'Any Change in the Law must be for Parliament'—Breen v Williams and Patient Access to Medical Records

Research Paper
No. 7 1996–97
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‘Any Change In The Law Must Be For Parliament’ - Breen v Williams And Patient Access To Medical Records

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3 February 1997
Acknowledgments

The author thanks Bill Bak for the assistance given in producing this paper.

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Contents

Major Issues ................................................. i
Introduction .................................................. 1
The High Court Decision in *Breen v Williams* ..................... 2
  The Facts .................................................. 2
  The Decision of Bryson J .................................. 3
  The Decision of the New South Wales Court of Appeal ........... 3
  The High Court Decision .................................. 5
    Implied Contractual Term ................................ 5
    Proprietary Right ........................................ 6
    Fiduciary Duty ........................................... 8
    Right to Know ............................................ 9
Government Response to *Breen v Williams* ....................... 10
Amendment to the Health Insurance Amendment Bill (No. 2) 1996 .. 11
Arguments for and against the Creation of a Right of Patient
  Access to Medical Records ................................ 12
  Arguments for the Creation of a Right of Patient Access to Medical Records ................................ 12
  Arguments against the Creation of a Right of Patient Access
to Medical Records .......................................... 14
Legislative Options for Creating a Patient Right of Access to Medical Records .......... 15
  The Access to Health Records Act 1990 (UK) .................. 16
  Health Information Privacy Code 1994 (NZ) ................... 18
  Extension of Freedom of Information Legislation .............. 22
  The Senator Neal Option .................................. 23
  A Commonwealth and State Co-operative Scheme ................ 23
Concluding Comment .......................................... 23
Endnotes ..................................................... 24
Major Issues

The High Court of Australia in *Breen v Williams* unanimously held that under the common law a patient does not have a right of access to inspect and or obtain copies of his or her medical records. In the course of their judgments Justices Dawson, Gaudron, McHugh and Toohey pointed out that any change in the law must come from the legislature.

Ms Breen appealed to the High Court from a decision of the NSW Court of Appeal, which had dismissed her appeal by a 2:1 majority. The appeal was based on four grounds:

- an implied contractual term between patient and doctor;
- a patient's proprietary right in the information in the medical records;
- a fiduciary relationship between patient and doctor; and
- a patient's 'right to know' all necessary information concerning his or her medical treatment.

All of Ms Breen's arguments were rejected by all members of the High Court.

Consumers of health care services in Australia have only a limited right to their medical records, generally under Freedom of Information legislation.

In New Zealand, the United Kingdom, Canada and most States in the United States, however, consumers of health care services have a legal right of access to their medical records.

Consumer groups have been campaigning for more than a decade for recognition of a patient right of access to medical records.

Patients have a non-statutory right to be informed of all relevant factual information contained in medical records held by a private practitioner through Australian Medical Association endorsed guidelines.

The Federal Government has not made clear its policy on patient access to medical records.
Access To Medical Records

On 13 December 1996 an amendment was moved in the Senate to the Health Insurance Amendment Bill (No. 2) 1996 relating to patient access to medical records. The amendment, which was subsequently negatived and referred to the Senate Community Affairs References Committee for inquiry and report by 25 March 1997, is the first attempt to establish a scheme of national application creating a patient right of access to medical records.

Arguments for the creation of a right of patient access to medical records are based on notions of individual rights. For example, the right to know what personal information is held about oneself and to ensure that the information is accurate is a fundamental privacy principle, and in the United Kingdom, Canada, New Zealand and in most States in the United States, patients have right of access to their medical records.

Arguments against the creation of a right of patient access to medical records are largely based on practical difficulties. For example, much of the information contained in medical records is incomprehensible to the majority of patients and medical practitioners do not have the time to explain complex medical terminology, or their notes, to their patients and it is too costly for private practitioners to provide their patients with access to their medical records.

Federal legislation creating a patient right of access to medical records held in both the public and private sectors could be drafted in five ways: (a) a separate Act along the lines of the United Kingdom legislation; (b) extension of existing privacy legislation along the lines of the New Zealand model; (c) extension of existing freedom of information legislation; (d) legislation along the lines of that proposed by the Senate amendment; and (e) a Commonwealth/State co-operative scheme.

It should be recognised that the scope of a federal legislative scheme is subject to the Commonwealth Constitution. While it is beyond the scope of this paper to detail the Commonwealth's constitutional power over health, it is emphasised that it remains unclear whether the constitutional heads of power on which the Commonwealth would have to rely would extend to regulating all holders of medical records.

Putting aside constitutional concerns, if it is to be accepted that patients should be more in control of their health care or should be better able to understand who else has access to their medical records, then it may be just a matter of time before a statutory right of patient access to medical records will be created by the Australian Parliament. A comprehensive regime similar to the New Zealand Health Information Privacy Code 1994 could be considered.
Introduction

Consumers of health care services in Australia have only a limited right to access their medical records, generally under Freedom of Information legislation and certain State regulations governing private hospitals, day procedure centres and nursing homes. In contrast, health care professionals and health insurance companies can all legally access personal medical records.

Consumers of health care in New Zealand, the United Kingdom, Canada and most States in the United States have a legal right of access to their medical records.

Consumer groups have been campaigning for more than a decade for recognition of a patient right of access to medical records. Consumer groups would argue that by seeing their medical records, consumers of health care services can become more involved and informed in their health care, more attentive to it and more in control of it. They can better understand who else has access to the information and thus be reassured that the information is being kept confidential.

A number of inquiries into Freedom of Information and the health care industry have recommended that the law be reformed to provide consumers with a right of access to their medical records and to protect their privacy.

A major issue in the debate in Australia has been the uncertainty of the common law position on access to medical records. This issue has now been resolved. In Breen v Williams the High Court unanimously held that under the common law a patient does not have any right of access to inspect and or obtain copies of his or her medical records. The decision of the High Court has sparked a call for legislative reform that would give patients a right of access to their medical records.

The movement for legislative reform has been given added impetus by a recent amendment moved in the Senate of the Australian Parliament. The amendment, which was subsequently negatived and referred to the Senate Community Affairs References Committee, is the first attempt to establish a scheme of national application for providing patient access to medical records.

The Federal Government has not formally responded to the High Court decision in Breen v Williams and has not made clear its policy on patient access to medical records. The
former Federal Government gave a commitment in 1995 to introduce legislation for patient access to medical records.4

The Commonwealth Attorney-General's Department in a recent discussion paper has proposed that legislation similar to the New Zealand model be enacted to protect records containing personal information held within the private sector.

This paper will: first, summarise the facts and judgments in Breen v Williams; secondly, note the Government's response to Breen v Williams; thirdly, summarise the recent amendment moved in the Senate of the Australian Parliament relating to patient access to medical records; fourthly, list certain of the arguments for and against the creation of a patient right of access to medical records; and fifthly, outline federal legislative options for the creation of patient right of access to medical records.

The High Court Decision in Breen v Williams

The Facts

In 1977 Julie Breen underwent a mammaplasty which involved the insertion of a silicone implant in each breast. Ms Breen subsequently developed breast capsules (i.e. scar-like tissue around her breast implants). In 1978 Ms Breen consulted Dr Williams, who performed a capsulotomy operation. In 1984, another surgeon removed the implants and performed a partial mastectomy after he diagnosed Ms Breen as having a leakage of silicone gel from one of the implants.

In 1993 Ms Breen sought from Dr Williams photocopies of documents relating to her medical condition. The documents were sought as a consequence of litigation in the United States against the Dow Corning Corporation, who were the manufacturers of Ms Breen's breast implants. Australian litigants were given an opportunity to 'opt in' to a settlement which had been given conditional approval by a United States court. It was a condition of opting in that copies of medical records in support of any claim be filed before 1 December 1994.5

Responding to Ms Breen's request for photocopies of documents relating to her medical condition, Dr Williams said:

As [your solicitors] well know, it is a longstanding legal tradition in the Country that such records are the doctor's property, an aide memoire to his treatment of the patient, and may only be released on production of a court subpoena.
Access To Medical Records

Accordingly the advice which I have received from my Medical Defence legal advisers is that this situation still holds, but that they would be very happy for me to release your records, were you to supply me with a document which would release me from any claim that might arise in relation to my treatment of you. 

Ms Breen did not accept Dr Williams’ offer and litigation ensued.

The Decision of Bryson J

Ms Breen commenced proceedings in the Equity Division of the Supreme Court of New South Wales. Bryson J, in rejecting Ms Breen’s claim of a right to copy or to have access to the medical records, stated:

The [respondent] was not made the [appellant’s] medical adviser for the purpose of making him a collector or repository of information for the [appellant] to have available to her for whatever purposes she chose. Collecting and retaining information by him was a purpose of the relationship, but it was a subsidiary purpose, to lead only to medical advice and treatment to be administered by him or on his referral. It is not in my judgment unconscionable for the [respondent] to retain the information and keep it to himself except when and insofar as it is required for the purpose of treatment by him. A doctor is not put in a position to receive, compile and retain information for the very purpose of having it available when it is required and for whatever purpose it is required.

The Decision of the New South Wales Court of Appeal

On appeal a majority of the New South Wales Court of Appeal (Justices of Appeal Mahoney and Meagher) agreed with the decision of Bryson J.

In his dissenting judgment, President of the Court Michael Kirby cited with approval the decision the Supreme Court of Canada in McInerney v McDonald which held that the doctor-patient relationship was fiduciary in nature and that a patient is entitled to reasonable access to examine and copy the doctor’s records. La Forrest J, writing for a unanimous Court, stated:

Information about one’s self revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one’s own. The doctor’s position is one of trust and confidence. The information conveyed is held in a fashion somewhat akin to a trust. While the doctor is the owner of the actual record the information is to be used by the physician for the benefit of the patient. The confiding of the information to the physician for medical purposes gives rise to an expectation that the patient’s interest in and control of the information will continue. The trust-like ‘beneficial interest’ of the
Access To Medical Records

patient in the information indicates that, as a general rule, he or she should have a right of access to the information and that the physician should have a corresponding obligation to provide it. ⁹

Kirby P would have granted Ms Breen's appeal in the following terms:

(a) DECLARE that the appellant has a right, upon request, to be given reasonable access by the respondent to examine, copy and/or at reasonable cost, to obtain copy of records or information concerning her, created or obtained by the respondent in the course of providing medical treatment or advice to her, being recorded in the medical records or in other tangible form in the possession, custody or control of the respondent, subject to the exclusion therefrom of such records or information as the respondent may lawfully exclude from such access;

(b) DECLARE that the respondent may lawfully refuse to provide access to the appellant to records and information in his possession:

(i) created or obtained solely for the benefit of the respondent in the conduct of his practice or in respect of which he may lawfully claim legal professional or other privilege;

(ii) the disclosure of which the respondent reasonably believes is likely to cause serious harm to the physical or mental health of the appellant; and

(iii) the disclosure of which would found an action for breach of confidence;

(c) ORDER that the respondent provide the appellant with reasonable access to records or information in his possession, custody or control as aforesaid concerning the appellant, subject to the exclusion therefrom of records and information in respect of which the respondent has a lawful excuse for not providing access... ¹⁰

Mahoney JA, while dismissing Ms Breen's appeal, was prepared to recognise that in some circumstances a patient may have or acquire a right to inspect a medical file. Mahoney JA stated:

That right may exist because she is in law the owner of the particular file; because of terms of the contractual arrangements existing between the patient and the doctor in respect of it; because the relationship between her and the doctor is of such a nature as to give rise to that right; or for other sufficient reasons. ¹¹

For Mahoney JA none of the above reasons had been established by Ms Breen.
Similarly, Meagher JA was prepared to recognise that a doctor may owe a patient a fiduciary duty. Meagher JA stated:

Whilst we must, of course, acknowledge that the list of persons owing fiduciary duties is not closed, and the boundaries of fiduciary duties uncertain in many respects, I can discover no principle analogous to that which Mrs Breen asserts. A fiduciary relationship usually arises where one dominant partner has some control over the property (and perhaps the person) of another. In that respect one could not quibble about a doctor being treated as owing a fiduciary duty towards his patient. But, if this be so, it is generally only to generate the usual fiduciary duties in certain circumstances—not to profit at his patient's expense (beyond his agreed fees) and not to put himself in a position where his interest would conflict with his patient's... All this may be conceded, but it does not amount to a demonstration that the doctor-patient relationship is of a fiduciary nature such as to generate in the patient a right to inspect the doctor's notes and records.

The High Court Decision

Ms Breen appealed to the High Court from the majority decision of the New South Wales Court of Appeal. Ms Breen's appeal was based on four main grounds: an implied contractual term between patient and doctor; a patient's proprietary right in the information in the medical records; a fiduciary relationship between patient and doctor; and a patient's 'right to know' all necessary information concerning his or her medical treatment.

All of Ms Breen's arguments were rejected by all members of the High Court. The reasons why Ms Breen's arguments were rejected are outlined below.

Implied Contractual Term

All Justices of the High Court held that some form of contract exists between doctor and patient. As this contract is generally informal the courts are obliged to formulate the rights and obligations of the parties to the contracts. As Gaudron and McHugh JJ stated:

... in cases where the parties to a contract have not attempted to spell out all the terms of their contract, the function of the court is 'simply ... to establish what the contract is, the parties not having themselves fully stated the terms'.

Ms Breen argued that there is an implied term in the doctor-patient relationship which requires a doctor to act in the best interests of the patient and that this includes an obligation to provide the patient with access to medical records. None of the Justices of the High Court accepted this argument.
Brennan CJ listed three situations where there is a common law contractual duty on a doctor to provide a patient or their nominee with information the doctor has acquired in the course of advising or treating the patient. As stated by Brennan CJ:

... I would hold that information with respect to a patient's history, condition or treatment obtained by a doctor in the course or for the purpose of giving advice or treatment to the patient must be disclosed by the doctor to the patient or the patient's nominee on request when (1) refusal to make the disclosure might prejudice the general health of the patient, (2) the request for disclosure is reasonable having regard to all the circumstances and (3) reasonable reward for the service of disclosure is tendered or assured.15

For Brennan CJ there was no evidence on the facts of the case to suggest that access to the medical records might have been necessary to diminish the possibility of prejudice to Ms Breen's health.16

Dawson and Toohey JJ, while acknowledging that the treatment of a patient may require a doctor to provide a patient with information necessary to ensure proper ongoing care, stated:

What can be said is that it was not necessary for the reasonable or effective performance of that obligation [to provide reasonable skill and care] that the respondent should be obliged to give the appellant access to her medical records... There can be no suggestion that it was an established professional practice for a medical practitioner to afford a patient access to the patient’s medical records—the evidence was entirely to the contrary—and in our view there is no foundation for the implied term upon which the appellant relies.17

Gaudron and McHugh JJ held that the common law did not imply a term in the contract between Dr Williams and Ms Breen that he always act in her best interests or that she had a right of access to the medical records. For Gaudron and McHugh JJ:

... the only relevant contractual term implied by law was to exercise reasonable care and skill.18

Gummow J held that it could not be said that contractual terms which entitled Ms Breen to examine medical records and obtain copies was necessary for the reasonable or effective operation of the contract between Ms Breen and Dr Williams.19

Proprietary Right

While Ms Breen conceded that she did not actually own the medical records, she argued that she had a form of proprietary right or interest in them that entitled her to access to them. None of the Justices of the High Court accepted this argument.
Brennan CJ held that documents prepared by a professional person to assist him or her perform their professional duties are not the property of the client. Brennan CJ stated:

In the light of that principle [documents prepared by a professional are not the property of the lay client], it is not easy to see what relevance the law of property has to the supposed right of the appellant to access to the respondent’s records. If (as it was put during argument) the respondent is said to have no proprietary right that would entitle him to refuse access, the question whether the appellant has a right to be given access still remains. On that approach, the supposed right (if any) must find some basis other than property. But even on that approach, the argument is flawed. Absent some right to require, or the exercise of some power to compel, production of a document for inspection, its owner is entitled by virtue of the rights of ownership to refuse to produce it. As for copying, where the professional person is the owner of the copyright, he or she has the sole right to copy or to permit the copying of the document.

Dawson and Toohey JJ held that the relationship between doctor and patient is a contractual one under which the doctor undertakes to treat and advise the patient and use reasonable skill and care in doing so, and that this does not afford a basis for a proprietary interest in records kept by a doctor for carrying out that function. In rejecting Ms Breen’s argument that she had a form of proprietary right or interest in the medical records that entitled her to access to them Dawson and Toohey JJ stated:

The appellant's contention is, however, that the information contained in the records can be separated from the records themselves and it is in the information that the appellant has a proprietary right or interest entitling her to access to the records. But there can be no proprietorship in information as information, it belongs equally to them both.

Gaudron and McHugh JJ held that documents prepared by a professional to assist them do work for a client are the property of the professional person, not the lay person. In addressing Ms Breen’s contention that she had a proprietary right or interest in the medical records, Gaudron and McHugh JJ stated:

The premise of this argument was that the records were not owned by anybody. However the idea that an item of personal property that has not been abandoned has no owner is ill-founded. Ownership may be divisible in the sense that one or more of the collection of rights constituting ownership may be detached and vested in a number of persons. Ownership may also be divorced from possession in numerous circumstances. But the notion that personal property that has not been abandoned may have no owner is one that is foreign to the common law. Statute or contract apart, medical records, prepared by a doctor, are the property of the doctor.

Gummow J held that the medical records were literary works for the purposes of copyright law and that on the facts of the case there was no evidence to support the existence of any copyright licence or consent being given to Ms Breen, either expressly or impliedly.
Fiduciary Duty

Ms Breen argued that the doctor-patient relationship is fiduciary in nature and that a doctor is in breach of a fiduciary duty if he or she does not provide a patient with reasonable access to his or her medical records. None of the Justices of the High Court accepted the existence of a fiduciary duty that carries with it a right of access on the part of a patient to medical records.

Brennan CJ held that while the doctor-patient relationship is one where the doctor acquires an ascendancy over the patient and the patient is in a position of placing his or her trust in the doctor, this does not give rise to a fiduciary duty to provide access to medical records. Brennan CJ stated:

Such a relationship [doctor-patient] casts upon the doctor the onus of proving that any gift received from the patient was given free from the influence which the relationship produces. But in this case the doctor has received no gift; he has taken no step to procure an advantage for himself. Nor has he taken any advantage of his ascendancy over his patient or of her trust in him. His refusal to give access to his records does not deny his patient a benefit to which the patient was entitled either by reason of his position as the appellant’s medical adviser and provider of medical treatment or by reason of the trust she reposed in him to provide medical treatment.27

Dawson and Toohey JJ, while acknowledging that duties of a fiduciary nature may be imposed on a doctor, also found no basis for the existence of a fiduciary relationship between a doctor and patient that carries with it a right of access on the part of a patient to medical records. Dawson and Toohey JJ stated:

Whilst duties of a fiduciary nature may be imposed upon a doctor, they are confined and do not cover the entire doctor-patient relationship. Thus a doctor is under a duty to protect the confidentiality of information given by a patient. And the doctor-patient relationship is such that any substantial benefit received by the doctor from a patient (other than proper remuneration) is presumed to be the result of undue influence with the doctor bearing the onus of rebutting the presumption... We can find no basis in the law of this country for discerning a fiduciary relationship between doctor and patient carrying with it a right of access on the part of a patient to medical records compiled by the doctor in relation to that patient.28

Gaudron and McHugh JJ, while suggesting that the categories of fiduciary relationships are not closed, held that a court cannot use the law of fiduciary duty to impose an obligation on a doctor to maintain and provide medical records to a patient. Gaudron and McHugh JJ stated:

In this country, fiduciary obligations arise because a person has come under an obligation to act in another’s interests. As a result, equity imposes on the fiduciary proscriptive obligations—not to obtain any unauthorised benefit from the relationship...
Access To Medical Records

and not to be in a position of conflict. If these obligations are breached, the fiduciary must account for any profits and make good any losses arising from the breach. But the law of this country does not otherwise impose positive legal duties on the fiduciary to act in the interests of the person to whom the duty is owed. If there was a general fiduciary duty to act in the best interests of the patient, it would necessarily follow that a doctor has a duty to inform the patient that he or she has breached their contract or has been guilty of negligence in dealings with the patient. That is not the law of this country... In this country a court cannot use the law of fiduciary duty to provide relief to Ms Breen which, if granted, would have the effect of imposing a novel, positive obligation on Dr Williams to maintain and furnish medical records to Ms Breen. It follows that Dr Williams does not owe Ms Breen any fiduciary duty to give Ms Breen access to the medical records that relate to his treatment of her.9

Gummow J held that to show a doctor owes a fiduciary duty in certain circumstances to a patient does not demonstrate a right in the patient to inspect and take copies of the notes and records of the medical practitioner.30

Right to Know

Ms Breen argued that there was a movement in the law of Australia towards a recognition of a patient’s right to know and that this was a reason why the Court should hold a patient to have a right of access to medical records concerning that person.31 Ms Breen argued that this movement is recognisable in Australian law in five ways: an acceptance of the principle of personal inviolability; a rejection of a paternalistic approach to the doctor-patient relationship; the rejection of the notion that the patient’s interests are to be determined solely by the medical profession; the imposition of judicially imposed standards; and the acceptance of patient autonomy.32 None of the Justices of the High Court accepted Ms Breen’s arguments.

Dawson and Toohey JJ, with whom Brennan CJ concurred,33 stated:

In any event, even if the movement in the law claimed by the appellant were to exist it could have no significance where established principle points to a clear conclusion as, in our view, it does in this case.

No doubt considerations of policy (and that is what this part of the appellant’s argument involves) may justifiably influence the adaptation or development of the law or the recognition of new categories where that is open upon the basis of settled legal principle. But policy considerations cannot justify abrupt or arbitrary change involving the abandonment of settled principle in favour of a particular result which is merely perceived as desirable...

... There is more than one view upon the matter and the choice between those views, if a choice is to be made, is appropriately for the legislature rather than a court.34
Gaudron and McHugh JJ stated:

While recent decisions of Australian courts have rejected the attempt to treat the doctor-patient relationship as basically paternalistic, it would require a quantum leap in legal doctrine to justify the relief for which [Ms Breen] contends.\(^3^5\)

Gummow J stated that Ms Breen’s argument for a legal doctrine of the right to know was abandoned in the course of argument before the Court.\(^3^6\)

**Government Response to *Breen v Williams***

Neither the Federal Attorney-General nor the Federal Minister for Family Services issued formal Government responses to the decision of the High Court in *Breen v Williams*. However, in a radio interview of 12 September 1996 relating to an Attorney-General’s Department discussion paper on privacy protection in the private sector,\(^3^7\) the Attorney-General stated:

This is only a broad discussion paper suggesting a review that might be developed through a consultation process. In its present terms, we are not proposing any specific arrangements for medical records, but obviously in the light of the decision of the High Court in Breen’s case, just recently, special consideration will need to be given to that, and Dr Wooldridge, the Minister for Health and Family Services and I will consider it in the course of the consultation process.\(^3^8\)

While the formal position of the current government as to providing patients with a right of access to medical records held by private doctors and health care providers is at best ambiguous, it may be noted that the Government did not oppose the referral of the amendments moved by Senator Neal (ALP Shadow Minister for Consumer Affairs) on 13 December 1996 relating to patient access to medical records to the Senate Community Affairs References Committee. Senator Neal’s amendments are discussed in a later section of this paper.

It is interesting to note the position of the previous government on patient access to medical records. On 13 December 1995, the then Minister for Human Services and Health and the then Attorney-General announced:

... patients will have the right to access their medical and health records held by private doctors and health care providers for the first time.\(^3^9\)

However, no details were forthcoming on how or when this access to medical records would become available.
Amendment to the Health Insurance Amendment Bill (No. 2) 1996

On 13 December 1996, Senator Belinda Neal (ALP Shadow Minister for Consumer Affairs) moved an amendment to the Health Insurance Amendment Bill (No. 2) 1996 relating to patient access to medical records. The amendment, which was subsequently negatived and referred to the Senate Community Affairs References Committee for inquiry and report by 25 March 1997, is the first attempt to establish a scheme of national application creating a patient right of access to medical records. The proposed amendment made it a condition of receiving a Medicare benefit that a person rendering a professional service (the provider) enter into an agreement with the Health Insurance Commission (HIC) to allow access to medical records that the provider holds about an individual if an application is made in writing for that access by:

- the individual; or
- a person authorised in writing by the individual; or
- if the individual is not capable of managing his or her affairs, a person appointed by a court to manage those affairs; or
- if the individual is dead—his or her executor or a person who may have a claim arising out of his or her death.

The term ‘medical record’ was defined to mean a record containing information about the individual’s health, including his or her medical history, information about any disabilities the individual has or has had, or information provided by or for the individual in connection with the donation by the individual of a body part or body substance of the individual.

Under the proposed amendment, a provider agreement would enable the provider to refuse access to medical records if the provider reasonably believed that allowing the access would be likely to cause serious harm to the mental or physical well being of an individual.

Other significant features of the proposed amendment included:

- access to medical records without paying a fee unless a copy or extract is supplied to the applicant;
- provision for the correction or medical records, and
- an appeals mechanism for a review of a decision of the HIC that Medicare benefits, or a specified amount of Medicare benefits, are not payable.
Access To Medical Records

As noted, Senator Neal's amendment has been referred to the Senate Community Affairs References Committee. The full text of the motion referring Senator Neal's amendment to the Committee is as follows:

... and that the amendments moved by Senator Neal in relation to access to medical records be referred to the Community Affairs References Committee for inquiry and report by 25 March 1997, with particular reference to the appropriate scope of Commonwealth legislation in this area and, in particular, the need for provisions including, but not limited to, the areas of:

(a) the scope of the application of the scheme;
(b) mechanisms to protect the interests of patients and third parties against potentially harmful disclosures;
(c) appropriate sanctions;
(d) mechanisms for decision-making and review of decisions;
(e) provision for parliamentary scrutiny and oversight of the arrangements; and
(f) exemptions that should be applied to the scheme.

Arguments for and against the Creation of a Right of Patient Access to Medical Records

As noted in the introduction to this paper, Justices Dawson, Toohey, Gaudron and McHugh held that any change to the law relating to patient access to medical records must come from the legislature. The following is a brief outline of arguments for and against the creation of a legislative right of access to medical records. For the most part, the arguments for are based on notions of individual rights, whereas those against are largely based on practical difficulties.

Arguments for the Creation of a Right of Patient Access to Medical Records

(a) The movement in recent times to providing patients with greater autonomy demands that patients should be given all information to enable them to make decisions about treatment options.

(b) It is a nonsense that patients have a right of access to medical records held by public authorities but not to medical records held by private practitioners.
Access To Medical Records

(c) As patients already have a right of access to medical records held by public authorities and access to medical records held by private practitioners through the court processes of subpoena and discovery, the recognition of a general right of access to medical records would be no more than an extension of a pre-existing right.

(d) A right to privacy enshrined in article 17.1 of the International Covenant on Civil and Political Rights, which Australia has ratified, supports the proposition that the Federal Parliament should create a right of access to medical records. The right to privacy has been interpreted to include the capacity of the individual to control perceptions of themselves contained in medical records. The Human Rights (Sexual Conduct) Act 1994 (Cth) is an example of the incorporation into federal law of a right to sexual privacy which flowed from article 17 of the International Covenant on Civil and Political Rights.43

(e) The right to know what personal information is held about oneself and to ensure that the information is accurate is a fundamental privacy principle.

(f) In the United Kingdom, Canada, New Zealand and in most States in the United States, patients have right of access to their medical records.

(g) Kirby P in his New South Wales Court of Appeal dissenting judgment in Breen v Williams listed nine reasons why the law should uphold the patient’s right of access to information in his or her medical records held by a medical practitioner. As stated by Kirby P, these reasons included:

... 

(2) The information concerns the personal integrity and autonomy of the patient. Whilst the medical practitioner has some interest in the records, that interest is secondary to the patient’s, whose physical and mental well-being is the very subject of them;

(3) Our society is more mobile today. Patients moving from one place to another should not be obliged to depend upon the willingness of a medical practitioner to provide access or to offer a summary. Whatever may have been appropriate in earlier times, a summary is not now an effective or adequate discharge of the duties to the patient inherent in the medical relationship;

(4) Changes in technology, including information technology and the technology of medical practice, make the provision of access to a patient’s information file (and, ordinarily, the provision of a printout or copy) more realistic and inexpensive today than was hitherto the case;

(5) Patients typically enjoy a different relationship to medical practitioners (and other professionals) today than was the case in earlier generations. Patients, mirroring the rest of the community, are typically better educated, less blindly trustful, more
assertive of their entitlement to information about themselves and medical care and to legal or other redress where this is not adequately provided. Rogers, in the High Court of Australia, illustrates the way in which our law upholds patient’s reasonable rights, even as against settled practices and opinions of the organised medical profession...

(7) The principles of common law and of equity should, so far as possible, develop in an harmonious way with developments of statute law. Such law has now afforded enforceable rights to access to medical records held on a patient in a public hospital or in other public records, both Federal and State. The Court was not made aware of any particular difficulties which this development of the law had occasioned either for the medical practitioners involved or for their relationships with patients...

Arguments against the Creation of a Right of Patient Access to Medical Records

(a) Access to medical records will promote and provoke baseless medical malpractice litigation.

(b) Patients already have a right of access to medical records held by private practitioners through the court processes of subpoena and discovery.

(c) Much of the information contained in medical records is incomprehensible to the majority of patients.

(d) Medical practitioners do not have the time to explain complex medical terminology, or their notes, to their patients and it is too costly for private practitioners to provide their patients with access to their medical records.

(e) The information contained in medical records could cause the patient unnecessary distress.

(f) Medical practitioners would have to keep in mind patient’s reactions when making or annotating a patient’s records and this would have an inhibiting effect on the information recorded.

(g) Patients already have a non-statutory right to be informed of all relevant factual information contained in medical records held by a private practitioner. At its meeting on the 29th and 30th October 1993, the Federal Council of the Australian Medical Association (AMA) endorsed the following guidelines on patients’ access to records concerning their medical treatment:
The patient has a right to be informed of all relevant factual information contained in the medical record, but all deductive opinion therein recorded remains the intellectual property of the doctor or doctors contributing to, or recognised employing hospital or other organisation maintaining the record. Where appropriate, such deductive opinion may be separately recorded.

On request, the patient should be informed of any or all content of the following sections of the medical record:

- History
- Physical Examination Findings
- Investigation Results
- Diagnosis (Diagnoses)
- Proposed Management Plan

The patient should be allowed access to any other contents of the medical record (such as reports by specialists) beyond the materials above specified only at the discretion of the doctor or doctors who completed the additional section or sections, or by hospital administration after consultation with the doctor(s) who completed such section or sections, or as the result of a legal requirement.

Doctors and hospitals are entitled to recoup their costs of providing information contained in a medical record from the patient or other legally authorised request for the information.45

Legislative Options for Creating a Patient Right of Access to Medical Records

Federal legislation creating a patient right of access to medical records held in both the public and private sectors could be drafted in five ways: (a) a separate Act along the lines of the United Kingdom legislation; (b) extension of existing privacy legislation along the lines of the New Zealand model; (c) extension of existing freedom of information legislation; (d) legislation along the lines of that proposed by Senator Neal; and (e) a Commonwealth-State co-operative scheme. Each of these options is outlined below.

It should be recognised that the scope of a federal legislative scheme is subject to the Commonwealth Constitution. While it is beyond the scope of this paper to detail the Commonwealth’s constitutional power over health and the constitutional problems inherent in establishing a federal scheme providing patient access to medical records, it is emphasised that it remains unclear whether the constitutional heads of power on which the Commonwealth would have to rely would extend to regulating all holders of medical
records. It may be noted that a co-operative scheme involving the Commonwealth and States would not be subject to these limitations.

The Access to Health Records Act 1990 (UK)

The Access to Health Records Act 1990 (UK) came into effect in November 1991. That Act was passed as a result of a decision of the European Court of Human Rights which held that the refusal to allow access by the applicant to certain health records was in breach of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950.46

Under section 3 of the Act an application for access to a health record, or to any part of a health record, may be made to the holder of the record by any of the following:

- the patient
- a person authorised to make the application on the patient’s behalf
- where the record is held in England and Wales and the patient is a child, a person having parental responsibility for the patient
- where the record is held in Scotland and the patient is a pupil, a parent or guardian of the patient
- where the patient is incapable of managing their own affairs, any person appointed by a court to manage those affairs and
- where the patient has died, the patient’s personal representative and any person who may have a claim arising out of the patient’s death.

The term ‘health record’ is defined in section 1(1) of the Act to mean:

... a record which—

(a) consists of information relating to the physical or mental health of an individual who can be identified from that information, or from that and other information in the possession of the holder of the record; and

(b) has been made by or on behalf of a health professional in connection with the care of that individual;

The Act extends to health records made or held by both public and private sector: registered medical practitioners; registered dentists; registered opticians; registered
pharmaceutical chemists; registered nurses, midwives and health visitors; registered chiropodists, dietitians, occupational therapists, orthoptists and physiotherapists; clinical psychologist, child psychotherapists and speech therapists; art and music therapists employed by a health service body; and a scientist employed by a health service body as a head of a department.

Section 5(1) of the Act places limits on the right of access to health records. Section 5(1) provides:

Access shall not be given under section 3(2) above to any part of a health record—

(a) which, in the opinion of the holder of the record, would disclose—

(i) information likely to cause serious harm to the physical or mental health of the patient or of any other individual; or

(ii) information relating to or provided by an individual, other than the patient, who could be identified from that information; or

(b) which was made before the commencement of this Act.

The third party identification exclusion contained in paragraph 5(1)(b) does not apply where the individual has consented to the application, or where the individual is a health professional who has been involved in the care of the patient.

The Act also provides, where necessary, for an explanation of terms used in a health record. Where an individual considers that information in a health record is misleading or incomplete, section 6 of the Act provides a right to request that the record be corrected. Where the holder of the health record agrees with the request a copy of the correction must be provided to the person requesting the correction. Where the holder refuses a request, a note of the matters in respect of which the information is considered to be inaccurate is to be attached to the health record and a copy of the note provided to the person requesting the correction.

Review of a decision to refuse access to a health record is by application to a court. Where a court finds the holder of a health record has failed to comply with any requirement of the Act, the court may order the holder to comply with that requirement. For the purpose of determining any question whether an applicant is entitled to be given access to any health record, or any part of a health record, the court may require the record, or part thereof, to be made available for its own inspection, but must not, pending determination of the matter in the applicant’s favour, require the record or part of it to be disclosed to the applicant or their representative.
Health Information Privacy Code 1994 (NZ)

The *New Zealand Privacy Act 1993* provides for codes of practice to be issued by the Privacy Commissioner to regulate the information practices of particular agencies and sectors. The first code to be issued under the Act was the Health Information Privacy Code 1993 (temporary). The 1993 Code was subsequently replaced by the Health Information Privacy Code 1994.

The Code operates in conjunction with the *Privacy Act 1993* (NZ), that is, where there is no specific provision within the Code regulating a matter, the Privacy Act applies. A breach of the Code has the same effect as a breach of the equivalent provision under the Act and attracts all the Act’s remedies.

The Code applies to the following information or classes of information about an identifiable individual:

- information about the health of that individual, including their medical history
- information about any disabilities that individual has, or has had
- information about any health services or disability services that are being provided, or have been provided, to that individual
- information provided by that individual in connection with the donation, by that individual, of any body part or any bodily substance of that individual or derived from the testing or examination of any body part, or any bodily substance of that individual or
- information about that individual which is collected before or in the course of, and incidental to, the provision of any health service or disability service to that individual.\(^{53}\)

It may be noted that the Code applies only to health information about identifiable individuals.

The Code lists the categories of organisations and health professionals who are defined as 'health agencies' and bound by the Code. These include:

- an agency which provides health or disability services
- within a larger agency, a division or administrative unit (including an individual) which provides health or disability services to employees of the agency or some other limited class of persons
• the Public Health Commission, a regional health authority, or an agency declared by the Minister of Health to be a purchaser for the purposes of the *Health and Disability Services Act 1993* (NZ)

• an agency having statutory responsibility for the registration or discipline of professionals under a health registration statute and

• an agency which provides services in respect of health information, including an agency which provides those services under an agreement with another agency. 54

Rule 1 of the Code provides that health information must not be collected by any health agency unless for a lawful purpose connected with a function or activity of the health agency and the collection is necessary for that purpose.

Rule 3 of the Code requires a health agency to give certain explanations to the individual when it collects information from that person, including:

• the fact that the information is being collected

• the purpose for which the information is being collected

• the intended recipients of the information

• the consequences (if any) for that individual if all or any part of the requested information is not provided and

• the rights of access to, and correction of, health information provided by rules 6 and 7.

Rule 3 of the Code also extends to representatives of a child or of a person unable to exercise their rights (e.g. where the individual has a disability).

Rule 6 of the Code provides individuals, or their representatives, to a right of access to personal health information, providing that information is held in a way that is readily retrievable. Where an individual is given access to health information, they must be advised that under rule 7 of the Code they may request the correction of the information. This rule applies to health information obtained before or after the commencement of the Code.

Under Rule 7 of the Code, where a health agency is not willing to correct a person’s health information in accordance with their request, the agency must take such steps, as are reasonable, to attach to the information, any statement provided by the individual of the correction sought. The person seeking the correction is not entitled to physically change their health information themselves, but is entitled to see and authorise any correction.
Access To Medical Records

made by a health agency. Rule 7 of the Code applies to health records composed before or after the commencement of the Code.

A health agency can only refuse to provide access to health information in the circumstances specified in Part IV of the Act. Where information is withheld the individual being refused access is entitled to be given: the reason for the refusal; if the individual so requests, the supporting grounds for the refusal; and information concerning the individual’s right to make a complaint to the Privacy Commissioner and to seek an investigation and review of the refusal.53

Under Part IV of the Act, a health agency may refuse to provide access to health information for reasons including:

• likely to prejudice the security or defence of New Zealand or the international relations of the Government of New Zealand

• likely to prejudice the maintenance of the law, including the prevention, investigation, and detention of offences, and the right to a fair trial

• likely to endanger the safety of any individual

• would involve the unwarranted disclosure of the affairs of another individual or of a deceased individual, and

• would breach an express or implied promise which was made to the person who supplied the information and which was to the effect that the information or the identity of the person who supplied it or both would be held in confidence.

Rule 9 of the Code prohibits a health agency from retaining health information for longer than is required for any lawful use. The destruction of a document containing health information is not required if it is necessary or desirable to retain that information to provide health or disability services to the individual concerned. Rule 9 of the Code applies to health information obtained before or after the commencement of the Health Code.

Rule 10 of the Code prohibits the use of health information for purposes other than the purpose it was obtained for, unless one of the specified exceptions apply. The exceptions include:

• that the use of the information is authorised by the individual concerned or their representative where the individual is unable to give their authority

• the purpose for which the information is used is directly related to the purpose in connection with which the information is obtained
• the source of the information is a publicly available publication, and

• the use of the information is necessary to prevent or lessen a serious and imminent threat to public health or public safety, or the life or health of the individual or another individual.

Rule 11 of the Code lists the circumstances where a health agency may disclose health information. These include:

• that the use of the information is authorised by the individual concerned or their representative where the individual is unable to give their authority

• the purpose for which the information is used is directly related to the purpose in connection with which the information is obtained

• the disclosure of the information is essential to facilitate the sale or other disposition of a business as a going concern

• disclosure of the information is required for the purpose of a professionally recognised accreditation of a health or disability service, a professionally recognised external quality assurance programme, or for risk management assessment

• to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution and punishment of offences, or

• the use of information is necessary to prevent or lessen a serious and imminent threat to public health or public safety, or the life or health of the individual or another individual.

Complaints of a breach of the Code must initially be directed through the relevant health agency which must designate a person/s to deal with complaints. Complainants also have a right under the Act to complain to the Privacy Commissioner. Civil proceedings may be brought before the Complaints Review Tribunal where complaints have not been resolved. The Tribunal has authority to grant a number of remedies, including: damages up to $NZ 200 000, restraining orders, orders requiring certain actions to be taken, and declarations.

The Commonwealth Attorney-General’s Department in a recent discussion paper has proposed that legislation similar to the New Zealand model be enacted to protect records containing personal information held within the private sector.56

Broadly, the approach of the Attorney-General’s Department would involve the application of statutory Information Privacy Principles (IPPs) to the collection, storage and security, access and correction, use and disclosure of personal information to the private sector. Enforceable Codes of Practice based on the IPPs would be developed for particular industries.57
Extension of Freedom of Information Legislation

The Commonwealth, all the States and the Australian Capital Territory have freedom of information legislation which provides individuals with a right of access medical records held by public authorities.\(^5^8\)

The scope of existing freedom of information legislation could be extended into the private sector. Existing exclusions, such as that contained in section 41(3) of the *Freedom of Information Act 1982 (Cth)* could be retained if this option were adopted. Section 41(3) provides an exception to access where disclosure might be prejudicial to the physical or mental health of the applicant.

It is should be noted that the Australian Law Reform Commission (ALRC) and Administrative Review Council (ARC) have rejected the idea of extending freedom of information legislation to the private sector,\(^5^9\) but in relation to access to medical records proposed the extension of the *Privacy Act 1988 (Cth)*.\(^6^0\)

The ALRC and ARC rationale for not recommending a general extension of the *Freedom of Information Act 1982 (Cth)* to the private sector was that:

... the democratic accountability and openness required of the public sector under the FOI Act should not be required of the private sector. As a general rule, private sector bodies do not exercise the executive power of government and do not have a duty to act in the interest of the whole community. Private sector bodies should not be under an obligation to disclose to any member of the public any document in their possession... In the Review's view strong justification would be needed to subject private sector bodies to the additional resource burden and potential threats to commercial operations that could result from a general extension of the FOI Act. The Review does not consider that such justification exists.\(^6^1\)

In relation to access to medical records, the ALRC and ARC stated:

The Review considers that access to health and medical records in the private sector could be dealt with in the context of a comprehensive national privacy regime. The importance of this issue points to the need for a national regime to be implemented quickly.\(^6^2\)

The stated ALRC and ARC rationale for extending the *Privacy Act 1988 (Cth)* in relation to medical records included:

The Review considers that people should have access to their personal medical records whether they are held in the private or public sector. The Review does not consider that that extending the Privacy Act to the private sector will place undue hardship on private medical practitioners.\(^6^3\)
The Senator Neal Option

As noted, Senator Neal's proposed amendment made it a condition of receiving a Medicare benefit by a person rendering a professional service (the provider) to enter into an agreement with the Health Insurance Commission (HIC) that they allow access to medical records that they hold about an individual if an application is made in writing for that access by certain persons.

The amendment proposed by Senator Neal was minimalist in its scope, that is, it only applied to a 'professional service' as defined in section 3 of the *Health Insurance Act 1973*. The amendment does not: extend to public hospitals; regulate the collection, storage, security and disposal of medical records; regulate the retention of medical records; or regulate the use and disclosure of medical records. It may be possible to extend Senator Neal's minimalist model to public hospitals by making it a condition of the receipt of payments for hospital services under the *Health Insurance Act 1973* that an agreement be entered into between a hospital and the HIC. It should be recognised, however, that the Commonwealth does not directly fund public hospitals.

However, it may be noted that it would be possible to construct a legislative scheme making health grants to the States and Territories subject to a requirement that the States and Territories require all holders of medical records to provide patient access to those records.

A Commonwealth and State Co-operative Scheme

A co-operative Commonwealth and State scheme is also a legislative option for creating a patient right of access to medical records. The advantages of such a scheme include uniform laws throughout Australia while State control is retained and avoidance of any Commonwealth constitutional uncertainties. Disadvantages include that implementation and amendments would require unanimous agreement and enactment.

Concluding Comment

The High Court of Australia in *Breen v Williams* unanimously held that under the common law a patient does not have a right of access to inspect and or obtain copies of his or her medical records.

In contrast to health care professionals and health insurance companies, consumers of health care have only a limited right to access their medical records.
There is a movement in developed nations to provide patients with all the information that enables them to make informed decisions about treatment options.

Is it to be accepted that patients should be more in control of their health care? Is it to be accepted that patients should be more involved and informed of their health care? Is it to be accepted that patients should be better able to understand who else has access to their medical records?

Putting constitutional concerns aside, if the answer to each of the above questions is ‘yes’ then it may be just a matter of time before a statutory right of patient access to medical records will created by the Australian Parliament. A comprehensive regulatory regime similar to the New Zealand Health Information Privacy Code 1994 could be considered.

Endnotes

1. Under the New South Wales Private Hospitals Regulation 1990, Day Procedure Centres Regulation 1990 and Nursing Homes Regulation 1990, patients treated in private hospitals, day procedure centres and residents or former residents of nursing homes can gain access to their medical records by making a written request to the licensee of the health establishment. As soon as practicable, the licensee must make the medical record available for inspection to the patient, the patient’s representative or a person nominated by the patient or their representative. There are certain exceptions to this access including if the medical practitioner in charge of the patient’s care advises that the request should be refused because it would be prejudicial to the patient’s physical or mental health. The patient or the patient’s representative must be given reasons why the request for access to the medical record has been denied. Where the patient or their representative disagrees with the information contained in the record, their own comments must be attached to the record on request. A patient or their representative may appeal to the Director-General of the Health Department against a decision of a licensee to refuse access to the patient’s clinical record.


5. It may be noted that Ms Breen could have obtained access to the medical records by compulsory court process. Ms Breen could have applied for an order for discovery of the records through the equitable jurisdiction of the Supreme Court of New South Wales. Another avenue for obtaining the records was by way of letters rogatory. As stated by Dawson and Toohey JJ:

   These were obtained by from the United States court by several lititgants in her position and orders were made by the Supreme Court of New South Wales
compelling the production of medical records to the Court in aid of the United States proceedings. The appellant did not avail herself of this procedure because, she said, the time available was too short; supra, note 3 at 777.

Kirby P, in his dissenting judgment in the New South Wales Court of Appeal, stated:

There is no doubt that access to the medical records could be secured by compulsory court process. Letters rogatory were secured from Judge Pointer in the case of several litigants. These in turn, resulted in orders by judges of the Supreme Court of this State for compulsory production of medical records to the Court in aid of the United States proceedings. The costs, delays and complications of this procedure were, self-evidently, significant. The time available was short. It was therefore decided by those advising Ms Breen and others in a like position (said to number 2,000 in a group represented by Ms Breen's solicitors and others in co-operation) to launch a “test case”; Breen v Williams (1994) 35 NSWLR 522 at 527.

6. supra, note 3 at 778.
7. Quoted by Gummow J in Breen v Williams, id. at 796.
9. Quoted by Kirby P in Breen v Williams, supra, note 8 at 545.
10. id. at 550.
12. A fiduciary duty is a relationship where one person is bound to exercise rights and powers in good faith for the benefit of another. As Brennan CJ states in Breen v Williams:

   "Fiduciary duties arise from either of two sources, which may be distinguished one from the other but which frequently overlap. One source is agency; the other is a relationship of ascendancy or influence by one party over another, or dependence or trust on the part of that other: supra, note 1 at 776."
Access To Medical Records

23. id.
24. id. at 786.
25. id. at 787.
26. id. at 802.
27. id. at 776.
28. id. at 781 & 785.
29. id. at 794.
30. id. at 807.
31. id. at 794 per Gaudron & McHugh JJ.
32. id.
33. id. at 777.
34. id. at 785 & 786.
35. id. at 794.
36. id. at 799.
38. P.M., 12 September 1996.
41. id., at 6972.
42. supra, note 3 at 786 per Dawson and Toohey JJ; at 795 per Gaudron and McHugh JJ.
43. Article 17 of the International Covenant on Civil and Political Rights provides:
   1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.
   2. Everyone has the right to the protection of the law against such interference or attacks.
44. supra, note 8 at 547 & 548.
45. Quoted by Gummow J, supra, note 3 at 795.
46. id., at 784.
48. id., Section 5(2).
49. id., section 3(3).
50. id., section 8.
51. id., section 8(1).
52. id., section 8(4).
54. id., subclause 4(2).
56. supra, note 37.
57. id., at 4.
58. *Freedom of Information Act 1982* (Cth)
    *Freedom of Information Act 1989* (NSW)
    *Freedom of Information Act 1982* (Vic)
    *Freedom of Information Act 1982* (Qld)
    *Freedom of Information Act 1991* (SA)
    *Freedom of Information Act 1992* (WA)
    *Freedom of Information Act 1989* (ACT)
60. id., at 208.
61. id. at 195 and 196.
62. id., at 207.
64. The term 'professional service' is defined by section 3 of the *Health Insurance Act 1973* (Cth) to mean:
    
    (a) a service (other than a diagnostic imaging service) to which an item relates, being a clinically relevant service that is rendered by or on behalf of a medical practitioner; or
    
    (b) a prescribed medical service to which an item relates, being a clinically relevant service that is rendered by a dental practitioner approved by the Minister for the purposes of this definition; or
(ba) a service specified in an item that is expressed to relate to a professional attendance by an accredited dental practitioner, being a clinically relevant service that is rendered by an accredited dental practitioner to a prescribed dental patient; or

(c) a service specified in an item that is expressed to relate to a professional attendance by a participating optometrist, being a clinically relevant service that is rendered by an optometrist, being a participating optometrist or an optometrist acting on behalf of a participating optometrist; or

(d) a pathology service that is rendered by or on behalf of an approved pathology practitioner pursuant to a request made in accordance with subsection 16A(4) by:
   (i) a treating practitioner; or
   (ii) another approved pathology practitioner to whom the treating practitioner has made a request for the service; or

(e) a pathology service (other than a service referred to in paragraph (d)) that is a clinically relevant service rendered by or on behalf of an approved pathology practitioner other than a medical practitioner; or

(f) a diagnostic imaging service that is rendered by or on behalf of a medical practitioner pursuant to a subsection 16B(1) request; or

(g) a diagnostic imaging service (other than a service referred to in paragraph (f)) that is a clinically relevant service rendered by or on behalf of a medical practitioner.