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[Mendelson, Danuta 2004, Health connect and the duty of care: a dilemma for medical practitioners, *Journal of law and medicine*, vol. 12, no. 1, pp. 69-79.](#)

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Danuta Mendelson*

“HealthConnect and the duty of care: a dilemma for medical practitioners”

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This article asks whether medical practitioners' duty of care to their patients will encompass participation in the HealthConnect shared electronic records initiative. Medico-legal aspects of the HealthConnect scheme relating to the nature of shared electronic health record summaries (SEHRS) are examined, focusing on their function as an element of patient care and their ultimate purpose. The analysis is based on the premise that an incomplete and hence inaccurate shared electronic health record summary is clinically and legally more perilous than no record at all.

Medical practitioners owe their patients a non-delegable duty to "exercise reasonable care and skill in the provision of professional advice and treatment".¹ The standard of reasonable care is determined by reference to "that of the ordinary skilled person exercising and professing to have that special skill".² The scope of the medical duty of care includes keeping adequate medical records. But should the notion of a medical record extend to "shared electronic health record summaries" (SEHRS)? The phrase "shared electronic health record summaries" refers to health-related information summaries about an individual that a hospital, physician or health care practitioner would collect at the point of care and electronically transfer to the HealthConnect repository to be "shared" with participating entities.

The origins of the HealthConnect scheme go back to 2000 when the National Electronic Health Records Taskforce, in its Report to Health Ministers titled *A Health Information Network for Australia*, recommended the creation of a nationally coordinated and distributed system of electronic health records. This scheme, having gone through a number of permutations, is now called HealthConnect.³ Its implementation is projected to commence in 2004.⁴

The HealthConnect scheme is not dissimilar to a number of overseas initiatives that aim to create national, State or provincial electronic networked databases of medical records.⁵ These schemes build on pilot projects initiated in the United States in the 1960s that aimed to improve inter-professional communications through the use of computerised electronic health records linked across an organisation.⁶ Today, probably all hospitals, clinics, allied facilities, private funds and the Health Insurance Commission operate different kinds of computerised patient record systems. Personal

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health information in an identifiable form is transmitted electronically among hospitals, doctors, health and diagnostic facilities, third party payers and governmental regulators – each of which may use the data for different purposes.⁷ However, apart from the Health Insurance Commission and private health insurance funds, which process electronic medical and pharmaceutical data nationally,

electronic records created by other organisations in the health sector tend to operate as discrete systems.

The national HealthConnect project is much more ambitious.⁸ According to Mr Tony Abbott, the Federal Minister for Health and Ageing:

The new integrated HealthConnect system will provide secure electronic health records for consumers wherever they go in the health system, providing the basis for improved decision-making and delivering streamlined care.⁹

The salient points of the HealthConnect system are as follows:

- an "opt-in" scheme in which a very wide variety of "health service providers" can choose to participate;
- participating medical practitioners, with the patient's permission, to create a SEHRS based on the practitioner's own consultation record;
- the patient to decide:
 - the content of SEHRS; and
 - access to SEHRS by "primary" and "secondary" users;
- SEHRS forwarded to and stored at a designated collection point; it appears that the Health Insurance Commission may be the collecting agency;
- access by other authorised "secondary" and "tertiary" users to the SEHRS library to be via their existing systems or via the internet.

If it is to fulfil the promise of providing "the basis for improved decision-making", the HealthConnect system will need to be embraced by all medical practitioners nationwide.

However, many legal, ethical and recordkeeping issues inherent in the HealthConnect scheme are yet to be resolved. The resolution of these issues will determine whether medical practitioners as a profession will participate in the scheme. This article briefly examines the concept of the HealthConnect scheme and the function of the shared electronic health record summaries, focusing on the reasons for and against the imposition of a duty of care on medical practitioners to participate in the scheme. In seeking to establish whether such duty will arise, the article discusses the distinction between medical records and SEHRS, the issues of integrity, accuracy and currency in the latter form of record, as well as their benefits and purposes.

The HealthConnect system

According to the *Financial Business Model* for HealthConnect, the concept of an integrated national health information network is akin to a library service:

with users adding, searching and retrieving documents from the library subject to a set of access rules. In this case the documents in the library will be consumer HER [health electronic records].¹⁰

The HealthConnect project is guided by a set of Design Principles. The first two principles state:

1. The consumer shall determine who has access to their HER data and the duration of that access; and
2. The provider together with the consumer, shall determine what clinical data is recorded for each specific health event.¹¹

Hence, subject to the individual health consumer's permission,¹² her or his personal health-related information will be collected in a standard, electronic format at the point of care, such as at a hospital or a general practitioner's clinic. This information would take the form of "event summaries", rather than the more extensive notes that a health care provider may keep. With the patient's consent, these SEHRS would be stored at a central, local or regional collection point as health data directories and at the federal level as health provider directories. The SEHRS would be accessible via a "secure network" to "primary users". Primary users will be consumers (patients) of "health services who may wish to review and add to their health records".¹³ The consumer can also authorise access by providers of health services, including doctors, nurses, pharmacists, allied health, community health, Aboriginal health and public health professionals, where the provider is "seeking information about a consumer they are treating".¹⁴ Though unarticulated in the documentation, the system will also allow the consumer to authorise her or his lawyers to access the *HealthConnect* system for litigation purposes.

Additionally, access, under special protocols, will be available to "secondary users" who are loosely divided into clinical and administrative "researchers" (including clinical, health service, administrative, statistical, consumer, epidemiological) seeking information to assist clinical decision-making, and "managers", including administrators, planners, policy makers, and organisations such as the Health Insurance Commission and private health insurance funds that may seek information to assist with management decision-making.¹⁵ Users will be able to access the SEHRS library via their existing networking systems or "a general purpose computer interface (Web Browser)".¹⁶

It is of concern that despite the imminent date for commencement, a detailed working model for collection and distribution of the SEHRS within the *HealthConnect* scheme is yet to be worked out. In 2000, the National Electronic Health Records Taskforce, in its Report titled *A Health Information Network for Australia*,¹⁷ suggested a nationwide monolithic model called HINA, which in 2002 was renamed *HealthConnect*. The Report contains a number of "clinical" examples illustrating the project's socio-economic foundations. The Report provides three scenarios of why a system of shared electronic health records summaries is urgently needed. The first of these scenarios concerns an incompetent patient with a closed head brain injury who, following an accident at work, is brought by ambulance to an emergency ward. The emergency personnel "cannot even put a name to their consumer until he regains consciousness",¹⁸ and as a result "make an avoidable mistake", which results in an adverse drug reaction. One may ask, how, without knowing the patient's name, could emergency personnel access his electronic health records under the *HealthConnect* scheme? Yet the issue is of great importance, for as Dr Pascal Gelperowicz, who works on an emergency ward, explained:

The majority of emergency physicians working in any emergency department would describe access to past medical history and records as crucial. Many situations necessitate rapid access to medical records as there is often no family member or corroborating medical historian to fill this role. What is less apparent though is the need for these services regularly; let me provide three examples. The first is the

patient who presents to emergency with chest pain and we are querying whether it is cardiac in nature – an ECG is performed which is abnormal and may reflect changes which are from a previous cardiac event or this presentation; rapid access to a previous ECG would allow swift implementation of cardiac

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treatment if required. A second example is the patient who says "I'm on three medications – one for my heart, one for blood pressure and another one for blood thinning" (a very common occurrence) – these presentations are often out of hours with no access to the patient's GP, pharmacist or family members; patients are notoriously bad at providing accurate data on medications and past medical events through no fault of their own. They may not understand procedures or findings of those procedures and there is the risk of loss of accuracy of history as time goes on. The final example represents a patient minority but an important minority and that is the drug-seeking or "ulterior motive" patient who presents a fictitious presentation and past history to negotiate personal gain; access to records on these patients would be extraordinarily useful.¹⁹

Thus, at least in the emergency ward, there is a need for quick access to diagnostic tests, past medical history, including allergies, and medication lists. Undoubtedly, an integrated network of accurate and comprehensive electronic health records accessible from many locations has the potential to improve the quality of care.²⁰

Will medical practitioners have a legal duty to create and use SEHRS?

Under the Australian federal system, the responsibility for health care is vested in the States and Territories. They have the power to enact legislation to control the registration of medical practitioners, and to impose conditions for the practice of medicine without infringing the *Commonwealth Constitution*.²¹ This means that medical practitioners could be compelled to participate in the *HealthConnect* scheme by State and Territory legislatures. The Commonwealth Parliament will only have the power to regulate this aspect of medical practice if the High Court of Australia considers that participation in *HealthConnect* is an incident of medical service through administrative procedures within the scope of s 51(xxiiA) of the *Commonwealth Constitution*.²² However, apart from legislative compulsion, would medical practitioners have a common law duty to participate in providing and utilising information contained in SEHRS? Their duty to participate will be conditional on the records generated through the *HealthConnect* scheme being accurate, reliable and trustworthy.²³

Difference between medical records and SEHRS

Medical records created by the practitioner have always formed an integral part of clinical care in the Hippocratic tradition.²⁴ A medical practitioner has a duty to create a record at the time of each professional encounter with the patient, and should do so on a continuing basis. It has been noted that medical records, through their style, content and sequence of information, reflect their creator's clinical reasoning

processes.²⁵ They also serve as an aide-memoire for the purpose of the patient's medical care and referral, as well as for practice management and teaching. Though characterised by their confidential nature, when disclosed under compulsion of law as part of the litigation process, clinical records also provide evidence of the processes of reasoning that lead to provisional or final diagnosis,²⁶ as well as decisions regarding treatment and advice provided to the patient. For example, lawyers acting for a client in a medical malpractice suit are expected to examine her or his clinical records before deciding whether to take on a case.²⁷ The information contained in the records enables them to assess the plaintiff's health status before the impugned

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medical intervention. As a general rule, the case will only be pursued if the records show that the condition is probably due to medical negligence by a doctor or a hospital rather than a pre-existing illness or condition.²⁸

Under the scheme, once the SEHRS is forwarded to HealthConnect, only the patient²⁹ and HealthConnect (or its commercial subcontractors) will have the right to alter its content. The issue of the authenticity, integrity and veracity of SEHRS as probative evidence will, no doubt, provide excellent earning opportunities (and headaches) for litigation lawyers.

However, apart from personal injury litigation, in the context of clinical practice, there are major reasons why it is doubtful that SEHRS will be of benefit in primary patient care. First, there is the probability of incompleteness and possible lack of integrity. Although the majority of patients will consent to include all information that a doctor would extract into the SEHRS template from her or his clinical notes, others may wish to withhold such vital information as abortion, depression, a psychotic episode or alcohol/drug dependence. Patients' choices regarding the content of SEHRS cannot be predicted in advance nor retrospectively ascertained. Second, summaries – by definition – are not sufficiently detailed to serve as a basis for medical treatment decisions (apart from emergencies where no other data are available), practice management and evidence of accountability. They are neither designed nor intended to replace proper clinical records and letters of referral created by the doctor. Third, the HealthConnect scheme is an opt-in system. Naturally, the comprehensiveness and thus the usefulness of SEHRS will be compromised without full participation by health care providers.

Will medical practitioners have a common law duty to participate in the Health Connect scheme?

The major policy argument for imposing a duty to participate in the scheme is that absence of medical records might pose a risk of misdiagnosis, allergic reactions, and sometimes of overdosing. However, it is difficult to imagine why, in private practice, a physician would be expected to consult SEHRS rather than full records. In an emergency ward, assuming their integrity, currency and accuracy, the existence and ready access to SEHRS containing lists of results from previous investigations may alleviate the pressure of undertaking *some* tests for *some* patients. For example, instant access to SEHRS containing details of previous ECGs could alleviate the risk

of misdiagnosis for a patient with an abnormal ECG, but an unconscious patient with a closed head injury would require brain imaging even if a brain scan had been taken two hours before the accident.³⁰ In the most severe and urgent cases, medical management is often not predicated on previous tests – in the sense that everything is done in a situation of high acuity irrespective of earlier tests, though obviously not in complete isolation. As a general rule, a previously normal test would not preclude repeating the test on the basis that something in the patient's condition may have changed, necessitating a casualty department presentation; tests may be falsely negative and require repeating.³¹ Thus, even with access to SEHRS, prudence (and the risk of malpractice litigation) would dictate repetition of the tests. There is also a technical question about access for patients who have not or are unable to consent, and where the unconscious patient's name is unknown.

The question whether participation in the *HealthConnect* scheme falls within the scope of the medical duty of care is conditional on the degree of acceptance by the profession of this scheme as a recognised element of competent medical practice. In all States of Australia³² (though not as yet in the

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Territories),³³ professionals, including medical practitioners, are not liable in negligence if they act in a manner that is widely accepted in Australia by peer professional opinion as competent professional practice. Courts will not intervene with the peer opinion, unless it is "irrational"³⁴ (in Victoria and Western Australia the threshold for the court's intervention is "unreasonable").³⁵ The legislation also provides that "widely accepted" peer professional opinions can differ, and "do not have to be universally accepted to be considered widely accepted".³⁶

Peer opinion regarding clinical acceptability or otherwise of the *HealthConnect* scheme will be influenced by the attitudes of the Australian Medical Association and specialist Colleges. These organisations will only embrace the *HealthConnect* scheme if the information contained in SEHRS is accurate, complete, up-to-date and confidential. Moreover, participation in the scheme should not be burdensome for practitioners,³⁷ in the sense that their therapeutic benefit should outweigh the time spent entering the data, operating the *HealthConnect* system and reviewing SEHRS.³⁸ In short, if the reasonable practitioner would not have undertaken the burden of participation in the scheme, no such duty to do so will arise.³⁹

Accuracy, integrity and currency of SEHRS

As noted above, medical practitioners will only have a professional duty to participate in the scheme if the accuracy, integrity and currency of the data contained in SEHRS is assured. The nationwide scope of the project raises technological and legal concerns regarding the issue of accuracy. Provided they are authorised by the patient, not only hospitals, day clinics, doctors, nurses and pharmacists but personal trainers, chiropractors, Chinese medicine practitioners, herbalists, naturopaths, osteopaths, iridologists and faith healers will have an input into the SEHRS through their own disparate "feeder" systems. Assuming that the messaging and routing infrastructure works flawlessly and all the data are successfully collected into the repositories, there is still no transparent way of ensuring that the information is accurate, current and has

not been tampered with. The technology is yet to develop processes that would verify whether the SEHRS data amassed in the repository are properly integrated and represent an accurate set of health delivery services in a summary form.⁴⁰ Moreover, despite some claims by private companies involved with providing software infrastructure for

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nationally networked health records systems outside of Australia,⁴¹ the present technology is not as yet capable of reviewing, prioritising, systematising and sorting out chronology (not merely the date but the sequence) of health service events and medications for every patient. For example, the provision of separate templates for recording different kinds of services and events will not be sufficient to sequence, prioritise and triage the SEHRS of a patient who visits a cardiologist, a surgeon, a faith healer, a herbalist and a pharmacist on the same day.

If the scheme were to be widely adopted by practitioners, in order to avoid liability in negligence the participating medical practitioner would be expected to study each SEHRS before making provisional diagnosis or deciding treatment options. Would he or she be also expected to make an audit to ascertain that the record is authentic? Even without the duty to audit, unless a SEHRS equivalent of triage is externally provided, retrieval of pertinent information from volumes of SEHRS accumulated over the years will be a time-consuming process effectively precluding the use of this kind of patient data in an emergency ward, and imposing a considerable burden on private professional practice.

Perhaps one of the most significant factors in consideration of the duty to participate is the fact that the purpose of SEHRS is external to the therapeutic relationship between the patient and the attending medical practitioner. These summaries are not intended to replace clinical notes, but are created jointly by the health care provider and the patient for the purpose of dissemination amongst future users of HealthConnect authorised by the patient. As envisaged by HealthConnect, patients, rather than doctors, will have ultimate control over the content of each SEHRS. Moreover, only the patient can determine who should have access to SEHRS.⁴² It is simply impossible to predict how many patients will withhold or change information relating to their health status or drug and alcohol abuse.

The case of [Bruce v Kaye \[2004\] NSWSC 277](#) may serve as an illustration of a patient whose control over a SEHRS would make it unreliable. The case involved Kristy Bruce. Her mother's uterus ruptured in the early stages of labour, and she was born by an emergency caesarean section on 21 March 1989 at the Royal Hospital for Women in Sydney, suffering from cerebral palsy. She brought action by her tutor⁴³ against specialist obstetrician, Dr Kaye, alleging that he negligently permitted the term of her mother's pregnancy to continue beyond 42 weeks.

The mother used five different surnames: Chevelle, Winbank, Anderson, Owen and Bruce. On 17 October 1988, she consulted the defendant as Ms Chevelle, for the first time. According to Dr Kaye's record, which was not disputed, Ms Chevelle told him that this was her fourth pregnancy and that she had delivered three children. In fact, she had had seven pregnancies, two of which had been terminated and one

miscarried.⁴⁴ More importantly, she did not disclose to Dr Kaye that on 3 March 1988, under the surname of Winbank, she had an abortion by curettage at the Royal Hospital for Women.

Also, for reasons of her own, Ms Chevelle informed Dr Kaye that she recently moved to Sydney from interstate. This was untrue. Moreover, neither during the first consultation nor subsequently did Ms Chevelle disclose to Dr Kaye that between June and October 1988, under different names, she consulted six different medical practitioners for prolonged obstetric consultations, and underwent five pregnancy tests. Ms Chevelle also did not tell Dr Kaye about the ultrasound test which she underwent at the Royal Hospital for Women on 22 August 1988 under the name of Sharon Anderson. That test showed that she was 12-13 weeks pregnant. Instead, she indicated that she was unsure of her dates. To enable him to estimate the date of confinement,⁴⁵ Dr Kaye arranged an ultrasound examination on

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19 October 1988. Soon after that second ultrasound Ms Chevelle went to Canberra, and consulted yet another medical practitioner, Dr Buchanan, who also arranged for an ultrasound. On her return to Sydney, she saw Dr Kaye, but did not inform him of her obstetric consultation in Canberra or the third ultrasound. Having systematically withheld relevant information, the plaintiff argued in court that Dr Kaye should have consulted her hospital records, which would have revealed, though under different names, both the results of the August ultrasound and notes about the March termination of pregnancy.

Rejecting this proposition, Grove J stated (at [24]):

The report of the August ultrasound and notes about the termination of pregnancy in March 1988 have been accumulated in the Royal Hospital for Women file. It was suggested in cross-examination that the defendant, as a visiting medical officer with rights to introduce patients into the hospital, could have accessed the file. I expect he could but I cannot conceive any reasonable cause for him so to do. If a patient gives no history of any such procedure or examination, it is not the duty of a medical practitioner to conduct an investigation into whether he has been deceived. There was no clinical or other reason for the defendant to go to the hospital files.

The patient in *Bruce v Kaye*⁴⁶ may have been at the extreme end of the spectrum. However, it is not difficult to imagine that some patients will withhold relevant information from SEHRS, or capriciously bar some medical practitioners from accessing them. Patients will have to be advised that in proceedings against a medical practitioner for negligence, their decision to either withhold data from or limit access to SEHRS may be considered contributory negligence on the basis that they had failed to take precautions against the risk of harm through absence of relevant information, which a reasonable person would take.⁴⁷ If the defendant medical practitioner can establish that a plaintiff has been warned that lack of information about a condition or treatment may result in misdiagnosis or ineffective treatment, the practitioner may succeed in establishing the legal defence of voluntary assumption of risk.⁴⁸

Judging by the statements of Grove J regarding a medical practitioner's scope of duty with regard to consulting medical records, the existence of the HealthConnect scheme

will not place doctors under a legal obligation to investigate whether anything in the patient's SEHRS has been withheld, altered or deleted. The problem is that the scheme may not, as the Minister asserted, "provide secure electronic health records for consumers wherever they go in the health system". Rather, it may provide a false impression of security with Swiss cheese health record summaries.

Will HealthConnect provide "the basis for improved decision-making and delivering streamlined care"?

There would be a strong argument for compelling medical practitioners to participate in the *HealthConnect* scheme if SEHRS were shown to improve clinical decision-making and enable the delivery of streamlined care. The National Health Records Taskforce in its Report provided a scenario illustrating of how such improvements would be achieved. The scenario involved a recommendation by a general practitioner for admission of a 70-year-old woman with fever and chest pain to a public hospital and her subsequent admission to its Accident and Emergency (A&E) department. According to the Taskforce's Report, the woman was visiting her family from interstate, and was "not known to the (male) general practitioner".

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Apparently, due to the time of admission and breakdown in communications with the general practitioner's locum, pathology and radiology tests were repeated twice. The Report scenario is written in the present tense:

She is asked about allergies and remembers that she had a rash after taking some cold tablets several years ago, but cannot remember any further details. She is prescribed intravenous penicillin and re-hydration. Treatment is commenced in the A&E department but produces a rapid deterioration. She becomes shocked and requires resuscitation. She is admitted to the intensive care unit. (Cost of two days in the ICU approximately \$3,000 ...) Alternative antibiotics are prescribed, she recovers and is discharged home after seven days in hospital.

The Report provides an alternative scenario with the *HealthConnect* scheme⁴⁹ in operation:

A new patient presents to the general practitioner complaining of fever and chest pain. She is a participant in HINA and gives her permission for him to access her personal health information via HINA. Her full medical history appears on the doctor's computer describing her general good health with a possible allergic episode to Amoxicillin some 15 years ago. The general practitioner refers her for pathology and radiology and sends an admission request to the admitting officer at the local hospital by secure e-mail. She then makes her way to the hospital. On her arrival, the admitting doctor reads the e-mail, examines her and checks the results of the pathology and radiology that have already been forwarded to the hospital. With her permission, he retrieves her medical history and notes the history of a possible allergic incident. He commences an alternative antibiotic and admits her to the ward. She returns home in three days.⁵⁰

The HINA or *HealthConnect* system notwithstanding, it would be unusual for a general practitioner who has arranged both the patient's hospital admission and the diagnostic tests not to request that the results be forwarded to the hospital either by

fax or e-mail. In this scenario, the patient from interstate gives her permission first for the general practitioner and then the admitting hospital doctor to access her SEHRS. As a result, both become aware of her past allergy to penicillin. But what if she, having given consent for access only within her State, were now unable to provide consent for the SEHRS access in Victoria? What if, over 15 years, the file with reference to the "allergic episode to Amoxicillin" became corrupted or lost? And even if the file were available, how long would it take to search through 15 years' worth of SEHRS files?

Confidentiality

Another issue raised by such searches is the patient's right to confidentiality within a therapeutic relationship and patients' interests in controlling access to sensitive medical information. While searching through the SEHRS files for records of allergies, the attending doctors may, by virtue of the process, read about the woman's past history of rape and attempted suicide, which is irrelevant to the diagnosis and treatment of her present condition (though it might be vital in other circumstances). As proposed, technological inability to categorise the SEHRS data by relevance to the patient's current condition, which is inherent in systems like the *HealthConnect* scheme, will pose a dilemma for patients.⁵¹

Patients can agree to the future disclosure of sensitive information contained in SEHRS on the understanding that the access to it by medical personnel will have to be virtually unrestricted.⁵² Alternatively they can exercise control over such data either by excluding it from SEHRS or restricting access to it, with the knowledge that their decision may lead to the risks of harm the scheme is supposed to prevent. Legally, the determination of the scope of medical duty of care involves balancing the probability and seriousness of suffering harm – such as an anaphylactic shock as a result of an allergy to penicillin – against the burden of taking precautions to avoid that risk as well as the social utility of the activity that creates the risk of harm. In the context of the scenario, the

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suggested precaution against the risk of allergic reactions is the participation in the *HealthConnect* scheme and medical utilisation of SEHRS. The social utility argument for declining such participation would assert that many patients may be embarrassed and distressed by the disclosure of sensitive health-related data for reasons other than the treatment of their particular medical condition.

In view of their dubious benefits, the uncertainty of their content and problems their retrieval and disclosure would impose in the context of primary patient care, professional medical bodies will be slow to endorse participation in the *HealthConnect* scheme as an integral part of competent medical practice.

SEHRS databases

Finally, the fundamental question that goes to the issue of medical duty of care is the major purpose of the scheme and the utilisation of SEHRS outside the clinical encounter.

Resolution of the issue of legal ownership of SEHRS will be vital to the question of which legal entity will have the right to disclose and sell the SEHRS databases in whole or in part to third parties. State, Territory and Federal Governments can already access large electronic databases relating to health;⁵³ therefore access to the SEHRS repositories will merely add to their already existing capacity for mapping clinical care patterns in order to develop economic and social policies for health and disease management. The SEHRS databases will, however, further enhance governments' ability to both check patients' entitlements to medications at concession rates,⁵⁴ and scrutinise the performance of individual health care providers, particularly in relation to the containment of health care costs. In the field of genomic research, large datasets (phenotypic data) that comprise longitudinal histories of health and illness of individuals may lead to a better understanding of the molecular underpinnings of disease.⁵⁵ Depending on the definition of "research" and the stringency of statutory privacy protection, private marketing research corporations may be able to purchase information collected in SEHRS to build patients' drug or health facility profiles and on-sell these personal profiles to pharmaceutical and private health care corporations so they can target more precisely the discrete niche market. Moreover, the information contained in SEHRS databases will be very useful to law firms which endeavour to target potential clients and induce them to join class actions against health care providers and pharmaceutical companies.⁵⁶ Employers and insurers may wish to access SEHRS databases as a prerequisite to hiring and rehiring or providing an insurance cover for both providers and patients.⁵⁷

Consequently, the various purposes for which these records are going to be created should be factored into determining the scope of medical practitioners' duties of care in relation to *HealthConnect*. It seems that there is more than one purpose for the introduction of this scheme. The information contained in SEHRS will no doubt be streamlined, but improving the quality of care by reducing replication of tests, and minimising the risk of adverse events due to lack of health care information are not the major reasons for the creation of the *HealthConnect* scheme. This being so, it will be difficult to persuade medical practitioners that participation in the *HealthConnect* scheme is within the scope of their professional duty of care.

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Postscript

Since this article was submitted for publication, the Federal Health Minister, Tony Abbott, announced that from July 2004, a Medicare smart card readable by a computer⁵⁸ will be available to residents of Tasmania (followed by South Australia and northern Queensland, then other parts of Australia).⁵⁹ The proposals are very vague. Apparently, the scheme may be run on an opt-in basis with patients-cum-customers buying the access to a smart health card system run by a private company.⁶⁰ The cards will initially include the patient's name, possibly a digital photo, health records such as drug allergies, and whether the holder is a registered organ donor. This information will be accessible to hospitals, doctors, pharmacists, Medicare offices and ambulances teams. However, the smart card's microchips are capable of containing much more health information, and, according to the Minister:

From next year Tasmanians will be able to use the cards at Medicare offices to obtain information about their immunisation records, see if they have qualified for the Medicare "safety net" and how much they have spent on pharmaceuticals.⁶¹

The Minister's statement suggests that the major function of the smart card will be to provide more particularised information to the Health Insurance Commission. This means that the Medicare number will almost certainly be embedded as the unique identification number. Presumably, for reasons of privacy, every card holder will also have a pin number to activate it, which might present difficulties in accessing the information when the patient is incompetent. As with the SEHRS, holders of the smart card will be able to control and delete any information from the electronic file.⁶² It is uncertain whether the new proposals will mean that the HealthConnect scheme has been discarded in favour of the smart card, or whether the two systems will operate side by side. However, it might be that the government has realised that, apart from costs, ethical, legal and practical deficiencies of SEHRS would make their use unacceptable in medical practice.

* MA, PhD, LL.M.; Associate Professor, School of Law, Deakin University, Burwood, Victoria.

Partly based on a paper presented at the Symposium on "Shared Electronic Health Records: Ethical, Legal and Recordkeeping Perspectives", part of the Australian Research Council Discovery Grant, under the auspices of Deakin University, Melbourne, 23 April 2004.

Correspondence to: Dr Danuta Mendelson, School of Law, Deakin University, Burwood Highway, Burwood, Vic 3125, Australia; e-mail: danuta.mendelson@deakin.edu.au.

- 1 [Rogers v Whitaker](#) (1992) [175 CLR 479](#) at 489.
- 2 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 586; [Rogers v Whitaker](#) (1992) [175 CLR 479](#) at 489; Wrongs Act 1958 (Vic), s 58(a); Wrongs Act 1936 (SA), s 40(a).
- 3 The author uses the term "consumer" when quoting from or describing the HealthConnect system, but refers to "patients" in her own analysis.
- 4 On 10 March 2004, the Australian Government Department for Health and Ageing announced that the whole-of-State implementations in Tasmania and South Australia will commence in July 2004, then moving to implementation in larger States, with Queensland as a priority: <http://www.health.gov.au/medicareplus/> viewed 6 July 2004.
- 5 Terry NP, "Electronic Health Records: International, Structural and Legal Perspectives" (2004) 12 JLM 26 (above).
- 6 Anderson JG and Aydin CE, "Evaluating Medical Information Systems" in Goodman KW (ed), *Ethics, Computing and Medicine* (Cambridge University Press, Cambridge, 1998) p 58.
- 7 Mendelson D, "Travels of a Medical Record and the Myth of Privacy" (2003) 11 (2) JLM 136.
- 8 The HealthConnect scheme is being implemented through Medicare and MediConnect. The MediConnect initiative, launched by the Australian Government in 2003, will form a database with electronic records containing personal information such as name, address, date of birth and Medicare card or Department of Veterans Affairs (DVA) file number. The electronic MediConnect records will be stored with the Health Insurance Commission. "Consumers will be able to have medicines information added to or taken off their record. Consumers will be able to choose who they want to view or use their MediConnect information. Doctors, pharmacists and authorised hospital staff will be able to do this – but they must have consumers' consent before they can do

- so": <http://www.mediconnect.gov.au/what.htm#info> viewed 6 July 2004.
- [9 http://www.mediconnect.gov.au/what.htm#info](http://www.mediconnect.gov.au/what.htm#info) viewed 6 July 2004.
 - [10 Financial Business Model, v09 \(July 2003\) pp 15-16, para 3.2.5.](#)
 - [11 HealthConnect Draft Systems Architecture v0.9, p 16, para 3.1.2.1.](#)
 - [12 http://www.healthconnect.gov.au/](http://www.healthconnect.gov.au/) viewed 6 July 2004.
 - [13 Financial Business Model, v09 \(July 2003\) p 15, para 3.2.5.](#)
 - [14 Financial Business Model, v09 \(July 2003\) p 15, para 3.2.5.](#)
 - [15 Financial Business Model, v09 \(July 2003\) p 15, para 3.2.5.](#)
 - [16 Financial Business Model, v09 \(July 2003\) pp 15-16, para 3.2.5.](#)
 - [17 A Health Information Network for Australia; Report to Health Ministers by the National Electronic Health Records Taskforce \(July 2000\): \[http://www.health.gov.au/healthconnect/pdf_docs/ehr_rep.pdf\]\(http://www.health.gov.au/healthconnect/pdf_docs/ehr_rep.pdf\) viewed 6 July 2004.](#)
 - [18 A Health Information Network for Australia; Report to Health Ministers by the National Electronic Health Records Taskforce \(July 2000\), p 92, Box 5.2, "Contrasting scenarios": \[http://www.health.gov.au/healthconnect/pdf_docs/ehr_rep.pdf\]\(http://www.health.gov.au/healthconnect/pdf_docs/ehr_rep.pdf\) viewed 6 July 2004.](#)
 - [19 Pascal Gelperowicz, personal communication, 5 May 2004.](#)
 - [20 Alpert SA, Health Care Information: Access, Confidentiality and Good Practice, in Goodman, n 6, p 88.](#)
 - [21 *British Medical Association v Commonwealth* \(1949\) \[79 CLR 201\]\(#\) at 253 per Latham CJ; cf *Kable v Director of Public Prosecutions \(NSW\)* \(1996\) \[189 CLR 51\]\(#\).](#)
 - [22 *General Practitioners Society v Commonwealth* \(1980\) \[145 CLR 532\]\(#\) at 560 per Gibbs J.](#)
 - [23 Iacovino L, "Trustworthy Shared Electronic Health Records: Recordkeeping Requirements and HealthConnect" \(2004\) 12 JLM 40 \(above\).](#)
 - [24 Hippocratic Writings \(Chadwick J and Mann WN \(trans\), Lloyd GER \(ed\)\) \(Penguin Books, Harmondsworth, 1983\).](#)
 - [25 Young DW, "What Makes Doctors Use Computers? Discussion Paper" \(1984\) 77 Journal of the Royal Society of Medicine 663, discussed by Anderson and Aydin, n 6.](#)
 - [26 Diagnosis involves scientific interpretation within a nosological paradigm of such factual data as symptoms of the patient's complaint, signs \(objective manifestations of disease\) and diagnostic tests.](#)
 - [27 See eg Legal Profession Act 1987 \(NSW\), ss 198J – 198N; Civil Law \(Wrongs\) Act 2002 \(ACT\), Pt 14.2.](#)
 - [28 All Australian jurisdictions provide some kind of statutory threshold that a plaintiff must meet before being able to claim damages for non-economic loss at common law: see Civil Law \(Wrongs\) Act 2002 \(ACT\), ss 99A, 99B; Civil Liability Act 2002 \(NSW\), ss 16, 17, 17A; Civil Liability Act 1936 \(SA\), s 52; Civil Liability Act 2002 \(Tas\), ss 27, 28; Civil Liability Act 2002 \(WA\), ss 9, 10; Civil Liability Act 2003 \(Qld\), ss 61, 62; Wrongs Act 1958 \(Vic\), s 28LB; Personal Injuries \(Liabilities and Damages\) Act 2003 \(NT\), ss 24, 26.](#)
 - [29 Design Principles, HealthConnect Draft Systems Architecture v0.9, p 16, para 3.1.2.1.](#)
 - [30 Pascal Gelperowicz, personal communication, 5 May 2004.](#)
 - [31 Pascal Gelperowicz, personal communication, 5 May 2004.](#)
 - [32 Civil Liability Act 2002 \(NSW\), s 5O\(1\): "A person practising a profession \(a professional\) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that \(at the time the service was provided\) was widely accepted in Australia by peer professional](#)

- opinion as competent professional practice." See also Civil Liability Act 2002 (Tas), s 22(1); Wrongs Act 1958 (Vic), s 59(1); Wrongs Act 1936 (SA), s 41(1); Civil Liability Act 2002 (WA), s 5PB(1); Civil Liability Act 2003 (Qld), s 22(1).
- [33](#) The Northern Territory is yet to undertake partial codification of negligence principles, and the Australian Capital Territory has legislation regarding standard of care but not specifically regarding professionals. Thus both Territories are governed by common law as stated in [Rogers v Whitaker](#) (1992) [175 CLR 479](#) at 487 and [Naxakis v Western General Hospital](#) (1999) [197 CLR 269](#).
- [34](#) Civil Liability Act 2002 (Tas), s 22(2); Civil Liability Act 2002 (NSW), s 5O(2); Civil Liability Act 2003 (Qld), s 22(2); Wrongs Act 1936 (SA), s 41(2).
- [35](#) Under the Wrongs Act 1958 (Vic), s 59(2), the court will not rely on peer professional opinion, if it considers the opinion "unreasonable". Under the Civil Liability Act 2002 (WA), s 5PB(4), the court will intervene in circumstances where "the health professional acted or omitted to do something which is, in the circumstances of the particular case, so unreasonable that no reasonable health professional in the health professional's position could have acted or omitted to do something in accordance with that practice".
- [36](#) Civil Liability Act 2002 (Tas), s 22(3), (4); Civil Liability Act 2002 (NSW), s 5O(3), (4); Civil Liability Act 2003 (Qld), s 22(3), (4); Wrongs Act 1936 (SA), s 41(3), (4); Wrongs Act 1958 (Vic), s 59(3), (4); Civil Liability Act 2002 (WA), s 5PB(3), (5).
- [37](#) In a suit in negligence against a medical practitioner relating to harm occasioned by the failure to utilise SEHRS, the plaintiffs would have to address, inter alia, the burden on the defendant medical practitioner of taking precautions to avoid the risk of harm, for which they claim damages.
- [38](#) Powsner S, Wyatt J and Wright P, "Medical Records: Opportunities for and Challenges of Computerisation" (1998) 352 *Lancet* 1617.
- [39](#) This is because the required standard of care is that which a reasonable person would exercise in the profession. In determining the precautions such a person would undertake to avoid risk, the burden imposed by the precaution is taken into account: Civil Liability Act 2002 (NSW), ss 5B, 5C; Wrongs Act 1958 (Vic), s 48(1), (2); Civil Liability Act 2003 (Qld), s 9(1), (2); Civil Liability Act 2002 (WA), Pt 1A, Div 2; Civil Liability Act 1936 (SA), s 32(1), (2); Civil Liability Act 2002 (Tas), s 11(1), (2); Civil Law (Wrongs) Act 2002 (ACT), s 43(1), (2).
- [40](#) Korpman RA, Uniform Data Standards for Patient Medical Record Information and the Electronic Exchange of Such Information, Testimony to the National Council on Vital and Health Statistics, 8-9 December 1998: <http://www.ncvhs.hhs.gov/981208tg.htm#Section-II> viewed 6 July 2004.
- [41](#) Gingrich N and Linn L, An Electronic Health Record Should be Created in 2004: A Report on the English Electronic Health Record, Center for Health Transformation: <http://www.healthtransformation.net/Projects/suppdocs/EHR2-29-04Final.pdf> viewed 6 July 2004.
- [42](#) The power to exercise actual control regarding access, integrity and long-term survival of the SEHRS will be vested in HealthConnect.
- [43](#) For an undisclosed reason, Kirsty Bruce's tutor in law (a court-appointed person to act as the next friend or guardian ad litem for a disabled party) was her sister rather than her mother.
- [44](#) [Bruce v Kaye \[2004\] NSWSC 277](#) at [21].
- [45](#) The second ultrasound was also performed by Dr Warren, but this time the mother used the name of Chevelle, and was referred by a different doctor. Dr Warren did not seem to have

realised the identity of the patient.

- [46](#) In the event, Grove J held that Dr Kaye was not negligent in allowing the pregnancy to proceed to 42 weeks, and that the sole cause of the plaintiff's damage was "the catastrophic uterine rupture ... which had started to manifest itself at Ms Chevelle's residence provoking the urgent dash to the hospital". The rupture was probably due to the weakness in the posterior wall of Ms Chevelle's uterus, which might have been caused by an inadvertent perforation in one of her previous abortions: [Bruce v Kaye \[2004\] NSWSC 277](#) at [91], [98].
- [47](#) In some jurisdictions, contributory negligence can defeat the claim: Civil Law (Wrongs) Act 2002 (ACT), s 47; Civil Liability Act 2002 (NSW), s 5S; Civil Liability Act 2003 (Qld), s 24; Wrongs Act 1958 (Vic), s 63.
- [48](#) [Romeo v Conservation Commission \(NT\)](#) (1998) [192 CLR 431](#); Civil Liability Act 1936 (SA), ss 36, 37; Civil Liability Act 2002 (NSW), ss 5F, 5G; Civil Liability Act 2002 (Tas), ss 15, 16; Civil Liability Act 2002 (WA), s 5M-P; Civil Liability Act 2003 (Qld), ss 13 – 16; Wrongs Act 1958 (Vic), ss 53, 54.
- [49](#) The Report uses the old acronym HINA (Health Information Network for Australia).
- [50](#) A Health Information Network for Australia: Report to Health Ministers by the National Electronic Health Records Taskforce (July 2000) p 175, Box 13.1 "Estimated costs using scenarios of adverse events": http://www.health.gov.au/healthconnect/pdf_docs/ehr_rep.pdf viewed 6 July 2004.
- [51](#) Alpert SA, Health Care Information: Access, Confidentiality and Good Practice in Goodman, n 6.
- [52](#) Paterson M, "Disclosing Health Information Breaches of Confidence, Privacy and the Notion of the "Treating Team"" (2003) 10 JLM 460.
- [53](#) Magnusson R, "Data Linkage, Health Research and Privacy: Regulating Data Flows in Australia's Health Information System" (2002) 24 Syd L Rev 5.
- [54](#) Carter M, "Integrated Electronic Health Records and Patient Privacy: Possible Benefits but Real Dangers" (2000) 172 MJA 28.
- [55](#) Detmer DE, "Building the National Health Information Infrastructure for Personal Health, Health Care Services, Public Health and Research" (2003) 3 BMC Medical Informatics and Decision Making 1: <http://www.biomedcentral.com/1472-6947/3/1#IDA0015H> viewed 6 July 2004.
- [56](#) See eg the web site of the American firm of Parker & Waichman, which now conducts general e-mail marketing campaigns suggesting that persons who have taken medications such as Zyprexa (olanzapine) to treat the symptoms of schizophrenia and bipolar disorder; Roaccutane (isotretinoin, known as Accutane in the United States) for treatment of severe nodular acne contact them: <http://www.yourlawyer.com/> viewed 6 July 2004. The ability to target individual patients would be a very enticing prospect to such firms.
- [57](#) Schwartz PM, "Privacy and the Economics of Personal Health Care Information" (1997) 76 Tex L Rev 1 at 18. Schwartz, citing the American study of Linowes DF, A Research Survey of Privacy in the Workplace (April 1996, unpublished manuscript, on file with the *Texas Law Review*), notes that "[a]ccording to one empirical study of privacy in the workplace in the United States, over one-third of Fortune 500 companies surveyed in 1995 admitted to using the medical records of their personnel in employment-related decisions".
- [58](#) In 1996, a report by the Council of Australian Governments' Working Group on Health and Community Services proposed an enhanced Medicare smart card called the "universal patient record" (ie, a universal identifier). The smart card would record basic data each

- time a patient dealt with the health and/or welfare system: Bryce S, The State of Surveillance
at <http://www.newdawnmagazine.com/Articles/State%20of%20Surveillance.html> viewed 6 July 2004.
- [59](#) Wroe D, "Medicare Smart Card on the Way", The Age, 25 June 2004: <http://theage.com.au/articles/2004/06/24/1088046223596.html?oneclick=true> viewed 6 July 2004.
- [60](#) AAP, Minister Wants Health Smartcards, *news.com.au*, 21 June 2004: http://www.news.com.au/common/story_page/0,4057,7865385%255E15306,00.html viewed 6 July 2004.
- [61](#) AAP, Minister Wants Health Smartcards, *news.com.au*, 21 June 2004: http://www.news.com.au/common/story_page/0,4057,7865385%255E15306,00.html viewed 6 July 2004.
- [62](#) AAP, Minister Wants Health Smartcards, *news.com.au*, 21 June 2004: http://www.news.com.au/common/story_page/0,4057,7865385%255E15306,00.html viewed 6 July 2004.