

24 June 2015

Mr Martin Bowles
Secretary
Department of Health
MDP 1003
GPO Box 9848
CANBERRA ACT 2601

By email to: ehealth.legislation@health.gov.au

Dear Mr Bowles

Re: Electronic Health Records and Healthcare Identifiers: Legislation Discussion Paper

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback to the Department of Health's *Electronic Health Records and Healthcare Identifiers: Legislation Discussion Paper* (the Discussion Paper). The RANZCP is supportive of the government's vision of a reliable, secure and trustworthy source of key clinical information that stands to enhance the effectiveness of healthcare delivery, reduce hospitalisations and ultimately save lives.

However, the RANZCP has concerns regarding how the Personally Controlled Electronic Health Record (PCEHR) system will work in practice – especially around issues of privacy and access to sensitive health information, which are especially relevant to patients with mental illness. These are also issues that were raised in the [RANZCP's response to the August 2014 PCEHR Review](#).

The PCEHR Review recommended that the PCEHR system transition to operate on an opt-out participation model for individuals in order to increase uptake of the PCEHR system and increase its value to, and encourage its use by, healthcare providers.¹ Accordingly, the Discussion Paper proposes that the PCEHR system – which currently operates on an opt-in basis – will now move to trials of an opt-out system in certain regions. Our understanding is that this means that individuals in these regions will automatically be registered for an eHealth record unless they advise that they do not want such a record.

¹ PCEHR Review, recommendation 13

While the RANZCP recognises the need to address what has up until now been a lack of meaningful usage of the PCEHR, the move to an opt-out model raises a number of serious questions around privacy, choice and duty of care, which need to be addressed. These issues include:

- For involuntary patients, those who are experiencing an acute episode of mental illness, or those with a significant acquired brain injury, for example, will a PCEHR still be automatically created? What are the implications if these patients are unable to fully understand the information provided to them about the PCEHR or the option of opting-out or withholding certain documents?
- Will a carer or guardian also have access to the PCEHR of their dependant? What are the implications for privacy should the dependant wish to withhold some sensitive health information from their carer but not their doctor? For example, a person may wish for their regular general practitioner to have information about their sexual health, but not their carer.
- How will the PCEHR interact with state-based guardianship laws, presuming that everyone has the capacity to make their own decisions, including about their medical care, unless there is evidence to the contrary? The laws also provide that people who require guardianship services, such as people with dementia, who are mentally ill and have acquired brain injuries, are able to make their own decisions in many circumstances if they are given the appropriate care and support. Careful consideration will need to be given to these issues so that people who are, for instance, mentally ill and utilising guardianship services, are given the appropriate level of autonomy and independence to make their own decisions about healthcare and treatment.

Another concern is the kind of information stored in the PCEHR. If particularly sensitive information to do with sexual health, trauma or mental health is recorded in the PCEHR, the patient may feel it necessary to disclose this information to some health practitioners and not to others. For example, if patients have received medical treatment following a sexual assault, they may deem this relevant information for the psychiatrist but they may feel disclosure to their podiatrist is unnecessary and invasive. Will there be levels of access depending on the sensitivity of information and its appropriateness to different parties? Will there also be any provision for hand-written records to be kept in parallel to record sensitive information or detailed records made during the interview with a patient or will clinicians be expected to operate in a paperless system, thus losing much useful detailed history? This detail is not only useful for clinicians assessing patients at a subsequent time but also for the preparation of medico-legal and other reports.

With respect to medico-legal and privacy issues, there are concerns around the potential for information to be inappropriately accessed and used. For example, there is a growing trend for solicitors to issue subpoenas of broad scope to obtain sensitive health information, often to be used in family law proceedings to 'dig up dirt' on estranged spouses.² The PCEHR, being a centralised location for much of the patient's health information, leaves patients

² J Levy, G Galambos, Y Skarbek (2014) 'The erosion of psychiatrist-patient confidentiality by subpoenas'. *Australasian Psychiatry* 22(4): 332-336.

particularly vulnerable with regards to this matter. RANZCP members have also raised concerns about insurance companies gaining access to health records and misusing this information in ways that are detrimental and unfair to the individual.

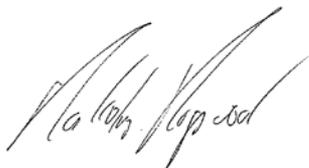
Currently, under the PCEHR Act, it is possible for the Systems Operator to be directed to disclose health information included in a consumer's PCEHR.³ The Discussion Paper proposes that the revised PCEHR system will move to a principles-based approach, which includes the purposes for which information can be collected, used and disclosed. However, the potential breadth of sensitive information contained in a PCEHR, and the potential for the misuse of this resource is an issue that the RANZCP considers requires further work.

The RANZCP also wishes to emphasise an important issue in relation to mental health diagnoses under the PCEHR system. Mental health diagnoses are often less clear cut than their physical health equivalents. Diagnoses can change as more information becomes available, research in the field develops or courses of treatment are found to be more or less effective. Therefore, a change in a patient's mental health diagnosis is a common occurrence and - if previous diagnoses are not critically reviewed - it can and does result in many years of unnecessary treatment and stigmatisation of the patients concerned.

Consequently, the RANZCP considers that more information is required as to how the issue of a changing diagnosis will be reflected in a PCEHR. If a diagnosis is made by one practitioner and then reviewed, changed or removed by another, for example, how will this show up? Are there measures in place to avoid stigmatisation of an individual due to an incorrect diagnosis? Any PCEHR system would need to be flexible enough to allow easy correction of mislabelling and adjustments made as the result of new information coming to light or a change in presentation.

If the RANZCP can be of any assistance in informing the development of policies to address the issues raised in this correspondence, or if you have any queries, please do not hesitate to be in contact via Ms Rosie Forster, Senior Manager, Practice, Policy and Partnerships, on email rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours sincerely



Professor Malcom Hopwood
President

Ref: 4139

³ Commonwealth of Australia: 2012. *Personally Controlled Electronic Health Record Act* s.69 [viewed 9 June 2015 http://www.austlii.edu.au/au/legis/cth/consol_act/pcehra2012473/s69.html].