AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

Submission of the Australian Medical Students' Assocation (AMSA) to the Senate Community Affairs Committee Enquiry into the Personally Controlled Electronic Health Records (Consequential Amendments) Bill 2011 and the Personally Controlled Electronic Health Records Bill 2011

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Preface

The Australian Medical Students' Association (AMSA) is the peak representative body for the 16 491 medical students in Australia. AMSA connects, informs and represents students studying at each of the 20 medical schools in Australia.

AMSA has been an active contributor to the development of the PCEHR. During 2010 and 2011, we participated in the National eHealth Transition Authority's (NEHTA's) stakeholder consultation meetings. We are pleased to see that some consideration of medical students has been incorporated into the legislation.

The medical students that AMSA represents will soon graduate and enter the health workforce. Training future doctors to effectively use and advise patients about the PCEHR will help drive the adoption of this new system in the medium term as students progress through their training. There is considerable opportunity for NEHTA and the government to engage with students, universities and individual medical schools to drive adoption of the PCEHR and AMSA hopes these opportunities are taken advantage of.

Summary of AMSA Recommendations to NEHTA

In principal, AMSA is supportive of the implementation of the PCEHR provided that it

1. does not act as a barrier to the provision of medical education by healthcare organisations and/or individual providers
2. maintains existing arrangements for delegation of authority to medical students and appropriate supervision of students in the clinical environment

Specifically, AMSA believes that

1. the legislation should specifically refer to medical students as a separate category requiring access to the PCEHR
2. medical students must be able to access the PCEHR as required during the course of their clinical training.
3. Through registration with AHPRA, medical students should be granted an HPI-I, which could only be attached to the HPI-Is and HPI-Os of supervising doctors and organisations.
4. sufficient resources, training materials and support (both practical and financial) should be provided to healthcare provider organisations and universities to ensure that medical students are thoroughly trained in the use of the PCEHR; and
5. training materials and support for curriculum development should be made available to medical schools. This should include practical and financial support.
6. medical students should not be subjected to the same penalties as registered medical practitioners if they fail to meet the expected standards of practice.

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1. Legal status of medical students

The establishment of the Australian Health Practitioner's Regulation Agency (AHPRA) in 2010 has formalised the legal status of medical students within the overall scheme of healthcare provider registration. This legislation recognises that the privileges afforded to medical practitioners in the healthcare system are limited with respect to medical students. It also identifies that the corresponding responsibilities that medical practitioners must meet are also limited when it comes to medical students. This includes standards of conduct, reporting requirements and payment of fees.

This is consistent with a common sense approach: while medical students are being trained, they ought to have limited rights and limited responsibilities in comparison to medical practitioners.

AMSA is concerned that the difference in rights and responsibilities between medical students and registered medical pracititioners is lost in the PCEHR Bill.

The Explanatory Memorandum accompanying the PCEHR Bill states that medical students are included under part (b) of the definition of an 'employee' in clause 5: "an individual whose services are made available to the entity (including services made available free of charge)." This implies a new legal status for medical students in the healthcare system.

AMSA is concerned about this implication and strongly recommends that this distinction is maintained. In order to do this, the legislation must recognise the established fact that students have limited rights and responsibilities while they are being trained.

Further, the current legislative provisions threaten to undermine the current arrangements of supervision of medical students in the clinical environment because:

1. the PCEHR legislation authorises students through the authority of a provider organisation
2. existing practice authorises students through the authority of an individual provider

Whilst a variety of arrangements exist between universities and hospitals to support students in clinical placements, in the majority of circumstances existing practice authorises students through the authority of an individual provider. The inconsistency between current practice and the PCEHR legislation, which authorises students through the authority of a provider organisation, is likely to compromise the current system of clinical supervision, as well as create difficulties for medical students to access the PCEHR system.

Recommendation 1: we recommend that the legislation specifically refers to medical students as a separate category requiring access to the PCEHR

2. Use of the PCEHR by medical students

Students need to access the PCEHR

Medical students are routinely required to access and use patient information as part of their clinical training, often for the purpose of assisting the provision of healthcare to patients. For example, medical students may be required to record notes in patient health records on hospital ward rounds, and to retrieve pathology or imaging results. Students are often required to present in-depth case reports for the consideration of clinical teams and to draft referral letters in general practices, which, along with other clinical activities, require detailed knowledge of patients' medical history.

These activities are an essential part of training for medical students that is normal to the current practices of providing healthcare in supervised teaching environments and consistent with the goals of the PCEHR.

Potential problems with the proposed system

Students are resourced by universities, not by healthcare provider organisation. AMSA is concerned that the current legislative provisions, whereby students need to be granted access by each healthcare provider organisation that they are placed in, do not allow for a range of situations where students will need to access the PCEHR.

After seeking feedback from AMSA representatives at each medical school in Australia, we have found there is a variable level of integration into existing healthcare provider organisation health record, identification and clinical software systems. In some instances, students are allocated an ID card and have access to electronic medical record systems. In other instances students are provided little or no direct access.

Currently, many students and junior doctors overcome this limitation through practical and informal arrangements whereby students gain access to patient information by utilising the account of a registered user. This is based on trust, and reflects the fact that the students activities are directly supervised by the doctor. However, this informal delegation of authority is imperfect, because it is an inconsistent and unreliable method to provide access to students and undermines the ability to track all users of the patient record system.

In some situations medical students are not seconded to an organisation at all, but instead work with an individual supervising doctor wherever they practice. For example, visiting specialists in rural areas often visit many organisations in the course of a short visit. A situation where medical students learning from visiting doctors are required to be authorised by multiple organisations is unlikely to be practically effective. However, under

the current framework students will not be able to access the PCEHR under the authority of the individual doctor. For many students such arragements may constitute a very large proportion of their exposure to a particular medical speciality or area of practice.

Solution

Students could be granted an HPI-I, which could only be attached to the HPI-Is and HPI-Os of supervising doctors and organisations.

This would require additions to the Concept of Operations, and to the legislation. However, it would provide a much more consistent approach to the way that students currently work within the system of healthcare delivery. Students are already registered with AHPRA, and so the processes to issues a supervised or conditional HPI-I could be adapted from existing processes. Given that students always have a supervising clinician or organisation, it would simply formalise this existing structure with respect to the PCEHR.

Recommendation 2: medical students must be able to access the PCEHR as required during the course of their clinical training.
Recommendation 3: through registration with AHPRA, medical students should be granted an HPI-I, which could only be attached to the HPI-Is and HPI-Os of supervising doctors and organisations.

3. Training medical students to use the PCEHR

In section 8.4.2 of the Concept of Operations of the PCEHR, there is some mention of resources for training and support during the implementation period. It appears to us that this refers predominantly to existing healthcare providers, and is not oriented towards future providers.

Support for teaching and training on the PCEHR

Practical support, in the form of training materials, curriculum development and suggestions for outcome and teaching points, form an important part of an overall drive towards adoption of the PCEHR. These could be adapted from planned training material, or could be specific to the university setting, for example taking the form of a dummy version of the online access portal for use during problem based learning scenarios.

Financial support for teaching and training is equally important. Analysis by the Medical Deans of Australia and New Zealand (Medical Deans) demonstrates that it costs between $50,727 and $51,149 per year to train a medical student. Currently universities only receive a proportion of this required funding from the Federal Government. Medical Deans state that there is a shortfall in funding of approximately $23,500 per year per medical student.# This figure does not take into account unpaid teaching, which comprises a very significant

proportion of medical education particularly in the clinical years of each medical program.

For a full discussion of funding arrangements for medical schools, please see the AMSA policy on "Funding of Medical Programs" at http://amsa.org.au/content/official-policy.

Without additional funds and practical support to teach and train students to use the PCEHR, it is very likely that this material will either not be taught, or will be added to the increasingly unsustainable unpaid work contributed by medical professionals to teaching medical students. It is essential to the future of healthcare delivery in Australia that the significant work and investment in the development of the PCEHR is also put in to training those future professionals who will use it the most.

Recommendation 4: sufficient resources, training materials and support should be provided to healthcare provider organisations and universities to ensure that medical students are thoroughly trained in the use of the PCEHR.

4. Administrative provisions of the PCEHR

Identification requirements

We have drawn attention to the variety of situations in which medical students are seconded to healthcare provider organisations in the course of their clinical training, and some of the issues arising from this.

Section 74 of the Bill establishes that these organisations will be responsible for ensuring that full identifying information is communicated to the system operator about every individual that accesses the PCEHR, and that this need happen every time a record is accessed. There is a penalty attached for each breach of this requirement.

Administrative red tape as a disincentive to train students

We are concerned that this requirement will add substantial administrative overheads to the process of accepting students into clinical settings for training purposes. Consequently, we are concerned that this additional administrative overhead will form a disincentive for medical practitioners and healthcare provider organisations to accept medical students for clinical attachments, and a disincentive for them to use the PCEHR.

It is clear to us that clinical training capacity in Australia is already stretched too far. From 2004 until 2010 medical student numbers increased by over 65%, increasing from approximately 9000 students in 2004 to over 15,000 in 2010.# Rather than introduce new disincentives and administrative barriers to accepting medical students into healthcare provider organisations for clinical training, we should be looking to provide incentives and break down barriers.

For a full discussion of increased medical student numbers and consequences for training, please see the AMSA policy on "Increased student numbers" at http://amsa.org.au/content/official-policy.

Recommendation 5: we recommend that training materials and support for curriculum development be made available to medical schools. This should include practical and financial support.

5. Penalty provisions

Penalties for unauthorised use

Clause 59 and clause 60 of the Bill provide for penalties against any person who accesses and uses information in the PCEHR without proper authorisation.

This is in line with the approach of the medical profession to patient privacy and the confidentiality of personal medical information. During the course of their studies, medical students receive thorough training on maintaining professional standards of patient confidentiality.

The Federal Government already recognises the unique position of medical students under the AHPRA legislation and AMSA recommends that a similar approach is taken to the PCEHR legislation.

The legislation must recognise that, while students are in the process of being trained on the principles and application of patient privacy and are required to access patient information as part of their course of study, it is inappropriate to hold students to the same level of accountability as registered medical professionals.

We expect to be held to a high standard and we aspire to fully uphold professional standards throughout our training. However, we do not believe that breaches of these clauses by medical students should result in the substantial financial penalties that are specified.

Recommendation 6: medical students should not be subjected to the same penalties as registered medical practitioners if they fail to meet the expected standards of practice.