

**THE AMA'S SUBMISSIONS ON
DRAFT HEALTH PRIVACY GUIDELINES**

2 August 2001

INDEX

1. **An Overview**
2. **Comments as to Format and Process**
3. **Comments on the Preliminary Views expressed in the Guidelines**
 - 3.1 The effects of the narrow interpretation of 'primary purpose'
 - 3.1.1 The meaning of 'primary purpose'
 - 3.1.2 The meaning of 'directly related to' and 'secondary purposes'
 - 3.1.3 The effects on consent requirements
 - 3.1.4 The effects on collection
 - 3.1.5 The effects on use and disclosure
 - 3.1.6 The effects on destruction of records
 - 3.1.7 The effects on the good practice of medicine
 - 3.1.8 The effects on medical codes of ethics and an industry privacy Code
 - 3.2 The narrow application of 'Research relevant to public health or public safety'
 - 3.3 Over prescriptive guidance
4. **Comments on the Questions Asked**
5. **Other matters of relevance**
 - 5.1 Retrospective Effect
 - 5.2 Access
 - 5.3 Security of E-health records
 - 5.4 Disclosing information to MDOs

Appendix

Comments on the Introduction (not reproduced)

1. AN OVERVIEW

AMA Overview of the Privacy Legislation

In relation to the *Privacy Amendment (Private Sector) Act 2000* (the Act), the AMA has long argued that overarching health privacy legislation is vital to adequately and appropriately protect patient privacy. However, the new privacy legislation fails to:

- ensure the security of electronic health (e-health) records; thus, it is incapable of preventing the on-selling of patient information to those organisations interested in developing commercial databases;
- adequately protect the privacy and confidentiality of 'incompetent' patients, such as children or those with a mental impairment, as the new provisions not only give a guardian access to the complete medical record of the patient but also provide the guardian with the means to alter the record;
- protect the medical practitioner's private or preliminary views in the thinking processes required for full medical assessments, accurate diagnosis and the formulation of treatment programs;
- sufficiently enhance the protection of patient privacy, while it imposes onerous and financially burdensome compliance obligations on health providers, the cost of which will inevitably be passed on to the consumer.

In relation to the *Draft Health Privacy Guidelines*, (the draft Guidelines), the AMA's view is that they require major revision. In terms of general considerations, they:

- are too long and complex to be practical and 'user friendly' for health providers;
- impose standards that exceed those set by the National Privacy Principles (NPPs) in the Act, thus, making compliance virtually impossible in certain circumstances;
- undermine best clinical practice;
- interfere with the medical practitioner's common law duty of care to their patients;
- conflict with national and international ethical codes of conduct;
- add substantial compliance costs that must ultimately be passed on to patients; and
- fail to recognise the medical profession's role in clinical training and medical research.

In terms of specific considerations, the draft Guidelines incorporate a fundamental error of interpretation of the NPPs, in applying an unwarranted narrow interpretation of 'primary purpose' and 'directly related secondary purposes' to the collection of information by health providers. The 'primary purpose' of collection of health information by health providers is 'the health care of the patient', as opposed to the definition in the draft Guidelines that limits the primary purpose by reference to an isolated episode of care. This indicates a failure to comprehend the very fundamental nature of health care itself, and has unintended but grave consequences to patient health and well being.

The flawed interpretation of NPP 2 makes unworkable the application of the NPPs generally in the context of the provision of health care.



'Health' refers to the physical health of the entire body, not just certain 'bits and pieces' (eg. limbs, organs). 'Well being' refers to one's welfare or mental, emotional, and even spiritual 'health' (and is thus intrinsically linked with one's physical 'health'). 'Health care' is thus comprised of *both* health and well being. It is holistic.

The care of patient health and well being is not achieved by episodic care. The process is not static, nor can it be temporally defined. One's past health and well-being impacts on one's current health and well being which in turn influences one's future health and well being. Health care is an on-going process that spans from conception through to death. Most valuable health care interventions are opportunistic, that is they are unrelated to the primary reason for the patient attending the doctor.

The narrow interpretation of 'primary purpose' and 'directly related secondary purposes' results in onerous restrictions on the collection, use, and disclosure of patient information that not only undermines the skills and expertise of the medical profession but potentially poses risks to patient health and well being.

Giving primacy to privacy considerations at the level that is required by the draft Guidelines will directly impact on the health care of individuals. The interpretation of primary and secondary purposes in the draft Guidelines gives supremacy to privacy considerations over the health care of an individual and as such this:

- impedes the ability of treating medical practitioners to consult with each other on clinically relevant information;
- places onerous restrictions on the collection, use, and disclosure of patient information by treating medical practitioners that obstructs the management of patient health;
- interferes with the clinical and ethical judgment of medical practitioners;
- undermines the primacy of the doctor-patient relationship (eg. by eroding the confidentiality imperative).

The AMA emphasises *that patient health and well being must be the primary consideration in the application of the NPPs and draft Guidelines to health providers.*

As such, the AMA recommends that the draft Guidelines be amended to:

- reflect their aim which is to 'explain how the NPPs apply in practice' (as indicated on p.14) and not to rewrite the NPPs.
- Recognise that the 'primary purpose' of collection of health information by health providers is 'health care' to align with the holistic and on-going nature of health care;
- reflect that the paramount concern of the health provider is the health and well being of their patient.
- reduce their size and make them more 'user friendly'.

2. COMMENTS AS TO PROCESS AND FORMAT

The Privacy Reference group spoke with one voice on issues of process and the format of the draft Guidelines. In particular, the group complained that the draft Guidelines then before them were too long and complex. This was ignored, and the draft Guidelines have been expanded upon considerably since that time.

Format

Of major concern is the length of the document. There is no call for such a consumer and health provider unfriendly set of Guidelines. Indeed its very length and complexity will engender suspicion and alarm amongst our members as to the 'lightness of touch' with which the Commissioner's Office may be expected to operate. Comparisons may be made with the way in which trade practices law has been applied to the health sector to the potential detriment of the relationship between the medical profession and the Commissioner's Office.

The length seems to be a product of two processes. One, is the attempt to prescribe a "privacy" solution for endless possibilities of complex medical/ethical situations that health providers might face. The other, is the gratuitous advisory and recommendatory content of the draft Guidelines that goes beyond the purpose of the Guidelines, namely, to inform health providers as to the way the Privacy Commissioner intends to interpret and apply the NPPs.

The object could be better achieved by simple commentary to the NPPs and the setting out of clear examples as to the way in which the NPPs are to be applied in the most common situations that health providers face.

That is not to suggest that guidance on the various complex health and ethical medico-legal situations that arise is unnecessary. Indeed this will be one of the major tasks of the Commissioner's Office over time and cannot be accomplished in a comprehensive and pre-emptive manner. Rather, the following approaches could be considered:

The Guidelines could point out that a health provider should carefully consider the facts, matters and circumstances that surround a particular situation, bearing in mind the need to comply with each of the NPPs and that the well being of the patient is the paramount issues. The Guidelines could state that the Privacy Commissioner intends to apply a "common sense" approach that takes into account the competing interests of privacy and a doctor's obligation to place priority on quality patient care. Where a dilemma is faced that is not clearly resolved by the Guidelines or the relevant Code of Conduct put out by the professional body under which the health carer works, the Guidelines should indicate that the Privacy Commissioner's Hot line is available for consultation and advice.

A Suggested Process:

1. Initially, the production of short explanatory Guidelines in a small booklet form that introduces the NPPs would be read by, and be of assistance to, both health providers and patients. The booklet might, ideally, have an introduction, set out the NPPs to provide the context for which the Guidelines are required, and allow the information which follows to be more easily digested. The example case scenarios should be clear-cut situations sufficient to illustrate the way in which the NPPs will be interpreted by the Privacy Commissioner and applied. Acknowledgment of more complex situations could be made, with an explanation that the application of the NPPs will vary depending upon the type of health service being provided and the various facts, matters and circumstances surrounding the particular situation.

A small blue book entitled "National Principles for the Fair Handling of Personal Information" was published by your Office in February 1998. It appears to be an ideal format. The Guidance Notes to the Principles take only 12 pages. Something along these lines – at least for the initial period until a fuller review of the workings of the implementation of the legislation is assessed, is likely to better meet the needs of both patients and health providers.

2. At the same time, valuable material in the lengthy draft Guidelines could form the basis for your Office's Manual for use by those manning the "Hot Line". The Manual could be available to the public or to any organisation that required it, and over the Internet.
3. The smaller Guideline Booklet might make reference to the Hotline Manual being accessible over the Internet. Organisations could be encouraged to contact the "Hot Line" if confronted with particular and urgent requests or problems that need immediate solutions.
4. A monitoring of the most common problems confronted by the "Hotline" could provide a useful guide to scenarios that might then be incorporated in a more expanded version of the Guidelines to be produced, say after a 6 or 12 month trial period.
5. Perhaps industry-related pamphlets could be produced to alert particular industries as to how the NPPs affect their particular operations. Most industries will no doubt attempt to produce such material in any event, or could work with your office to do so.
6. To the extent that the Privacy Commissioner intends to take a strict approach to the NPPs that is not indicated by the legislation or on the face of the NPPs, then this has to be made clear in the Guidelines as a general principle, without attempts to prescribe conduct in endless possible scenarios. Organisations can then be made aware of the need to take extra care in the way in which they apply the NPPs to their activities, and ensure compliance programs are in place.



3. COMMENTS ON THE PRELIMINARY VIEWS EXPRESSED IN THE GUIDELINES

We are invited to comment on the preliminary views expressed in the draft Guidelines.

The AMA's primary concern is that the Guidelines prescribe conduct that goes beyond the requirements of the NPPs by attributing meanings to key concepts and phrases used in the NPPs that go beyond the intention of the legislative scheme. The AMA identifies three main concerns in this respect which are as follows:

(1) 'Primary purpose'

The prime concern is the narrow interpretation that the draft Guidelines gives to the concept of 'the primary purpose' for collection, referred to in NPP2. The interpretation of 'primary purpose' is a critical matter which underlies the whole privacy scheme. The information collected for the 'primary purpose', or a secondary purpose directly related to the 'primary purpose' of collection, can be used or disclosed for that purpose without necessarily obtaining the individual's consent.

A narrow interpretation of the primary purpose of collection by a health provider has a very significant impact on the approach taken by the whole of the rest of the draft Guidelines in illustrating the way in which the NPPs will be applied by the Commissioner. The AMA sees that the flawed interpretation of this concept has arisen from a fundamental misconception of the role of health providers - registered medical practitioners in particular.

The narrow interpretation, in turn, limits what falls within secondary purposes that are 'directly related' to the primary purpose and substantially widens the nature of what falls within the concept of 'secondary purposes', inappropriately catching and thus obstructing, the use and disclosure of health information for the purposes of ongoing health care.

As a consequence, the consent requirements of the NPPs become unworkable in a medical treatment context and this places patient health at risk. Further, where consent is required from a person other than the patient (where the patient is incompetent or unable to provide consent) confidentiality is eroded.

The all-pervading effect of the draft Guidelines' absolute requirement of patient consent throughout the health care processes, is contrary to good medical practice and is in conflict with many provisions of medical ethical codes of conduct. This is not a consequence of the NPPs, but arises out of the ill-conceived view of how they are to be applied to health providers.

We set out below the unintended consequences of the narrow interpretation of 'primary purpose' by dealing with:

- 3.1.1 the meaning of 'primary purpose'
- 3.1.2 the meaning of 'directly related to' and 'secondary purposes'
- 3.1.3 the effects on consent requirements of the interpretation of these phrases
- 3.1.4 the effects on collection



- 3.1.5 the effects on use and disclosure
- 3.1.6 the effects on destruction of records
- 3.1.7 the effects on the good practice of medicine
- 3.1.8 the effects on medical codes of ethics and an industry privacy Code.

(2) Effect of the draft Guidelines on medical research

The AMA is also concerned about the narrow view taken by the draft Guidelines of when consent can be dispensed with in the interests of medical research. Under this head we deal with the narrow view of what falls under 'Medical Research relevant to public health or public safety', and when it is "impracticable" to obtain consent for the purpose of using information for medical research.

(3) The draft Guidelines are over prescriptive

The third main concern of the AMA with which we deal in this submission is the over-prescriptive nature of the draft Guidelines. Under this head we deal with excessive compliance costs and the additional compliance requirements imposed by the draft Guidelines, and over prescriptive guidance generally.

3.1 'Primary Purpose'

Although we are asked to comment on the views expressed in the draft Guidelines in the order they appear, commencing with 'consent' is impracticable until we first deal with the concept of 'primary purpose'. The concepts of 'primary', 'directly related' and 'secondary purposes' set the parameters of third party consent requirements. The extent to which patient health and patient confidentiality is affected by the way in which these concepts are defined is illustrated below.

The narrow interpretation of 'primary purpose' adversely effects the medical practitioner's professional conduct of clinical practice as follows:

- It obstructs the use and disclosure of health information by a medical practitioner for the purpose of promoting a patient's health. The narrow interpretation in turn narrows the circumstances of when a matter is 'directly related to the primary purpose', and when a person might reasonably expect health information to be used for that directly related purpose.
- It leads to errors and confusion in the draft Guidelines in relation to all issues relating to consent. So long as the 'primary purpose' of collecting health information by a medical practitioner is not interpreted widely enough to include the patient's health care generally, the consent requirements that flow will impede the medical practitioner's ability to properly care for the patient.
- The consequence of the stringent consent requirements by other persons when a person is 'incompetent' or unable to consent bring privacy concerns in direct conflict with patient/doctor confidentiality. This occurs as a result of a parent, relative or guardian being provided with a patient's health information in order that the consent requirements are complied with.
- In setting out how a medical practitioner should act in the many different examples raised, the draft Guidelines form something akin to a code that is to be given supremacy over doctor's medical, legal and ethical obligations. Only an express intention in the legislation can, in our submission, take away the medical practitioner's requirement and right to assess the delicate balance between privacy, confidentiality and what is in the best interest of the patient's health and well-being.

The draft Guideline's determination of what is or is not in the patient's interest and what is the reasonable balance between often competing principles of patient confidentiality, health and privacy, should not supersede well-developed principles of clinical and ethical practice that have been the subject of proper processes of public scrutiny. Medical practitioners work under best practice guidelines, or codes of ethics. The Australian Divisions of General Practice, for example, have appropriate guidelines for the management of personal health information that seem to meet the requirement of the NPPs.

The draft Guidelines (as opposed to the NPPs) are being developed to explain how the NPPs apply in practice, not to regulate the practice of medicine. As such, they must not prescribe:

- the manner in which practitioners should communicate with patients;
- how a practitioner should conduct himself/herself;
- what histories are appropriate to take from a patient;
- the manner in which a practitioner should assess, diagnose and formulate treatment plans;
- the order of priorities in attending to patient's health care.

Although we assume that the Commissioner does not intend the draft Guidelines to compromise best clinical practice, it is imperative to understand that they seriously interfere with the medical practitioner's professional duty to exercise his or her best clinical judgment in the professional care of a patient's health.

Placing privacy above best clinical practice endangers patient health and well being and is ethically unacceptable.

3.1.1 The meaning of 'primary purpose'.

The Guidelines at p.49 dealing at 5.1 with **Key concepts relating to use and disclosure**", under the heading of Primary Purpose state:

The 'primary purpose' of collection is the main reason an individual attends or makes use of a health service.-What is considered to be the 'primary purpose' of collection should be interpreted carefully

As a guide, the Privacy Commissioner would consider a reasonable interpretation of "primary purpose". In the health context for example, the assessment or treatment of a particular condition.

This would include the initial assessment, diagnosis or treatment of an individual for a particular condition and further treatment and care, beyond the initial consultation where this forms part of the treatment of the original condition

Submission One

The 'primary purpose' of collection of health information by a medical practitioner should not, in the interests of patient care, be so narrowly construed. So far as medical practitioners are concerned, the 'primary purpose' of collection is for 'the health care of the patient'.

The NPPs

The meaning ascribed by the draft Guidelines to the 'primary purpose' of collecting health information is not contemplated by NPP2. That NPP specifies that there is only one primary purpose, although it envisages other secondary purposes, more than one of which may be directly related to the primary purpose.

In defining the primary purpose for collection of health information by a health provider with reference to the particular condition about which the patient consulted the health provider, an assumption is made that an individual consults a health provider about only one condition. Even if that were the case, so far as the patient is concerned, it is often not the fact, so far as the health provider, the general practitioner in particular, is concerned.

What is the primary purpose in the case of a patient who presents for two discrete reasons – one a cut finger (a condition) and the second, a request for a Pap smear? The Pap smear can't even be characterised as 'directly related' to the primary purpose of collecting health information, while the primary purpose is narrowly construed with reference to the cut finger.

'Primary purpose' in NPP2 is capable of bearing the meaning 'the health care of a patient' when applied to all health providers. This is consistent with its natural and ordinary meaning. To apply an artificially narrow meaning to the phrase would, in our submission, require the legislation to expressly indicate that to be the case.

AIHW studies

Support can be found for the need to widen the meaning of 'primary purpose' in the context of the collection of health information by health providers in the joint report of The University of Sydney and the Australian Institute of Health and Welfare of the national BEACH (Bettering the Evaluation and Care of Health) survey of general practice activity.

The report "General Practice Activity in Australia 1999-2000", at xiv found that General Practitioners (GPs) could record up to four problems at each patient encounter. According to the findings of the report, medical problems were managed at a rate of 147 per 100 encounters. In NPP terms under the meaning ascribed to 'primary purpose' by the draft Guidelines, this means there could be four primary purposes, contrary to its dictate that there is only one.

At 2.5 (p.7) of the report is a diagrammatical BEACH relational data base illustrating that *reasons for encounters* have only an *indirect relationship with problems managed*. All types of management are directly related to the problem being treated.

At 6.2 (p.25), it is explained that reasons for encounters are those concerns and expectations which patients bring to the GP. According to responses from GPs, these were expressed in terms of one or more symptoms (eg 'itchy eyes' 'chest pain') or in diagnostic terms (e.g 'about my diabetes' or 'about my hypertension') or in request for a service ('I need more scripts", or 'I want a referral') or an express fear of a disease ('I want a check up'). These reasons for encounters are expressed before the health assessment, diagnosis or management processes commence. Multiple problems might be managed at one encounter, some of which may be unrelated to the reason for the encounter.

The need for management of some problems might not be appreciated by either the medical practitioner or patient at the initial encounter. They may become apparent, say after a patient is sent to hospital for an unrelated problem, and the assessment, diagnosis and management of the problems continue with the use of the original information collected. The management of a patient's health cannot be dissected into the management of various conditions.

Submission Two

It is not appropriate for the draft Guidelines to be used as a device to ensure the supremacy of privacy over other medical, legal and ethical obligations surrounding the health care of a patient.

A medical practitioner owes a duty of care to the patient

A medical practitioner owes a duty of care to the patient. The standard of care is that reasonably expected of the ordinary skilled person exercising and professing to have a special skill. In exercising the duty of care owed to a patient, a medical practitioner is expected to regard the patient's interests as paramount. As a professional matter, the

medical practitioner must also regard the relationship as one based on trust and respect of confidentiality and the patient's need for health privacy.

A patient's health is put at risk and a medical practitioner is exposed to a suit for damages for negligence if he or she, in regarding issues of privacy as supreme over considerations of patient health, fails to pursue all reasonable avenues available to assess, diagnose and treat a patient for any condition about which a medical practitioner might become aware, or might reasonably be expected to be aware.

Thus, despite the privacy legislation, a medical practitioner is expected to take all steps to discharge his or her duty of care, and this might mean following up on a patient who unreasonably refuses consent required, or chooses to ignore medical advice. Such 'aggressive outreach' is a requirement of quality medical practice, and has been recognised as such by the courts. This may entail a medical practitioner contacting a family member to ensure that medication has been taken, or an appointment followed up.

In fulfilling the duty of care, it has to be understood that in most episodes of care a full medical history is usually required irrespective of the presenting condition. This history is necessarily used and disclosed at times without the consent of the patient for the purpose of the ongoing health care of the patient. The paramount consideration is the health and well being of the patient, of which privacy is but one of the considerations to be taken into account.

By way of example:

The case of a patient attending upon a general practitioner for a cut finger.

The patient cannot be expected to know when attending a medical practitioner for a cut finger, that the investigation and treatment indicated might be for, say epilepsy that contributed to a causal chain of events leading to the finger being cut, or for anxiety or stress – a more serious condition, but which contributed to the minor ailment.

The patient might not expect a medical practitioner who is dressing the cut finger to ask a woman 'when did you have your last Pap smear?' and to record the answer. A failure to do so when the opportunity arose as a consequence of the attendance by the patient for the cut finger could cause a medical practitioner to later have to defend him or herself on a civil claim by the patient for damages for negligence.

Thus, the primary purpose of a medical practitioner's collection of health information is for the purpose of caring for the patient's health and well being. Given the medical practitioner's professional and legal obligations, it cannot be narrowed down to the diagnosis and treatment of separate presenting conditions. *The NPPs do not specify that it should!*

Confusion in the draft Guidelines

The definition at p.49 of the draft Guidelines of 'primary purpose' prevents medical practitioners from taking the view that the primary purpose of collecting health information is for the health care of the patient. It confines it to the assessment and treatment of a particular condition.

However, at p.51 under **5.3 Primary Purpose**, para. 2, the draft Guidelines state that the health provider should be quite specific about what they consider the 'primary purpose' to be if they choose to rely on this concept (rather than seeking the individual consent) and the basis for use and disclosure of information in certain circumstances.

To a medical practitioner the primary purpose of health information is quite specific - the patient's health care. Medical practitioners when attending patients for presenting conditions often provide some preventative medical advice, or take and record the blood pressure as a matter of course, and the information collected for all those conditions is intended to be used and disclosed in the management of the totality of the patient's health.

By way of example:

An obese patient attending for a cut finger might be provided with advice from the medical practitioner on how to prevent heart attack in later years. A 32 year old patient is not likely to attend the medical practitioner in order to ask how he or she might prevent a heart attack when 80 years of age.

At one point in the draft Guidelines there is recognition of this. At p.70 at **7.2**, in the context of NPP 4.2 that requires destruction of information that is no longer required for the purposes for which information can be disclosed under NPP2, the draft Guidelines indicate those purposes encompass "the treatment and care of an individual and related purposes".

Yet, at p.51 under **5.3 Primary Purpose**, para. 3, some examples of 'primary purpose' are given. They include 'seeking advice from a General Practitioner about a condition'. This example highlights the ill-conceived notion of what the role of a General Practitioner is. The dot point should be omitted or replaced with 'the health care provided by a General Practitioner'.

While the narrow interpretation of a health provider's 'primary purpose' remains, compliance with the privacy legislation might be assured, but the health of the community will be the first casualty.

Answering the Privacy Commissioner's Concerns

The *Explanatory Memorandum* to the Act suggests that the 'primary purpose' is somewhat narrower than the service provided. Explanatory Memoranda have to be read in the context of the object pursued by the particular legislation or the 'evil' that is to be remedied. In relation to the privacy legislation, the NPPs are to be applied to services provided by large private organisations including insurance companies, manufacturers, retailers, and organisations who sell their products through direct mailing, as well as to *all* health providers.

If a person attends an electrical store to purchase an electric stove, the personal information collected from the purchaser is for the primary purpose of selling and perhaps delivering and installing the stove, not for providing electrical services generally. Using the personal information collected for the organisation's overall purposes of selling electrical goods is too broad a 'primary purpose' from the individual's perspective.

The medical practitioner, by contrast, as a professional imperative has a duty to ensure that all aspects of a patient's health are looked after. The health information collected whilst attending to a patient's cut finger is necessarily collected not only in order to attend to the minor ailment, but for the purpose of the patient's health care generally, because of the essential nature of the service provided by the medical practitioner.

The *Explanatory Memorandum* has to be taken in context of the scheme of the legislation that it explains. In this case, that is to prevent the unwarranted and unwelcomed intrusion by organisations, generally recognised as being for profit motives, into the privacy of individuals, such as the use of personal information for targeting vulnerable groups of individuals for marketing campaigns. The NPPs have to be construed and applied in the context of that scheme. There is no express intention revealed in the Act that warrants an application of the NPPs that gives privacy supremacy over the medical practitioner's duty of health care to the patient.

The Commissioner's office has explained the need to protect those people who, despite the danger of misdiagnosis, or secondary consequences at a later date, only want to be treated for specific symptoms and do not want to reveal the whole of their medical history.

This is currently, and will remain the patient's right. No one can force a patient to provide particular information, and the AMA's *Code of Ethics* specifically informs medical practitioners to respect this right. However, the view of 'primary purpose' taken in the draft Guidelines attempts to entrench that stance for all patients. Those patients who might expect their medical practitioner to take a holistic approach to their health care will be required to take onerous steps to ensure, by providing necessary written consents, that their medical practitioner is not constrained by Guidelines under the Act in the provision of their health care. Further, the approach taken in the draft Guidelines serves to increase the vulnerability of those less assertive patients who depend upon their medical practitioner to take care of the health in a holistic manner.

Basically, the onus is on the patient to ensure that if he/she wants holistic health care, then he/she must be available at all times to provide necessary consents every time their medical practitioner attempts to discuss their health care management with another person (including consulting with other practitioners). This onus is also placed on guardians of 'incompetent' individuals. If the patient (or their guardian) finds the consent expectations too strenuous or impractical and chooses not to be tracked down every time consent is needed under the draft Guidelines, then their health care suffers. In essence, the patient is being placed in the position of having to choose between holistic health care with the provision of being consistently available for consent (perhaps an invasion of privacy itself?) or complete privacy of their health information.

If 'primary purpose' is purely encounter related, before a patient's ongoing health care is attended to, say, where the patient is indisposed, the consent of a relative must be obtained to comply with the draft Guidelines. This might entail the medical practitioner revealing the HIV status of the patient. This breach of confidentiality strikes at the heart of the patient privacy that the privacy legislation sets out to protect.

Submission Three

The broad description of 'primary purpose' as 'the health care of the patient' will allow all health providers, even those who hold themselves out as providing only a limited health service, to take into account considerations of privacy and confidentiality of the patient as part of the overall provision of services for the well-being of the patient.

In the alternative, to cover the case of health providers who are not registered medical practitioners or whose profession has not developed best practice guidelines or a code of ethics, the 'primary purpose' might be better described as 'the provision of the particular service as to which a health provider holds themselves out as reasonably trained, skilled or competent to provide'. This holds good for most health providers including medical practitioners.

3.1.2 The consequential meaning of 'directly related to' and 'secondary purposes'

As a consequence of the narrow interpretation of 'primary purpose', a similarly narrow interpretation follows for 'secondary purposes' that are 'directly related' to the primary purpose. 'Secondary purposes' then correspondingly encompass a broader range of purposes for which health information is collected than would be the case if the primary purpose was construed to include collection of information for the purpose of the patient's overall health care.

Interpretation of 'secondary purposes'

Clear examples of secondary purposes are:

The use of personal health information for the purpose of direct mailing, say to promote pharmaceutical products, or providing information for the purposes of market research, or to raise money.

However, at p.49 under the head 'Secondary purposes' of the draft Guidelines it is suggested that an example of a secondary purpose is to:

follow up with individuals after a particular course of treatment, or consulting with other health providers to seek a second opinion.

The risks to patient health

In a medical practitioner's view, these examples must form part of the 'primary purpose' for which the information was collected – the health of the patient - as does a follow-up for a general health check.

No issue should be raised as to when, whether or in what circumstances these matters are 'directly related' to the primary purpose of collection of health information, or whether or not a patient would reasonably expect them to be so regarded.

Consent, in the normal course, is best practice. It is likely to be obtained where appropriate. However, to place an absolute consent requirement in relation to consulting other health professionals or for the purpose of following up medication compliance, or treatment plans cuts across the standards of care that is reasonably expected of a medical practitioner, as pronounced by the courts and reaffirmed in recent cases.

By way of example:

A patient attends a general practitioner with menopausal symptoms and seeks advice. The general practitioner is informed that the patient has a history of back pain for which a consultant has prescribed morphine. The practitioner notes this and, not wanting to either alarm the patient, nor undermine the patient's confidence in the consultant, does not further explore the back pain condition. The general practitioner provides HRT patches, there being nothing in the health information provided that contra-indicates that management.

The current situation:

After the patient leaves, the general practitioner makes a phone call to the consultant to clarify the source of the patient's back pain. The GP seeks confirmation that a tumour as a differential cause of such severe pain that warrants morphine has been negated. If not, HRT may be contra-indicated. As a consequence of the free and frank disclosure between the two medical practitioners about the information each holds in relation to the patient, the general practitioner is reassured and has no need to contact the patient or alarm her, or one or other medical practitioner contacts the patient for follow-up care.

Under the NPPs in the absence of the Guidelines:

Both medical practitioners can freely use and disclose the health information they have collected from the patient for the purpose of the patient's health care.

Under the draft Guidelines:

The GP has two options available.

- (a) *To take no action, the patient having chosen to consult the two medical practitioner's for two discrete concerns, the GP not wanting to unduly worry the patient, nor to undermine her confidence in the consultant.*

A possible outcome:

It transpires that the back pain was undiagnosed hormonal receptive cancer and the HRT contributes to its aggressive progress.

- (b) *To explain the GP's concerns, as remote as they are, and to obtain the patient's consent to contact the consultant. The back pain was due to nerve entrapment requiring temporary pain relief.*

Possible outcomes:

The patient gave consent and worried unduly about the outcome. The patient refuses consent, on the ground that she has had HRT before, and she can't cope without it, and wants to take the risk of any possible harmful effects.

The purpose of these scenarios is to illustrate the importance of medical practitioners being free to ascertain all medical information required in order to provide necessary information to their patient that would facilitate informed participation by the patient in their own health care. The risk to patient health from the above scenario does not arise if the plain meaning of 'primary purpose' is given to the medical practitioner's collection, use and disclosure of the health information.

Where consent of another person is required.

To require the consent of a patient before a medical practitioner is free to consult other health providers where the consent of a parent or relative is required in the case of a child or a person unable to provide consent due to the nature of the illness can force a medical practitioner to breach long accepted standards of confidentiality, as well as compromise the health care of the patient. We deal with the aspect of confidentiality in more detail below.

The Guidelines should not contemplate that a relative can, for privacy reasons alone, exercise the power of veto over a medical practitioner from consulting another health care provider on any matter that relates to the care of his or her patient, whether or not it is a life threatening situation.

3.1.3 Effects on Consent Requirements

Consent is required for the secondary use and disclosure of health information. So long as the use and disclosure of health information for a purpose other than the condition for which it was collected is characterised as 'secondary purposes' then patient consent is required before health information can be used and disclosed purely for the health care of the patient.

This result causes a medical practitioner insurmountable obstacles to the proper provision of patient health care. The implications are far reaching.

Implications for the conduct of clinical practice

Currently acceptable clinical and ethical practice allows the medical practitioner to exercise his or her best clinical judgment as to when consultation and formulation and consent in relation to the management of health care of the patient is required.

Best practice is to involve patients in all formulations. Best practice is different from privacy. There are other industry checks and balances to encourage best practice. Health providers work under best practice guidelines and codes of ethics and they are subject to conditions of accreditation and registration board requirements.

Best practice dictates that medical practitioners take advantage of a collegiate environment and consult freely with each other. At times, consent for this course might not only delay the assessment, diagnosis and health management process, but might cause undue alarm to the patient, or undermine the patient's confidence in the practitioner, or the patient/doctor relationship of trust.

The draft Guidelines (through the narrow interpretation given to 'primary purpose') discourages open and free consultations, and the seeking of second opinions when the opportunities arise. It can have an adverse impact on patient health, as well as exposing a medical practitioner to claims for negligence. Consent for every use and disclosure of health information not directly related to an original condition must interfere with timely medical management.

Consent on behalf of another person

The narrow meaning given to 'primary purpose' and the consequent impractical consent requirements, disadvantages the patient who is not able or legally capable of giving the required consents.

The patient's medical management is at stake

The draft Guidelines point out that the individual must have the capacity to provide consent, and a capacity to understand what they are consenting to. Sometimes children are too young to provide legal consent, and the parent lacks the English language skills to understand, and an interpreter is required or the patient is mentally disabled or

unconscious. This is reasonable until applied in the context of the consent being required at each use and disclosure of health information to any person that, while required for their health care, was collected for an unrelated medical condition.

In that context it translates into a directive that use and disclosure of health information for the purpose of ongoing medical treatment should be *delayed* until proper consent is obtained, in all but emergency situations.

Worse, the consenting relative, parent or guardian has the power of veto over the use and disclosure of the information, despite the health care needs of the patient.

Thus, the mentally able, awake and alert, adult English speaking patient will be entitled to receive appropriate health advice and treatment promptly. Not so the mentally disabled, the child with a non-English speaking parent or the unconscious.

Their privacy is paramount, and they are not in a position to be consulted in order to change this priority.

The medical practitioner who has the confidence of his or her patient and is privy to all their personal information, might be better placed to make decisions for the patient than another person to whom detailed information needs to be given to ensure the consent is fully informed. On the interpretation to the NPPs given by the draft Guidelines, the medical practitioner can do this in the interest of the patient, only under NPP 2.1 (e)(i), where disclosure is necessary to lessen or prevent "a serious and imminent threat" to the patient's life, health or safety.

This limited let-out, (which the Privacy Commissioner has conceded is too restricted) on the interpretation taken in the draft Guidelines, highlights the error of interpretation of the NPPs. The exception in NPP 2.1 (e)(i) is intended to apply to dispense with consent (whether or not the person is legally competent or able to give it) in the situation where, personal information of one individual, needs to be disclosed to another. The disclosure to the police might be necessary of a patient's mental state where there is a "serious and imminent threat" to the life, health or safety of *another* individual or *other* individuals. It might include the disclosure of a patient's HIV status to a partner of the patient. It was not intended to impede patient care whenever there was not a "serious and imminent threat" to the patient's life, health or safety. Nor does it, if the proper construction is given to 'primary' purpose and 'secondary' purposes in the NPP.

The error of interpretation can only work against the prompt and appropriate health care being given to patients, without adding to the protecting of their privacy.

Confidentiality is at stake

When consent is to be obtained from a family member (say if the patient is too ill to exercise the right to consent), or a parent in the case of a child, confidentiality is put at risk.

By way of example:

A patient is unconscious or too ill to consent. The medical practitioner with specific health information given for another treating purpose, needs to share that information with another practitioner in order to have the patient treated, say in relation to pregnancy or HIV/AIDS. But to do so, the consent of a relative has to be obtained. To obtain that consent the information that the patient is pregnant, or has HIV/AIDS, has to be disclosed to that relative. Thus, in order to obtain consent, confidentiality has to be breached.

Not all medical encounters are face-to-face. GPs do not always see the patient when a clinical service is provided. Confidentiality of test results should nevertheless be maintained.

By way of example:

A GP on seeing a record of a service or results of a service, might suspect, find or diagnose a condition not related to the reason for the encounter (e.g. a blood borne disease discovered from a blood test for another purpose). The GP may need to explore this aspect of the patient's health with others, or authorise further testing of the blood sample without the opportunity of discussing the issue with the patient, who might be indisposed. To obtain the consent of a relative to a further test, say for HIV/AIDS, would constitute a serious breach of patient confidentiality.

The British Medical Association in giving ethical guidance makes the point that:

“Confidentiality is owed equally to all patients regardless of their age, status or mental capacity. The fact that individuals are incapable of consenting (be it due to immaturity, temporary or permanent lack of capacity or an inability to communicate) neither implies that their information can be less closely guarded nor that it cannot be shared when it would clearly be in their interests to do so.”

Medical practitioners in these situations traditionally weigh the need for someone to consent, say to an operation, with possible breaches of confidentiality that occur in the process of obtaining consent from another person.

A medical practitioner might well require the input and consent of another person in the absence of the patient being able to give it, but in his or her clinical judgment the practitioner might prefer to make the decision in the best interests of the patient's health and well being.

Implications for teaching hospitals

We support the written submissions to the Commissioner's Office prepared by Dr Baggoley, Chairman of the Committee of Presidents of Medical Colleges and Group Medical Director of Adelaide Community Healthcare Alliance in which he states that it is unrealistic to get patient consent in a wide range of situations. Dr Baggoley provides the examples of examination of pathology specimens by a number of practitioners and students who have access to the patient's records for training purposes and practices in



public and private training hospitals when patient information is passed from one practitioner to another, and where trainee's and students are involved

Implications for medical practitioners complying with medical indemnity requirements

Medical practitioners have a duty to inform insurers of adverse medical events without obtaining the consent of the patient for the use and disclosure of their health information. They are generally obliged to provide the relevant health information, and not to do anything that might be taken as admitting liability for an adverse outcome without the permission of the insurer. Obtaining a patient's consent might compromise the medical practitioner's right to indemnity.

Arguably the NPPs, rather than the draft Guidelines, provide an obstacle to the use and disclosure of patient records to medical indemnity organisations and insurance companies as part of the notification of adverse incidents that might result in a civil claim against a medical practitioner by a patient.

It is the AMA's view that NPP2 is capable of being construed to support the use and disclosure of a patient's health information under qualified privilege to an insurer, MDO or legal adviser, without the patient's consent. It is a secondary purpose directly related to the primary purpose of the provision of health care. The second requirement for the dispensing of consent is met, as a patient who has had an adverse medical outcome would reasonably expect the medical practitioner to use and disclose the information for this purpose.

NPP 10.1(e) supports this interpretation, allowing the collection of health information about an individual where it is necessary for "the establishment, exercise or defence of a legal or equitable claim".

However, the draft Guidelines, in construing 'primary purpose' and 'directly related secondary purpose' as narrowly as it does make compliance with MDO requirements or insurance company obligations impossible.

Submission Four

If the proper meaning is given to 'primary purpose' for which patient health information is collected, then the use and disclosure of health information for the purpose of medical defence purposes does not require the patient's consent.

3.1.4 Effects on Collection

The NPPs

The AMA has no difficulty with NPP1 in the context of the privacy principles set out applying to the collection of personal information about the patient of a health provider.

The formulation of NPP1 clearly intends that to be the case.

Thus, if a third person provides unsolicited information to a health provider about that provider's patient, the principles set out the obligations of the health provider.

Difficulties only arise if an attempt is made to apply NPP1 to the information collected from a patient of the health provider about a third person (eg. a family member). In that event NPP 1.4 would need to be interpreted broadly enough to allow acceptance of the proposition that it is neither reasonable nor practicable for a health provider, on being given information from a patient about another family member, or work colleague, to interrupt the consultation to obtain the consent of that individual, or the information direct from that individual.

In therapeutic roles, counsellors, psychologists, general practitioners and psychiatrists take histories as they are related often including sensitive information about third parties. In the therapeutic setting, the careful recording by a counsellor or medical practitioner of information as it is given by a patient about a third person, is important for the assessment and treatment of the patient, whether or not the information about the third person is accurate or not.

A greater difficulty is encountered in this context by NPP 1.5 that requires the third party (e.g. the family member) to be made aware of all the matters listed in NPP 1.3. It is the AMA's submission that this consequence is not intended by the NPP in the health care setting, and that the NPP should be read down so as to apply only in the context of unsolicited information being received *about* a patient of the health provider. The same applies to NPP 10.1

This submission is supported in law by the common law concept of "fiduciary relationship" that exists between, for example, solicitor and client, or practitioner and patient. That relationship also protects a person from an action for defamation by the common law (and statutory) defences that exist of qualified privilege.

In any event, the NPPs and the draft Guidelines to the legislation are to be applied subject to existing legal obligations, and in our submission, they should be applied in a manner that does not cut across the rights and privileges granted by the existing law.

The AMA still envisages difficulties with the qualifying phrase "serious threat to the life or health of any individual" in NPP.10.1(c). That difficulty is the pitting of the privacy principle against confidentiality.

The situation arises commonly where consent of a third person is required in the case of a child, an aged person, a legally incompetent person or a person otherwise incapable of giving consent for the collection of information necessary for their health care.

Confidentiality is breached if the parent or relative or guardian of that person is to consent to the collection of information, say from an HIV clinic, a maternity clinic and so on, when the consenting person was not previously aware of the patient's HIV status, pregnancy and such.

The draft Guidelines

Bearing in mind the above, and the wider health purposes for which medical practitioners collect information, the draft Guidelines in relation to Collection are over-prescriptive and restrictive.

This applies to p. 35 under **3.2 "Collect only necessary information"** and p 36 under **3.3 "Collecting information with consent"**. By way of illustration is the example given at the bottom of p. 36. It indicates that if a test were sent to a pathology laboratory by a GP, it would be reasonable to assume that the individual has given implied consent for that practitioner to collect the results from the laboratory.

If the proper construction is given to the 'primary purpose' for the collection of health information, the consent is not required. Further, if a person consents to a test being done for the purpose of their practitioner diagnosing and treating a condition, we argue that a patient's consent would have to be withdrawn before a medical practitioner could justify a failure to obtain the result. A delay in order to obtain consent, or a failure to follow up because of a lack of express or implied consent could expose the medical practitioner to an action for negligence.

The AMA also recommends that the draft Guidelines be modified to ensure that there are no obstacles to the medical practitioner taking careful wide ranging medical histories as it is given without the consent of third parties referred to by the patient. This privileged information might be crucial for sexual therapy or counselling for work stress. It is imperative for the Commissioner's Office to understand that doctor/patient confidentiality incorporates the 'sanctity' of the medical record – this includes information about the patient and information given by the patient in regard to third parties, (e.g. family members).

Further, the draft Guidelines should not place any obstacle not already contained in the NPPs in the way of a medical practitioner from collecting information from a third person for the purpose of properly caring for the health of a patient.

We again endorse the comments made by Dr Baggoley in his submissions to the Commissioner's Office in this respect. A requirement for consent to be obtained from family members before a medical practitioner can collect information from a patient about family matters that might be used and disclosed in future patient care, interferes with the therapeutic process which should not be stopped for the purpose of getting the consent. It

also interferes with the patient's family relationships – in itself not in the interest of the patient or the person about whom information is collected.

Further, proper medical history taking in general clinical practice includes a section of family medical history. A family medical history is imperative for proper health care as certain diseases have familial linkages (e.g. cancer, heart disease, genetic diseases). Also, a general family history can provide information on environmental and behavioural risk factors that may have or are currently impacting on the patient's health.

It is fundamental to all medical teaching that the history is critical to successful treatment and to good communication. To change the fundamentals of this teaching could threaten public health.

To the extent that the draft Guidelines dictate just what and how much information is to be collected by making reference to the condition for which a patient seeks a health service only encourages sub-standard clinical practice and undermines health care. This threatens patient safety and is unacceptable.

3.1.5 Effects on Use and Disclosure

NPP2 requires consent to be provided before there is use and disclosure of personal health information for secondary purposes (not directly related to the primary purpose, and as to which the person has a reasonable expectation that the information will be used and disclosed for that purpose).

As indicated above, a clear example of when consent is required is where the collected health information is to be used, say for direct mailing of cancer patients to solicit funds for cancer research. The information collected for the purpose of treating the patient is being used for a secondary purpose of fund-raising, not directly related to the treatment of the patient.

Problems arise for health providers, and medical practitioners in particular, not with this privacy principle on its face, but with the way in which it is to be applied according to the draft Guidelines. Under the draft Guidelines the 'primary purpose' of the collection of the health information is for the patient's treatment of cancer rather than for their health care generally. Secondary purposes for which consent is required includes the range of medical activities that involve the use and disclosure of patient's health information directly related to the patient's general health care.

The far reaching effect of the narrow ambit of 'primary purpose' in the draft Guidelines carries with it the following consequences:

Encourages selected information giving

The draft Guidelines encourage the individual not to reveal the apparently unrelated medical conditions. The medical practitioner has a duty to inform the patient of this right. The more limited the information provided by the patient, the greater the difficulty in properly attending to the patient's health care. Less than full medical histories, compounded by obstacles of onerous consent requirements works to enhance the chances of misdiagnosis and adverse outcomes, and detracts from holistic health care.

By way of example:

An adult male was having treatment for AIDS and attended a GP for inoculation against the flu. The GP advises the patient that he is not obliged to provide full medical details. The patient is relieved that he does not have to admit the medication he is on which would reveal his disease. Within weeks of the flu shots the patient died from the interaction of the flu shots with his medication.

Discourages pre-emptive investigations

The use and disclosure of health information in order to investigate a suspected health condition is not always 'directly related' to the primary purpose of a presenting condition, nor might the unrelated health condition be reasonably contemplated by a lay patient.

By way of example:

A GP might arrange for a blood sample to be taken for a discrete purpose, such as to test for hormone levels, or say, infection. The laboratory telephones to inform the GP that the test indicates an abnormality in cell count unrelated to the condition being tested. The GP provides the laboratory with a further history for the purpose of carrying out a full blood count, or other tests on the blood sample.

While the use and disclosure of the health information forms part of patient health care, under the draft Guidelines patient consent is required. Obtaining the consent causes delay, the possibility of a further blood sample being required, and possibly undue patient alarm.

Discourages the consultation between colleagues

The draft Guidelines discourage the collegiate practice of medical practitioners freely consulting with each other. The professional tradition of sharing information is a valuable community resource. The conventional Counsels Chambers housing barristers in competition with each other arises from the tradition of barristers sharing information, discussing difficult cases and mulling over solutions to difficult client problems. It is not always possible to do this with de-identified material. In turn, professionalism demand that confidences be kept and patient and client privacy be respected and preserved. Consent being required in these circumstances can undermine patient confidence, and where a patient is not easily contactable, work against prompt medical attention.

Discourages the seeking of second opinions

Best practice dictates patient involvement in their own health care and that generally entails patients consenting to second opinions being obtained. Medical practitioners determine whether this is appropriate for a particular case by exercising their best clinical and professional judgment.

However, at p.57 of the draft Guidelines under the head of 'Second opinions' in two directive paragraphs about this complex issue, the collegiate nature of medical practice is totally ignored, as too is the duty of medical practitioners to assist with the training of practitioners and nurses in the hospital context. Above all, the draft Guidelines ignore the medical practitioner's fundamental duty and expertise to give priority to do what is best in the interests of the patient's health.

Places obstacles in the way of medical practitioners informing concerned relatives or friends of patient progress

As a matter of courtesy, and in the interest of the patient, medical practitioners make decisions as to whom and what, if any, and in what circumstances, progress reports are given to concerned friends and relatives. In their clinical judgment, they balance the anguish suffered by the waiting relatives with the invasion of privacy the critically ill patient

might suffer. This might entail disclosing health information without disturbing the patient in order to obtain their consent.

But for the draft Guidelines view of what 'primary purpose' and 'directly related' encompass, reporting to a relative on a critically ill patient's progress without the patient's consent would be permitted under NPP2's exception as the disclosure is 'directly related' to the health care of the patient.

Puts obstacles in the way of health care teams.

The draft Guidelines acknowledge that health care teams may need to share the health information of a patient where they are caring for an aged or disabled patient. That acknowledgement does not overcome the breach of privacy that, under the narrow definition of 'primary purpose', will occur in the course of the sharing of patient information.

By way of example:

A health care team caring for a number of aged patients routinely meet, say each morning, to exchange information, or to 'hand over' to another team, at which meeting, details about the patients' health are discussed. A patient who has been admitted, for say emphysema, may have developed bedsores. In disclosing this secondary condition to the carer responsible for bathing the patient, it might be necessary to disclose the patient's HIV status. It might be necessary to reveal that a patient with dementia has developed incontinence for the purpose of ensuring the bed sheets are changed regularly.

The use and disclosure of the health information for secondary purposes of attending to newly developed conditions is not, under the draft Guidelines, directly related to the condition on admission for which the information was collected. The consent of all the patients before any particular matter is discussed does not arise if the 'primary purpose' includes attention to the overall health of a patient irrespective of the condition or purpose for which the patient has been placed in care.

Puts obstacles in the way of ethical facilitators

Some hospitals provide a clinical ethics service. It provides a facilitating resource for the assistance to disputing carers, be they part of a health care team, or carer relatives or a mixture of those. Issues arise within carer teams. A dispute might arise within the caring team of a seriously ill patient as to whether palliative or curative treatment should be given. Broad discussion is necessary to identify the alternative courses or to resolve differences or obtain a consensus before the patient is brought into the discussion. This process breaches the draft Guidelines. Yet, it is not in the patient's interest to be informed about the dispute over the patient's care for the purpose of obtaining the patient's consent for the dispute to be aired. It might be deemed preferable by the carers that the patient's input is obtained once the care team has resolved their differences.

On an appropriate interpretation of 'primary purpose', the NPPs can be applied to accommodate the trend for the future that facilitates the means by which patients can make

informed decisions about their own care. There is a trend to have less paternalism in patient care and more family and patient involvement in the patient's medical care. The introduction of medical or ethical facilitators to ensure that conflicts between the carers are resolved and that care alternatives can be presented to the patient in a constructive manner is in the interest of the patient's health. On a proper reading of NPP2, the disclosure to the facilitator and family members is directly related to the general health care of the patient, though it may be unrelated to the patient's original presenting illness.

Places privacy ahead of patient health care

Often is the case where a medical practitioner whose skills and training are limited to a particular field, wishes to report a medical observation about a patient to the patient's GP without raising the matter first with the patient.

By way of example:

An ophthalmologist observes signs of depression in the patient being seen for eye problems. Not being comfortable raising the matter with the patient, which might provoke an expectation in the patient that expertise is at hand, the ophthalmologist exercising appropriate clinical judgment, chooses to mention the matter to the referring GP. The ophthalmologist is not a trained counsellor and by mentioning the matter to the patient might find him or herself having to discuss the options and provide advice. Further, mentioning the matter can impinge on the doctor/patient relationship already developed.

Again, such a course is not in breach of the NPPs in relation to use and disclosure, so long as the information collected is regarded as having been collected for the primary purpose of the patient's health care, and not secondary to the purpose of treating the patient's vision. Under the draft Guidelines, privacy over rides the patient's health care and the course chosen by the ophthalmologist is a breach of the NPPs.

Prevents debriefing of medical practitioners, psychiatrists and psychologists in particular

The draft Guidelines do not cater for the debriefing that takes place when necessary of a psychologist or psychiatrist. The information used and disclosed in such a situation was not collected for this purpose, and the patient is not likely to have expected it to be so used for such a purpose. However, if the 'primary purpose' of the collection is regarded as being for the patient's health care, then the use and disclosure for debriefing purposes of information collected not directly related to the presenting problem is 'directly related' to that purpose. It would defeat the purposes of the therapy if the patient's consent had to be obtained.

Places obstacles to health providers being in the same 'loop'

The exchange of information generally between treating medical practitioners is necessary if practitioners are all to stay in the same health care loop in respect of the patient. The narrow definition of 'primary purpose' threatens the GP's role as the coordinator of the

management of the patient's health. GPs need to receive information back from consultants to whom they have referred a patient, and consultants need to obtain additional information from GPs, and enter into discussion about various aspects of a patient's health care, not only the condition for which the patient was referred.

By way of example:

A GP who looks after the well being of the patient might not see fit to be intrusive about the extent of a person's smoking habit. The GP might judge that this might weaken the bond that exists between practitioner and patient. However, on noticing nicotine on the patient's fingers the GP decides to pass information about the patient's smoking habits to the consultant who is investigating the patient's varicose vein condition. According to the draft Guidelines, it is collected as secondary information and disclosed as such as part of the notes without consent. However, the consultant has sufficient information to provide the patient with gratuitous preventative advice as to how to prevent heart condition in later years.

In summary:

The lines between information collected for one health purpose and the health of a patient generally are not clear. For collegiate medicine, the distinction between primary and secondary purposes as defined by the draft Guidelines is obliterated. The practice of modern medicine is a response to the community thrust that patients should not be treated as the product of their disparate parts. On collecting patient information a medical practitioner does not know what is relevant for the presenting problems or for future ongoing care or for preventative care.

3.1.6. Effects on Destruction of records

NPP 4.2 requires records to be destroyed or permanently de-identified if no longer needed for any purpose for which the information may be used or disclosed under NPP 2.

The AMA has no difficulty with this privacy principle so long as a reading of 'primary purpose' in NPP2 is 'health care'. If, however, the draft Guidelines' interpretation of 'primary purpose' with reference to an episode of care is accepted, then the consequential episodic destruction of a patient's health record is required under NPP 4.2.

Understandably, this is not recommended by the draft Guidelines. Such an application of NPP 4.2 would be contrary to some State legislation and inconsistent with best practice guidelines, some codes of conduct, and the AMA's position statement.

At this point in the draft Guidelines at p.70 at **7.2**, there is recognition that the purposes for which information can be disclosed under NPP2 encompasses "the treatment and care of an individual and related purposes". It states that when information is no longer required for these purposes they should be destroyed or de-identified. This construction of NPP2 for the purposes of NPP4 is consistent with the construction the AMA urges ought to be attributed to 'primary purpose' in NPP2 throughout the whole of the draft Guidelines.

Confusion in the draft Guidelines

The draft Guidelines go on to raise the benefits and risks of keeping health information for a longer period, and contradicting earlier statements suggesting that health providers are free to make a decision in relation to how long the records are kept.

The question of whether the patient's consent is required to destroy the records, or alternatively, to keep them beyond the time they are required to be kept, is not raised.

3.1.7 Effects on the good practice of medicine

The NPPs were not devised to regulate the conduct of health providers and the way in which they are to conduct their businesses or practices, nor to prescribe the nature of the health provider/consumer, or doctor/patient relationship.

It is the AMA's submission that the *primary purpose* of the draft Guidelines is to inform the health provider and the public of the way in which the Commissioner's office will interpret and apply the draft Guidelines. The *secondary purpose*, as evidenced by the draft Guidelines' raising of the level of the NPP requirements, is clearly to ensure self-regulation – rather than reliance upon the weak enforcement powers provided for in the legislation.

In attempting to achieve this secondary purpose, the Guidelines have the potential to destroy a foundation of the art of medicine developed over 2500 years. The consequences of the narrow interpretation of the concept of the 'primary purpose' for which medical practitioners collect patient health information are so profound, that, in the AMA's submission, if the legislature intended such consequences, it would have been expressly stated.

The intent of the legislation was to target commercial collection of information which would pose an invasion of a person's privacy, and not to interfere with a medical practitioner's clinical judgment as to what detail they take down when taking histories for the purpose of providing physical or therapeutic medical care.

If accepted in their current form, the draft Guidelines will interfere substantially with the manner in which medical practitioners assess, diagnose and treat their patients, the way in which they inform themselves in order to provide quality care, the process of their intellectual thinking, and the means they employ to confirm or exclude differential diagnoses.

3.1.8 Effect on medical codes of ethics and an Industry privacy code

The NPPs are intended to provide minimum standards for the protection of individual privacy. The draft Guidelines provide advice and recommendations to medical practitioners to put in place higher standards in order to avoid the attention of the Commissioner's Office.

Our concern is the inappropriateness of this approach in relation to medical practitioners. There is a need for the Commissioner's Office to acknowledge the unintended consequences of a general application of maximum privacy standards on health professionals and the practice of medicine.

Medical practitioners are professionally – ethically and legally - bound to regard their patient's well-being as paramount and are trained, skilled and competent to deal with tensions that might arise between ensuring patient privacy and properly caring for their patient, conducting research in the public interest, and fulfilling medical training obligations.

So long as the draft Guidelines view of 'primary purpose' is maintained with its consequential effect on the NPP consent requirements for use and disclosure of health information for the purpose of caring for patient health, an industry code, at least as stringent as the draft Guidelines cannot be contemplated.

However, if the draft Guidelines were appropriately adjusted, an industry code, if necessary could narrow down the areas where consent is required to ensure the privacy of patients.

Medical practitioners as a matter of best practice and in accordance with their professional duties and their primary role of looking after their patient's well being, involve their patient in decisions about their health. They seek consent for disclosing patient information, undertaking procedures and so forth, where appropriate, and where necessary, seek the consent of parents, relatives and guardians. Their professional codes of conduct reinforce these obligations.

With the privacy legislation taking effect in December 2001, reviews of relevant codes of ethics will ensure consistency with the NPPs. However, the draft Guidelines, in prescribing the supremacy of privacy over health care and confidentiality considerations, make this an impossible task.

3.2' Narrow application of "Research relevant to public health or public safety."

The restrictive meanings given to 'research relevant to public health or public safety' and when it is 'impracticable' to obtain consent in NPP10.3 have profound consequences for medical research.

Public health or public safety

The NPPs dispense with consent in some circumstances where it is necessary for research relevant to 'public health or public safety'. At pp.119 –120 of the draft Guidelines examples are provided of that type of research. Reference is made to research into "communicable diseases" and "polluted waterways". While not intended to be inclusive, the very raising of such examples implies some limits on the type of medical research to which the NPPs refer. No restriction of the NPP in this regard should be implied.

Submission Five

All medical research should be regarded as relevant to 'public health or public safety'.

- All medical research is approved by a properly constituted ethics committee which follows guidelines developed by the Australian Health Ethics Committee of the National Health and Medical Research Council of Australia. The Committee's Statement on research involving human subjects is referred to the Minister for approval under the Council's enabling Act. It is then published by the Council and issued as Public Policy. It deals with matters of privacy as well as the range of other ethical matters relating to research. The Statement, amended from time to time is drafted after a wide consultation process that takes place in accordance with the Act. It is the key document under which all medical research takes place.
- The Statement clearly recognises the need for research in the areas, for example, of dementia, psychosis, the emergency care of children (where consent is a problem), the use of antibiotics. It is not appropriate for the draft Guidelines to presume to limit by examples what is to be regarded as medical research relevant to public health or public safety.
- The narrow interpretation of what is valid medical research for the purposes of consent requirements interferes significantly with the medical training protocols of private hospitals, which are today, often teaching hospitals.

The draft Guidelines need say no more than to make general reference to the Guidelines that are in the public domain and accepted as public policy.

The draft Guidelines' failure to regard the medical profession and their regulating bodies as 'competent' under NPP 10.3 thwarts the researcher's determination of how health information collected for the purpose of medical research, can be used and disclosed for that purpose.

'Impracticable'

Further, the narrow interpretation given by the draft Guidelines as to when it is 'impracticable' to obtain consent for the purposes of using information for research is also not warranted. The draft Guidelines rule out 'impracticable' as including 'inconvenient' or 'commercially unprofitable'.

Submission Six

'Impracticable' should include where the research is: "otherwise not viable (that is, so inconvenient or unprofitable that the research would be hindered)"

In order that important medical research is not obstructed by such a restrictive interpretation of the NPPs, it would serve the public interest better to state that 'impracticable':

"includes not viable (that is, so inconvenient or unprofitable that the research would be hindered)".

Reports in the United Kingdom indicate that lifesaving research into cancer and a host of other diseases could be effectively halted by a continuing row over patient privacy. The UK National Cancer Registry – a record of cancer cases acknowledged to be one of the best in the world, and the cornerstone of a large proportion of cancer research, might be left irretrievably damaged by the row, according to experts. There is widespread confusion over whether doctors and hospitals can legally supply confidential information about their patients to research projects without their consent. It is said that the erosion of data will almost certainly lead to an increase in cancer deaths unless action is taken quickly.

It is impractical (because of inconvenience and cost) to get consent from the thousands of patients for statistical purposes, and cruel when usually the consent needs to be obtained often just after the patient has received devastating news of their conditions.

Medical professionals, having historically been given the status of a profession, in return owe an obligation to the community in terms of ensuring quality control programs, ongoing medical research, medical training in teaching hospitals, and a collegiate approach to ensure high standards of public health. The willingness of doctors to fulfil these roles will wane under the weight of the regulatory nature of the draft Guidelines. Their work will be eroded by the draft Guidelines' undermining of the well-developed ethical rules and public policy under which medical practice, research and training has been carried out.

It is in this context and with the greatest respect to the Commissioner, that we do not regard it as the role of the Commissioner's Office to undermine the various tried and tested professional codes of conducts and the public policy in place in relation to ethical and privacy issues that underpin the way in which research is conducted by the stroke of the privacy pen.

3.3 Over prescriptive guidance

Increased compliance costs

We endorse the comments made by Mr Charles Alexander, senior partner responsible for Minter Ellisons', solicitors, privacy practice:

The Explanatory Memorandum stated that the amendments which extended privacy protection to the private sector would result in:

'.. modest compliance costs associated with a sensible, light-handed statutory privacy scheme'

The recently produced draft Guidelines suggest that the Privacy "Commissioner proposes to take a very strict approach to the implementation of the Guidelines which will be anything other than a 'light touch' and which will involve substantial compliance costs.

Then, to ensure that compliance is equated with good business, a privacy audit is required before a health provider is given the certifying "blue tick". This is not a legislative requirement, but may become necessary as a commercial reality. The cost of the audit in addition to the compliance regime, as required by the draft Guidelines, is likely to be beyond the reach of most unincorporated health providers.

Compliance requirements beyond what the NPPs require

NPP 1.3 and 1.5 and 5 state that an organisation must take 'reasonable steps' to ensure that the patient is aware of a list of matters surrounding the collection of personal information. The draft Guidelines provides advice as to what steps should be taken that go beyond what is 'reasonable' to make compliance with these NPPs a nightmare for health providers. The draft Guidelines in specifying what information is to be provided to a patient and the way in which it is to be given go well beyond the NPPs' requirements.

At p 42 under 3.6 the draft Guidelines provide by way of example what a practitioner should do if, having been so informed, a patient decides not to provide the medical practitioner with information on current medication. The draft Guidelines prescribe that the further information that should be provided is about any possible health consequence or adverse affects that may arise, say if additional medication is prescribed.

The advice, with privacy being its paramount object, ignores the medical practitioner's duty of care to the patient, and the right not to expose him or herself to civil suits for damages. To so limit the medical practitioner's conduct is not warranted by the NPP, which merely requires the practitioner to inform the patient of the consequences. One obvious consequence might be that the medical practitioner is unable to diagnose or treat the patient. There might be other options. The gratuitous advice as to what information the medical practitioner should provide should be removed from the draft Guidelines.

The draft Guidelines purport to set out what comprises 'reasonable steps' to comply with the NPPs in relation to bringing information to the attention of the patient. The 'shoulds' that are incorporated in the draft Guidelines are not appropriate. The NPPs set out clearly what is required in this respect and imply that a common sense approach to the application of the NPPs applying their natural and ordinary meaning is required. Clearly there will be circumstances where the health provider will consider the whole of the facts, matters, and circumstances to decide whether or not the NPP can be complied with in the context that the patient's health and well being is the paramount concern.

In relation to NPP 5 which refers to the need for a document setting out an organisation's policies on its management of personal information, the draft Guidelines at 8.1, however, raise the standard of compliance by suggesting that more than just a pamphlet is required. Further, at 8.2 set out under 8 dot points what the policy should address, in addition to prescribing under 8.3 what more general information should be provided.

Onus on health provider to prove consent

The view taken in the draft Guidelines of when consent is required and what constitutes consent makes proving consent very difficult. In this respect the draft Guidelines reverse the civil standard of onus of proof and go so far as to say that:

Failure to object does not imply consent ...because it will not be clear that the individual exercised an informed choice (for example, the individual may have thrown the form in the bin without reading it). It will also often not be clear that the individual's failure to respond was a positive decision. In many cases it will be likely that individual did not respond because doing so involved costs or too much effort.

This approach virtually means that any consent will have to be an express consent.

Interference with the relationship of trust

How does a medical practitioner achieve the vital communication required with a patient to obtain their trust when the compliance to privacy as interpreted by the draft Guidelines requires the medical practitioner to inform the patient in a manner akin to what a policeman is required to inform the arrested person: "You have a right to remain silent, however, anything that you do say, may be taken down". For the medical practitioner this will require: "You do not need to provide any personal information, but the less you provide the more limited I will be as your practitioner to provide effective treatment" and further "the law requires you to give (particular information) if I am to treat you, but not (this particular) information, and you are entitled and free to view the records I write about you, and correct any errors I might make, etc."

The draft Guidelines adopt a much more stringent means to comply with the NPP requirement and prove that the Act has been complied with. The draft Guidelines are disruptive to proper communication through a trusting relationship between practitioner and patient. Lack of communication is one of the major complaints of patients about medical practitioners, not over communication.

Over-prescriptive nature of the draft Guidelines in general

There are many examples of this, noted in the course of these submissions. At p.44, at para. 3.7 under the example of collecting unsolicited information, this might be appropriate advice where information is received unsolicited about possible child abuse. However, the draft Guidelines go on to deal with complex ethical, moral and professional dilemmas outside the purview of the NPPs. Over-prescriptive ways of handling the situation are provided. This is inappropriate, as one mode of conduct cannot necessarily be indicated for all situations. This should be left to the discretion of the health provider in the knowledge of the duty to comply with the NPPs.

NPP 8 provides that a service should be provided anonymously or with the use of aliases where it is lawful and practicable to do so.

The way in which the draft Guidelines deal with this at p.47 is not appropriate. A practitioner must take into account all the facts, matters and surrounding circumstances before deciding what if any service can properly be provided, or the best manner in which the matter can be handled in the interest of the patient.

Public interest considerations might also have to be taken into account in the presence of any obvious 'doctor shopping' for dangerous medications.

The draft Guidelines go beyond indicating the way in which the Commissioner's Office will reasonably interpret and apply the NPPs. They dictate in great detail the manner in which a medical practitioner is to exercise his or her professional judgment in a clinical situation. They take away the medical practitioner's ability to practice holistic medicine, and the capacity for a GP to be a trusted family practitioner.

The draft Guidelines offer often unhelpful, gratuitous advice that raises more uncertainty in the application of the NPPs than it resolves. For example, the draft Guidelines contain a warning to health providers that telling a patient the information to which the patient is entitled under the legislation is not always enough!

The draft Guidelines are prescriptive of how medical practitioners should practice medicine, relate to their patients and relate information. The views dictate methods of history taking and direct the use and disclosure of it, such that if followed, therapeutic treatments would be disrupted and poor outcomes would result.

If the misconceived and gratuitous advice in the draft Guidelines was followed by medical practitioners, dangerous "U.S. style of managed care" could eventuate, medical practitioners being directed to deal only with presenting symptoms and directed not to interfere in their patients taking ill-informed approach to their health care. It infringes on the patient's right to seek the style of medical care they choose, medical practitioners being prevailed upon to comply with the advice offered in the draft Guidelines as to how they obtain the medical information they require and as to how they deal with it. Some patients want holistic health care, and not to be forced into a managed care system of treatment for presenting symptoms only.

4 COMMENTS ON THE QUESTIONS ASKED

We are invited to comment on the questions asked:

While the draft Guidelines overstep the legislative privacy framework as set by the NPPs, the AMA is unable to offer much in the way of constructive comment about the questions raised.

Given that the questions arise from a misconception of the primary role of a health provider, the scenarios raised in the draft Guidelines raise more questions than they answer, ignore the very different answers that are produced by slightly different factual situations, and are prescriptive to the point of cutting across centuries of legal/medical/ethical/consumer input in the development of competent professional standards of health care.

Generally the examples given raise complex ethical medical issues that confront practitioners daily, and they purport to provide answers that would constrain a medical practitioner exercising his or her clinical judgment as to what is best for the patient. In the examples given questions are raised and solutions offered that do not admit a different outcome depending upon the particular facts, matters, and circumstances that face a patient and practitioner. They raise more questions than are answered, and offers simplistic advice.

The examples offer little guidance as to the way in which the NPPs should be construed.

The AMA provided advice on some of these issues at the outset that was rejected by the Commissioner's Office. The thrust of the guidance offered by the AMA was that if the Commissioner reviewed the narrow interpretation taken of the NPPs and in particular, recognised that the 'primary purpose' of a medical practitioner collecting health information is for the purpose of taking care of patient health, many of the questions raised and confusing answers offered would not be required.

That unwarranted and unreasonably restrictive interpretation of NPPs 1 and 2 gives rise to the need for a multitude of examples and lengthy and complex draft Guidelines in an attempt to provide a workable and practical administration of the Act. That object has, in our opinion failed, because of a fundamental misconception of the nature of medical practice, and what is required for the professional to practice it with excellence.

The scenarios set out and the conduct prescribed goes well beyond the requirement of the NPPs in directing medical practitioners conduct, patient relationship, the way of working through a diagnosis and the way in which treatment is to be provided.

5. OTHER MATTERS OF RELEVANCE

We are invited to comment on other matters of relevance under the draft Guidelines. Rather than doing this, we take the opportunity to reiterate some of our major concerns with the NPPs generally as applied to health providers. We have concerns as to the retrospective effect of the NPPs in so far as the use and disclosure of material collected before the commencement date of the Act; the provisions for access to patients of medical practitioner's notes; and the issue of e-health security generally. We are also concerned if the NPPs prevent a medical practitioner from disclosing patient information to an insurer, medical defence organisation, and legal advisers.

These are matters that require monitoring in the two-year period allowed before the legislation is to be reviewed.

5.1. Retrospective effect

The NPPs come into effect on 21 December 2001. It is intended that the NPPs are to apply to information collected after that date. However, the legislation appears to be retrospective in effect, in that, any personal information referred to or 'used' after that date, though collected before that date, becomes information 'collected' after that date. In relation to medical practitioners who, for professional and legal reasons, must refer to patients' past records, this imposes an intolerable burden. It might not be an unreasonable administrative burden or expense to provide a patient with the full past records, but in circumstances where the notes were created without this being in mind could interfere with the doctor/patient relationship and cause confusion and undue agony to patients who might not understand the significance of early differential diagnoses, for example.

5.2 Concerns about Access

Protection of medical practitioner's private or preliminary thoughts

Assessment, diagnosis and treatment involves the practitioner's clinical judgment and often his or her thinking is assisted by aides memoir and consideration of differential diagnosis which should be confidential until the practitioner commits to a professional opinion and management plan. The NPPs as to access fail to protect the medical practitioner's private or preliminary views in the thinking processes required for full medical assessments, accurate diagnosis and the formulation of treatment programs

It is a competent medical practitioner's duty to consider all differential diagnosis, the more serious, even if remote, to be investigated and negated before a conclusion is reached for a common cause of a set of symptoms. Access to notes indicating various thought processes and possible diagnosis can cause undue and unnecessary alarm to some patients. Access to notes that record suspicions and queries can undermine patient confidence, say, where a medical practitioner indicates 'query psychosis?' being the cause of pain symptoms in the absence of any organic signs.

The causes for concern about patient access to notes might lead to undesirable note-taking practices.

By way of example:

A medical practitioner at the hospital emergency department, faced with a patient admitted with abdominal pain with no organic cause, might make a differential diagnosis of narcotic use for the benefit of the next practitioner on duty. This is likely not to be noted so long as the patient is able to access the notes.

Patient's rights to confidentiality

The patient's right to privacy should not compromise confidentiality.

We have spelled out in detail the difficulties that might arise from a parent or step-parent having access to young children's clinical notes in which a medical practitioner has included suspicions in the course of consultations. Even a child of 10 years is entitled to confidentiality

By way of example:

A medical practitioner at the hospital emergency department is unlikely to make a note of the suspicion that a young patient is being abused by the patient's parent, guardian, or relative of guardian, so long as that parent or guardian is at liberty of obtaining the notes. The next practitioner on duty will not have the benefit of the surmise.

Access to Process Notes compromises the therapeutic effect

Psychiatrists take down facts as described. It might include hearsay but it is nevertheless important for the therapist to note it as told. Whether the information is truthful or not might indicate something in itself.

As part of the therapeutic process, psychologists and psychiatrists are trained to record their own reactions to their patients, and dynamic aspects of the doctor/patient relationship. The psychiatrist might note, for example, their own adverse or positive reaction to the patient, as the therapy is interactive.

It is not appropriate, nor in the interests of the patient therapeutic process that the patient have access to such notes. The therapist will not show the notes to the patient. While patient access might not be life threatening it can be disruptive of the treatment.

Process Notes about third parties

Counsellors, psychologists, general practitioners, and psychiatrists all necessarily take down information as it is given, histories that detail work and home experiences and inter personal relations, and in so doing often collect sensitive information about other people. This occurs in the treatment of work-related stress, anxiety and depression, and discussions of matrimonial problems. Therapy for sexual difficulties involves disclosing sensitive information about other people.

On one view of NPPs 1.4, 1.5 and 10.1, the information noted about employees, family members and loved ones, is only to be collected from, or with the consent of the person about whom the information is given. If that is correct, it means an end to most therapeutic sessions, and severely restricts medical practitioners from caring for their patients' health.

Patient access to computer screens

The suggestion is made in the draft Guidelines that patients should be able to see computer screens as information is entered. To comply with this requirement probably means that computer screens have to be situated for the patient's viewing convenience. This in itself could cause breaches of security and privacy. This gratuitous advice, which oversteps the requirements of the NPPs, is liable to lead to breaches of security, privacy and confidentiality. It is also likely to be impracticable.

Correction of records

Patients may be entitled to correct any errors. This makes it difficult for medical practitioners to later work back on their thinking processes, explain the assumptions upon which opinions and diagnosis are based, or the reason for differential diagnosis. It is also unrealistic for patients to have the ability to correct notes taken down in the course of therapeutic processes. The psychologist or psychiatrist needs to rely on the ability to review the notes as taken down, whether the facts recorded are true or false.

The medical practitioner needs to be free to note the circumstances in which the change was made and keep a record of the original entry. There could be serious implications in court proceedings where changes are made, and where, after the event, practitioners try to provide reasons for items in their reports or sickness certificates, not knowing what facts, history and assumptions existed at the time when they held an opinion.

Over-riding legal professional privilege

If an insurance company or MDO or legal firm receives legal advice or a medical opinion containing patient health information, (at present protected under the common law by legal professional privilege), under NPP6 a patient is entitled to obtain access to that information. The exemption contained in NPP6.3 is not broad enough.

Cost of provision of Access

NPP 6.4 sets out the basis upon which charges for access can be made. However, at p.80 of the draft Guidelines offers condescending encouragement that health providers will provide access without charge. This is inconsistent with at least one State or Territory legislative provision in relation to access.

Further, there follows misleading and deceptive advice in relation to a medical practitioner's entitlement to a Medicare rebate if providing access to a patient's health record in the course of a consultation. Any entitlement to a Medicare rebate arises out of

the fact of the consultation, and the suggestion that the costs of photocopying the records or any other administrative charge is partially covered by Medicare is wrong.

5.3 E-health security

The Privacy Commissioner clearly has insufficient resources and powers to deal with potential breaches in privacy from e-health records. Governments are inattentive about such issues. Take for example the Federal Government's requirement that patient information is to be transferred, with no encryption requirement, for the purposes of a medical practitioner receiving a Practice Incentive Payment (opposed by the AMA).

The legislation lacks the teeth to prevent on selling of patient information and the development of electronic databases from the patient health information. The question is whether the so-called de-identified material is genuinely de-identified, and how easily can it be re-identified.

The push to make profits in GP's practices bought by corporate interests raises the risk of inappropriate 'data-mining' of personal data for commercial purposes. The potential insecurity of information held on-line and the speed with which it may be disseminated are real causes for concern.

5.4 Disclosing information to MDOs

The other serious matter of concern any impediment that the NPPs might impose to medical practitioner's using and disclosing health information to the insurers, MDOs, legal advisers and expert medical witnesses. We have dealt with this issue above, as we are of the view that a reasonable application of the NPPs imposes no impediment, and that the draft Guidelines should reflect this.

Related to this however, is the patient right to access created by NPP 6. If a medical practitioner provides an insurer or MDO with health information about a patient in the course of complying with insurance policy requirements, or to a lawyer in the course of seeking advice, then, despite the common law protection of legal professional privilege, NPP6 requires that the patient has access to this information. The exemption contained in NPP6.3 relates only to existing or anticipated legal proceedings.