



2 November 2001

Health Records Act Implementation Group
Office of the Health Services Commissioner
Level 30, 570 Bourke Street
Melbourne VIC 3000

Original sent by email c/- hra@dhs.vic.gov.au

**PROPOSED STATUTORY GUIDELINES UNDER THE
HEALTH RECORDS ACT 2001 (Vic)**

Thank you for the invitation to comment on the draft Statutory Guidelines which address those matters specifically requiring published guidance by the Health Services Commissioner.

The ADAVB recognises that improvements in medical and dental diagnosis and treatment are dependent on evidence-based research, and in the promulgation of research findings to practitioners so that they advance their knowledge and skills.

Essentially, we have little concern about the application of the guidelines to any research activity that may be undertaken by our members either on their own account, or in relation to projects mounted by third parties. Likewise, we do not anticipate any issues or problems in connection with application of the guidelines to any research we may conduct ourselves, or have conducted on our behalf as a professional association.

Possible requirements to notify all patients of record within a practice of the closure or disposal of a practice may however be onerous, especially given the high turnover of patients in many practices, and we therefore suggest that the most simple and cost effective measures should be considered in this area.

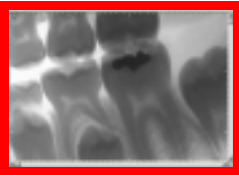
Branch representatives would be pleased to hold further discussions with HSC officers to expand on the matters contained herein, if this is helpful.

Yours sincerely

A handwritten signature in black ink that reads 'Garry Pearson'.

Garry Pearson
Chief Executive Officer

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1. RESEARCH GUIDELINES – HPP 1.1 (e)(iii) & HPP 2.2 (g)(iii)

Q.1. What research activities does your organisation undertake that involves the collection, use or disclosure of identifying health information (including health, disability or aged care information)?

Many dentists are involved in research activities, whether it be on their own behalf, as part of post-graduate academic work, or in preparing presentations to colleagues at seminars, conferences, and more privately at study club functions.

The ADA is not a clinical research body that uses identifying health information. However, case study material is often published in its Newsletter as part of the continuing education function. Furthermore, the ADA also conducts numerous seminars and conferences at which individual patient conditions and case studies are highlighted.

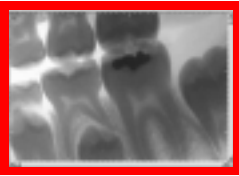
Federally, the Australian Dental Association Inc. (ADA Inc.) provides secretariat support for the Australian Dental Research Foundation (ADRF), which funds various research activities by dentists. The ADA Inc. also publishes the Australian Dental Journal, which is the pre-eminent dental research journal in Australia. The State and Federal parts of the ADA are autonomous, but affiliated. The ADAVB has therefore drawn the attention of the proposed guidelines to the Federal body's attention.

Dentists, Risk Management advisors and Association representatives all make use of clinical information in educational programs. Patient identities are never highlighted, although in rare circumstances a clinical image may identify a patient to someone they know simply by virtue of the unique nature of the patient's condition e.g. facial scarring.



Q.2 If your organisation does not undertake research itself, does it disclose the information for the purpose of research (by allowing outside researchers access to the health information held by it)?

Members of the ADA are occasionally asked to complete surveys and questionnaires to assist student research projects, public sector agencies or indeed the Association itself. No patient identifying information is sought in these, and the statutory guidelines are unlikely to be involved.



Q.3 What processes are in place for approval of research or research requests?

The ADA's research activities are generally limited to obtaining opinion from members or the public on various policy issues, and so any data sought from these sources is unlikely to involve identified personal health information. What research is done requires approval by the Branch Council or Executive Committee.

The ADA does not initiate clinical research projects, but if asked to participate in data collection (refer Q.2 above) will not do so without evidence of ethics approval for the project.

Q.4 What processes do you currently adopt to determine whether to collect, use or disclose health information for the purposes of research?

Dentists involved in lecturing and presentation roles will select treatment examples which effectively illustrate a technical or clinical issue. Identifying details are removed in such cases

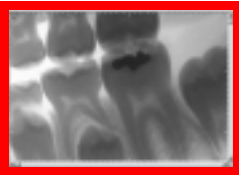
Q.5 What aspects, if any, of the practices outlined in this paper would be appropriate for your organisation?

Research: The ADA has only occasional arms-length involvement in research activities. Some of our members however, are active researchers. Either way, the National Health and Medical Research Council (NHMRC) Guidelines are appropriate and receive conformity.

Sale, transfer or closure of a practice: This is an issue that concerns the ADA and a greater number of members from time to time. Our views on the matter are detailed in response to Questions 11, 12 and 13 below.

Q.6 For those organisations which do not currently have access to an ethics committee process for review of research proposals, would access to such a committee be appropriate? If not, what other mechanisms might be appropriate?

Individual dentists involved in formal research are required to carry this out through either an academic or research institution that has an Ethics



Committee. For example, the ADRF uses an ethics committee process, and this would be one of the main avenues through which our members might be involved in research proposal review.

The ADA is not involved at first hand in such clinical research, and therefore is only obliged to check the approval and credentials of anyone seeking assistance with a research proposal.

Q.7 **Would the criteria listed on pages 12-13 and in Appendix 2 provide sufficient basis for guidelines for the purposes of HPP 1.1 (e)(iii) and 2.2 (g)(iii)?**

Yes. The list is broad enough to encompass all circumstances in dentistry.

Q.8 **What changes would be needed to adapt them for use:**
➤ **in non-institutional settings?**
➤ **by organisations that do not provide health, disability or aged care services?**

None in a dental context.

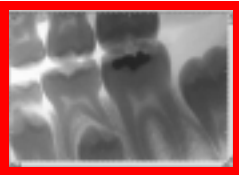
Q.9 **From a consumer perspective, what mechanisms would be appropriate to ensure that the privacy of health information is safeguarded when research of the type discussed above is being contemplated?**

Anonymity of individuals, especially in the case of widely based, representative data collection, where obtaining individual consent is impractical.

Q.10 **Are there particular categories of information or consumers which would warrant additional or different standards being set?**

Not in connection with particular categories of dental research.





2. SALE, TRANSFER, AMALGAMATION OR CLOSURE – HPP 10

Q.11 What additional steps should a health service provider be required to take to notify users of the service of the sale or closure of the practice or business?

The discussion paper canvasses a range of options from the present requirement of a newspaper notice through to a full mailout to all patients of record within a practice. Given that the average turnover of dental patients in a general practice is around 25% per annum, and that practices in transient areas such as St Kilda and Elwood might have an annual turnover of 60%, the more onerous approaches are impractical.

Depending on the extent to which the guidelines require practitioners or organisations to notify **all** patients who have attended for treatment, the direct and indirect costs of compliance could run to tens of thousands of dollars.

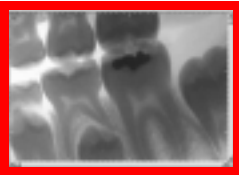
It is generally considered that a lapse of over twelve months, places a patient outside the category of being a patient of record. The ADA's own principles of ethical practice highlight the following:

“It must be recognised that patients have a right to consult any dentist, or change dentists at will, even during the course of treatment.”

In these more consumer oriented times, dentists are no longer able to think of their patients as having a lifelong commitment, or even an extended commitment, to their practice.

Where a practice has been sold, it will often be a requirement of the sale contract, especially where part of the sale price included a goodwill component, that the vendor provide the purchaser with a letter of support for distribution to patients of record. This should not be made a mandatory requirement however, for each and every practice sold as a going concern.

Walk in and walk out arrangements are rare when dental practices are sold, and there is often a defined period where the departing practitioner will work alongside the incoming owner to assist in the transition.



As patients contact the practice for their next appointment, they will be advised of the changed ownership, and will of course have the opportunity then to decide whether they wish to remain patients of that practice. The new owner is likely to announce their involvement in the practice by public notices and paid advertisements, and in local communities, word of mouth also plays a significant role.

As regards closure of a practice, we suggest that if any further notification requirements (over and above newspaper publication) are imposed they should be advisory in nature, and may include:

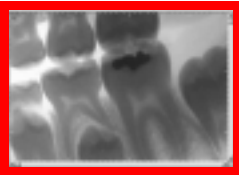
- posting of a sign on the door or external wall of the practice;
- mailout to all patients who have made forward appointments with the practice, or who are considered to be undergoing a continuing course of care; and
- recorded message, for say 2 months, on the old practice phone number.

We are loath to accept that a surviving spouse or an executor (as distinct from a Trustee) should be made subject to financial sanctions for breach of these guidelines (should they become part of the statutory guidelines), as provided for under the Health Records Act.

Indeed, while there was comment on the enforceability of the Statutory Guidelines, we did not find any discussion of the sanctions issue in the Issues Paper, and would welcome further comment on this matter by the HSC.

It is not clear to us what provisions apply to the resignation of a registered health care provider from a practice in which they were the sole responsible custodian of confidential records. Where a registered practitioner resigns from a corporation or dies, who bears what obligations under these guidelines? In some corporatised practices, a Clinical Director is placed in charge of clinical data, which is separated from address and account data used for administrative purposes. The clinical records are considered to form part of the assets of the practice but access is restricted to qualified and registered personnel.

Sometimes when a practice is closed, the goodwill (and therefore the records) may be sold to another practice. In these circumstances, there would usually be a letter from either the original practice or the new one, advising of the changed circumstances. This form of record transfer is not the same as when a practice is sold as a going concern.



Q.12 Should different notification requirements apply when a practice or business closes down due to the death of a health, disability or aged care service provider? What would they be?

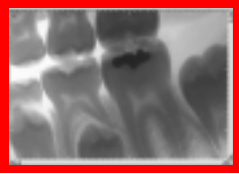
The same approach suggested above should be used, although obviously those patients who were in the middle of a course of care would need to be advised to either seek further treatment from another practice of their choosing, or ideally be appropriately referred for further care. Again this approach should be recommended via advisory rather than statutory guidelines.

Similar arrangements would need to apply where a practice was closed due to the de-registration of the practitioner. In this case however, it is not clear who would be responsible or “in control”, since unregistered and unincorporated persons may have no accountability to either the HSC or the registration board.

Notification arrangements where a practitioner has their registration and practising rights suspended due to a finding of unprofessional conduct by a registration board, need to be considered according to the circumstances of each case. In most instances, the patients affected will be readily able to complete any short course of care with another dentist nearby, however this will not always be so easy.

In one recent case, the ADAVB was obliged to arrange for around 60 patients who were in the middle of orthodontic courses of care to be referred on to (numerous) other practitioners, when an orthodontist was suspended with only a few hours notice. Our concerns about that problem were subsequently acknowledged by the Board, and in a later case involving orthodontists, efforts were made to ensure that patients were provided with continuity of care.

In the initial case, obtaining and transferring the relevant records was an onerous and demanding task. As it happened, most patients needed to have their treatment recommenced, and those dentists who took over responsibility for these orthodontic patients were generally obliged, and indeed would elect to develop a fresh diagnosis and treatment plan, and to generate their own primary records from scratch.



- Q.13** Would the notice requirements appropriate for patients or clients with ongoing and primary care relationships with their health service provider be appropriate for situations where the relationship is of a different order, such as with pathologists and radiologists? If not, what notice requirements should apply?

These relationships are only transient ones, and the laboratories and individuals involved return all key records relating to the patient to the primary care provider. There should not be any requirement for such ancillary services to notify patients of sale, closure or sale.

END