

AUSTRALIAN INSTITUTE OF HEALTH SURVEYORS

NATIONAL CONFERENCE

WENTWORTH HOTEL, SYDNEY

WEDNESDAY 30 SEPTEMBER 1981

HEALTH CARE, CHANGE AND LAW REFORM

The Hon. Mr. Justice M. D. Kirby
Chairman of the Australian Law Reform Commission

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I have three-quarters of an hour in which to cover a topic which is of great complexity, but which will become of increasing importance to Australia's hospitals and to the medical and paramedical staff who operate them. The business I am in is the future; taking our laws, our lawmakers and the legal profession into the future — perhaps even harder than working in hospitals. Occasionally, in my more frustrated moments, I wish there were available a beneficial anaesthesia that could be administered to overcome the attitude, red tape and other impediments that sometimes stand in the way of prompt law reform. But this is not to be; reforms must be justified in the open and piloted through the political process. In a sense, that is why I am here before you today : to tell you something of the work of the Australian Law Reform Commission as it may affect you.

THE AUSTRALIAN LAW REFORM COMMISSION

Let me say first of all a few things about the Law Reform Commission itself. It is a permanent authority established by the Federal Parliament to help the Federal Attorney-General in what I might call the 'too hard basket' of large and difficult problems. Though it is a permanent institution, it is a small one, with 11 commissioners and only four of them full-time. There is a research staff of eight and the Commission is established in Sydney. At any given time the Commission is working on about eight major projects of national law reform. The Commission receives tasks, as has been said, from the Federal Attorney-General. It cannot initiate its own projects. In this way it works upon projects of legal reform which have been identified as necessary to our country by the elected representatives of the people. Because all save one of the commissioners are lawyers, the practice has been developed of collecting an interdisciplinary team of

consultants to help us in each and every project. The Commission publishes tentative suggestions for reform in discussion papers which are then distributed widely for expert and public comment. The issues are then debated in the public media and exposed in seminars and public hearings throughout Australia.

In its six years of operation the Law Reform Commission has reported on a wide range of topics from complaints against police and criminal investigation to breathalyzer laws, defamation law reform, reform of the law of insurance, the rules that should govern the census, principles controlling the sentencing of convicted Federal offenders and so on. The proposals of the Commission have been adopted into law both at a Federal and State level, so that the business I am in, though a scholarly business, is not an academic business. It is nothing less than the renewal of the Federal laws of Australia. A number of our reports have seen close co-operation between lawyers of the Commission and the Australian medical, hospital and nursing professions. For example, we were asked to devise a law which would govern human tissue transplantation. In that project the Commission had the participation of Sir Zelman Cowen and Sir Gerard Brennan, two of Australia's finest lawyers. They were then members of the Commission, Sir Zelman having since left for another job in Canberra and Sir Gerard Brennan being the most recent appointment to the High Court. In our report on human tissue transplantation, we faced many hard questions. When it was delivered, the British Medical Journal and the Lancet praised both its content and the way in which we had developed our proposals in close consultation with the community. The draft legislation which was attached to the report has already been adopted in substance in three jurisdictions of Australia, including Queensland. It is under consideration in the rest of the States in Australia and I understand it is before the Cabinet of this State. The report shows what can be done in law reform by co-operation between doctors and health workers and by the participation of the general community, for it was not only the medical profession and the lawyers of top talent whom we consulted.

I like to think of the Australian Law Reform Commission as a catalyst for action by short-term parliaments. It helps our political representatives to face profound, long-term, complex, sensitive and controversial questions. A number of the Commission's projects are relevant to the concerns of hospitals and the medical, paramedical and support staff who man them. Four examples may be mentioned. The report on criminal investigation dealt with the rules which should govern the power of entry, search and seizure by Federal police and Federal officials, a matter of increasing importance in an age of Federal funding of health care. The project on privacy protection, which is still current, is concerned with the regime that should govern personal data, including medical

and hospital records. As more and more of these data are computerised and as the old intimacy of the medical relationship is diminished in the search for greater efficiency and economy in the use of medical and hospital records, countries of the Western community, including Australia, are forced to consider the adequacy of old laws and the development of new laws to protect the privacy of the individual. Thirdly, our project on child welfare laws in the Australian Capital Territory, upon which we are about to report, required us to consider the question of compulsory reporting of suspected cases of child abuse and the handling of cases of child abuse by hospitals, including the power of a hospital to detain children short of judicial authorisation in emergency cases. The duty of confidentiality to the patient may be diminished by the duty compulsorily to report particular diseases or suspected signs of child abuse. However, without such a report, a multi-disciplinary attack on the problem may never be possible. Finally, our current inquiry directed toward the development of a Federal law of evidence for Federal courts in Australia requires us to re-examine the scope of professional privilege, including that of the doctor and the health care provider in the revelation of their dealings later to courts. Should courts of law in criminal and civil cases suffer no barrier to the disclosure of all relevant facts in the search for truth, or should our laws of evidence and other rules acknowledge that there are competing public interests which, even at the loss of the discovery of the truth, must be upheld, for example, to support the confidences shared with a professional health care provider?

BACKGROUND TO PRIVACY

The Commission is now moving towards the completion of a report on privacy protection laws at a Federal level in Australia and we hope to have our report completed by the end of the year. In order to focus public debate, we produced two discussion papers dealing with a whole range of dangers to privacy in modern Australia. The first of these, Privacy and Intrusions, dealt with such matters as the growing number of government intrusions by way of statutory authority to enter premises, search and seize property and so on, and the growing capacity of surveillance inherent in the facility of telephonic interception listening devices, optical scrutiny and so on. Unregulated areas of private intrusion which cause concern include telephone canvassing, direct mail advertising, sale of address lists and the like. The second discussion paper, Privacy and Personal Information, is more relevant to this audience and I believe of greater long-term significance. It deals above all with the potential danger to individual privacy arising from the growing computerisation of personal information in our society. It suggests new laws for the security of personal information, the rules by which information may be kept and for the duration of its maintenance. It also suggests a general statutory right of

access to personal information about oneself. It suggests exceptions which should be clearly provided for by law, but proposes the adoption of the general principle that in the computer age we should normally have rights of access to computer records about ourselves. It is this right which has formed the core of overseas privacy protection laws in North America and in Western Europe. It is a right that has already been partly embraced in the Freedom of Information Bill which is presently passing through the Federal Parliament. The general principle I have referred to is justified on the basis that the individual ought normally to be able to see how the computer sees him in order that errors may be corrected, out of date information removed or explained and unfair material annotated with the subject's own version of events.

THE PRIVACY DEBATE

Since the Law Reform Commission published its proposals along these lines, most Australians have indicated their support, in principle, for a regime of openness. However, it is when it comes to the application of this fine principle to particular personal information systems that the problems tend to start. The Commission has suggested that, in reality, there must be exceptions for national security and for defence material. There must also be exceptions for police intelligence, as disclosing the identity of informers will obviously destroy the source of the information and probably diminish much police effectiveness. It is suggested that the professional confidences of lawyers must be excluded in conformity with the long-held principle of the protection of the confidence of the client. However, it is also proposed that medical and hospital records should be omitted from the new regime. Otherwise, it is said, vital information may not be recorded for fear of damaging the personal relationship between the health care provider and the patient, necessary for the good treatment of the patient.

CHANGES IN HEALTH CARE DELIVERY

A number of changes in the delivery and organisation of health care services and in health recording practices have, I think, created an urgent need for Parliament to develop a new set of rules which will bring completeness and clarity to the law governing confidentiality in the hospital context. The use of electronic data processing in both private and public sectors of health care and related services is already widespread and we all know it is growing at a rapid rate. Computers are now in use in the health field in all Australian States, in the Australian Capital Territory and, as I learned recently, also in the Northern Territory. In Victoria, for example, many hospitals have either installed their own system or are utilising the services of a local computer service bureau. In New South Wales a number of systems have been developed and introduced into hospitals on a

regional basis. Similar developments have occurred in other States. Some Adelaide hospitals, for instance, use personnel payroll computer services provided by the health computing service at Monash University in Victoria. Other local computer service bureaux operate in Victoria and are used by health care services. In the future, if they do not already exist, we can expect computer linkage systems between the hospitals in Australia, between Australian hospitals and computer service bureaux, and between Australian hospitals and service bureaux overseas. The Health Computing Service, on a fee for service basis, provides services for approximately 130 separate clients, some being annexes of specialist departments within a larger health care complex. This centre provides services specifically relating to medical records in excess of forty clients. The main utilisation of these computer facilities by hospitals relates to admission and discharge information, patient location, state of accounts and morbidity statistics. In hospitals the computer centre facility is utilised for installing an on-line dedicated system, being terminal, and also printers and associated software. Each of these hospital systems is connected to the computer centre by a dedicated Telecom landline, that is, a landline which is only utilised by the hospital involved. Ten hospitals in Melbourne are currently linked to the computer centre in this manner. The hospitals, however, are not linked to each other or to other institutions or computer centres. It appeared in 1979 that interest was growing amongst health care providers in a linkage of that type and that some form of inter-hospital linkage would likely be introduced in Victoria in the next decade. When the Law Reform Commission conducted its public hearings on privacy in Melbourne, we were told that the scheme for such a linkage was well advanced. Such an inter-hospital linkage is now operating in New Zealand, where it is known as the Central Patient Medical Index, or PMI. It was introduced in 1976, and has since been operated by the New Zealand Department of Health.

THE CONSEQUENCES FOR PRIVACY

Particular problems arise as a consequence of the use of electronic data processing in the hospital context. Changes in the delivery and organisation of medical health care services place privacy and confidentiality of the patient at risk to a far greater extent than could have been envisaged in the period when the framework of rules for determining the legal implications of the hospital/patient and doctor/patient relationships was originally developed. The existence of patient medical records is a relatively recent event in the history of the delivery of medical care. For centuries doctors enjoyed an absolutely direct and personal relationship with their patients which rarely involved a third party, much less a hospital computer service.

The original concept of the doctor writing notes for his own benefit, around which the contractual and equitable duties of secrecy were established, has inevitably changed to one where he and many others write notes not only for their own benefit but for the benefit of colleagues and other health care providers who are or might become involved in the sphere of the patients concerned. Other related developments include that of a problem-oriented medical record, which makes all information more readily available and enhances the possibility of illegal intrusion. Rather than encouraging patient confidentiality on important issues, this record probably detracts from it. Another new development in the hospital context is that of peer review, the implementation of which is being promoted by the Australian Council on Hospital Standards. Peer review is a formal process requiring the gathering of statistical and other information, and descriptive reporting, on the performance of individual commissions. The purpose is to allow feedback to aberrant professionals. The peer review system provides access to information by the professionals concerned and any commission whose work is questioned has a right to appeal to any of his or her colleagues in relation to privileges which may be curtailed.

Other developments relevant to patient privacy occurring in the medical field are:

- . The generally shorter hours worked by doctors, involving more use of multi-doctor patient treatment, more partnerships and more locum services.
- . Increasing mobility amongst doctors and patients, resulting in much more transient professional relationships and communications than existed in the past.
- . Better educated and increasingly independent patients willing to seek second opinions and to change doctors.
- . A growing surplus of doctors in some parts, the shift towards salaried medical employment and the development of teams consisting of general practitioners, specialists, nurses, social workers, psychologists, psychotherapists and so on to be found in a diversity of settings such as community health teams, health centres, abortion clinics and sports medicine clinics.
- . The development of clinical education and the involvement of medical and other students in a wide variety of innovative community settings.
- . Innovations in record-keeping practices. Some hospitals leave the medical record at the foot of the patient's bed or allow them to take the record home. Others adopt a far more old-fashioned technique.

- . A growing circle of secretarial, clerical, administrative and computer staff associated with the flood of patient information obviously has implications in the spread of personal information.

These are just some of the new phenomena in the medical field, and taken together they provide an environment where patient privacy and confidentiality are at greater risk than they were in the past.

THE EXISTING LEGAL PROTECTION

The existing legal remedies for mishandled information address themselves to the relatively rare situation where the patient subject becomes aware of the mishandling, and as a consequence is hurt by it. He may then sometimes claim damages to compensate him for what he has lost as a consequence of the mishandling or he may obtain an injunction to prevent repetition. The compensation for a loss after a wrong is done is an unsatisfactory way of securing fair record-keeping practices in hospitals. An analogy can be drawn between hospital record-keeping practices and factory safety precautions. The factory worker who loses an arm as a consequence of the factory owner's negligence may of course sue for damages and he may have entitlement to workers' compensation, but these remedies are not considered sufficient by Parliament as an inducement for the maintenance by factory owners generally of adequate safety precautions. Detailed regulations set out safety precautions to be followed in factories for the protection of workers and an inspectorate is assigned the task of assuring these safety standards are complied with. The law does not limit the weapons in its armoury to those which apply after the injured worker receives the injury.

The problem of ensuring compliance with adequate data security practices in hospitals is compounded by the fact that, as a consequence of the introduction of electronic data processing, there is an increased chance of people being hurt without their ever knowing it. Medical records are already of great interest to health insurance, they are certainly of great interest to government payers, to law enforcement authorities, to welfare departments, sometimes to schools, to researchers, to credit grantors and to employers. Attempts are made in the hospital context to avoid the curiosity of such groups being satisfied at the expense of the patient's privacy, but pressures and opportunities for disclosure are great. There is certainly no effective law in Australia to prevent widespread disclosure and the lack of centrally adopted data security standards makes intrusion into hospital records a real possibility. At present in Australian hospitals, information sharing in the hospital context itself is not limited to a 'need to know' basis but may be communicated freely even to the idly curious, a situation of which patients in

our country are generally unaware. A patient whose blood group has been misrecorded or transferred inaccurately from a data storage facility elsewhere may very soon discover that his personal information has been mishandled, but a patient whose child has been incorrectly assessed in a hospital may not be aware that this is the reason why a welfare benefit, such as a handicapped child allowance, has been disallowed or cancelled. Varying ethical codes apply. Indeed, in certain areas of health care practice there is a total absence of any kind of formulated ethical code. Varying levels of appreciation of legal rights and liabilities exist, arising quite understandably from the vagueness and vagaries of the existing legal framework. As a result, disclosure and other information handling practices will vary from place to place. They range from the dangerously restrictive computer program concerning a patient's general treatment, denying a pharmacist information that would have indicated that an incorrect drug would have been prescribed, to the dangerously slack, where a nursing aid revealed details of a patient's health and financial position to a private investigator.

The Law Reform Commission has published two discussion papers, but time does not permit me to give a detailed discussion of the various proposals in them. They have been thoroughly debated in a whole range of services throughout the community. We are nearing the completion of our report and hope to finish it early next year. Three of the recommendations, however, are of particular importance in the context I have been addressing. They are the proposals for subject access to personal records, the limitations on disclosures from the record normally without a patient's authorisation, and the formulation through the mechanism of a Privacy Council of legally enforceable standards for data security in record-keeping practices generally and specifically in the context of hospitals.

ACCESS BY PATIENTS TO PERSONAL RECORDS

Dealing first with patient access, one can approach the issue in two ways. First, one can say that as a matter of ethics and morality people's information practices should be fair and that fairness can only be achieved where there is mutuality or a sharing of knowledge and control between a record-keeper and a record subject. Access is essential to achieve mutuality, and mutuality in record-keeping practices is essential if individual autonomy is to be upheld in the face of the developments in information practices which may put the control by the individual over his own destiny at risk. If this argument does not appeal to you and you want something more hard-nosed, then resort may be had to a more pragmatic approach, namely that because there is now a risk of medical records being more widely shared with others interested in their contents, it is crucial that the record should be kept as accurate as possible, and for the patient

to know what is being recorded and to be able to correct inaccuracies. No-one doubts that the future will be one in which more and more decisions are made about all of us, not on the basis of close personal encounter between a decision-maker and the subject of his decision, but on the basis of someone somewhere tapping up a computer profile, making decisions which can profoundly affect people's education, career advancement, government benefits and so on. The possibility of access will create greater objectivity and accuracy in recording information about patients. Of course, there is no doubt that there will be a limited number of situations in which any right of access which would be exercised by the patient would do harm to the patient, and that must be taken into account.

An argument related to the foregoing in support of access runs as follows : those who might oppose access would nevertheless agree that there ought to be limitations on disclosures of the hospital record. Most opponents of access would nevertheless agree that a hospital record ought generally not to be disclosed without the consent of the patient. But if you think about it, a patient cannot really give consent unless he knows what he is consenting to and he will not know what he is consenting to unless he has a general access to the record from which it is proposed to make a disclosure.

Submissions to the Law Reform Commission on the issue of patient access fall into three groups. At one end of the scale are the various associations and organisations which by and large quite vigorously oppose access. At the other end of the scale are representations from individual doctors and allied health professionals who take the view which can be rather crudely summed up by the submission of one of them to the effect that 'the patient might just as well have access to his record, everyone else does'. Sitting on the fence are some groups representing medical record administrators who, whilst generally in agreement with the principle of patient access, are aware of attendant problems.

The essential issue in my mind is whether, even if there is genuine value in creating mutuality in the hospital/patient, doctor/patient relationships, a right of access to written records would be of much help to the average patient. Would it in fact prove counter-productive to his interests, bringing about double entry hospital record-keeping, causing the patient who gained access to become confused or anxious as a result of newly-found information, antagonising doctors and encouraging corrosive attitudes of non-co-operation, attitudes capable of a spillover into other areas of their work.

The Commission has received submissions opposing access from doctors representing the interests of large institutions and from associations, formal and informal, representing the interests of various health care workers. Although varied in nature and content, these submissions basically provide variations on the one theme, mainly that the doctor should decide what patients need to know about their records and that any interference with the doctor's judgment might leave patients to become worried, undermining good medical care. Submissions emphasised the fiduciary relationship between doctor and patient, pointing out that access would be a violation of the duty to withhold information which would be harmful to the best interest of the patient as a matter of sound medical judgment or, summing it up, doctor knows best. The submissions claim that patient access could bring about an increase in the danger of unauthorised access, particularly if a copy were released to the patient. They emphasise the threat which patient access would hold to the developing process of peer review.

None of these fears seems to have been borne out by the United States' experience where patient access is already fairly widely distributed and by the experience of record-keepers in the health care area in Australia who presently allow access. In the United States, the general rule has been adopted by law that Federally-funded hospitals must give patients access to their hospital records. Many objections were, of course, raised to the rule when it was first introduced. Some related to costs, others related to the issues of principle. However, in a number of the States in the United States the principle has been adopted, giving the patient the right to inspect, and in some instances to obtain, copies of hospital records. Colorado, for example, applies its statute not only to hospital records but to records held by private physicians, psychologists and psychiatrists. Some States exclude psychiatric records in their legislation, whilst some cover only hospital records. In some cases the hospital authority itself determines how much of the record the patient may see. The experience of Federal hospitals under the Privacy Act in the United States would appear to allay fears about the number of requests for patient access and the cost of administering the patient access scheme. At a Federal level, with a total estimated hospital patient population of five million persons, requests by patients for records from the Bureau of Medical Services numbered about 3,000 in the first three years.

One consideration which has sparked the cause for changes in the law is the enormous increase in the bulk of personal medical and hospital information. Until the last War most health information was confidential and securely kept by a local family physician in a sole practice. In circumstances such as these the total medical record was generally little more than a small card with entries showing the dates of visits,

medications prescribed and the charges. Security, confidentiality and privacy were protected by such a system. The physician was usually able to store more intimate personal and private details about the patient's medical and emotional condition in the safe crevices of his mind. A recent report in the United States of the Privacy Study Protection Commission to the President put the modern problem in these words:

in contrast a modern hospital medical record may easily run to a hundred pages, the record of a family physician may still hold information on ailments and modes of treatment but may now also note the patient's personal habits, social relationships and the physician's evaluation of the patient's attitudes and preferences often in excessive detail.

That abuse can occur is clearly demonstrated in the same US report. It points out that hospital records are routinely available to hospital employees and the police on request. Most of these people are medical professionals who need such access in order to do their job, but not all of them are. Besides the physician, the psychologists, nurses, social workers, therapists and other licensed or certified medical practitioners and para-professionals, there are nearly always medical students and other people in training programs conducted either by the medical care institution itself or affiliated with the institution. These people, too, have access to the medical records for training or job-related purposes as do non-professional employees and voluntary workers. Attention is drawn in this US report to a case in 1976 where a firm was established in Denver precisely to provide a variety of investigative services by the surreptitious acquisition of medical record information from hospitals and physicians, which was then sold to investigators and lawyers for a variety of purposes. One of the sources of information was a hospital employee. A Grand Jury condemned the laxity of the hospital security measures. The question we have to ask is whether this kind of abuse could happen or has happened in Australia. The Hospital and Allied Services Advisory Council has expressed its concern that it could.

There are other problems in addition to the burgeoning growth of medical and hospital records now affected increasingly by computerisation. The obligation to answer subpoenas and the increasing inquiries by insurers and researchers all procure information which was formerly thought to be strictly private and confidential. The list of notifiable diseases and notifiable conduct continues to expand. The reasons for securing this information increase in an interdependent society and again it is useful to look at the US report:

There are few statistics indicating the number of requests for medical record information that are not directly related to the delivery of medical care, but testimony before the commission suggests that the number is high, for example, the director of the Medical Record Department of a six-hundred bed university teaching hospital testified that he received an estimated 2,700 requests for medical information each month, some 34% of them from third party payers, 37% from other physicians, 8% in the form of subpoenas, and 21% from other hospitals, attorneys and miscellaneous sources. The attorney for the Mayo Clinic testified that the clinic receives an estimated 300,000 requests for medical record information a year, some 88 of them patient-initiated requests related to the claims for reimbursement by health insurers.

Modern hospital administrators, whether in public or private hospitals, large or small hospitals, computerised or manual hospitals, who are anxious to uphold at least sufficient privacy so as not to damage the trusting relationship which is vital for proper health care of the patient, must attend to these concerns. The United States President's report on privacy recommended many new laws to protect privacy in the United States, including in the medical and health care area. These proposals arose from the US Commission's conclusions that the medical/health care relationship in America today is becoming dangerously fragile, as the basis for an expectation of confidentiality is undermined more and more.

A legitimate and enforceable expectation of confidentiality that will hold up under the revolutionary changes now taking place in medical care and medical record-keeping needs to be created. Expectations of confidentiality upheld by the law and rights of patients to have access to hospital records, sometimes through intermediaries, would seem to be the direction which future Australian privacy laws affecting your profession will move. The experience of Australian health and welfare organisations which presently allow subject access is increasingly studied.

The reaction of those hospitals which already have introduced a system of patient access is generally one in favour of the system once introduced. There are many cases which have come to our notice in the course of our inquiry concerning organisations which once held to what I will call 'the British system of secretive administration', but who eventually provided a more open system which once introduced is found to be entirely satisfactory. One interesting example is that of a child welfare charity studied by the Law Reform Commission which keeps files on each child received into its care, including a report received from the referring organisation, a medical report, a psychiatric report, if

it is applicable, and a contract worked out with the natural parent or guardian at the time of admission. All of these files are now written in a way that when the child reaches the age of 18 years, the child should be able to read it. In preparing the file on the child, subjective assessments and value judgments are avoided as far as possible. The social worker knows that it may be read. Loose assertions such as the child's mother has the morals of a prostitute or that the father seems to be a violent man, found in many other health care reports studied by the Law Reform Commission, are avoided in the reports of this organisation. The objective facts are set down in the agency files, rather than subjective and sometimes ill-considered conclusions drawn from facts. Files are maintained on prospective foster parents who also have a right of access. Once again, these files are delicate and highly personal. They contain social histories, behavioural assessments obtained from various separate interviews with each prospective parent, and from an interview with both applicants conducted together. The experience of this organisation with such forms of access has been highly positive. Obviously, in Australia, with so much professional resentment to subject access, it could only be gradually introduced in a hospital context.

The Law Reform Commission's proposals include one for a Privacy Council which could establish standards for record-keeping practices for hospitals and other bodies which keep personal information. Such a Council would also lay down the principles of subject access. Not only should access rights be introduced gradually in the hospital context, they should also be limited to that part of the record which may be considered the official record, consisting of personal factual details about the patient, social and family history, complaints, tests, examination results, the record of diagnosis, treatment summaries, drug regimes, payment information and other data which might be called official. Access should be subject to certain limitations, such as where the subject's interests themselves require a limitation. In this case access might be permitted only through a third party. Interestingly enough, this is the principle that is adopted in the Freedom of Information Bill which is before Federal Parliament. It permits patient access to Federally held personal medical records but permits only intermediary access to cases where it is thought that access directly would do damage or harm to the patient. Introduction of access rights to hospital records would seem to me to pose no problems and could prove a benefit in securing greater privacy protection in the Australian hospital context. There are other matters dealt with in my paper related to data protection and data security, but I want to allow some time for an exchange with you and therefore I will not read all of them.

HEALTH CARE PROFESSIONALS AND THE COURTS

Can I mention briefly the other two matters which are before the Commission which concern health care professionals. One of them is the reference of the Law Reform Commission on evidence law. That sounds a very technical sort of project and indeed it is. It seems to be a long way distant from the concerns of health care providers, but it is not. One of the greatest legal battles in the United States was the development of a Federal law of evidence in that country: it began in the thirties and was not finished until 1975. We hope to be a little faster. One of the sorest problems was the question of professional privilege. In three jurisdictions of Australia — Victoria, Tasmania and the Northern Territory — a privilege attaches in civil cases to the disclosure of personal information to a doctor or medical practitioner so that, without the consent of the patient, the confidences that are disclosed in the course of the health-giving relationship cannot be disclosed to the court, even though they might be absolutely vital information for the discovery of the truth by the court. The policy of the law has been that of weighing, on the one hand, the desirability of the court's getting at the truth and, on the other hand, the desirability of encouraging the other social policy of promoting complete frankness between the health care provider and patient. The latter is essential so that people are not inhibited when they go to health care providers in giving them the full facts, lest at some future, far off time, the doctor or other provider be forced to give the information to court.

In the United States the committee which examined this subject said that, in the ultimate, it was more important that courts should be able to get at the truth because their duty was to resolve peacefully the battles in society and that justice would be truly blindfolded if we gave privilege beyond lawyers and police informants to more and more classes. It was said that if a privilege was given to doctors we would soon have the dentists, the physiotherapists, the accountants and the bankers claiming that their personal confidences ought similarly to be protected. The courts would ultimately be put in the position where, in many cases, confidences could not be disclosed because the giver of the confidence refused to permit it. In America the committee urged that the classes of protected confidence should be kept down, rejecting the notion of a general protection of medical information for journalists' sources or for bankers' information. They said it should be limited to lawyers and police information. Once their report was delivered a tremendous hubbub occurred and great pressure was applied to undo the package and, indeed, the whole exercise, thirty years of it, almost came to nought over this issue.

In the end a compromise was struck by which the general package was adopted in the Federal rules of evidence but this particular question of privilege, whether it extends to journalists, doctors, health care providers, dentists and so on, was left to be determined by the State courts, in the same way as the laws of Australian Federal courts are the laws of the State in which the Federal Court of Australia sits.

When I was in the United States a couple of weeks ago, I was told by the President of the ABA, the American Bar Association, that they were looking to us in Australia to solve this problem for them. I told him without any hesitation that the self-same pressure groups which had set upon the Congress, when that package came before the Congress in the United States, will be alive and well, waiting in the wings in relation to the subject in Australia.

THE VIEW FROM THE WITNESS BOX

I imagine that some of you at various times have had to give evidence in courts. One of the dangers of reviewing the law of evidence in a group which is overwhelmingly one of lawyers is the danger that, because of the technical nature of the exercise, you will look at the problem simply from the perspective of the repeat players, the people who are familiar with, have grown up with, are comfortable with, and sometimes know, the laws of evidence in the courts. To try to avoid this, we have attracted to our team a number of people from other disciplines, including psychiatry and psychology, who can teach us about modern research on memory and children's evidence. We in the law generally, in criminal matters, require children's evidence to be corroborated, because of what the courts in the past have said is the notoriously unreliable evidence of children. Yet research that has been done, both in North America and Sweden, tends to suggest that, at least in identity evidence, children unencumbered by the prejudices that are entrusted on people as they grow older, tend to be far more accurate in their perceptions and recall of identity questions than adults tend to be.

In relation to this project, too, I would invite the suggestions of people who have had dealings in courts and who perhaps do not have any particular specialty such as psychiatry or psychology or the like, but who have seen the performance and do not think much of what they have seen, or think that it could be improved in some way or who have suggestions for the improvement of the way court procedures take evidence. Although we are limited to Federal courts, obviously what goes on in the local magistrates' courts or what you may have seen in the old Local Government Appeals Tribunal or in other bodies,

is relevant. Frequently people tell me that the chief complaint they have about courts and tribunals is that they cannot hear a word of what is going on. They sit in the back of the proceedings, not knowing what on earth happened to their fate or to their case. I think this is the sort of thing that should be constantly said to lawyers so that in dealing with the reform of the law, they do not forget the reality of what they are dealing with in their concern for the great principles and issues before them.

OVERVIEW

The matter about which I have talked to you today, the question of privacy protection and the right of access, is not some local aberration of a few evangelists in the Law Reform Commission concerned about privacy and determined to make the life of people in hospitals and health care services difficult. I have recently chaired a committee of the OECD which was working on the design of the principles that should govern trans border flows of data, that is, the movement of data by computer from one country to another. In Europe they have found that data protection laws can be completely frustrated by, for instance, the simple expedient of keeping German personal data in a computer in Switzerland and retrieving it when they need it. It was an interesting thing when we sat down with all the languages, the variety of legal traditions and the different machinery of dealing with things, that when you looked at just what they had done, whether it was in Sweden or Canada or whether it was in Spain or in Austria, or in the United States or Scandinavia generally, an interesting thing was that the common point, the golden thread through their legislation, was this principle of individual access. There are of course many other questions on privacy protection, such as the impact of computers in our society, not least on employment levels, on the vulnerability of the wired society, computer crime, the admission of computer evidence in court and so on. But the matter of the privacy of individuals in the computer age is one which is accorded great attention in Europe. It has not really caught the imagination out here. In this 'lucky country' we think all of these problems will pass us by but when you sit down with people from The Netherlands, with fresh memories of the way in which The Netherlands administration's records, passed to the Gestapo in the German invasion, could translate perfectly innocuous information into literally matters of life and death, you realise that things can go wrong.

I am not a scaremonger but I do not think that nothing will go wrong here. It is important, keeping to our traditions, that we set in place laws which are apt for

our time, a time of tremendous social and technological advance. Well, that is what I came to say to you today. I would commend these issues to your attention. When the report of the Law Reform Commission on the project of privacy protection comes to hand, I would commend it, too, to your earnest consideration.