Introduction

Dr David Gronow

The talk tonight is the reform of the NSW Coronial System and we have 2 speakers who are going to speak to that the first tonight will be Dr Robert Day. Robert is currently the Director of Emergency Medicine at the Royal North Shore Hospital in Sydney and has been in that role since 2006. This is an extremely busy unit and has seen 90,000 patients in 2018. He is an emergency medicine specialist and a fellow of the Australian College of Emergency Medicine since 1993. He has been a Clinical Senior lecturer with the University of Sydney and has extensive experience in disaster medicine and medical commemoratory of the City of Surf race from 2018. He has also been extensively involved in Medico Legal reporting both to the NDO's and to the Coroner, so welcome and we look forward to your speech.

Dr Robert Day

Thank you very much for the invitation to speak tonight. I'm going to leave the Reform of the Coronial system to Hugh who obviously knows a lot more than that than me. I'm going to talk about a slightly different aspect of something that does impact on the Coronial cases as well as the Medico Legal cases involving NSW hospitals and that's around the growth and evolution of the electronic medical record.

When I do expert reviews, I often get one, two, three or four folders of notes that have been printed out and it's becoming less and less representative of what's actually within the electronic medical record and I thought that it was important that people like this group know what those changes have been, and what's actually out there, maybe even from a personal point of view.

First, just a brief history of how the electronic medical record has developed over the past 12 years. It was only in the early 2000's - emergency department have been a bit of a canary in the coalmine with a lot of these electronic records - and in the early 2000's we had a thing called EDIS. It was just a patient tracking system there were no real notes associated with it.

From about 2007 there was money put into the system to develop a more comprehensive electronic medical record and in 2008 there was Cerner, which is a big American Multinational IT company, and a product of theirs called 'Firstnet' which had started to roll out throughout all NSW hospitals, and then in 2010 a business case was approved to roll out beyond emergency departments and throughout the whole hospital system. The aims of the electronic medical record have been very worthwhile with things, like to have an actual integrated system where all patients notes and their radiology and pathology all immediately available, where doctors seeing a patient can come and consult their past records at that point, they can see records from other hospitals , where people have been recently. It really improves quality of patient care and efficiency and safety and of course the inputs of management data by which hospitals are run.

In 2011 there were a lot of negative reviews of what was happening and there was a big independent review of the Firstnet system across emergency departments run by Deloitte's and Firstnet was about as popular as rabies. 98% of users were dissatisfied with it,- it was slow, it was unreliable, it kept breaking down and it was very clunky. It took lots and lots of clicks to get to anything that people actually wanted to do and it was really reducing productivity. As usual there were the excuses as to why it wasn't working and then they decided to do something abut it and there was a remediation plan - so over the next few years there were various upgrades to the electronic medical record. It was introduced across all NSW hospitals and not only to emergency

departments .It was bought into inpatient care, outpatient care and even things like surgical theatres.

So where are we up to now?

The first thing is that it's probably not 98% popular now but it's much, much better and more reliable - I think no one would go back to paper notes anymore. All documentation is now done on the electronic medical record, there are a few paper remnants but not really many remaining. All pathology and radiology can be ordered and looked at on the system, all observations that patients have like their vital signs are all recorded in the system and we can access previous medical records for patients increasingly right across the system as I'll show you. As I said it's not just emergency departments it's right across the hospital spectrum now there is an electronic medical record so there is a thing called 'PowerChart ' for inpatients, there is SurgiNet for operating theatres and they are well integrated, those 2 systems. There are a number of other bits and pieces that aren't that well integrated; there is an imaging radiology information system that is only partially integrated. Just in the last year there is ICU system called 'eRIC' that's been rolled out that isn't integrated at all with the rest of the hospital computer system. There is a thing called the NSW HealtheNet which is linked to 'Firstnet' and the impatient PowerChart and through that we are able to see radiology that's done in other hospitals - we are able to see notes in other hospitals and we are able to see people's MyHealth record now. So there is a huge amount of data out there that is able to be accessed.

We've got this very broad and complex electronic medical record and one of the issues is that it is held among multiple systems which are partially integrated with each other. There are still a few bits of paper floating around and now certainly for staff looking after patients there is now this huge amount of data on patients that is available whenever they present to hospital. One of the issues is that it is seen as the source of truth, so that everything in that record should be factual but of course as more and more people are inputting information into it and there is a large amount of data and things can be repeated and repeated and so there is often questions about what's written in there and what's been written multiple times whether it is a complete source of truth. We know in fact that it is not often.

I think that a lot of these issues are problematic for both medical staff looking after patients and for the legal system. So for doctors, there is vital information about patients hidden in these systems at various different points, but there are often no pointers as to where that information lies. With the vast amount of information that's available, it's difficult in one encounter to actually necessarily access all that's there. There are not good summaries in the notes as to what the issues are for patients. As I said the one question is about the truth, is it factual information that you read in the last entry? And increasingly - you see this a lot - is that because it is an electronic record, people are often slow typers, a lot of the young doctors are incredibly quick typers, but people like myself are slow typers, because of time constraints people usually cut and paste or they use shortcuts that mean that the information is often repeated because its been cut and pasted again and again or they use shortcuts that may not reflect what's actually going on. In the last 12 months we've had the electronic medications as well so the old paper medication charts are now a thing of the past which has caused a whole new set of problems with medication errors that weren't there before because we're using a new electronic system which people have all been trained in using but it's a very, very complex system.

Issues for medical reviewers of documents is when you get all those folders, the question is, is all the relevant documentation there? And I'll talk about this more in the next few slides.

These pre-formatted notes are often a shortcut that doctors can just press a button or two and a whole set of notes can come up which they can then amend for each individual patient. Of course a lot of things may not be that relevant and when you're reading notes there is a question whether a lot of it has been performed or not. And again this cut and paste of summaries of old notes which are then put into current notes don't talk about whether that history has been taken and if it's true. You see a lot of things that have been repeated and repeated now for years and they then become the truth.

One of the issues with electronic records is the loss of flow: in the old written notes you get one note continuously flowing with another. That isn't necessarily happening as much anymore - people can modify notes, the notes can be written at a later time so then they go in at the time that they've been written not necessarily when the patient has been seen. Importantly there is a real loss of flow with the way notes get put in one after the other by lots of different people. Often it's very hard to find out what the actual thought process was of people as they wrote those notes - they were seeing the patient and come up with differential diagnoses but a lot of that is lost in an electronic record.

For the legal and paralegal system, as you request a hospital to produce notes it's a clerk in medical records who is responsible for printing out all those notes and with the electronic medical record, it really is a function of their training and what they know what actually gets printed out. And clearly not all the available medical records are being produced and I don't think that's necessarily anyone's fault. I think that a lot of it is the complexity of the system. Some of the notes are transient particularly in the way they are formatted and it may not be possible to produce some of the notes that are there. I'm going to got through a few examples of things that may be missing. This is normally the documentation tab. It is just one tab and that is normally what gets printed out and not much more. There are pages and pages of other documentation of things that people have put into the record. There are lots of other things - this an extract where someone has rung into the emergency department saying that a patient is coming in. There a lot of notes around that for a patient coming into hospital but I don't think I have ever seen one of those produced in medical records that I have been sent. This is the summary page that we use as our basic page looking at patients and going through all their data but again this is just a transient page that will be lost once a patient, for instance, leaves the emergency department. Where the arrow is, that is our link to HealtheNet . We can go into HealtheNet and we can see various bits of information from the patient outside of the hospital so we see the hospitals that they've been to in the past, we can see all their imaging and pathology from hospitals that they've been to and we can also now see if someone has a MyHealth record and we can see the data in that. Of course there are levels of privacy to stop us looking at it if people have put barriers there but there's also a break the glass that we can use in an emergency situation where we actually really need to see their medical data and they get notified about who has looked at that. As you can see this has opened up an enormous amount of information that is available.

This is the electronic chart that all people's vital signs or observations go into. You occasionally see it but it's very rarely reproduced. There are various alerts that patients may have in their file that we may see when they arrive into hospital but again it is not a something that will generally be produced in a medical record. There are lists of orders and lists of times and all those orders are things that have been done, so blood tests, medications and again - this is not something you would usually see in a medical record being produced. That's the electronic medication chart and this is a summary sheet that lies behind the patient medical record - it is a list of everything that happened to them, when they were seen by people, when things were ordered, when tests were done, when

tests arrived. It's incredibly useful. When I'm in my hospital position looking at what's happened to a patient this would be the first thing I'd look at but again I've never seen one in a medical record. It comes back to the question of what is the medical record for the patient. When we consult different teams in the hospital, when people go to beds and things like that, there are records produced when all that happens and when the consult is made and again this is all in the background of the medical record but not necessarily in any documentation.

Recently when I did another talk for a medical audience I had a look through 75 cases that I had done for the TMF over the last 5 years and I looked over some of the issues around those cases that were common issues - but certainly documentation was one of the issues that came up again and again. And there really is not a lot of evidence that having an electronic medical record is improving documentation and a lot of it is around the use of preformatted notes that have a lot of information but don't really clearly say what's been done, the use of cut and paste and just writing things done , not of when advice had been sought and who it was sought from and a list of diagnoses. Often a diagnosis has to be put in the system, but often it has to be related what's called IC D 10 coding to allow billing and things that like that to happen - but it's often not highly related to the real diagnosis the client has. It's one of the issues with electronic medical records and from my point of view there was often, in written documents, more synthesis of thought about what was happening with the patient and with a electronic record with people typing this tends to get lost.

So where is the EMR going to?

We've got a very complex system which I think is only going to increase as more and more areas become part of it in the hospital. I think there are a lot of not integrated or poorly linked systems at the moment. I think this volume of information about patients is only going to increase and there are various implications that we'll have to think about.

The whole process has clearly been of benefit for both patients and for clinicians. I think there are a lot of privacy issues in that a large numbers of health providers have access to medical records and, ensuring patients' privacy across a whole system is maintained, is a huge issue for us. It's really vital that there is correct information in the record and that records are corrected if incorrect information is in there. There's no mechanism to do that at the moment, so for clinicians and for reviewers and probably for coroners as well there is information overload now with the large amount of records that is available for everybody. There is an underlying issue of accessing all that information and getting it presented. At the moment most of it's coming but there is a lot of relevant material that isn't appearing in records that are being sent. I think we are getting to a point that somebody is actually going to have to forensically look at the electronic record, on a computer, rather than getting reams of paper or folders. There is a question about what is the patients' health record. There is a lot of ancillary data and summary data that is able to be generated from the record and there is question about what should be available as part of the health record and what is the background information that isn't necessarily available.

This issue of information overload is going to be increasingly important for us. The question for reviewers of notes and for coroners is going to be about, with all this information available, the medical staff and other staff only have a set period of time to be able to actually look and see what is actually in that record. There is going to be vast amount of data available to them so what is reasonable?

Dr David Gronow

Well thank you, I think that has probably raised a few questions for later on. I would now like to introduce our second speaker, Hugh Dillon. He is an Associate Professor of the University of NSW Law School, he is a retired Deputy State Coroner and a Magistrate to the end of 2016. He was appointed Magistrate in 1986 and the Deputy State Coroner in 2008 and has conducted numerous high profile cases and enquiries and inquests. Before his appointment as a magistrate he practiced law in the NSW Council of Social Services and the NSW Ombudsman and the Commonwealth DDP. He was a member of the National Judicial College of Australia and in 2014 a Churchill fellow, his project being the development of ideas for raising the coronial performance standards. He has edited the NSW Australian Coroners manual in 2015. Welcome.

Dr Hugh Dillon

Well thank you. I think we're just going to have a new slideshow.

Well, David, thank you very much for that introduction and I'm honoured to be invited by the society to speak to you tonight about a topic that I think is important and is certainly very important to me. It's great to see some old friends here, this is not a light topic I have to say and I'm not here to amuse you really. I'm sure all of us this week have been thinking about death and death investigation due to the appalling events in Christchurch which have left so many people shattered and terrified and bewildered. Those events have caused a massive ripple affect across our country, across New Zealand and around the globe. I'm sure like me most people in this room are feeling bewildered and possibly broken hearted by the fact that so much cruelty has been inflicted on so many innocent people and particularly by an Australian, some of the victims were as young as three years old. We all know that sudden death is shocking and confusing, it staggers us when it happens and especially when it's violent.

One of the reasons for having Coroners in coronial systems is to help bereaved people, relatives and others involved make some sort of sense of what has happened. Communities are also affected, families and communities want to know why these things happen and whether we can do something about it to prevent them happening in the future.

People sometimes talk about closure, personally I don't believe there is such a thing as closure after such a sudden or violent or bewildering death but I do think finding answers helps. People have burning questions and sometimes if Coroners can help the bereaved find answers to the burning questions that can give them the courage to face the challenge of going on living. Which is often a genuine challenge. I can't imagine what it's like to be part of that community in Christchurch, but some people will be wondering what its all about and how they can possibly find the willpower to go on living. So, Coroners and Coronial systems can play an important role I think in supporting those people in facing up to those challenges, unfortunately though, in NSW anyway, I don't think that our system is up to the task. I think that our system finds it difficult to find the support that those people need or all those people want.

So why do we need reform?

I think we need reform because the system is obsolete. It was designed in the days of the steam age. The 1901 Coroners act gave the Magistracy the control of the Coronial system and it has remained in the hands of the Magistracy ever since. Frankly the structure hasn't changed very much at all since 1901, and I think we need reform not only because it's old and obsolete but like stream engines, which the best of them operated at around 8 or 10 percentage efficiency, the Coronial system isn't very efficient and there are better alternatives available. Unlike most Coronial systems in Australia and indeed the world, the NSW system is a small component of a much larger organisation - the

NSW Local Court. So the Coronial system itself is under resourced, has a flawed structure, is subordinated to the priorities of a much larger organisation and the work is entirely different from the day to day work of Magistrates. The Local Court is a high volume criminal court which places enormous emphasise on clearance rates. It seems to me that there's very little room for compassion in a system that places such stress on KPI's and if a culture of compassion isn't what drives or motivates Coroners or what that system is all about, if that culture of compassion isn't animating a coronial system then I wonder what the point is. Now some senior Magistrates in NSW refer to the Coronial jurisdiction as a tick in box or a tick and flick jurisdiction. Now that phase implies opening files as fast as possible and closing them again with a minimum amount of effort. It implies, I think, a profound lack of understanding of the complexities of coronial work, it also implies a lack of respect for the dead, for their bereaved relatives, for coronial work itself and for the potential of the coronial system to prevent future death and injury. And possibly it implies a lack of respect for corners and those that do coronial work that includes solicitors, barristers, doctors, many others, police officers court counsellors and others who are involved in this system. And while I endorse the need for efficiency in Coronial work I don't think the cultures fit together at all I believe they need to be separated. But there are other reasons I think for a Coronial system.

I'm going to put up some statistics that I hope you can all read.

There are about 6,600 deaths reported to Coroners every year in NSW. In NSW we spend about $1,065 per case, in Victoria they spend about $2,600 per case, in Victoria they spend about 16.5 million per annum on recurrent expenditure in their system. In NSW we spend about 6.5 million a year on recurrent expenditure. We have the 4th highest or 4th lowest clearance rate in the country, in the Commonwealth, we clear about 98% of cases per year in our Coronial system. The real problem though is not the statistics per se but the structure of our system. The comparison between Victoria and NSW goes beyond simply statistics and how much money they spend and how much money we spend. In NSW about half the cases that we get are reported to Country coroners, country magistrates. In NSW country magistrates are also Coroners, so say something like 46 – 48 % of cases go to them. That's a throwback I think to the steam age. Now it may be that NSW, because of the hidden costs that aren't necessarily quantifiable spend, maybe it's possible that we spend almost as much as the Victorians do, but if that's the case then we are giving a poor-quality service for all that money spent and if that's not the case then we are getting cheated in my opinion. Why is that? It's because the Victorians have a made for purpose system. They have a specialist Coroners court with 9 Coroners, we have 5 full time coroners positions, our country magistrates are also criminal lawyers who spend most of their time doing criminal work, they do Coronial work after hours and some of it they don't do themselves. They get support staff to make many of the decisions.

Country magistrates are not resourced, nor are they trained, nor do they get the volume of work that you need to develop coronial expertise. So people in the country are getting a second rate service compared with those who are in the metropolitan area who are having their cases dealt with by full time specialist coroners. I'd like to say I think that the current group of coroners that work at Lidcombe are possibly the best team of full time Coroners NSW has ever had. It's an excellent group. It's the system that's the problem. For historical, cultural and administrative reasons the system is poorly organised, it's really sort of a cottage industry. Coroners can make their own decisions about what inquests they conduct, there are a small range of cases which our mandatory, such as homicides, missing persons, deaths in custody, deaths in police operations but by and large most of these cases which could go to inquests but aren't going to inquests because Coroners can make decisions saying I'm not going to hold an inquest.

The last recorded full year which was 2017, there were only 84 inquests held in NSW. Twenty-seven of them were held in the country, now there are 36 country magistrates so on average country magistrates are doing less than 1 inquest per annum per coroner. That's important because if you think that the importance of the Coronial system is not only finding out what happened, but partly it's about trying to prevent future deaths, then it's in holding inquests that death preventative recommendation can be made. If we're doing so few inquests this system isn't working properly.

That I think is a sort of representation of the kind of system we have it sort of works, it's a Heath Robinson machine if that means anything to anybody. A Heath Robinson machine is a strange device for doing things that's cobbled together in an extraordinary way, and this is a sort of joke example of it, which is in Birmingham Museum.

So what's happening?

There is a review at the moment which has been conducted since 2014 by the NSW Justice Department. To me this review seems to be a process a little bit like a thing they are trying to emerge a thin man from the body of a fat man. There is a contest of ideas and it's a struggle. A number of people and organisations like the the Law Society, like Community Legal Centres, like PIAC, Public Interest Advocacy Centre, the Crown Solicitors Inquiry Group Lawyers, Ex State Coroner Michael Barnes, me and others have been arguing to the Attorney General and to the Justice Department that we actually need a whole new system, we need a specialist Coroners court which will be a multidisciplinary system. For reasons I've touched on my preference would be for a whole new Court or Tribunal even, which would be completely divorced from the Local Court.

Change is frequently unpleasant for organisations as we all know. Robert Day's description of the new medical record system I'm sure created some wringing of hands in the medical system in the hospitals. Change is difficult, in the NSW Local Court, predictably there is resistance and there is defensiveness. Criticism is regarded in some quarters as personal criticism and of course it's not but it's regarded that way. So there is a struggle, an intellectual struggle but it's also a political struggle. It is evidence to the NSW Parliament's Legal Affairs Community in September last year, the Attorney General conceited that there are 2 views about the future of the NSW Coronial System and they're are irreconcilable. So the hope is that this review that is currently being conducted will resolve that contest of ideas, presumably by the end of this year we'll know the outcome. I'm hoping that there will be a radical change.

In my view the NSW Government needs first to decide what the purpose of the Coronial system is and then to design its organisation around those purposes or that theory or policy rather than the reverse, trying to retro fit it as it has been for the last 118 years or so into the Local Court, into the Magistracy. And I think that the principles that we need to think about when we're thinking about such a project are these; respect for human life - you would think that would be fundamental and it is fundamental, its human life. Protection of human life is a basic human right. But if you think about this throwaway line about the Coronial system being a tick and flick jurisdiction or a tick a box jurisdiction there's not much real respect then shown for that fundamental human right, that principle. The second idea I think that needs to be embraced wholeheartedly is the idea of the system being used to prevent future death and injury and if you adopt that principle, I mean everybody working in the system believes that, but that has implications and it's the implications that are really the problem. We can give tacit consent or we can even give it express consent to the idea, we can nod towards it but it has implications and the third principle I think is one of the implications. We need to adopt a public health and safety approach and an epidemiological approach. Some Coroners at Lidcombe have embraced this fully, for example, one of my friends here

is counsel assisting in an inquest that is going to be conducted into deaths at music festivals. They are going to take the approach of looking at a number of these cases seeing what are the risk factors, who are the populations at risk and what are the measures that might be taken to mitigate or even eliminate those risks. That's the epidemiological approach, that's how the coronial system can do its best work in my opinion given the scarcity of resources for many of the people that we care about.

A fourth principle of course is that this system can be used to heal people, not just grieving families but also others who are involved in these deaths that come before the Coroners. I have seen a number of cases, and my friends who are involved in inquests have seen numbers of cases with a catharsis of healing occur. There's a case that my friend Peggy Dwyer who is here tonight and I did many years ago that involved the death of a young woman in the country. She was a rouseabout in the shearing team and the family were distraught at her death of course and had many, many burning questions and at the end of the inquest, I left the bench and walked out haven given my reasons and my counsel assisting, Peggy Dwyer came to my room and said 'Come and see this' and I opened the door into the courtroom and there was the father of the girl who died and the man who ran the sheering team hugging one another in tears, both of them were crying and both of them had come to a relationship of reconciliation. Those are magic moments of course and they don't happen all that often but that sort of healing is happening I think regularly and more often then we expect in these sort of cases and the more we can create these sort of events, those sort of opportunities for people, doctors being able to talk to their patients when they are advised by lawyers not to or these sort of things perhaps, the open disclosure system aught to work better than having doctors being able to talk to their patients or to their patients families only at an inquest 2.5 years after the event.

But inquests can have that healing affect, but not just an inquest, these 6,500 cases are all worthy of some sort of therapeutic approach. All those 20,000 odd - I suppose it is families or family members that lose their loved ones deserve some sort of respect and some sort of healing approach from our Coronial system.

The fifth principle I'd like to underline is the question of the accountability of the state, of course it's obvious in relation to deaths in custody and police shootings and the like, but there are also cases such as when involuntary patients die in psychiatric units or something from psychiatric units, when kids in care die, when elderly people in care die, when disabled people die, when the state has some sort of duty of care or some sort of moral responsibility for these people the Coronial system of course can keep the state or bring the state to account. This does not mean we take a shame and blame approach, very much the reverse. Bringing the state to account can mean looking at systems, how did the system fail these people, if it did, sometimes it didn't, sometimes the system did a very good job and the death was one of those things, it was unfortunate, that happens often. But in scrutinizing these cases we keep the state honest or can keep the state honest.

The sixth principle I think is that the coronial system has to be treated as a multidisciplinary complex, it's not just Coroners, Coroners are just lawyers. They are not medically trained, they're not scientifically trained in those cases and they work with many others that make a contribution to the system. Forensic pathologist, family counsellors, police officers, lawyers who represent people, lawyers who assist Coroners, ad hoc experts, Rob Day for example has written reports for Coroners on a number of occasions and including for me. Those people are all involved in the system and we need to respect their roles and the important contributions they make, they are all integral parts in the system. This should not be seen as some pyramidical structure, where starting with the Chief Magistrate at the top and working our way down to the bereaved families. The bereaved families are an important and integral part of the system too, they have things to say, they have questions to

raise and of course the service should be all about them. One of the lessons, I should say I've been lobbying government now since I left the Coroners court at the end of 2016 and I was doing my best when I was within the system to try and push fresh ideas along as well. One lesson that I've learnt over the last few years of lobbying is that having good ideas is not enough, a form has to be driven and governments have to be brought to see a problem before they see a solution. It's a surprisingly slow process I have to say, I'm amazed that after the review started in 2014 I'm standing up in front of you and still arguing for a change and still haven't seen a final report of this review. And as I say there is a thin man trying to get out of the fat man and the fat man is - possibly we could call it a bloated bureaucracy - I'm not just quite sure of that. Anyway it's a very slow process and I remain hopeful.

So what's it all about?

Some of you may recognise this sculpture if you've ever been to Berlin, if you haven't been to Berlin you should go, but if you have been to Berlin you should see this sculpture, it's in a small building on the Neue Wache and it's in the German memorial to those who died in the wars of the 20th Century. And the sculpture, the artist is a woman called Kathe Kollwitz. Kathe Kollwitz left Germany in 1933, she was an anti-Nazi, she hated what the Nazis stood for and after the war she was bought back to Germany and she was invited to make this sculpture. It's of a mother and child. I'm sure you can see that. But it's particularly moving, I think it represents grief, it represents loss. For me it represents how all these people in Christchurch are feeling, all people in London are feeling and elsewhere, and other places are feeling, but it also represents all the grief and the loss that the relatives of the 6,500 people whose deaths are reported to NSW Coroners are feeling. It's that's sense that Samuel Johnson the great English writer talked about there will be no remedy for grief, of us wanting to turn time back, to have that time back again. Kathe Kollwitz lost her son in the first months of the First World War, she knew that kind of grief intimately, she saw her son I suppose before he went to war but she never saw him again. And it's that sense of loss that makes us want to bring back time, bring back that person that we have so suddenly lost.

We can't do that of course but we can do something to help heal that feeling, to give people courage to keep going and to find real meaning in their lives. That's all I have to say about this and I thank you for listening to me.

Dr David Gronow

Thank you very much to both the speakers, we have some brief time for some questions from the floor. Information overload.

Guest –

My name is Jimmy from Westmead. I would like to ask a question is regarding the medical record and who owns it. And the context of the question is really because I'm working with some US researchers and the context of the question is regarding the core medical record and what the medical researchers in the US where there is such a legislation called a [ ] legislation according to the data within the medical record belonging to the patient. Now in stem cell research, cloning your gene is vitally important but it's not protected but isolated from the insurance industry, particularly when you're dealing with genetic disorders. Do you know what the legislation is actually saying in this country?

Dr Robert Day

There are probably more expert people than me here who know a lot more about it. But certainly in the NSW hospital system the patient doesn't own the medical record, of course they have access to the record and freedom of information that they can see their own medical records and everything is there but it is being done with another person there to explain the record to them if they need to see it. Of course there is also privacy legislation which is very important as well that if you can see the record and access to those records, your specific question though I can't answer.

Guest (Richard Jones)

Thank you, Richard Jones, I have a question for each of you. For Dr Day, it worried me a little bit that you said it's not the real diagnosis for billing purposes. If it's not the real diagnosis in these electronic records what's the use of it? And I had a question for Mr Dillon, you said that a Coroners services should be healing, but I wonder how that can be healing 2.5 years down the track.

Dr Robert Day

Every patient who comes through an emergency department or who goes through the hospital system has to have a diagnosis or number of diagnoses put into the system and those diagnoses are then used and put into groups to fund the hospital system with things called NWAUs that are national weighted activity units that are then used to fund hospitals. It is mandatory for every patient that goes through the emergency department to have a diagnosis put in and those diagnoses have to be picked from a list and sometimes the list doesn't really explain what's going on with a patient very well but the diagnosis always has to be in there, so often a diagnosis you see on a discharge letter or a list of differential diagnosis is not necessarily, usually it's related to, but not necessarily exactly what happened to the patient. And of course it's very beneficial for hospitals to have lot of diagnoses and lots of high paying diagnoses, so there are actually people called 'coders' in the hospital medical records department who go through patient records to extract various diagnoses that will pay well through a patient stay so a lot of this is related to money.

Hugh Dillon

May I call you Richard? The question that Richard Jones raises I think is a really interesting one and it's a very important one. You're right. There is a difficulty in bringing about healing 2.5 years after the event. A very good example of that is an inquest I did involving a woman who died in a cardiology procedure, or as a result of a cardiology procedure. The cardiologist in the inquest asked me whether he could speak directly to the family and I said yes. He turned to the family and the husband of the woman who died shouted at him 'If you said something 2.5 years ago it might have made a difference'. He was not open I think to the possibility of a therapeutic approach at that time. On the other hand I don't think it can't happen. Many of the inquests, including the one I spoke about with the young woman in the shearing team, died around about 2 years before the inquest was held. That's not ideal I would say. Personally I think grief has an arc, somewhere around about 12 months to 18 months is a time when people can cope with an inquest without being retraumatised by it. But I do know that we can do better than we do. In Ontario they run very few inquests, they do about 20 a year but they have many more informal meetings, for example between medical practitioners and families, a sit-down meeting, sort of open disclosure that I suppose it is, but not just with medical practitioners but with police officers, prison officials and others. I think we can employ that sort of procedure a lot more than we do. There is already some work being done and done everyday along those lines, there are court counsellors, there are counsellors in the department of forensic medicine, there are groups who support the families of suicide victims and other things which are related to the Coroners court. So it's not all about

inquests, in fact most of it is not about inquests. I think we can certainly do better and that should be acknowledged by the Justice Department.