AUSTRALIAN PRIVATE HOSPITALS' ASSOCIATION

FIRST NATIONAL CONGRESS

SYDNEY, 22 JUNE 1981, 2.45 P.M.

DOCTORS, HOSPITALS AND THE COURTS

OR THE VIEW FROM THE WITNESS BOX

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

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THE AUSTRALIAN LAW REFORM COMMISSION

I have half an hour in which to cover a number of related topics which are of great complexity but which will become of increasing importance in Australia's private hospitals and for the medical and para-medical staffs who man them. The theme of your Congress is 'Into the Future'. Well, that is the business I am in. Taking our laws, our lawmakers and the legal profession into the future may be harder even than the job that faces your profession. Occasionally, in my more frustrated moments, I wish there were available a beneficial anaesthesia which could be administered, to overcome the attitudes, red tape and other impediments that stand in the way of prompt law reform. That will not be. Accordingly, reforms must be justified in the open and piloted through the political process. In a sense, that is why I am here today : to tell you of some of the work of the Law Reform Commission as it may affect your discipline.

Let me say, first of all, a few things about the Commission itself. It is a permanent authority established by the Commonwealth Parliament to help the Commonwealth Attorney-General and Parliament with what I might call the 'too hard basket' of large and difficult problems. Though it is 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 established 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. It may not initiate its own programme. In this way, it works 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 which are distributed 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 Commission has reported on a wide range of topics from complaints against police and criminal investigation, to Breathalyzer laws, insolvency laws, defamation law reform, reform of the law of insurance, the rules that should govern the census, the 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 in Australia.

A number of our reports have seen close co-operation between the lawyers of the Commission and the Australian medical, hospital and nursing professions. We were asked, for example, to devise a law which should 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. The report faced many hard questions. When delivered, it was praised in the British Medical Journal and the Lancet. The draft legislation attached to the report has been adopted, in substance, in three Australian jurisdictions. I understand that it is shortly to be adopted in another State. It is under consideration in the rest. This report shows what can be done in law reform by co-operation between doctors and lawyers of top talent and by participation of the general community. The Australian Law Reform Commission is a catalyst for action by short-term parliaments. It helps our political representatives to face profound, long-term problems.

ISSUES RELEVANT TO HOSPITALS

A number of the Commission's projects are relevant to the concerns of private hospitals and the medical and para-medical staff of those hospitals. I mention four examples:

- The report on Criminal Investigation dealt in detail with the rules which should govern the powers of entry, search and seizure by Federal police.[1]

- The project on privacy protection, which is still current, is concerned with the regime which 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.

- Our project on child welfare laws in the A.C.T., upon which we are about to report, has required us to consider the question of compulsory reporting of suspected cases of child abuse. The duty of confidentiality to the patient may be diminished by a duty compulsorily to report particular diseases or suspected signs such as child abuse. Without such a report, a multi-disciplinary attack on the problem may never be possible.[2]

- Finally, our current inquiry, directed towards the development of a Federal law of evidence for the Federal courts in Australia, requires us to re-examine the scope of professional privilege, including that for the doctor and other health care provider. 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 the laws of evidence, and other rules, acknowledge that there are competing social interests which, even at the loss of the discovery of truth, must be upheld, for example, to defend confidences shared with a professional health provider.

PRIVACY LAW REFORM : PATIENTS' ACCESS TO RECORDS?

The Commission is now moving towards the completion of its report on privacy protection laws at a Federal level in Australia. 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 the modern Australian community. The first, Privacy and Intrusions[3], dealt with such matters as:

- the growing power of government intrusions by way of statutory authority to enter, search and seize property;
- the growing capacity of surveillance inherent in the facility of telephonic interception, listening devices, optical scrutiny and so on; and
- unregulated areas of private intrusion which cause concern, including telephone canvassing, direct mail advertising, the sale of address lists and so on.

The second discussion paper, Privacy and Personal Information[4], is of more immediate relevance to this audience and of greater long-term significance. It deals, above all with the potential danger to privacy arising from the growing computerisation of personal information. It suggests new laws for the security of personal information, for the rules by which information may be kept and the duration of its maintenance. It also suggests a general statutory right of access to personal information about oneself

with exceptions clearly provided for by law. It is this right which has formed the core of overseas privacy protection laws in North America and Western Europe. It is a right that is already partly embraced by the Freedom of Information Bill which is passing through the Federal Parliament. It 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.

Since the Law Reform Commission published its proposals along this line, most Australians have supported in principle this regime of openness. It is when it comes to the application of the principle to their particular personal information system that the problems start. It is suggested that there must be exceptions for national security and defence material. That appears just. It is suggested that there must be exceptions for police information. Obviously disclosing informers would destroy the source of information and much police effectiveness. It is suggested that the professional confidences of lawyers must be excluded. It is also suggested that medical and hospital records must 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.

In the United States, the general rule has been adopted by law that federally aided hospitals must give patients access to their hospital records. Many objections were raised to this notion when it was first introduced. Some objections related to the costs. Others raised issues of principle. However, in addition to the Federal laws granting patient access, a number of States of the United States have now adopted the same principle, giving the patient a right to inspect and in some instances obtain copy of his hospital record. 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. Some cover only hospital records. In some cases the hospital authorities determine how much of the medical record the patients may see. The experience of Federal hospitals under the Privacy Act of the United States would appear to allay fears about the number of requests for patient access and the costs of administering such access. At a Federal level, with a total estimated hospital patient population of 5 million, requests by patients for records from the Bureau of Medical Services numbered only about 3,000 in the first three years.

One consideration which has sparked the calls for changes in the law on this subject is the enormous increase in the bulk of personal medical and hospital information held in our society. 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 charges. Security, confidentiality and privacy were protected by this system. The physician was usually able to elaborate intimate private details of the patient's medical and emotional condition from the 'safe crevices of his mind'. A recent report of the United States Privacy Study Protection Commission puts this modern problem in these words:

> In contrast, a modern hospital medical record may easily run to 100 pages. The record of a family physician may still hold information on ailments and modes of treatment, but also now note the patient's personal habits, social relationships and the physician's evaluation of the patient's attitudes and preferences, often in extensive detail.

That abuse can occur is clearly demonstrated in the same United States report. It points out that:

> Hospital records are routinely available to hospital employees on request. Most of these people are medical professionals who need such access in order to do their jobs, but not all of them are. Besides the physicians, 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 programmes conducted either by the medical-care institution itself or affiliated with the institution. These people, too, have access to medical records for training or job-related purposes, as do non-professional employees and voluntary workers.

Attention is drawn to one 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. It 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 hospital security measures'. The question we have to ask is whether this kind of abuse could happen or has happened here in Australia. The Hospital and Allied Services Advisory Council was concerned that it could.

There are other problems in addition to the burgeoning growth of medical hospital records now abetted increasingly by computerisation. The obligation to answer subpoenas, the increasing inquiries by insurers and researchers all procure information which would formerly have been thought strictly private and confidential. The list of notifiable diseases and conduct expands. The reasons for securing this information increase in our interdependent society. Again, it is useful to look at the United States 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 600-bed university teaching hospital testified that he receives an estimated 2,700 requests for medical record 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 relating to claims for reimbursement by health insurers.

Modern hospital administrators, whether in public or private hospitals, large or small hospitals, computerised or manual hospitals, anxious to uphold at least sufficient privacy so as not to damage the trusting relationship that is vital for proper health care of the community, must attend to these concerns. The United States President's report on privacy recommended many new laws to protect privacy in United States medical and hospital health care. These proposals arose from that Commission's conclusion that:

> The medical care relationship in America today is becoming dangerously fragile as the basis for an expectation of confidentiality with respect to records generated in that relationship is undermined more and more. A legitimate, 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 in which future Australian privacy laws affecting your profession will move.

EVIDENCE LAW REFORM : VIEW FROM THE WITNESS BOX?

Now, let me change tack to a related but different topic. I refer to our inquiry into the law of evidence in Federal courts in Australia. Such an inquiry may seem remote to the concerns of your Conference and to hospital care. But it is not. It is a matter upon which the Commission, with small resources, is at the threshold of very important decisions. They are decisions which will affect your operations and we will be glad for your participation in them.

Until now, in Australia, Federal courts have applied the law of evidence of the State in which they happen to be sitting. The growth in the number of Federal courts, the expansion in their importance and jurisdiction and the ease of modern travel may make it important to develop a single new law of evidence applicable throughout the country in those courts. This was done in the United States in 1975. The resulting Federal Rules of Evidence have been adopted not only at a Federal level but also now in about half the States of the United States. Our inquiries may lead to similar changes in Australia. It is therefore important that we get our conclusions right.

On this subject too, the Commission has issued a discussion paper inviting public and expert comment. Among the questions raised by the discussion paper are the procedures we adopt in the taking of evidence in court, the adversary trial and the very purpose of the courtroom trial. Should courts be searching for the truth? Or should they have no greater duty than to solve the issue in controvery brought to them by the parties : whether the Crown or private litigants?

I imagine that there are many serving in hospitals throughout Australia, whether in the medical profession or otherwise, who have come to give evidence at court and been struck by the procedures which lawyers adopt. A frequent complaint made by witnesses is that they simply cannot hear what is going on in court. The judge and the barristers, 'repeat players' in the courtroom drama, know what they are about. Though the courtroom is given to the public, the lawyers do not always conduct themselves in such a way that they can be heard throughout the courtroom. Sometimes, when the drama is raised, of course, the participants can be heard beyond the courtroom. But often the muted exchanges between the Bench and the Bar table get lost and parties, witnesses and mere observers get forgotten in the lawyers' endeavour efficiently to despatch the court's business. It is vital, as it seems to me, that courts should not only normally be open to the public but that the public should be able to hear, and if possible to understand, what is going on. Some judges make it their business, especially when members of the general public are present, to ensure that this principle is observed.

In the past, reforms of the law of evidence have been very much lawyers' business. Judges, practitioners and law teachers have battled away for this view or that. Should spouses be able to give evidence for the prosecution against another spouse? Should they be exempt from that embarrassment or compellable or merely permitted if they choose? Should children's complaints in criminal cases require corroboration to be acceptable? Should unsworn evidence from the dock be permitted in a criminal trial? Or should this historical relic of the time when the criminal accused could not given evidence at all, be abolished as it has been in Western Australia and New Zealand?

There are many similar questions that are raised by our inquiry into evidence law, some of them originating from the growing computerisation of records and the need to modify the strongly oral tradition of the trial system which we have inherited from Britain.

A recent study in Canada is reported to have shown a deep-seated prejudice in the legal profession against research about how the law actually operates. This prejudice was explained by a research director in the following terms:

> Amongst practising lawyers, there seems to be a lack of understanding of fundamental research. There is an overwhelming pragmatism. ... Law exists if it can be applied in the courts and if a judge will accept it. Research into speculative areas is not so much law but something else. The problem is that legal education does not encourage lawyers to [research]. The medical profession went through a similar crisis many years ago before attitudes changed. Now there is a lot of medical research that does or that does not produce any immediate apparent benefit to the doctor in his office. Yet the doctor's attitude towards research is positive.[5]

Attitudes amongst lawyers in Australia to research of this kind may not be altogether difficult from those in Canada. The Australian Law Reform Commission has frequently found scepticism and even frank opposition to research about how the law actually operates in practice. We are not deflected by this opposition because it is vital that law reforms which are to last should be based upon a thorough-going understanding of the actual operation of the legal system in practice. It should take into account the views of those who will be the subject of the law, the 'law consumers' if you like. In the field of evidence law reform, the subjects of changes to the laws of evidence are, potentially, <u>every</u> member of society. Relatively few people will get through life without going to court as a witness, as a litigant or as an observer. It is therefore important, in a society increasingly well educated and demanding rationality in its laws and legal procedures, that the laws of evidence should have regard to the perceptions of what is fair that exist in the community generally.

It is for that reason that we are keen to add to the view of evidence law reform that will be received from expert lawyer, judge, psychologist and policeman, the perceptions from the witness box. It is vital that we get the assistance of witnesses, including expert witnesses from hospitals, from the medical profession and other branches of the health care professions, who come to court and have views about the appropriateness of what they find there when they arrive. The manner in which expert testimony is received, tested and evaluated in our courts, is an obvious example. The procedures for the subpoena of documents is another. The way in which evidence must overwhelmingly be given by oral testimony in court, with busy witnesses waiting often long and unexplained intervals for the convenience of the court, is yet another. In Europe much more business in the courtroom is done on written material. The written word may be read on average four times more quickly than oral testimony may be given. It involves less inconvenience to witnesses. Yet it is impossible to cross-examine a written page. The opportunity to scrutinise and test in open court by adversarial procedures the evidence of witnesses has long been held to be a key virtue of our trial system. A German judge has written a paper for the Legal Convention to be held in Hobart in the next few days. He asserts that the trial system of England and Australia, when compared to the judicial inquiry system of courts in Europe, is a Rolls Royce compared to a 'dusty Volkswagen'. But he asks the significant question : how many of us can afford a Rolls Royce and when do we need a Rolls Royce in preference to a Volkswagen?

PROFESSIONAL CONFIDENTIALITY

I have said that the Law Reform Commission is looking at the subject of evidence law reform with a view to basing its proposals upon an understanding of how things actually operate. One of the issues before us is one upon which you may be able to help. Until now, in most parts of Australia a communication by a person to a doctor or other health care provider is not generally protected from disclosure to a court of law. Exceptions to this general rule exist under the Evidence Act of Victoria, Tasmania and the Northern Territory[7], but even in those jurisdictions medical confidences must be disclosed to criminal courts. The privilege does not apply in civil proceedings where the sanity of the patient is in issue. Furthermore, it exists only in respect of a communication with a medical practitioner. All courts seek to avoid invasions of confidential communications. But in point of law, the protection of a patient's confidences in Australia rests on shaky ground. It is not so in the United States where most of the States provide a legally enforceable protection against non-consensual disclosure, even to a court, of a patient's intimate health details.

One of the questions we must ask in the Law Reform Commission's inquiry is whether we should go down the same track as the United States.

The arguments for the extension to patients of a privilege akin to that enjoyed by lawyers' clients are based in part on matters of principle and ethics and in part on a practical consideration of maximising the effectiveness of the health care relationship:

. The ethical obligation of health care providers is ancient. Patients reveal information at times when they are vulnerable and highly dependent.

. Other relationships such as lawyer and client or police and informer are no more important than the relationship of health care provider and doctor.

. Unless people suffering from illness can approach their doctors with a guarantee of confidentiality, they may withhold information.

On the other hand, opponents of the grant of a special legal protection for health confidences have listed a number of important considerations that must be weighed:

. Courts should generally have access to all relevant facts to help them to a just resolution of the issues before them.

. The categories of absolute privilege are few and should not be expanded. An attempt to expand the categories to journalists against the disclosure of their sources was recently defeated in the United States and in Britain.

. If the health care relationship were privileged, it would not stop there. Bankers, insurers, accountants and others receiving confidential information would seek an extension to them.

. Although some protection exists in some parts of Australia, there is no evidence that the lack of an enforceable health privilege against non-consensual disclosure has diminished the capacity of doctors and hospitals in those jurisdictions where the privilege does not exist, to provide assistance.

NEED FOR DATA : AN APPEAL FOR HELP

To assist the evaluation of these arguments for and against a health care privilege in courtrooms, the Law Reform Commission has appealed for information on the practical operation of the current law. The kind of information we need is as follows:

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

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

- Cases where the health care provider has deliberately not recorded relevant data for fear that medical or hospital records may be subsequently subpoenaed by a court or trial 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 under compulsory 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 hospital or doctor.

Any other observations on the reform of the law of evidence with perspectives from the witness box will assist the Law Reform Commission to put forward proposals to the Federal Parliament which do not suffer from lawyerly myopia. It will be vital, as we move to reform the laws governing the procedures of our courts, that we take into account the views of witnesses, litigants and the consuming public generally. On the specific subject of health care privilege, sound law reform, like sound medical progress, must be based on detailed factual data. My principal purpose in coming here today is to tell you of the way in which we operate and to appeal for your support and assistance both as health care providers and as citizens.

FOOTNOTES

1. Australian Law Reform Commission, Criminal Investigation (ALRC 2) (Interim), 88ff.

2. Australian Law Reform Commission, Child Welfare : Child Abuse and Day Care (Discussion Paper No. 12), 25ff.

3. ALRC DP 13, 1980.

4. ALRC DP 14, 1980.

5. Canadian Bar Association, National, June 1981, 6.

6. W. Ziedler, Paper for the Australian Legal Convention, Hobart, July 1981, unpublished.

7. Evidence Act 1958 (Vic), s.28; Evidence Act 1910 (Tas), s.96; Evidence Act 1980 (NT), s.12. See generally Australian Law Reform Commission, Reform of Evidence Law (Discussion Paper No. 16, 1980, 5).