likely to attach significance to it.'<sup>5</sup>

However, did the fact that the surgeon failed to mention the risk to Mrs Whitaker actually *cause* her injury? Danuta Mendelson argues that the connection is remote and that 'there is a long bow between being negligently deprived of the right to make informed decisions ... and compensation for physical damage which results not from lack of skill

and care in the performance of the operation but from random and rare complications which are inherent in the nature of the particular condition that the operation is to remedy.'<sup>6</sup>

The High Court, however, clearly thought that the failure to inform Mrs Whitaker of the possible risks was a direct cause of her injury. It was stressed that Mrs Whitaker was a nervous woman who had asked the surgeon several times about possible complications. On the day of the operation she had asked if her good eye could be covered to protect it and she gave evidence that she would never have had the operation had the surgeon told her there was any risk, however remote, of blindness. The remote risk of blindness was of significance to Mrs Whitaker and in not informing her of this risk, and therefore leading her to have an operation she would not otherwise have had, the surgeon had caused her injury.

It was, in some ways, an unsatisfactory decision. While information about risks may make a difference if surgery is elective or cosmetic, as was the case with Mrs Whitaker, what if the operation had not been elective? What if a patient was not informed of a risk in an operation that was necessary?

***Chappel v Hart (1998)***

*Chappel v Hart*,<sup>7</sup> the most recent High Court case on the subject, was eagerly awaited in the hope that it would clear up whether the failure to warn a patient of risk in itself causes injury. Lavery says that those in the legal profession involved in medical negligence litigation 'were hoping that this decision would clarify many uncertainties resulting from the decision in *Rogers* six years ago.'<sup>8</sup>

The facts of the case were simple. Mrs Hart underwent an operation performed by Dr Chappel, an ear, nose and throat specialist. The purpose of the operation was to relieve

Mrs Hart's difficulty in swallowing, eating and digestion as well as a continuous sore throat, all the result of a pharyngeal pouch in which food was being caught. Dr Chappel proposed a procedure called a Dohleman's operation. During the procedure, Mrs Hart's oesophagus was perforated. The expert medical witness at the original trial testified that this is a well-recognised complication that occurs somewhere in the region of once in every 20 to 40 operations. On rare occasions, however, bacteria is present and there is a risk of inflammation. This may then lead to the remote possibility of infection and then loss of function in a vocal chord. Mendelson points out that 'until it actually occurred in Mrs Hart's case, this particular complication was apparently so rare that it was not described in medical textbooks.'<sup>9</sup>

Following the perforation of her oesophagus, Mrs Hart developed an infection and significant damage to her voice resulted. She was eventually forced to retire from her position as a senior teacher with the NSW Education Department on medical grounds.

Like Mrs Whitaker, Mrs Hart did not suggest that the procedure itself was negligently carried out. Rather, she argued that Dr Chappel was negligent in his failure to warn her that the surgery carried with it an inherent risk of permanent damage to her vocal chords. She gave evidence, and Dr Chappel accepted, that when asking about risks prior to the operation, Mrs Hart had said, 'I don't want to wind up like Neville Wran,' an allusion to the then NSW Premier.

Dr Chappel conceded that he had been negligent in not informing Mrs Hart of the possible damage to her vocal chords. However, he argued that this in itself did not *cause* her injury because, unlike *Rogers and Whitaker* where the operation was elective, Mrs Hart's surgery was necessary and could not be avoided.

Regardless of when she had the operation the risk was still there and she still had to have the surgery. Mrs Hart argued that if Dr Chappel had informed her of all the facts and risks she would not have undergone the operation at that time but would instead have had it at a later date at the hands of a more experienced surgeon. Interestingly, there was no evidence presented as to whether the risk of injury would have been lower if a more experienced surgeon had performed the operation. This seems to have been assumed.

## Causation

After ten months of deliberation the High Court found in favour of Mrs Hart. Essentially, in a 3:2 decision, it was decided that the failure to warn Mrs Hart of the risks *did* cause her injury, despite the fact that the operation was necessary.

Gaudron J. said that if evidence shows that the injured person would have acted to avoid the injury if adequate warning had been given, then common sense would say that the lack of warning caused the injury. She rejected the suggestion that the risk of injury would have been the same, saying that the damage that was suffered was not 'exposure' to risk but the actual harm that eventuated. Gummow J. followed what is called the 'but for' test, saying that 'but for' Dr Chappel's lack of warning Mrs Hart would not have had the operation. In all likelihood, he continued, if the surgery had been performed at a different time then Mrs Hart would not have suffered the injury and therefore Dr Chappel's failure to warn must have caused the injury. Kirby J. reached the same conclusions.

## Disagreement

There was, however, a significant minority of the court who did not agree with this reasoning. McHugh J., for example, compares the case to a defendant negligently failing to warn a plaintiff that a particular

route is subject to landslides. 'No causal connection will exist between the failure to warn and subsequent injury from a landslide if every other available route carried the same degree of risk of injury from a landslide. In such a case, the injury suffered is simply an inherent risk in the course of action pursued by the plaintiff.' In this particular case, he suggests, the *risks* are the same, regardless of when the operation is performed, or who performs it. Mrs Hart had to have the operation and the risk of injury would always have been there. She and Dr Chappel were just unlucky.

The disagreement between the members of the High Court shows just how difficult it can be for lawyers to give black and white answers to questions of this nature. In fact, as Lavery pithily puts it, 'the application of the "common sense" test of causation resulted in members of the Court questioning each other's common sense.'<sup>10</sup>

## Conclusion

It is difficult not to believe that the members of the High Court who dismissed the appeal by Dr Chappel did so in order to send a warning to the medical profession of the importance of supplying patients with *all* information regardless of whether or not the doctor concerned feels that it is necessary. This is particularly the case given the *lack* of evidence that at the hands of a more experienced surgeon the risk of injury would have been lower. Dr Chappel seems to have been punished for random chance. If all the circumstances had been the same with the one difference that Dr Chappel *had* warned Mrs Hart, then there would have been no liability.

With this in mind, Kirby J's comment that he was initially sympathetic to Dr Chappel's argument but eventually found against it because he felt that there was a need to set standards 'which uphold the importance of the legal duty that was

breached,' sounds as much like a social decision as a legal one.

Kirby J. reiterates that 'the requirement to warn patients about the risks of medical procedures is an impor-

## *Dr Chappel seems to have been punished for random chance*

tant one conducive to respect for the integrity of the patient and better health care. In Australia, it is rigorous legal obligation. Breaches must be treated seriously.' He goes on to say that, 'these standards have fairly been described as onerous. They are. But they are the law. They are established for good reason. When not complied with ... it should occasion no surprise that legal consequences follow.'

What *Rogers v Whitaker* and *Chappel v Hart* do is send a warning to medical practitioners. They must not make the mistake of believing that they know better than their patients. It might be true, but it is still the patient's decision to make. The High Court has just made that abundantly clear.

## ENDNOTES

<sup>1</sup> Andrew Dix et al., *Law for the Medical Profession in Australia*. (Melbourne: Butterworth-Heinemann, 1996), 2<sup>nd</sup> ed. 101.

<sup>2</sup> Dix, 101.

<sup>3</sup> *Bolam v Friern Barnet Hospital Management Committee* [1957] 1 WLR 582.

<sup>4</sup> (1992) 175 CLR 479.

<sup>5</sup> *Rogers v Whitaker*, 490.

<sup>6</sup> Danuta Mendelson, 'The Breach of the Medical Duty to Warn and Causation: *Chappel v Hart* and the Necessity to Reconsider Some Aspects of *Rogers v Whitaker*.' *Journal of Law and Medicine* 5 (1998), 312-318, 314.

<sup>7</sup> [1998] HCA 55 (unreported). URL: [http://www.austlii.edu.au/au/cases/cth/high\\_ct/1998/55.html](http://www.austlii.edu.au/au/cases/cth/high_ct/1998/55.html). All other references will be to this url.

<sup>8</sup> James Lavery. 'Chappel v Hart: the High Court's lost chance.' *Australian Health Law Bulletin* 7/3 (1998), 25-30, 25.

<sup>9</sup> Danuta Mendelson, 313.

<sup>10</sup> Lavery, 26.

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Anna Stokes

# Misuse of Prescription Medication

*This article outlines the growing problem of misuse and abuse of medication by some people in Australia. It then explores possible solutions that aim to improve the health of those people and questions whether the solutions maintain the privacy and confidentiality of all those who receive health care.*

## Prescription Medication as a Drug Problem

With the escalating drug problem in Victoria it is not surprising that recent statistics show that up to 10,000 patients a year are being treated in Victorian hospitals for drug overdoses. However, what can surprise some people is that most of those seeking treatment have not overdosed on illegal drugs but rather on prescription medications such as tranquillisers, anti-depressants and analgesics. Over the past two years the number of people overdosing on prescription medication has risen steadily.<sup>1</sup> The number of people who have taken deliberate overdoses compared to either the number who are first time drug users or who have accidentally taken overdoses is unclear. However, the problem that this crisis highlights is that people can gain access to large quantities of prescription medication as well as other potentially dangerous medication and that this can gravely endanger their health. The problem is not restricted to those who deliberately seek vast quantities of medication for recreational use. It also includes those who are not receiving adequate treatment for chronic pain and the elderly who are not always aware of the mixture or quantity of medications that they have been prescribed. I will first consider the case of those who deliberately seek prescription medications.

## Doctor Shopping

The term 'doctor shopping' is often used to describe the behaviour of people who visit numerous different GPs seeking prescriptions for particular medications. The Health Insurance Commission (HIC), which is responsible for Medicare and the Pharmaceutical Benefits Scheme

(PBS), has estimated that savings of up to \$31 million a year could be made by reducing the waste in both Medicare consultations and PBS prescriptions generated by doctor shopping.

The Health Insurance Commission defines a 'doctor shopper' as a person who visits more than fifteen GPs in a year and who obtains more medication than is clinically necessary  $\frac{3}{4}$  defined as approximately 50 or more PBS prescriptions during a 12 month period. Doctor shoppers, according to the HIC, obtain mainly benzodiazepines, which are anti-anxiety agents and muscle relaxant sedatives, narcotics and codeine compounds, which are used for the relief of severe pain.<sup>2</sup>

### *doctor shopping is a very complex medical and social problem*

In an attempt to reduce the cost of doctor shopping to the health care system as well as improve the health status of patients who are doctor shopping, the Commonwealth Government established the Doctor Shopping Project. The project's preliminary findings suggest that doctor shopping is a very complex medical and social problem and one that will not have an easy solution. In 1996-7, 10,114 people were considered doctor shoppers according to the HIC's definition given above. This at first may not seem to be an enormous problem. However, if the definition of doctor shopping is altered slightly so that it includes those people who see ten or more different GPs with in a 12 month period the number of people classified as doctor shoppers would increase to approximately 250,000. It appears then that there are a large number of people who need help to manage their health care because

people should not generally need to visit even ten different GPs within a year.<sup>3</sup> The difficulty at the moment is to identify the individuals who need assistance. Helping improve the health of individuals with a doctor shopping problem would also serve the government's aim of reducing the costs of the PBS and Medicare.

The preliminary findings of the HIC's investigation into doctor shopping provides statistical details about the geographical distribution of shoppers as well as their key features and the tactics that they use to acquire prescriptions. The statistics reveal that the majority of doctor shoppers live in the lower socio-economic suburbs of capital cities. However, the fact that wealthier doctor shoppers may exist is hidden because they may obtain their target drugs by paying for their medical consultation and obtaining their medication on private prescriptions thus avoiding Medicare and the PBS. Doctor shopping behaviour may be the result of poorly managed pain relief. An example may include those individuals who have started taking medication due to chronic pain but without the appropriate management plan or follow through by one doctor, have found themselves addicted. Alternatively, doctor shoppers may be experiencing chronic pain as a result of a medical condition and are seeking large quantities of medication in the hope of obtaining adequate pain relief. Most doctor shoppers are addicted to the medication they are seeking prescriptions for. However, some seek medication not only for their own use but also to sell.

## The Elderly

Increasingly, older people who are

living either independently or in aged care facilities are taking a variety of medications. While some have one GP they have seen for many years, others see several doctors or perhaps one doctor predominantly but for other small problems they may visit others. It is difficult for many non-medical people to remember what medications they are taking but for the elderly who may be taking a mixture of medications such as anti-hypertensives, blood thinning agents or a variety of other medications, remembering what drugs one is taking becomes increasingly difficult. Elderly patients then run the risk of not telling a treating doctor about their other medications and then be prescribed a medication that is incompatible with another one that they are already taking. The problem of mixing medications, the resulting adverse drug reactions and drug-related behavioural events are not confined to the elderly and such situations can result in hospital admission.

## Management of Medication Misuse

The aim of the Doctor Shopping Project is not just to reduce the costs of Medicare and the PBS. It also aims to improve the health of doctor shoppers, to reduce the number of drugs supplied in excess of therapeutic need and to reduce the risk of such drugs being misused by either the doctor shopper or other individuals. The doctor shopping project involves identifying doctor shoppers (sometimes after their suspected behaviour has been reported to the HIC) and then a HIC pharmacist makes contact with one or more of the patient's GPs prior to contacting the individual concerned. If the doctor feels that contact with the patient is appropriate, the patient is then asked whether they consent to the HIC having access to their medical records. If consent is given, the doctor shopper's case is reviewed and if they are found to have a problem they may either receive further counselling and ongoing treatment by one

GP or their future medication use may be monitored and counselling suggested if the problem continues. Severe cases of doctor shopping, in which there is an intent to deceive the medical practitioner by supplying false and misleading information, can constitute 'medifraud' and penal-

### *the Doctor Shopping Project aims to improve the health of doctor shoppers*

ties apply.

Another project aimed at reducing the harms caused by drug misadventure in the elderly involves consultant pharmacist reviewing and monitoring the medication of elderly patients especially in aged care facilities.<sup>4</sup> This project will also contribute to significant savings in PBS expenditure as a result of improved patient compliance, improved prescribing habits of doctors and a reduction in the number of adverse drug reactions.

## Pharmacy Intranet

In another project, the Pharmacy Guild of Australia hopes to establish a national Pharmacy Intranet in association with other interested parties. According to the Guild the Intranet would improve the timing and quality of communication between pharmacists, public funding and regulatory bodies. It is hoped that by the year 2000 all Australian community pharmacies will be connected to an on-line, interactive intranet. The Pharmacy Intranet would interface with a variety of bodies including: Governments, in order to check things like eligibility criteria for benefits such as the Safety Net as well as to check a patient's other medication purchases. Interfacing with other health care professionals would allow verification of prescriptions and interfacing with pharmaceutical manufacturers and wholesalers would allow on-line queries about product information and stock control. An additional interface with providers of a range of banking and financial services would allow for processing of claims (eg Medicare)

and common bill payments.

## Benefits of an Intranet

Individual consumers will gain some benefits from an Intranet especially older people and those with chronic illnesses. Such benefits might include assistance with medication management, easier eligibility checking for PBS and accurate recording of PBS Safety Net details, access to an electronic medication database and accurate provision of information about their prescribed pharmaceuticals.

Pharmacists will benefit by improving their role as a health care provider, reduced administration, enhanced knowledge base and electronic links with doctors for prescribing. Doctors will also benefit as a result of better communication with pharmacists as well as access to an enhanced database for prescribing.

The wider community stands to gain significantly if an Australia wide Intranet is established by improving control of medication abuse and misuse, reduced costs to the community as a result of a reduction in drug-related hospital admissions, better information available for emergency departments as well as access to quality information about medications, self-care, vaccinations etc available at pharmacies.

The Commonwealth Government has perhaps the most to gain by the introduction of a Pharmacy Intranet. The Government would have a better system for monitoring the cost of the PBS, reduced cost of the PBS because of the reduction in medication abuse and misuse, monitoring of doctor shopping and improved efficiency of administration. The Government would also have a more accurate means to administer the Safety Net and a framework on which to base other health payments.

## Ethical Issues in Monitoring Medication Use

I have already detailed the potential benefits of the doctor shopping project and of the future Pharmacy Intranet. However, these types of projects can only be conducted using information that has been generally accepted as private and confidential. Risking patient confidentiality and privacy cannot be done without a serious reason. Adequate safe guards must be put in place to ensure that such information remains as pri-

***the community stands to gain significantly if an Australia wide Intranet is established***

vate and confidential as possible. HIC pharmacists contacting suspected doctor shoppers' GPs prior to receiving an individual's consent to do so, might be a breach of confidentiality. GPs discussing the physical and mental state of a particular patient without that patient's consent does not seem appropriate. Perhaps, patients should be contacted by the HIC prior to the HIC requesting information from GPs. Suspected doctor shoppers should be approached by counsellors to investigate whether an individual has a doctor shopping problem, is addicted to prescription medication, or suffers chronic pain which requires above standard treatment with pain relief medication. The individual should then be asked if the HIC can liaise with the individual's GPs.

The Pharmacy Intranet also raises privacy and confidentiality issues. They too should inform all their consumers that information about their medication is being held on a central pharmacy database. While an individual's consent should always be sought regarding medical information the law does allow for exceptions to be made.

Medicare and the PBS are part of the publicly funded Australian health care system. The government has a responsibility to the community to ensure that the limited funds available for health care are spent in the most effective and appropriate ways. Spending millions funding unnecessary medical prescriptions and GPs

visits is a waste of precious health care dollars. As a result regulatory bodies such as the HIC should ensure that as little waste occurs as possible whilst attempting to maintain patient confidentiality regarding medical information at all times. Those people using vast quantities of prescription medication, which is not needed for a medical condition, should be located and supported to give up their doctor shopping habit. People must realise that medical resources cannot be misused in such a way.

## **The Law, Privacy and Confidentiality**

The Commonwealth *Privacy Act* provides that a Commonwealth agency that obtains information for one purpose cannot use it for any other purpose unless:

- The person has consented
- It is necessary to prevent serious or imminent threat to someone's life or health
- It is required or authorised by law
- It is reasonably necessary for law enforcement or revenue protection; or
- It is directly related to its original purpose.<sup>5</sup>

This Act then supports a pharmacy intranet as long as a consumer gives consent or there is reason to believe that a person's use of medication poses a serious risk to their health. Section 130(3) *Health Insurance Act* (1973) and section 135(A) of the *National Health Act* contain exception provisions which enable the release of personally identified Medicare and PBS information in certain circumstances where this is considered necessary in the public interest. Guidelines have recently been established to distinguish 'necessary' from 'convenient' and 'helpful'. Individuals whose information is to be released should be consulted and their consent sought where it is reasonable to do so.

*Medicare and Pharmaceutical Benefits Programs Privacy Guidelines* are issued under Section 135AA of

the *National Health Act* 1993 and are legally binding. The guidelines provide that:

- Medicare and PBS data must be stored separately and linked or combined only in defined circumstances for short periods of time.
- Claims information should be de-identified after it is five years old. There is a provision to re-identify information and the guidelines set out the circumstances and safeguards.
- Under 1996 amendments, data which is the result of linking, comparing or combining records or information, must be destroyed within three months of being brought into existence.

These guidelines certainly restrict the use of medical and PBS data. Linking this kind of information appears to be the most effective and perhaps only way of preventing harm to individuals who misuse prescription medication. If an individual's consent is sought wherever possible prior to the release or linking of information then both the doctor shopping project and the Pharmacy Intranet appear to be ethically acceptable ways of preventing harm to individuals. In particular, it will help the elderly and all those who may deliberately or accidentally misuse prescription medication. At the same time both projects will help to reduce any unnecessary costs of Medicare and the PBS.

### **ENDNOTES**

<sup>1</sup> Darren Gray, 'Most overdoses on legal drugs,' *The Age* 21 January 1999, statistics supplied by the Victorian Injury Surveillance System.

<sup>2</sup> Alison Stanfield, 'Consumers Shop Till They Drop To Obtain Adequate Treatments,' *Links: Consumers and General Practice Newsletter* No 18 July (1998), 3.

<sup>3</sup> Health Insurance Commission Professional Review Division, 'About Doctor Shopping' <<http://www.hic.gov.au/HTML?PRS?dshop.shtml>>

<sup>4</sup> The Pharmacy Guild of Australia Website <<http://www.guild.org.au/community/facts/consultant.htm>>

<sup>5</sup> 'Getting Connected: The National Pharmacy Intranet Demonstration Project,' Discussion Paper Sept 1998. ❖

# Ethics and the Practice of Psychiatry. A Brief Review.

*This article explains the professional role of psychiatrists, starting with the training required, their ethical code and their relation to other doctors. There follows a discussion of the ethics of confidentiality and privilege, the use of legal powers, and the misuse of skills and boundary violations.*

A psychiatrist is by definition a medical practitioner who works with patients who have mental difficulties and biopsychosocial problems. Contrary to some current beliefs, especially in some migrant groups of our population, psychiatrists do not only deal with those having severe mental illness such as schizophrenia, psychotic forms of depression and the dementing and related disorders. Whilst they do handle such things and some psychiatrists specialise in dealing with those patients, psychiatrists are also involved in helping people deal with a whole range of emotional and behavioural problems, including complicated and unusual personalities.

The training profile varies from country to country but here in Australia and New Zealand the psychiatrist has undertaken at least: six years of under-graduate training to qualify as a doctor; an obligatory internship year usually in a hospital context; an additional one or two years in further experience of a clinical nature, usually in general medicine or neurology.

That is to say that by the time the trainees leave the various programs, they have had extensive and intensive experience in the biopsychosocial aspects of human life and its consequences and methods of helping where necessary.

There has of course at times been much criticism of the medical model and sadly the majority of such criticism is biased and worse ill informed. Perhaps a precis as I see it of the medical/psychiatric model might help towards understanding. The task of the doctor/psychiatrist is to determine

1. What is the problem?

2. How did it seem to come about?
3. Who is the person who has this problem, and how did they get to be that person?
4. Can/should anything be done to help, and if so, what?

This seems to be relatively simple but it requires sophistication and knowledge to do it well. The decision to intervene or not, and to what end, can be critical. One must establish the difference between normality of behaviour and reaction, and pathology. In the latter case it is necessary to establish that the problem is, or may, or can become, biologically or psychosocially disadvantageous to self or others.

All doctors are registered and this is required by law in each country.

***the decision to intervene or not, and to what end, can be critical***

The registration to practise is based on the primary medical degree. Other higher degrees or specialist diplomas or fellowships are noted. The entitlement to practise as a specialist and to receive appropriate rates of payment as a specialist from insurance and government agencies is determined by a special body. Its determination results from assessment of postgraduate training and qualifications.

## Ethical Code

All doctors are bound by the same basic code of ethics and in addition to that, are also bound by codes of ethics of associations to which they may belong, such as the AMA or colleges related to specialties.

A rather basic, often unwritten but always taught, concept or instruction does or should underwrite everything that we do. 'First do no

harm.' Nevertheless, one must understand that occasionally that cannot always be achieved for in dealing with some disaster or other, for example a terrible cancer or infection, at times normal tissue or organs may unavoidably be damaged whilst trying to remove or cure the illness. This also to some extent can apply to psychiatric problems.

I will not elaborate upon the general ethical codes but move specifically to those applying to psychiatrists. In Australia and New Zealand, the vast majority of psychiatrists belong to the Royal Australian and New Zealand College of Psychiatry.

The summary of that college's code of ethics is as follows:

1. Psychiatrists shall have respect for the essential humanity and dignity of each of their patients.
2. Psychiatrists shall provide the best possible psychiatric care for their patients.
3. Psychiatrists shall hold information about the patient in confidence.
4. Psychiatrists shall obtain consent from the patient before undertaking any procedure or treatment.
5. Psychiatrists shall not allow the misuse of their professional knowledge or skills.
6. Psychiatrists shall continue to develop their professional knowledge and share this knowledge with colleagues and other relevant health professionals.
7. Psychiatrists shall share the responsibility of upholding the integrity of the medical profession.
8. Psychiatrists conducting clinical research shall adhere to those relevant ethical principles embodied in national and inter-

national guidelines.

9. Psychiatrists in their society shall strive to improve the quality of psychiatric services, promote the just allocation of these services and contribute to the education of society regarding mental health.

Such principles overlap in some respects, or are identical with, those applying to medicine in general and other specialties. Some of them apply specifically to psychiatry at least to a great extent. The fundamental Hippocratic principle that whatever the physician does should serve the benefit of the patient is, or should be, the drumbeat behind everything else in relation to practice. Nowadays socio-political and economic constraints increase the degree of difficulty in achieving that good across the whole of medicine and certainly in psychiatry.

In a brief presentation like this one can only touch on some of the major issues which preoccupy us.

## Issues

First and most important to consult and/or be treated by a psychiatrist is essentially just the same as being treated by any other specialist. Also many family physicians have some psychiatric skills and in fact all under-graduates have a short period of psychiatric training as in the other specialties. Some family physicians

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specialist***

choose to take further courses in psychiatry and many GPs, if not most, use some psychiatric skills informally or formally in their ordinary work. Of course they very properly refer to the specialist when the nature of treatment, and or its intensity, warrant such referral—which may also be required for diagnostic purposes. Psychiatrists also work closely with other specialists

and family doctors in relation to a wide range of primarily non-psychiatric illness. This is most clearly seen in consultation liaison work where psychiatrists often belong directly to the surgical or medical team. Here the relationship between mind and body becomes most evident. Vital and innovative work has occurred across the fields, but especially in oncology, pain control, mutilative injuries or surgery, other body image problems and rehabilitation. An important ethical issue here is the provision of such consultation. If, for whatever reason this is not done, the patient is effectively deprived of a demonstrably valid aspect of care.

## Confidentiality and Privilege

All doctors are bound to keep communications between patients and themselves in strict confidence. There are few exceptions to this. In normal practice including that of psychiatry, it is wise and necessary to keep notes and other records and of course office staff have access to such files when handling them. The staff too are bound to keep anything they may learn about patients as secret. Where other doctors and nurses form part of a treating team it is proper and essential to have appropriate communication again with the confidence requirement.

Where the confidence can be broken is under instruction from a court in criminal matters, but not usually in civil cases. Also a patient can ask for his/her information to be provided to others for purposes of consultation with other health professionals or to aid their own lawyers. In some specialised forensic assessments for legal firms, statutory bodies, e.g. TAC or Workcover, the presumption of confidentiality does not apply with reference to the assessment and provision of a report and the patient does, or should, understand this. In some other areas there is a statutory requirement to act—for example if one becomes aware

that child sexual abuse has occurred then one must notify. Also one is allowed to breach confidentiality in the public interest in a case where one knows that there is possible imminent danger of serious physical assault to another by one's patient—that is to warn the other person.

## Legal Powers

Doctors have been given unusual legal powers in society. This is to ensure that patients who need treatment for their own care and protection or that of others and who cannot or will not consent to such treatment, by a process of certification (of one form or another) can be constrained and required to have treatment. Such treatment can occur either in a hospital setting, or nowadays in the community. Contrary to

***doctors have not been trying to  
control or certify any and every-  
body***

popular belief born out by my own experience in psychiatry over forty-five years as a specialist, doctors have not been trying to control or certify any and everybody but the reverse, trying to have people freed from legal restraints and back where possible to the community. In any case, in Victoria, the certifying process is bound by a variety of qualifications and constraints and subject to review by a special board. (These controls derive from a report into the Mental Health Act in Victoria and recommendations for change—which led to the 1986 Victorian Act. I was one of the three authors of that report).

## Misuse of Skills

The knowledge and skills of psychiatrists can be, and have been, abused and have been so abused particularly when affected by fanaticism of belief and political force. In Nazi Germany an Act was passed in relation to 'lives unworthy to be lived' on which the euthanasia program for mental defectives and

chronic psychotics was based. In that program some very eminent doctors/psychiatrists participated. At the same time one must realise that it progressed in much secrecy and the majority of German doctors and psychiatrists had nothing to do with it. Some very prominent psychiatrists used their skills and power to subvert political/military action and protect individuals from death by giving them psychiatric illness status. One is also reminded of the German psychiatrist in World War 1 who placed himself on the same rations as his patients and lost over 40% of his body mass.

There is much literature about the abuse of psychiatry in Russia, with dissent against the communist regime being called illness and often brutally treated as such in special hospitals. It was a major scandal and subject to much international adverse comment. However, an old Polish friend told me that the reverse applied in Czarist times when political prisoners were at times called mad by the psychiatrists to prevent them being killed or sent to Siberia. Things turn around.

## Boundary Violations

Another major ethical concern is that of boundary violations of a sexual nature. Here we are talking of adult to adult sexual activity and not that involving children. Such boundary violations are common across the professions and by no means only concern doctors or psychiatrists. For

example psychologists, teachers, nurses, ministers of many denominations, Roman Catholic priests and religious etc. The boundary violation involves an abuse of power, breach of the fiduciary relationship and a failure to understand and deal with the dynamics involved. In fact, many studies indicate that doctors and psychiatrists are no more likely to offend than members of other such groups. However, a number of factors peculiar to psychiatry warrant consideration. (Before attending to that I must exclude the person who is simply predatory in any profession who deliberately uses his/her position to exploit and abuse the interaction.) Boundary violations are regarded as improper, harmful and damaging, in both the short and long term.

The problem for psychiatry lies in the duration of treatment and interactions, which in some, especially psychotherapeutic forms of treatment, can be both intensive, prolonged and in an emotionally intimate way, in a proper professional sense. There are considerable dangers in such work. Subspecialty training is usually required, or certainly advisable, for those undertaking such work. In the general training, young psychiatrists learn about the emotional intensity and the complex entanglements and mutual misperception which can arise from what is called transference and counter transference in patient or doctor. Great skill is needed to deal with these feelings and ideas to help avoid muddles where such

ideas or feelings are seen as 'real', rather than projective aspects of a complex interaction, which properly handled, can form vital parts of therapy. If not properly handled, they can be very destructive to both patient and doctor, both personally and professionally when boundary violations occur. Such matters are dealt with very firmly by the Medical Board and the College of Psychiatrists. Such boundary violations do great harm to the patient, the medical profession and how it is regarded by the public. Nevertheless, it is important to remember that the vast majority of doctors hold firmly to the ethical beliefs and requirements.

It is interesting that codes of conduct established at least 2,500 years ago have endured so well. Probably because they have demonstrated the core needs of good healthy clinical practice and have proved beneficial to patients, the community and the medical profession. Cosmetic changes have occurred over time to cope with social and technical change, yet the core remains the same. Hippocrates, or whoever actually wrote the oath, should be proud.

✦

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