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WELLINGTON MEDICO-LEGAL SOCIETY

DINNER, 28 APRIL 1981

KENNEDY ELLIOTT MEMORIAL LECTURE 1981

MEDICINE AND LAW REFORM

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

March 1981

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THE KENNEDY-ELLIOTT SERIES

I am honoured to be invited to deliver the 1981 Kennedy Elliott Lecture. It is named for the foundation member and first President of this Society, who died early in 1968 and in whose memory the Memorial Lecture was established. With but two exceptions, it has been held annually since 1969. I am the fourth judge to be invited to speak in the series. It is humbling indeed to follow in the footsteps of Sir Thaddeus McCarthy, who in 1969 talked of emerging changes in the medico legal field, Sir David Beattie, now your Governor-General, who in 1971 spoke on organ transplantation, and Sir Owen Woodhouse who in 1979 discussed that most stunning of New Zealand law reforms, the accident compensation scheme.

Sir Thaddeus came to Australia last year to speak of press freedom at the American Bar Association conference in Sydney. Sir David Beattie was himself born in Sydney. He, like Sir Zelman Cowen, the Governor-General of Australia, is a law reformer of great distinction. Sir Zelman was a member of the Australian Law Reform Commission until his appointment as Governor-General designate of Australia was announced. Sir David Beattie was the author of the important report on reform of the courts in New Zealand, the great substance of which has been adopted with commendable speed, despite the inclusion of many radical and far-sighted proposals for reform. Sir Owen Woodhouse has contributed greatly to law reform in Australia as well as New Zealand. Although it is true that his proposal for an Australian Accident Compensation Act is not yet in operation, the daily evidence of the injustice of the ramshackled system of tort law compensation (even as supplemented by workers' compensation and motor vehicle insurance) convinces many thinking lawyers in Australia and beyond that the solution for the compensation and rehabilitation of victims of accidents is the solution you have innovated in New Zealand.[1]

Nearly every one of the addresses given in the Kennedy Elliott series is relevant to a task assigned by the Attorney-General of Australia to the Australian Law Reform Commission. Sir Thaddeus McCarthy's address on medico-legal changes would embrace a number of our tasks. Sir David Beattie's exploration of organ transplants foreshadowed many of the issues we had to examine in the inquiry which led on to our report, Human Tissue Transplants.[2] The legislation proposed in that report has been adopted, with some modifications, in three jurisdictions of Australia, is promised in a fourth and is under consideration in the rest. Professor Aldred's 1973 lecture on medico-legal communication and Mr. Arndt's study of the adversary system of justice in 1974 both address matters relevant to the latest project before the Australian Law Reform Commission on reform of the law of evidence in Federal courts and Territory courts in Australia. Lord Devlin, one of the foremost legal thinkers of our century, has lately criticised the adversary system which we in Australia and New Zealand inherited from Britain.[3] In the Law Reform Commission's discussion paper, we raised the possibility of grafting on to our present system certain features of the European procedures of judicial inquiry.[4] In practical terms, the debate raises the issue whether the judge should have and exercise a reserve power to call witnesses whom the parties before him fail to summon, or to require the production of documents which the parties in court fail or refuse to produce. The examination in 1975 by Sir Charles Burns of medicine, the law and alcohol explored issues which were raised by the Australian Law Reform Commission's inquiry into Alcohol, Drugs & Driving.[5] That report explored the need to push forward the use of science and technology as a means of detecting objectively the presence in motorists of dangerous levels of alcohol and also of other intoxicating drugs to which the Breathalyzer instrument is not specific.[6] In 1978 Dr. S.W.P. Mirams explored the vexed topic of psychiatry and political dissent. Although the Law Reform Commission has not yet examined mental health laws, there is certainly evidence in Australia that a 'second wave' of mental health law reform is now well under way.[7] Many more citizens are involuntarily confined to mental hospitals than to prisons in Australia. It is important that our criteria and protections for involuntary confinement in the case of mental illness should be no less sensitive and scrupulous than those which have been fashioned over the centuries for the criminal justice system.

Of Sir Owen Woodhouse's exposition of the accident compensation scheme, I need only say that the major law reform task on this subject in Australia has been done, under the leadership of Sir Owen Woodhouse himself.[8] To the usual impediments of vested interest groups, funding and effecting so radical a proposed change must, in Australia, be added certain constitutional problems because of the limited power of the Federal Parliament to enact comprehensive laws on this topic. Law reform in a federation is more difficult, some would say more exciting, than in a unitary state such as New Zealand.[9]

Finally, in 1980 Professor Weston spoke of child abuse. The next report of the Australian Law Reform Commission will be on the subject of the reform of child welfare laws in the Australian Capital Territory. In this project the Commissioner in charge of our report is himself a New Zealander — Dr. John Seymour, formerly of the Auckland Law School and now at the Australian Institute of Criminology in Canberra. Already discussion papers have been published debating the reforms necessary to achieve a child welfare system which properly balances due attention to the underlying needs of the child with the child's right to have due process of law when charged with a criminal offence.[10] The issue of child abuse and the debate about compulsory reporting by doctors and others of suspected cases of child abuse have each promoted a lively debate in Australia.[11] Four jurisdictions already provide for compulsory reporting to some extent.[12] Others provide for and protect voluntary reporting. Despite the provision of statutory obligations, the Commission has been informed that compulsory reporting of suspected child abuse cases by doctors has not increased markedly. One doctor told our public hearing in Canberra that whatever the law said, he would never breach the confidence of the patient, would always resist becoming the 'agent of the authorities' and would always see his duty as one of helping and treating those who came to him and nothing else. I have no doubt that this view is not an idiosyncratic one — and it illustrates vividly a problem when our two disciplines intersect.

I list these projects of the Australian Law Reform Commission, and measure them against the diverse and interesting topics which have been examined in the Kennedy Elliott series, to establish my credentials. The Australian Law Reform Commission has not been consigned to narrow topics of a technical character of interest to lawyers only. All of our projects have been addressed to problems of Australian society and of concern to ordinary people. Many of them, including many I have not mentioned, have been relevant to the interface between law and medicine. That interface is growing rapidly. It emphasises the importance of medico-legal societies and of the coming together of the health care and legal professions.

NEW DILEMMAS OF MODERN MEDICINE

Many puzzling, indeed intractable, medico-legal problems lie ahead. They raise the gravest moral issues that will require all the wisdom which our two old professions can offer to society and its lawmakers. These questions have been pressed upon us with increasing urgency in recent years. Our two disciplines have exhibited diffidence and uncertainty in respect of many of them: each reflecting deeply-felt divisions of opinion in the community at large.

When in 1978 Sir Roger Ormrod, a Lord Justice of Appeal in England, and himself a trained physician, delivered his sterling lecture 'A Lawyer Looks at Medical Ethics' he took an optimistic stance. First, he suggested that the problem of resolving the extremely difficult moral questions raised by advances in medical technology was in part the product of 'marked and widespread changes in moral attitudes':

> The questioning of accepted knowledge has extended to the questioning of moral attitudes, that is, of course, in the Western world, the moral teachings of Christianity. ... This means that the support of a form of authority, the accepted moral code, has largely gone with the consequence that we are now faced repeatedly with choices which have to be made by each one of us on each occasion for ourselves, where before little or no question of choosing would arise.[13]

As I have said, Lord Justice Ormrod was optimistic. He claimed that the privilege of choice facing doctors, lawyers and society at large should not be regarded as a 'regression':

> However disturbing and difficult the consequences may be, the ability to choose imposes immense responsibilities, but it represents one of the greatest achievements of humanity.[14]

No issue of this kind has provoked more widespread or passionate debate in Western countries than the issue of abortion law. The controversies which have surrounded the New Zealand attempts to legislate on this topic appear to be still very much alive in New Zealand.[15] In Australia, evidence of the passion generated by this issue was seen in the last general election where the outcome in one or more electorates depended on the attitude of the candidate to abortion law. Furthermore, an attempt by government to secure the passage of the original Human Rights Commission Bill foundered on the opposition of certain Members of Parliament to the absence of a provision guaranteeing the 'human rights' of the unborn foetus. A Bill in new form, referring to the rights of the child, was enacted in March 1981.

The counterparts to the 'right to life' movement in society are those who urge that there is a 'right to die'. Voluntary euthanasia, at least in the case of the serious ill, incapacitated and dying is not the notion of a few disturbed cranks. In England and doubtless in this country, sincere people have taken up the cause as an aspect of civil liberties. In October 1980 Exit, the British Society for the Right to Die with Dignity, published a book containing a great deal of information specifically aimed to ensure that those who attempt to kill themselves do so with efficiency and success. The London Times cautioned that people who contemplate suicide did not always do so calmly and dispassionately, taking all factors for and against into consideration.

It urged that the book could lead to unnecessary deaths and should not be published.[16] The Secretary of the British Medical Association added his voice, urging a reconsideration of the publication of the booklet. Needless to say, countless letters to the Times followed.

There is a clear line between active euthanasia, the deliberate termination of life, with the concurrence of society, generally to avoid pointless suffering, and passive euthanasia, by which people are allowed to die naturally without intrusive medical treatment. But the problems raised by this debate merge into the abortion debate when we face the dilemma sposed by the birth of a child 'monstrously deformed'. According to Professor Peter Singer of Monash University in Melbourne, doctors are increasingly facing up to the question and saying 'enough is enough'. Professor Singer is quoted as saying:

> What sometimes happens is the parents will leave the baby in hospital and eventually it will develop some form of infection, possibly pneumonia. ... The doctors will then not treat it. They could easily give it a shot of penicillin ... but they let it die.[17]

The Australian Nobel Laureate for Medicine, Sir Macfarlane Burnet, reflecting on the nearly universal taboo against discussion of death, in countries such as New Zealand and Australia argues vigorously for the right to die and in some circumstances the right to let die. He asserts, as a fact, that this already happens in Australia:

> [C]ompassionate infanticide is already standard practice where the product of birth is such as to justify the term 'monstrous', i.e. where there is a gross and physically disgusting malformation such as anencephaly (complete absence of brain). Severe spina bifida, where there is no possibility of effective surgery, is not infrequently dealt with by allowing the infant to die under sedation.[18]

To fill the gap and to seek to answer the questions raised by euthanasia in a less haphazard way, a new Bio-ethics Research Centre is being established at Monash University. Specifically, it is to address the question of whether the distinction between knowingly allowing a patient to die, and positively helping in the process, is one that is and can be preserved in medical ethics and law.

According to a Gallup Poll, 72% of Australians believe that if a patient suffering from an incurable and distressing illness wishes to end his life, a doctor should be 'allowed to supply the means'. 24% disagreed and 4% were undecided.[19] In the United States, following the Karen Quinlan tragedy, legislation was enacted in a number of States to permit an adult person of sound mind to execute a declaration which directs the withholding or withdrawing of 'extraordinary life-sustaining procedures' once he or she is adjudged to have met certain preconditions, including terminal illness.[20] In Australia, two Bills have been introduced along the same lines. In South Australia a Bill for a Natural Death Act was introduced to:

> enable persons to make declarations of their desire not to be subjected to extraordinary measures designed artificially to prolong life in the event of a terminal illness.

That Bill lapsed but I understand that it will be reintroduced. A second measure has now been introduced into the Victorian Parliament for a Refusal of Medical Treatment Act. The aim of the latter Bill is to enable persons to refuse medical treatment in certain circumstances, namely when they are 'suffering from a fatal condition and desire "not to be maintained by life-sustaining procedures"'.[21] These Bills are a sign to us that the debate has now reached the Antipodes. It seems likely that in the future it will have to be addressed by the medical and legal professions, and by the law itself, not left to the moral judgment of the individual doctor who happens to be on duty, guided by uncertain laws and not always reinforced by clear and commonly accepted moral precepts.

The so-called 'right to die' leads naturally to the debate about the definition of death itself. In his 1971 lecture, Mr. Justice Beattie spoke of this topic.[22] He pointed to the potential conflict which could arise between the duty owed to the intended donor and the effort of the transplant team to secure a healthy and viable organ. Wisely, he also mentioned the importance of securing an approach to the definition of death which would 'allay public anxiety' and 'accord with the concept which the ordinary man has of death'.[23] He mentioned the need of the professions to take the public into their confidence and asserted, correctly I am sure, that:

> the answer to bad newspaper publicity is not no newspaper publicity but better publicity'.[24]

In its exercise the Australian Law Reform Commission developed a definition of death for all legal purposes which accepted the concept of 'brain death':

A person has died when there has occurred —

(a) irreversible cessation of all functions of the brain of the person; or

(b) irreversible cessation of circulation of blood in the body of the person.[25]

Because the proposal was preceded by interdisciplinary consultations and widespread public debate, there was general acceptance of it. But to assure complete public confidence in death, diagnosed by reference to irreversible cessation of all functions of the brain in transplant cases, the Commission proposed strict preconditions. These included the consent of two medical practitioners, each of whom has carried out a clinical examination of the person, each of whom has been for a period of not less than five years a medical practitioner, and one of whom is a specialised neurologist or neurosurgeon or has other prescribed qualifications.[26] The importance of ensuring that the diagnosis should be made by doctors independent of the transplant team was also stressed.[27] The proposed definition is in operation in three jurisdictions already.[28]

In Britain, in 1980, a noisy controversy broke out following a Panorama programme on B.B.C. television criticising the adequacy of current medical practice in Britain for the determination of brain death. Ministers and the organised medical profession attacked the B.B.C. The number of kidney transplant operations in Britain fell by half following the programme, allegedly because of a fall in the availability of donors.[29] Rather than beat the air of protest, The Lancet urged that the Royal Colleges should organise an immediate study of 500 patients meeting the criteria of brain death, and then submit them to E.E.G. examination to determine whether any show evidence of cortical activity.[30] Influenced by British practice, and resistant to tying a legal draft to a particular technology, the Law Reform Commission omitted a prerequisite statutory requirement of E.E.G. examination before a legal determination of brain death could be made.[31] The British debate illustrates the importance of lawyers and doctors having a clear understanding of the problems and practice of the other, where their disciplines intersect. This is not to say that we should write E.E.G. examination into our laws. Medical knowledge is advancing and changing with such rapidity that particular specific criteria or equipment embedded in a statute may well become outmoded or obsolete, yet remain legally compulsory.[32] But where language of generality is used in the law, it is important that the medical profession adopt adequate checks to assure consistency of practice with proper standards. Otherwise self-discipline will give way, under public pressure, to discipline by others.

In March 1981 the second Australian 'test tube' baby was born. There is no doubt that the development of in vitro fertilisation requires urgent attention to deal with important and complex legal problems.[33] But there are many even more exotic subjects awaiting our consideration. I have said nothing here of the dilemmas raised by the possibility of cloning.[34] The special problems of the ageing in our nursing homes were recently called to notice by a Sydney magistrate.[35] These problems will surely increase with the demographic shift to the aged in both Australia and New Zealand.[36] I have said nothing about cancer treatment, the right of the patient to know and the duty of the doctor to explain a diagnosed condition and the nature and risks of treatment proposed.[37] I have said nothing about the consent of young persons to medical treatment, although we all know that this is a subject of great moral and legal uncertainty. It has been the subject of a number of law reform reports.[38] I have not mentioned the dilemmas of the surrogate mother. I have barely hinted at the problems of genetic engineering, the first of which came last year before a bemused and divided Supreme Court of the United States.[39]

MEDICAL PRIVACY

The issue which has caused the liveliest debate between the medical profession in Australia and the Australian Law Reform Commission arises from a general reference given to the Commission by the Attorney-General of Australia on the subject of laws for the protection of privacy. The concerns of this project go far beyond the particular problems of medical privacy and the confidentiality of doctor-patient files. They extend into the growing powers of officialdom to enter, search and seize property; new business methods which involve intrusive practices; optical and listening devices and other modern means of surveillance and the general increase in the computerisation of personal information, with its capacity to create a total 'data profile' on the individual, upon the basis of which important decisions will be made by government and by business. Tentative proposals for federal legislation in Australia have been put forward in two discussion papers of the Commission.[40] In the course of debating the general problem, a number of issues relevant to the medical profession are raised:

- Should patients generally have a right of access to medical and hospital records about themselves and if not, with what exceptions, according to what principle and with what alternative safeguards for accuracy and up-to-dateness as personal medical records are increasingly computerised?

- Should a parent have a right of access to medical information about a child, and if so, to what age and with what exceptions if the child claims a privilege to have advice on intimate personal medical problems kept confidential with the doctor?

- What rules should be followed to ensure respect for individual privacy in the conduct of scientific research? Should informed consent of the patient be required and subject access guaranteed?[41] Is there a danger that a requirement of specific consent may prevent epidemiological and other medical research on anonymous hospital and medical records, such as the research done which showed side effects in the use of oral contraceptives? The latter research was the result of large-scale studies in which hospital and medical records were used, and which would have been impossible to carry out had the actual consent of the patients been required.[42]

- Should courts have an unlimited right of access to personal medical files, as in most jurisdictions in Australia, or should there be a privilege against disclosure to the court, without the patient's consent as in some Australian jurisdictions[43] and as provided under s.8 of the New Zealand Evidence Act 1908? Should this privilege be extended from civil trials to criminal cases, so that people with problems of drug addiction and sexual deviance may nonetheless seek out medical help without the risk of compulsory disclosure to a criminal court.[44]

- Are psychiatric records, with their specially intimate disclosures, in a particular class? Should safeguards as to notice to the patient be introduced whenever a patient's records are subpoenaed by the Crown or third parties?.

The patient's entitlement to access to medical and hospital files, must be seen as one aspect only of a general right of access. This is the facility which 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 Australian 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 an 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.

DOCTOR'S PRIVACY?

Some medical opponents have even adopted a somewhat 'mercantile' stance. A resolution for consideration at a recent medical conference in Australia 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.[45]

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 the Australian Parliament does in fact provide for certain exceptions and for intermediary access in the case of some medical material.[46] The New Zealand Committee on Official Information contemplated exemptions to protect the privacy of individual citizens and public health and safety.[47] But the New Zealand report did not deal with the limitations (if any) which should exist upon individual access to medical data about himself in the hands of government. It is clearly an issue for future debate in New Zealand.

The notion of complete denial of patient access to doctors' records, whether held by a government or private doctor or hospital, based on the claim of the doctor's or hospital's privacy without the doctor's or hospital's consent, is not a notion which currently appeals to me. If the principle of record-keeper privacy becomes paramount, we can probably throw the debate about subject privacy out the window.

The Australian Law Reform Commission's proposal is that a health care record keeper 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.[48] The general reaction to this proposal in the public hearings held by the Commission throughout Australia 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 the public hearings of the Australian Law Reform Commission, representatives of the General Practitioners' Society in Australia 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 Australian Department of Health. Complaints were 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[49] and even alleged victimisation of general practitioners who held out against the so-called 'health bureaucracy'.[50] Attention has been drawn to s.104 of the National Health Act 1953 (Aust) which provides extremely broad powers of entry, search and seizure to persons authorised by the Australian 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 Australian 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 Commission has proposed a uniform regime, requiring, normally, judicial authorisation before such powers of entry, search and seizure may be exercised.[51]

When it comes to access by government officers to patient records for the purposes of investigating frauds against the revenue or other offences provided for by law, some diminution of doctor-patient confidentiality seems 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 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 Australian Pharmaceutical Benefit Scheme currently involves payments of substantial sums by the Commonwealth, presently running at in excess of $300million per year. 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. 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 bitter controversy in Australia is the computer 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 Australian Department of Health has argued before the Law Reform Commission 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 the drug 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 the facility of computer analysis, it is true that the prescription patterns of doctors were not considered a legitimate matter of concern to Departments of Health. One of the issues before the Australian 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. Many doctors in Australia resist these developments, even to the extent in some cases of refusing to use prescription forms which facilitate computer scrutiny of the kind I have mentioned. On the other hand, there will certainly be many in Australia and, I suspect New Zealand, who would 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 this debate, which is continuing, 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 this conduct impacts 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 Australian Law Reform Commission's papers was to show that in Australia at present the law's protections are feeble and new guardians are necessary to speak up for privacy and to defend it against erosion. I expect that in New Zealand you will need to turn, in due course, to the same debates.

FACING THE DILEMMAS: THE ROLE OF LAW REFORM

Parliament, courts and medical congresses rarely provide a suitable forum in which to gather the interdisciplinary expertise and widespread community participation necessary to provide long-term solutions to the problems I have listed in this address. Nor can medico legal societies usually do more than identify problems and explore their boundaries briefly and within the proper social purposes they fulfil. We in Australia have developed in the Law Reform Commission an unlikely but, so far successful, institution to help lawmakers face up to some of the problems. Released from courtroom limitations, armed with a team of consultants from all branches of the medical profession, theologians, moral philosophers and others, we can face up to many of the acutest dilemmas of our time. Moreover, we can provide guidelines and laws that will benefit doctor and patient and the community as well. I well remember the days when Sir Zelman Cowen (now Governor-General) and Sir Gerard Brennan (now a Justice of the High Court of Australia) sat at the table of the Law Reform Commission. With the top medical talents of the country, some of the best lawyers contributed to the solutions for one particular dilemma, namely the law for human tissue transplantation. These solutions were submitted to public hearings and professional seminars in all parts of Australia. Television and radio were used to present the issues and to raise community appreciation of the vexing problems at stake. In the end, a report was drawn in which the options were clearly stated. On one or two of the issues, the Commissioners themselves divided. But the legislative arm of government was helped in a unique interdisciplinary way to face up to the issues involved. The result has been legislation both at a State and Federal level and more is promised. Clear guidance was given to all involved: patients, their relatives, hospital staff and medical practitioners.

I do not pretend that all of the issues which I have mentioned are susceptible to easy resolution. Some intractable problems do not even submit to ready debate and discussion. Others will never result in consensus, however informed and however sincere the participants. But many do. And many will require attention in the decade ahead. On the issues such as I have listed tonight, our parliamentary representatives on both sides of the Tasman need help. It is a matter of satisfaction to me that the Australian Law Reform Commission in some of its tasks has been able to translate the splendid idea of the medico-legal society into a practical catalyst for detailed research, widespread consultation and, then, legislative action. There is no doubt that in years ahead much more action will be needed.

FOOTNOTES

1. See G. Palmer, Compensation for Incapacity: A Study of Law and Social Change in New Zealand and Australia, O.U.P., Wellington, 1979. Cf. T.G. Ison, Accident Compensation, Croom Helm, London, 1980.

2. Australian Law Reform Commission, Human Tissue Transplants, (ALRC 7), 1977.

3. Lord Devlin, The Judge, O.U.P., 1979, 60.

4. Australian Law Reform Commission, Discussion Paper No. 16, Reform of Evidence Law, 1980 (ALRC DP 16).

5. Australian Law Reform Commission, Alcohol, Drugs & Driving (ALRC 4), 1976.

6. Cf. New Zealand Road Safety Committee, 'Blood-Alcohol and the Demerit Point System', Report to the House of Representatives, 1968 (Mr. D.J. Carter, Chairman).

7. M.D. Kirby, 'Mental Health Law Reform: The "Second Wave"', in Medical Journal of Australia, April 1981, forthcoming. See also the address by Mr. J. McLay, Minister of Justice, Wellington School of Medicine, repoprted Auckland Star, 19 March 1981, 10.

8. Australia, National Committee of Inquiry into Compensation and Rehabilitation, Report, 1974.

9. Palmer, n.1 above.

10. Australian Law Reform Commission, Discussion Paper No. 9, Child Welfare: Children in Trouble (ALRC DP 9), 1979.

11. ibid, Discussion Paper No. 12, Child Welfare: Child Abuse and Day Care (ALRC DP 12), 1980.

12. ibid, Child Welfare (ALRC 18), 1981, forthcoming. Compulsory reporting is provided for by the Child Welfare Act 1939 (NSW), s.148C; Community Welfare Act 1972-1979 (S), s.82d; Health Act 1937-1948 (Qld), s.76M and Child Protection Act 1974 (Tas), s.8(1).

13. Sir Roger Ormrod, 'A Lawyer Looks at Medical Ethics', in (1978) 46 Medico-Legal Journal, 18, 21.

14. ibid.

15. See e.g. J.B. Elkin, 'Definition Issue in the Abortion Row', in Auckland Star (N.Z.), 22 December 1980.

16. The Times (London), 18 October 1980 ('The Road to Dusty Death').

17. Cited the Age, 19 November 1980.

18. Sir Macfarlane Burnet, 'Endurance of Life: The Implications of Genetics to Human Life', 1978, 96. Cf. P.J. Kearney, 'Medical Wisdom and Ethics in Treatment of Severely Defective Newborn and Young Children', ed D. Day, Eden Press, Montreal, 1976, 60.

19. Australian Public Opinion Polls (The Gallup Method), 4 December 1979, Poll No. 06/6/79.

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