THE INTERNATIONAL ORGANISATION OF PRIVATE
AND INDEPENDENT DOCTORS
INAUGURAL CONGRESS, SYDNEY, 15 APRIL 1981

DOCTORS' CONFIDENTIALITY AND LAW REFORM

The Hon. Mr. Justice M.D. Kirby
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SUMMARY

The Australian Law Reform Commission is a permanent body established by the Australian Federal Parliament to report to the Attorney-General on the review, modernisation and simplification of federal laws in Australia. One of the reports of the Commission, Human Tissue Transplants (ALRC 7, 1977) has been widely praised, including in the British Medical Journal. Its recommendations are substantially in operation in three Australian jurisdictions and under consideration in the rest. Mr. Justice Kirby will describe the Commission and its interdisciplinary procedures. He will refer to three current projects before the Commission that are of concern to doctors, both in Australia and beyond, namely:

- Privacy protection. Protecting the privacy and confidentiality of medical records.
- Child welfare. The compulsory reporting of suspected cases of child abuse.
- Evidence privilege. The issue of whether medical practitioners should, like legal practitioners, have a special privilege against the obligation to disclose confidences in court trials or whether, as in most parts of Australia, such confidences should be subject to compulsory subpoena process, whether the patient consents or not.

Mr. Justice Kirby will be anxious to secure comment and suggestions on these topics, not only to promote a lively conference session but to assist the Law Reform Commission in its work.

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THE AUSTRALIAN LAW REFORM COMMISSION

The private and independent medical practitioner remains the key figure in the provision of health care to the Australian community. It is important that the law should reserve its relevant operation upon his activities to the minimal functions necessary to protect the interests of patients, doctors and society's interest in the success of the health care relationship. You will have matters to discuss, in many ways more beneficial to the profession and to the community, than the interface between law and medicine. But that interface is growing and there is no sign that the growth will abate. I have spoken on many previous occasions of the tremendous challenges facing the legal and medical professions in the resolution of the complex moral and social issues raised by advances in medical technology.[1] I do not propose to canvass today the medico-legal problems of euthanasia, abortion, artificial insemination, cloning, mass clinical trials, genetic manipulation and so on. Nor do I propose to speak about large areas of law reform which are already identified, but which have not yet been examined by the Australian Law Reform Commission. One of these is mental health law reform.[2] Another, specially suitable for the International Year of Disabled Persons, may be the reform of the law governing the rights of the mentally retarded.

Instead, I propose to take the opportunity of this brief encounter to tell you something about the Australian Law Reform Commission and then to examine some of the tasks which have thrown us into contact with the medical profession, in a way that will be relevant for the future conduct of private general medical practice in Australia. Specifically, I wish to speak about the project which the Commission has for the suggestion of new laws for the protection of privacy in Australia: a matter of relevance to the privacy and confidentiality of health records. I will examine briefly a task before us relevant to child welfare and child abuse. I also propose to speak of our latest task, which requires us to examine the reform of the law of evidence in Federal Courts.

One of the rules we must consider is the privilege (if any) which should attach against the involuntary disclosure to courts of medical records, containing the intimate details which are part and parcel of the health care relationship typically established between doctor and patient.

The first point to be made about the Law Reform Commission itself is that it is not a privacy committee. It is not established to evaluate the fine tuning of privacy claims. It is not limited to privacy issues, nor indeed to the medico-legal relationship. It is a permanent authority established by the Australian Federal Parliament to help the Federal Attorney-General and Parliament with what I might call the 'too hard basket' of legal problems. Though a permanent institution, it is a small one. There are 11 Commissioners, four of them full-time. There is a research staff of eight. The Commission is stationed in Sydney. At any given time it is working on about eight major projects of national law reform. The Commission receives its tasks from the Federal Attorney-General, and may not initiate its own program. In this sense, we work upon projects of legal reform which have been identified as necessary 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 in every project. The Commission publishes tentative suggestions for reform in discussion papers, distributed for expert and public comment. The issues are then debated in the public media and exposed at seminars and public hearings throughout Australia. In its six years the Commission has reported on a wide range of topics from complaints against police and criminal investigation, to Breathalyser laws, insolvency laws, defamation law reform, reform of the law of insurance, the rules governing the Census, the principles controlling the sentencing of convicted federal offenders and so on.

One of our reports was of specific relevance to the medical profession. We were asked to devise the law which should govern human tissue transplantation. Our report, Human Tissue Transplants[3], was developed under the leadership of Commissioner Russell Scott and with the participation of Sir Zelman Cowen and Sir Gerard Brennan, the latter recently elevated to the High Court. Sir Zelman and Sir Gerard were then part-time members of the Commission. The report addressed and identified the hard policy questions which had to be faced by any law on human tissue transplantation:

- How should 'death' be defined in an age of hospital ventilators?
- Should donations still be required, or could a system of 'opting out' be adopted as in France?
- Should donations to siblings of non-regenerative organs ever be permitted in the case of legal minors?

. Should specified organs (e.g. the pituitary) be available for retention following an autopsy, because of the great value of such an organ to society in the preparation of drugs dependent upon a hormonal extract or should respect for the integrity of the human body require its burial or cremation with the body?

These hard questions were faced by us. A report was delivered which was praised in the British Medical Journal and the Lancet. It has already been adopted in substance in three Australian jurisdictions. I understand it is shortly to be adopted in another State and is under consideration in the rest. The report has been translated into Spanish for use in South America: not a usual place of export for our legal ideas. It shows what can be done in law reform by co-operation between doctors and lawyers of top talent and by participation of the whole profession and the general community. We exist as a catalyst for action by short-term Parliaments, to help our political representatives to face long-term problems. A number of the Commission's reports are now being translated into law, both at a Federal and State level in Australia. Accordingly, the process we are engaged in, including today, is an aspect of the lawmaking process of our country.

THE EVIDENCE REFERENCE: MEDICAL PRIVILEGE

The chief current concern of the Australian Law Reform Commission, which is of interest to medical practitioners is the reference on privacy protection. I will come back to this. But first I wish to say something about a new but related task which has been assigned to us, to advise on the reforms necessary in the rules of evidence which are observed in Federal and Territory Courts throughout Australia. The reference is a wide-ranging one. In it, we are being led by Commissioner Tim Smith, a Melbourne barrister. Already, the Commission has distributed widely a discussion paper on evidence law reform.[4] That paper ought to have wider currency in the medical profession than it has so far enjoyed. No doctor who has ever been to court, whether on behalf of a patient (as a witness) or in relation to litigation involving himself, will have come away without some impressions of the trial system and, possibly, thought for its reform. In this, as in all our tasks, we have assembled a team of consultants ranging from judges, lawyers, a magistrate, a senior police officer to academic writers and a psychologist observer of the court scene. At a meeting of Commissioners with the consultants last month, one consultant, a senior member of the Queensland Bar, criticised the failure of our paper to address separately the interests of witnesses and their rights in relation to the giving of evidence. Another consultant, an experienced judge, suggested that the time had come for the law to enshrine the principle that witnesses should be permitted to give their own version of relevant facts, in their own terms, without interruption.

Among the issues which evidence law reform in Australia does raise are several which will be of interest to the medical profession:

- Is the adversary trial system which we have adopted from Britain the most satisfactory procedure for ascertaining the truth, or should we seek to graft on to it aspects of the judicial inquiry system which is observed throughout Europe? In short, should the judge have his own independent duty to call witnesses or summon documents or should he continue to be the neutral, rather silent umpire of the parties' battle?

- Are the psychological assumptions we make in the conduct of courtroom trials justified by modern empirical evidence? In particular, our reliance upon human memory and oral testimony of it (frequently months or years later) may be very unreliable, if current studies of memory and perception are accepted.

- Are some of the rules, devised in earlier times, which prevent relevant evidence getting before the decision-maker in the court, in tune with modern attitudes? Is it still acceptable to provide that a spouse is not compellable (or even competent) to give evidence in a trial of the other spouse? If this rule is still relevant, should the definition of 'spouse' be extended today?

- In an age where increasing numbers of records are being submitted to computerisation (including medical and hospital records) should we further amend our evidence laws to facilitate the admission of documentary computer printouts? What securities should be adopted to ensure a capacity to test and check such records, which may be as reliable only as those many hands that originally constructed them?

One issue is of specific and direct concern to doctors. At present, under Australian law, a communication by a person to a doctor is not generally protected from disclosure except by the Evidence Acts in Victoria, Tasmania and the Northern Territory.[5] In the other States and Territories of Australia, a communication by a patient to a doctor is not protected from a court subpoena addressed to the doctor. If relevant to the issues before a court, a doctor must, if so ordered, disclose his patient's confidences, whether the patient or the doctor wants it or not. Courts do not like forcing people who receive information in confidence to disclose them to the court without consent. However, at present in most jurisdictions of Australia (and in Federal Courts sitting in those jurisdictions[6]) the doctor can be compelled, against his wishes and the patient's desires, to disclose the relevant medical history in open court.

Arguments against this present position are based in part upon matters of principle and ethics and in part upon practical consideration of maximising the effectiveness of the doctor/patient relationship. In summary, the argument for changing the current law in most parts of Australia and providing an enforceable privilege to medical practitioners could be expressed as follows:

- The ethical obligation of doctor confidentiality is ancient. It dates back at least to the Hippocratic Oath. Patients give their confidences to doctors upon a reasonable expectation that they will be protected by the law. They do so at a time when they are vulnerable and highly dependent on doctors for help. Perhaps they give little thought then to possible later use in courtrooms. Certainly their overwhelming concern is to get treatment and help.

- Other relationships are currently protected and will not be interfered with by courts, except in the most extreme cases. The relationship of a client and his lawyer or of an informer and the police are no more needing of protection than the relationship of a patient and his doctor.

- Unless persons suffering from illness can approach doctors with a lawfully supported right to privacy and confidentiality, they may withhold information or even refrain from seeking treatment. The effective medical treatment of the public is at least as important as the due administration of justice. It should be given equal treatment and protection against non-consensual disclosure to courts.

- Some medical data contains specially sensitive and intimate details, the disclosure of which would positively harm either the subject's medical treatment or his reputation in society.

On the other hand, opponents of the grant of a special legal protection for medical confidences have listed a number of considerations which must be weighed by the Law Reform Commission in reaching its conclusions on this issue:

- Courts should generally have access to all relevant facts which will help it to just conclusion of the issues before them. The exceptions which prevent a court thoroughly investigating a relevant issue may reduce its capacity to ascertain the truth and thereby hinder the courts in one of their primary tasks.[8]

- The categories of absolute privilege are few and exist for very long established reasons of public policy. Police informers secure privilege because disclosure of their identity could destroy this source of information and even sometimes endanger the life of the informer. Lawyers secure it so that the very business of

adversary litigation may be done. The claims by journalists to a privilege against disclosing sources have recently been rejected by the Supreme Court of the United States[9], the House of Lords[10] and recent law reform reports.[11] It is claimed that the categories of privilege should not be extended for they impede courts doing the essential task of resolving disputes in society. If courts cannot do this successfully, social tranquility is threatened and this has a significance beyond the particular concerns of individual doctors and patients.

Already, it is claimed, there are too many impediments in the way of courts getting at the truth of matters. Extension of another impediment by way of privilege for doctors would lead on to claims by dentists, hospitals and other health providers. It would not finish there. There would be claims by others who receive information in confidence: bankers, insurers, accountants. This could result in a society in which courts were deprived of an important range of critically relevant evidence. In justifying privilege for doctors, it is necessary to distinguish others who receive information in confidence. Yet if they cannot be treated differently, we will be left with a system which results in courts deciding cases on part only of the relevant factual base. That would be bad for society which should not have to depend on whether a party consents to relevant evidence going before the court.

Finally, critics of the claim for medical privilege point out that although it is available in some states of Australia, it is not available in others. Yet there is no evidence that the lack of an enforceable medical privilege against non-consensual disclosure has diminished the capacity of doctors in some jurisdictions of Australia to receive precisely the same information as their counterparts in those jurisdictions where the privilege exists.

How do we resolve the conflict between these competing claims, each of which has merit? A recent report by the Institute of Law and Medicine in New South Wales has suggested that one way is to provide a broader discretion for weighing the claim for medical confidentiality against the claim for a trial on all relevant facts. An alternative approach is to confer on medical practitioners precisely the same privilege as is enjoyed by lawyers.[12] Of course, there is nothing a lawyer likes so much as a precedent. But the precedents in this area are themselves conflicting. The self-same House of Lords which refused to extend the law of privilege to journalists in respect of their sources not long since declared that confidential communications to child welfare agencies to prevent child abuse were entitled to a new privilege.[12]

The growth of professional counselling, and the advantage taken of it by ordinary citizens, has led to pressure to re-examine the existing privileges for confidential communications. A number of law reform reports refused to recommend any legislative change.[14] Others recommend modest legislative changes, such as extension of privilege to patent agents.[15] The Canadian Law Reform Commission proposed a broad 'general professional privilege' in its report on Evidence[16]:

> A person who has consulted a person exercising a profession for the purpose of obtaining professional services, or who has been rendered such services by a professional person, has a privilege against disclosure of any confidential communication reasonably made in the course of the relationship if, in the circumstances, the public interest in the privacy of the relationship outweighs the public interest in the administration of justice.

However, a recent Task Force, set up to endeavour to reconcile the conflicting proposals on this subject in Canada, was not convinced that the public interest would be served by enacting a privilege for communications during any professional relationship. It also rejected privilege for clerical communications. One member dissented, proposing a special privilege in respect of patient consultation with a psychotherapist.[17]

In the United States, uniform Federal Rules of Evidence were adopted in January 1975, culminating nearly 30 years of effort directed to secure reform and modernisation of this area of the law. The final draft proposed to Congress by the US Supreme Court suggested privileges to include trade secrets, lawyer-client, husband-wife, doctor-patient (but applicable only to psychotherapists), the identity of informers, secrets of state and official information. However, when the draft came before the House of Representatives these proposed provisions were deleted and the law on privilege was one of the few items left to be dealt with by different State laws, as distinct from the single uniform Federal law. The Congressional Report notes:

> From the outset it was clear that the content of the proposed privilege provisions was extremely controversial. Critics attacked, and proponents defended, the secrets of state and official information privileges. ... The husband-wife privilege drew fire as a result of the conscious decision of the Court to narrow its scope from that recognised under present Federal decisions. The partial doctor-patient privilege seemed to satisfy no-one, either doctors or patients; ... Since it was clear that no agreement was likely to be possible as the content of specific privilege rules, and since the inability to agree threatened to forestall or prevent passage of an

> entire rules package, the determination was made that the specific privilege rules proposed by the Court should be eliminated ... leaving the law in its current condition to be developed by the courts of the United States utilising the principles of the common law.[18]

There the matter rests today in the United States. Although nearly half of the States of that country have now adopted the Federal Rules of Evidence, and though it constituted a major achievement, it is sobering to think that the whole ship nearly foundered on the physician-patient privilege issue. In more than two-thirds of the states of the United States and in Puerto Rico and the District of Columbia, a physician-patient privilege has been created by statute. The terms of these statutes vary. In some, the privilege applies only in civil cases. In some it is made expressly inapplicable in actions against a physician for malpractice. In some there are provisions for waiver. In about half the states, narcotics legislation specifically over-rides the privilege.[19]

The net results of this analysis is that the law on the subject of the privilege of medical confidences is in confusion in Australia as elsewhere. At the very least, the inquiry by the Law Reform Commission should provide an appropriate vehicle to allow us to assess the competing social values at stake. It is an issue which should not be approached from a narrow viewpoint: 'the lawyers have it, therefore so should we'. The implication of the privilege should not be exaggerted. It does not exist in many Australian jurisdictions. Yet the patients still trust their doctors with intimate confidences. Courts will usually seek to protect confidential information, if this can be done. Even where privilege exists, it may be over-ridden by the relevance of facts to criminal or fraudulent conduct. Nonetheless, an important debate remains. Upon that debate we seek the views and advice of medical practitioners in Australia. I hope these views will not be tendered in a selfish spirit of narrow concerns which overlook the community's legitimate interest in courts resolving disputes normally on the basis of the best available relevant material. Specifically we would welcome information on:

- Cases where doctors have been forced unwillingly to disclose medical confidences with serious consequences for the health care relationship with the patient or for the treatment of the patient.

- Cases where doctors suspect that patients have not disclosed information important for health care, for fear of prosecution, compulsory reporting or subsequent subpoena of the doctor and his records by a court or tribunal.

- Cases where doctors have deliberately not recorded relevant data for fear that medical records may subsequently be subpoenaed by a court or tribunal and disclosure of the relevant confidence would do disproportionate damage to the patient or his treatment.

- Cases in ethnic or other isolated or close-knit patient groups where disclosure, either undercompulsory reporting provisions or pursuant to subpoena, has led not merely to embarrassment but to positive harm in the treatment of the patient or positive damage to the practice of the doctor.

Sound law reform, like medical progress, must be based on empirical data. I invite the medical profession of Australia to provide that data to the Australian Law Reform Commission to assist it in its tasks.

CHILD ABUSE: COMPULSORY REPORTING BY DOCTORS

It is not only in courtrooms that the confidentiality of the doctor-patient relationship may be eroded. The identification of the phenomenon of child abuse, a realisation of the lasting harm that can be done by such conduct, and a desire to assist, counsel, treat and (if ultimately necessary) punish some at least of those involved in child abuse situations, has led to a widespread endeavour by legislatures to impose upon relevant personnel a duty to report detected or suspected cases of child abuse. Mandatory reporting is not just an Australian phenomenon. In many overseas countries, indeed in every State of the United States, compulsory reporting legislation in some form has been enacted.

The issue comes before the Australian Law Reform Commission in connection with its inquiry into the child welfare laws of the Australian Capital Territory. The present Child Welfare Ordinance 1957 does not deal specifically with child abuse. Two Child Abuse Committees have been established in Canberra to receive, investigate and deal with reports voluntarily made. Most jurisdictions of Australia have adopted laws requiring compulsory reporting. In New South Wales, South Australia, Queensland and Tasmania legislation imposes on medical practitioners a duty to report where evidence of maltreatment comes to their notice in the course of their professional duties. In Victoria the Government has announced its decision to maintain voluntary reporting and to evaluate the results of mandatory reporting practices in the other States. In Western Australia and the Northern Territory there is as yet no compulsory reporting legislation.

An issue before the Law Reform Commission is whether the Australian Capital Territory should follow so many other jurisdictions with compulsory reporting requirements, and if so, in what terms. The submissions received by the Commission both at public hearings and in writing reflect strongly divergent views. They ranged from simplistic submissions which assume that a compulsory reporting requirement will somehow solve all of the problems of child abuse to the expressed opinion of one medical practitioner at the public hearing in Canberra that even if a law were introduced requiring compulsory reporting, he would not obey it out of respect to his 'higher' duty to the patient.

Again, this is a matter still before the Commission. It is not a matter upon which the Commission has reached any final conclusions. Our report on this subject will be published later this year. It may be helpful, however, to list in outline the main arguments that have been advanced to us both for and against compulsory reporting. In favour of the enactment of legislation requiring doctors to report suspected cases of child abuse are the following arguments:

- Children need special protection by the law, for they have fewer means to help themselves. Compulsory reporting signals society's commitment to positive steps for the protection of children, who may be specially vulnerable.

- Introduction of compulsory reporting is invariably accompanied by an increase in the cases coming to notice, although not, it should be said, much of an increase from reports by medical practitioners.

- Compulsory reporting will provide statistics upon which research can be conducted to isolate the causative factors and effective treatment of the child abuse syndrome. Otherwise, it is a problem likely to be continually swept under the carpet by an embarrassed, disbelieving society.

- The obligation to report eases the relationship between doctor or other health care provider and parents, in that the doctor or other helper can explain his report as an obligation imposed by law, not something he has volunteered to do.

- Reporting will ensure the availability of multi-disciplinary aid in a complex problem, frequently with social welfare implications. Although medical paternalism and scepticism about social welfare workers is well known, it is not justified in an area such as this which is not readily susceptible to a purely medical cure.

. Finally, it is suggested that more knowledge about child abuse as a result of compulsory reporting will generate public and political pressure for the provision of adequate services and resources necessary to break the cycle of child abuse in succeeding generations.

As against these arguments, there are many opponents of compulsory reporting. In addition to the arguments based upon a duty of confidentiality owed by a doctor to a patient and the danger of undermining this relationship by constantly adding new duties to compulsorily report (venereal diseases, poisons and drugs, shotgun wounds and now, as is suggested, cancer). The following additional arguments are put forward:

. Compulsory reporting turns doctors into agents of the state, something for which they are neither by training or inclination well suited. It undermines their image as helpers — the role for which they are trained and suited.

. Reporting may discourage parents and caretakers from seeking help, especially medical attention, for children who have been injured, because it will become known that seeking help may lead to report and even court action.

. Far from helping a child, the compulsory report may lead parents to blame the child for a report, thereby precipitating further incidents of physical abuse or prolonged emotional maltreatment.

. The provisions for compulsory reporting are virtually unenforceable, for it is difficult to prove (even if a statutory penalty is provided) that the medical practitioner ought to have known that the medical condition upon which he was concentrating could have occurred only as a result of child abuse.

. In small communities, in the many remote areas of large countries such as Australia, the fact of a report will soon get around. It is said to be contrary to Australian social mores to report a person to the authorities. Especially if the report proves to be mistaken or unfair and particularly if a charge arising out of it is later dismissed, the effect upon the reporting doctor's reputation and practice could be significant. The fear of the loss of patient patronage and consequent loss of income is not to be dismissed lightly.

Other arguments have been pressed upon the Commission urging that in lieu of a duty to report, the law should be content with provision for voluntary reporting by doctors and other health care agents: protecting bona fide reports against legal or professional actions, whether in the civil law, criminal law or professional disciplinary tribunals.

There is no doubt that child abuse is a serious, sad feature of our time. Every jurisdiction in Australia is concerned with it. The approaches taken have, as I have shown, varied. The danger to medical confidentiality as to privacy generally lies not in its overnight disappearance but in its gradual erosion. In deciding whether compulsory reporting of child abuse should be legislated, consideration must be given to weighing the impact of such a measure upon the undoubted benefits to patients and to society as a whole, of the general regime of confidentiality between those who treat and those who are treated.

THE PRIVACY ISSUE AND MEDICAL RECORDS

I now turn to the different but related issue of privacy. The Law Reform Commission is inquiring into federal laws relating to privacy. Though federal legislation on the doctor-patient relationship may be enacted in respect of Federal Courts and Federal Territories or relationships with federal agencies (including the Commonwealth Department of Health) there is no constitutional power either for an omnibus national Privacy Act or a Commonwealth statute dealing with every aspect of the privacy of the relationship of doctors and patients in Australia. Under the Constitution, the matter is overwhelmingly subject to State laws, as it is in the United States and Canada. Nevertheless, within the federal area of concern, we have put forward discussion papers with a number of suggestions, several of which have proved controversial.

One relates to patient access to medical records. Another relates to limitations on disclosure of information contained in medical records. So far as patient access is concerned, it is an aspect only of a general right of access which is the facility that has been adopted in many laws on privacy and data protection as a security for the accuracy, up-to-dateness and relevance of the data profile of the individual. In suggesting a right of subject access, the Law Reform Commission is in no way singling out the medical profession. On the contrary, the suggestion is that the right of access is a general remedy that will become increasingly important in an age of computerised data bases containing data profiles upon all of us.

Some commentators have asserted that medical records, though personal and about a identifiable patient, are in a special category and should not be subject to the general rule of access. Some opponents propose the denial of patient access on the basis of possible ill effects on the patient's health or welfare. Others suggest it may possibly reduce the inclination of practitioners (or more so hospital staff) to record, in reliable records, opinion, comment and other observations which may be useful for a total profile of the patient and for his treatment, but not suitable to be seen by the patient who could be embarrassed, hurt or confused by the entry. Others urge that a right of access would put pressure on already hard-pressed doctors and hospital staff, who do not have appropriate facilities for inspection. It is pointed out that problems of identification could arise. Where group or family records are kept together, problems of separation and possible loss of records could arise.

Some opponents have even adopted a somewhat 'mercantile' stance. One of the resolutions for consideration by a recent conference of the General Practitioners' Society reflects this approach. It read:

> That this conference believes that medical records of a doctor's opinions about any particular patient are private to that doctor and that it would be an invasion of the doctor's privacy were his written thoughts to be made available to the patient ... without the doctor's prior consent.[20]

If this rule were to become commonly accepted in record systems generally, every bureaucrat and administrator would claim that notes on individual citizens were his own notes. No matter how untrue, prejudicial, out-of-date, irrelevant or unfair they were, he could claim to deny access, without his consent, lest there be an invasion of his, the record-keeper's, privacy. It seems unlikely to me that privacy should be given such a connotation. What we are dealing with here is the power of the individual to have control over information about himself. Increasingly in the future decisions about all of us will be made on the basis not of personal interview and observation but of recorded information. It is for this reason that the laws of so many countries have adopted the general principle of the right of access. The information penumbra which surrounds us should normally be accessible to us so that we can see ourselves, literally, as others see us, in the computer. It is a matter of keeping control over the extensions of one's data personality. There may be reasons to provide for exceptions. The Freedom of Information Bill before Federal Parliament does in fact provide for certain exceptions and for intermediary access in the case of some medical material.[21] But the notion of complete denial of patient access to doctors' records on the basis of the doctor's privacy without the doctor's consent is not a notion which currently appeals to me.

If the principle of record-keeper privacy becomes paramount, we can throw the debate about subject privacy out the window. The Law Reform Commission's proposal is that a health care record keeper in federal areas should be entitled to require indirect access to an intermediary, but only when he believes that there is a risk of significant harm to the patient or to a third party if direct access is allowed.[22] The general reaction to this proposal in the public hearings held by the Commission has been favourable.

Much more controversial is the disclosure of confidential patient information to third parties, whether within large institutions, by compulsory reporting requirements to government and its agencies, to government inspectors of various kinds and to organs of peer review.

In a number of our public hearings, representatives of the General Practitioners' Society and others have come forward to make submissions addressed to all of the above issues but specially concerned with the activities of officers of the Commonwealth Department of Health. Complaints have been made of the violation of doctor-patient privacy by the manner, time and place of interrogations of medical practitioners, the seizure and removal of confidential patient files, the interrogation of patients (many of them sick old people without first asking the doctors involved[23] and even alleged victimisation of general practitioners who held out against the so-called 'health bureaucracy'.[24] Attention has been drawn to s.104 of the National Health Act 1953 which provides extremely broad powers of entry, search and seizure to persons authorised by the Minister of Health or the Director-General. No precondition of judicial warrant, given upon proof of reasonable grounds, is required in such cases. One of the factors addressed in the Law Reform Commission's discussion papers was the erosion of privacy by the proliferation of powers of this kind: doubtless intended for a good social cause but often expressed in the most ample language and without the preconditions of independent judicial scrutiny which are the special mark of those countries which take their law from England and which since Magna Carta have sought to preserve people and their property from sudden unexpected official intrusion.

The Law Reform Commission has proposed a uniform regime, requiring, normally, judicial authorisation before such powers of entry, search and seizure may be exercised.[25]

When it comes to access by Commonwealth officers to patient records for the purposes of investigating frauds against the Commonwealth revenue or other offences provided for by Commonwealth law, some diminution of doctor-patient confidentiality may be inevitable. Even in the case of legal practitioners' privilege, so well entrenched and long established, the privilege may be overridden in certain circumstances where the dealing between lawyer and client is itself fraudulent or criminal. It would appear to me to be too facile to say that a doctor's records should not be examined without his consent (or even his patient's consent) when investigating an offence alleged against the doctor or patient himself. Otherwise, we could sometimes be committing investigation and enforcement of the criminal law and breaches of statute to the consent of the very person under suspicion or other persons upon whom he may sometimes exercise influence. The Pharmaceutical Benefit Scheme of the Commonwealth currently involves payments of substantial sums by the Commonwealth, presently running at in excess of $300 million per year. Unhappily cases of frank fraud or practices forbidden by the National Health Act do occur, involving medical practitioners and their patients. Committees of inquiry have been established as an alternative to court actions against doctors, but whether in court or in a committee of inquiry, provision is made for sanctions. Sometimes, let us be perfectly frank, sanctions are entirely warranted. I have been impressed with the sincerity with which representatives of the various branches of the medical profession have asserted that their concern is not to protect the dishonest, fraudulent doctor or patient, but to ensure that in investigating cases, the privacy of patient records should, so far as possible, be guarded and secured, and the investigation limited so far as possible so that it does not unnecessarily upset sensitive, worried and sometimes highly vulnerable patients.

One matter which has been the subject of a submission by the General Practitioners' Society is the analysis of prescribing patterns followed by particular doctors. It is claimed that this intrudes upon the privacy of the relationship between doctor and patient. On the other hand, the Department of Health has put to us the contention that reports on doctors' prescribing practices are generated by computers sometimes at the request of the individual doctor and frequently for general statistical information on the use of particular drugs. The machinery, it is said, provides an opportunity for doctors to compare their own particular prescribing patterns with the average of other doctors. It is acknowledged that in some cases there are justifiable reasons for differences. But in other cases, it is claimed, there is a legitimate social entitlement to call differences to attention and even, possibly, to raise the question of irregularity. Mention was made in one submission to us of the use of Depo-Medrol. The average dispensed price of pharmaceutical benefits for this drug is less than $5 for five ampoules. The drug has a

Commonwealth dispensed price of $14.07. It is the highest priced of the relevant long-acting injections. Long-term usage of the drug is said to produce unwanted systemic effects, including so-called 'moon-face' changes. The Australian Drug Evaluation Committee has reported on adverse drug reactions. It is claimed that, in these circumstances, there is a legitimate social interest in prescription patterns, which go beyond the normal in relation to this drug. It is expensive to society as a whole. It may be potentially damaging to patients. At the very least doctors who are well out of line with the average should, so it is said, be counselled, lest they are not aware of problems and side effects.

In days gone by, before national health and computer analysis, it is true that the prescription patterns of doctors were not considered a legitimate matter of concern to Departments of Health, Commonwealth or State. One of the issues before the Law Reform Commission is whether the introduction of public funding and the potential of computer scrutiny warrants a breakdown in the absolute confidentiality of the doctor-patient relationship. I realise that some doctors have their doubts, even to the extent in some cases of resisting the use of prescription forms which facilitate computer scrutiny of the kind I have mentioned. On the other hand, there will certainly be many in our society who will say that he who pays the medical piper may call the tune, at least to the extent of protecting the revenue against clear exceptional claims and protecting patients against individual practitioner ignorance or oversight.

In advance of the delivery of the Law Reform Commission's report, and indeed of the relevant decisions, I cannot inform you of our final thinking on these topics. But two things stand out. First, the day of the medical 'lone ranger' seems to have passed. The price of public funding and escalating health care costs is inevitable pressure to monitor to some extent the conduct of medical practitioners as their practices affect the revenue: whether by frank fraud or, as is much more difficult, by eccentric prescription patterns. Secondly, the privacy of the doctor-patient relationship is still important for its success. Intrusions upon it should be few. When they occur they should be handled sensitively and always with respect for the intimacies of the patient, given usually upon an expectation that normal privacy and confidentiality will be observed.

Nobody claims that privacy is an absolute value. It is relative to other competing social claims. Working out the balance between individual privacy and the legitimate demands of modern society is a difficult process. The main point of the Law Reform Commission's papers was to show that at present the law's protections are feeble and new guardians are necessary to speak up for privacy and to defend it against ever-increasing official powers, new business methods, optical listening and other surveillance devices and above all, the new technology of informatics: computers linked by telecommunications.

I record the appreciation of the Law Reform Commission for the help which we had from the Australian medical profession in our privacy and child welfare projects. I hope that we will have as much and more help as we embark upon our new inquiry into reform of the law of evidence.

FOOTNOTES

1. See M.D. Kirby, 'Medicine, Law Reform and the Future', The Sir Henry Simpson Newland Oration, Sixth Australian Medical Congress, Launceston, 12 February 1981, mimeo; ibid, 'New Dilemmas for Law and Medicine', Malcolm Gillies Oration 1980, mimeo, September 1980.

2. ibid, Mental Health Law Reform, 20th Barton Pope Lecture, 1980, mimeo, September 1980, sub nom 'Mental Health Law Reform: The Second Wave' in Medical Journal of Australia, forthcoming.

3. ALRC 7, 1977, AGPS, Canberra.

4. The Law Reform Commission, Discussion Paper No. 16, Reform of Evidence Law, 1980.

5. ibid, 5. See Evidence Act 1958 (Vic), s.28; Evidence Act 1910 (Tas), s.96; Evidence Act 1980 (NT), s.12. The Victorian Act is typical:-

> 28(2) No physician or surgeon shall without the consent of his patient divulge in any civil suit action or proceeding (unless the sanity or testamentary capacity of the patient is the matter in dispute) any information which he has acquired in attending the patient and which was necessary to enable him to prescribe or act for the patient.

28(3) Sub-section (2) shall cease to have any application in —

(a) an action brought under Part III of the Wrongs Act 1958 to recover damages for the death of the patient; or

(b) proceedings brought under the Workers Compensation Act 1958 to recover compensation for the death of the patient —

if the person bringing or continuing the action or proceedings calls as a witness any physician or surgeon who has attended the patient.

6. Federal courts apply generally the laws of evidence of the state or territory in which they happen to be sitting. This is the result of ss.79 and 80 of the Judiciary Act 1903 (Cwlth).

7. Institute of Law and Medicine (NSW), 'The Law and Medical Confidentiality', 1980.

8. ibid, 30.

9. Bransburg v. Hays; in re Papas: United States v. Caldwell, 408 US 665, 690 (1972). Cf. in re Farber, 99 S.Ct. 598 (1978).

10. British Steel Corporation v. Granada Television Limited [1980] 3 WLR 774.

11. Law Reform Commission of Western Australia, Privilege for Journalists, Project No. 53, Perth, 1980. Cf. New Zealand, Torts and General Law Reform Committee, 'Professional Privilege in the Law of Evidence', Wellington, 1977.

12. Report, op cit n.7, summary, 5.

13. D. v. National Society for the Prevention of Cruelty to Children [1978] AC 171.

14. Canada, Report of the Special Senate Committee on Mass Media, The Uncertain Mirror, Ottawa, 1970, 105-6; Ontario Law Reform Commission, Report on the Law of Evidence, 1976, 144-6; English Criminal Law Revision Committee, 11th Report, Evidence (General), Cmnd. 4991 (1972), 157-61.

15. English Law Reform Committee, 16th Report, Privilege in Civil Proceedings, Cmnd. 3472 (1967).

16. Law Reform Commission of Canada, Report on Evidence, 1975 (Draft Evidence Code, cl. 40-41).

17. Canada, Federal/Provincial Task Force on Uniform Rules of Evidence, Report, 1981, Uniform Law Conference of Canada, 491, 493.

18. United States Code, Congressional and Administrative News. Federal Rules of Evidence with Official Legislative History, West, 1975, No. 12A, 42.

19. E.M. Morgan, 'Basic Problems of State and Federal Evidence', 5th ed (J.B. Weinstein), 115.

20. Draft resolution, in Papers for the 14th Annual Conference of the General Practitioners' Society in Australia, March 1981, mimeo.

21. Freedom of Information Bill 1979 (Cwlth), cl. 30(3).

22. The Law Reform Commission, Discussion Paper No. 14, Privacy and Personal Information, 43.

23. D.P. Mackey, Submission, Exhibit H3, Transcript of public hearings of the Law Reform Commission (Privacy Protection), Hobart, 21 November 1980, Transcript, 693.

24. ibid, Exhibit H3.

25. Law Reform Commission, Criminal Investigation (ALRC 2), AGPS, 1975, 88ff; ibid, Discussion Paper No. 13, Privacy and Intrusions, 1980, 40ff.