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TO DISCLOSE OR NOT TO DISCLOSE:

MEDICAL CONFIDENTIALITY AND THE HEALTH INFORMATION PRIVACY CODE 1994

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ABSTRACT

This paper looks at the rule against disclosure, together with some of its exceptions, as set out in rule 11 of the Health Information Code 1994, and compares it with the legal position in New Zealand prior to the Privacy Act 1993 and the above mentioned Code. The object is to determine whether or not the Code has made a difference, and if so, to what extent.

The paper shows that the Code reflects the existing law with regard to confidentiality of "health information", and that there are only a few minor additions to the law as it was before. The conclusion is reached that even though the Code has not made significant changes to the law with regard to the disclosure of "health information", it has made a considerable difference by having the legal position clearly set out in a statutory document, and by being backed by the Complaints Procedure of the Privacy Act. An unlawful disclosure of "health information" can now easily be redressed, whereas this was not previously the case.

The text of this paper (excluding contents page, footnotes, and bibliography) comprises approximately 14,600 words.

I INTRODUCTION

The Privacy Act 1993 came into force on 1 July 1993 and has as one of its main purposes the promotion and protection of individual privacy in general accordance with the 1980 OECD Guidelines on the Protection of Privacy and Transborder Flow of Personal Data.[1]

Shortly after the enactment of the Privacy Act 1993, a temporary code[2] concerning health information was released. The Health Information Privacy Code 1994 (hereinafter called "the Code") replaced the temporary code in late 1994 and provides stringent controls on the collection, use and disclosure of medical and health information by agencies within the health sector. The code was issued at the Commissioner's own initiative[3] because he was aware of the urgent need of an early emphasis on privacy in the health and disability sector.[4] It has been recognised that health information is a particularly sensitive type of information for which there was only haphazard protection under (previously) existing legislation and professional ethics.[5]

The Code covers the same ground as the Information Privacy Principles in the Privacy Act. In some respects the obligations under the Code are more stringent than those in the Information Privacy Principles. At the heart of the Code are 12 "health information privacy rules"

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1 B Slane "Update on the Impact of Privacy on Medicine and the Law" Address by the Privacy Commissioner to Second Annual Medico-Legal Conference, 20 April 1994, Auckland, in *Health Information & Privacy in New Zealand. A Compilation of Health Information-related Materials on the Privacy Act 1993 and the Office of the Privacy Commissioner July 1992-May 1995* (Auckland, 1995) 52.

2 Codes of practice can be issued under Part VI of the Privacy Act 1993.

3 See s 46 of the Privacy Act 1993.

4 B Slane "Health Information, Privacy, Confidentiality and Medical Ethics" Address by the Privacy Commissioner at the Wellington School of Medicine, 9 February 1994, in *Health Information & Privacy in New Zealand* 26.

5 "Changes to Privacy of Information Bill",22.3.93 in *Privacy: New Zealand. A Compilation of Materials on the Privacy Act 1993 and the Office of the Privacy Commissioner Vol Two February 1994 to December 1994* (Auckland,1995) 246.

(together with 11 operative clauses) which replace the 12 Privacy Principles of the Privacy Act. Each rule refers to "health information" and "health agency" and therefore only applies to health agencies and only to those agencies in their dealings with health information. In their dealings with non health type personal information (such as employee information) health agencies will have to be aware of obligations under the more general Information Privacy Priciples.[6]

The Code is embedded, as it were, in the Privacy Act and must therefore be read together with other parts of the Act that are relevant to health information.[7] The complaints procedure, for example, which is set out in Part VIII of the Act, is crucial when a rule of the Code has been breached.

Rule 11 of the Code is entitled "Limits on Disclosure of Health Information" and deals with the right of an individual to control the disclosure of his or her own health information to third parties. Rule 11 is one of the more important rules, and the one that departs to the greatest degree from Principle 11 in the Privacy Act. It is also the longest rule and has the greatest number of exceptions.[8] Prior to the Privacy Act and the Health Information Privacy Code, the obligation upon doctors[9] not to disclose (or to disclose) information about patients, was governed by medical professional ethics, legislation, and by the common law.

The purpose of this paper is to consider various aspects of the disclosure of health information, and, by examining both rule 11 of the Health Information Privacy Code (and any other, relevant

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6 B Slane "What you must know about privacy" Address by the Privacy Commissioner to the Health Sector Risk Management Conference, Auckland, 19 October 1993 in *Health Information & Privacy in New Zealand* 19.

7 Some of these parts are printed as an appendix to the Code. Extracts from Part VIII, however, are not included.

8 "Beyond the Temporary Code" in *Health Information & Privacy in New Zealand* 72.

9 This obligation did not apply exclusively to doctors and could also apply to other health professionals and health workers.

provisions of the Code or the Privacy Act 1993) and medical confidentiality as it existed prior to the Code, to determine whether the Code has in fact made a difference, and if so, to what extent. The length of this paper precludes a detailed discussion of all the exceptions listed under rule 11(2), and for this reason some of them have deliberately been omitted, in order to concentrate on those that would more easily be associated with confidentiality prior to the enactment of the Code.[10]

II TO WHOM DOES CONFIDENTIALITY APPLY ?

A Health Agencies Bound by the Code

The term "health agency" is defined in clause 3(1) by cross-reference to clause 4(2), which sets out the "agencies" to whom the code applies. The main agencies are those providing health and disability services. Many of these agencies will be health professionals, both registered and unregistered who provide health services or disability services. Under this heading are also Crown Health Enterprises (CHEs) and other licensed hospitals, ambulance services, old people's homes and the blood transfusion service[11]. Employees of such agencies are also included. Other classes of agencies include purchasers of health services (such as the RHAs, and the Public Health Commission), and the Accident Rehabilitation and Compensation Insurance Corporation (ACC). Clause 3(1) has been added to the definition in clause 4(2), namely that for the purposes of rule 11 a health agency that no longer provides health and disability services is included, as well as the personal representative of a health agency (being a natural person) who at the time of his death held any health information. The net is cast very wide: one could probably safely say that anyone who comes into contact with the health information of an identifiable

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10 The following exceptions have been omitted: rule 11(2)(a);(c);(e);(f);(g);(h) and (k). The writer also admits that the exceptions chosen for discussion represented a personal choice of those which seemed to be more important or more interesting. It is felt that a discussion of those that were omitted would not have changed the conclusion that is ultimately reached.

11 Commentary to the Code 7.

individual in the scope of his or her employment or volunteer service, or is still in possession of such information, would be considered an agency for the purposes of the Code.

B Persons to whom Confidentiality Previously Applied

Prior to the Privacy Act and the Code confidentiality with regard to health information applied particularly, but not exclusively, to doctors. They were (and still are) bound by professional ethical codes[12], and may also have had statutory[13] and common law[14] duties not to disclose such information. Other health professionals, such as psychologists, nurses, dentists and physiotherapists, may also have been bound by their respective professional ethical codes[15], as well as having possible statutory and common law duties not to disclose information. Other health workers and employees who, in the scope of their employment or volunteer service, came into contact with the health information of identifiable individuals, may also have had a duty of keeping such information confidential, but only if a statutory[16] requirement applied to them, or if confidentiality was a term of their employment contract, or if they were bound by a common law duty[17]. The doctrine of vicarious liability would also have found application in this context, so that an employee of a health professional, such as a receptionist, would also have been bound by the duty to keep information confidential.

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12 See below part VI B.

13 See below part VI C.

14 See below part VI D 1-6.

15 See, for example, the Nursing Council of New Zealand's "Code of Conduct for Nurses and Midwives" January 1995, principle 3.4, which deals with confidentiality.

16 See above part VI C 2. Confidentiality applied to the employees of the institutions to which the Hospitals Act 1957 and the Area Health Boards Act 1983 related.

17 The most obvious example would be where a fiduciary relationship could be established. See part VI D 5.

Prior to the Code there could possibly have been persons who, although they would now be classified as "health agencies" by the Code, were not under any duty not to disclose the health information of an identifiable individual. The Code has ensured that no one who deals with the health information of identifiable individuals in the scope of his or her profession, employment, or volunteer service is omitted from the category of "health agencies".

III CONFIDENTIAL INFORMATION

The Code is concerned with a wide range of information or classes of information about an identifiable individual. Clause 4(1) sets out exactly what health information includes. Health information is divided into five groups. The first four include the following: information about the health, medical history, disabilities of and health and disability services provided for that individual, or information derived from the testing or examination of any body part or any bodily substance of that individual. The fifth group consists of information about that individual which is collected before or in the course of, and incidental to, the provision of any health or disability service to that individual.

Prior to the Code information which would have been considered as confidential in the context of medical confidentiality would have been covered by the first four groups listed in clause 4(1). This would have included information on patient records, namely information given orally by the patient, information given by others, information generated by the doctor from his own obsevervation (diagnosis and prognosis), and information acquired from X-rays, pathology tests etc.[18] However, the fifth category mentioned above, namely information about that individual which is collected before, or in the course of, and incidental to the provision of any health or disability service to that individual, expands the scope of health information that was previously considered as confidential. It means,

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18 J M Jacob "Confidentiality: the Danger of Anything Weaker than the Medical Ethic" (1982) 8 Journal of Medical Ethics 18.

in effect, that information such as an individual's name, address, telephone number, ethnicity, religion and billing information is included here.

Should a doctor now wish to disclose a patient's name, address and billing information to a debt collector, or warn another doctor that a patient is a bad debtor, these disclosures will have to meet the requirements of rule 11, seeing that such information is included in "health information".

Information such as religion and membership of RSA which, until recently, was routinely collected on admission forms of patients at hospitals and then disclosed to enable chaplains[19] and volunteer workers to visit these patients, are examples of such "incidental" information. The Code and a general awareness of privacy issues have led to a change in such procedures. Admission forms now inform patients of the purpose for which information such as religion is being collected[20] and enable patients to indicate whether they wish this information to be disclosed to the relevant chaplains.

IV DECEASED PERSONS

An individual is defined by the Privacy Act 1993 as meaning "a natural person other than a deceased natural person"[21]. Clause 4(1) of the Code provides only that the Code applies to "an identifiable individual". Rule 11, however, makes it clear that the rule concerning disclosure applies equally to living and deceased individuals. Subrules 1(a)(ii) and 1(b)(ii) of rule 11 use the words "where the individual is dead", and subrule 5 provides that "this rule applies to health information about living or deceased persons.." Subrule 6 further states that rule 11 "applies to health

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19 "Issues Paper no 1: Hospital Chaplains and Health Information" in *Health Information & Privacy in New Zealand* 124.

20 See rule 3(1)(a)-(c) of the Code.

21 Section 2.

information about any identifiable deceased person, for not more than 20 years after the day of that person's death".

This subrule reflects the traditional ethical principle stated by the British General Medical Council (GMC)'s *Blue Book*[22], paragraph 91:

> The fact of a patient's death does not of itself release a doctor from the obligation to maintain confidentiality.

This principle is echoed in the NZMA's revised *Code of Ethics* of 1989 which mentions that it is a principle of ethical behaviour to "protect the patient's secrets, even after his or her death".[23]

In 1984, Stephen Lock, editor of the British Medical Journal, discussed the position of disclosures about the health of public figures and historical documents.[24] After receiving a letter from the GMC noting that an obituary notice had disclosed confidential medical information about the late General Orde Wingate whose cerebral malaria had led to an attempt at suicide, the GMC emphasised that the death of the patient did not absolve the doctor from the obligation of confidentiality. Lock's reaction was to defend medical journalists and historians, quoting Lord Moran's disclosures about the health of Winston Churchill.[25] The GMC finally agreed that it was not improper to reproduce information already "on the record" in books or in court proceedings.

Prior to the Code the legal position, apart from this ethical principle, was not altogether clear. Kennedy and Grubb[26] point out

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22 *Professional Conduct: Fitness to Practise* (February 1991).

23 D Collins *Medical Law in New Zealand* (Brooker & Friend Ltd, Wellington, 1992) 3.

24 D Cole *Medical Practice and Professional Conduct in New Zealand* (School of Medicine, Auckland,1988) 21-22.

25 Lord Moran, in a biography of Churchill, disclosed details of the strokes and other illnesses which he suffered while in office. See IE Thompson "The Nature of Confidentiality" (1979) 5 *Journal of Medical Ethics* 60.

26 I Kennedy and A Grubb *Medical Law: Text with Materials* (2 ed, Butterworths,London, 1994) 643.

that the crucial question is whether the right to have information kept confidential is a right which passes as a chose in action to the estate. However, there seems to be no case law on this point.

Rule 11(5) of the Code confirms the ethical rule, namely that the disclosure of health information of deceased individuals should be treated in the same way as that of living individuals. The limitation of 20 years after an individual's death (subrule (6)) represents an addition to the ethical rule, as no such limitation existed before. One should note, however, that the disclosure of information about public or well known figures may well be permissible without the consent of the individual, under subrule (1)(d), namely that the source of the information is a "publicly available publication".

V CHILDREN

A Children, Disclosure and Representatives in the Code

The Privacy Act 1993 defines "individual" merely as "a natural person" and does not make specific reference to children.[27] The same applies to the Code. The implication is that children are to enjoy equal rights of privacy with adults. Rule 11(4)(b)(i) and (ii) provide that a health agency, when requested to disclose information by a representative of an individual in terms of the Health Act section 22F(1)[28], may refuse to disclose such health information to the representative if the disclosure would be contrary to the individual's interests or the agency has reasonable grounds for believing that the individual does not or would not wish the information to be disclosed.[29] The Code defines the "representative"

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27 S 2. See also "United Nations Convention on the Rights of the Child: Initial Comments from the Office of the Privacy Commissioner" in *Privacy: New Zealand* 98.

28 This section provides that information must be disclosed upon the request of the individual about whom the information is held, or a representative of that individual or any other person who is providing or about to provide health or disability services to that individual.

29 A typical example of such a refusal would be in the case of child abuse or sexual abuse, where the information may reflect badly on the parent or caregiver.

of an individual under the age of 16 years to be his or her parent or guardian.[30] This definition is inconsistent with the Guardianship Act 1968 which provides that guardians have the authority to make medical decisions on behalf of children under 16 who are not capable of making their own decisions. The Code uses the alternative concept of "parent" which is not synonomous with that of a guardian. Parents do not always have legal rights to control the upbringing of a child.[31] This inconsistency complicates a situation which is already fraught with difficulties.

Subrule 2(b)[32] of rule 11 provides that health information may be disclosed if disclosure is "by a registered health professional...to the principal caregiver or a near relative of the individual concerned in accordance with recognised professional practice and the disclosure is not contrary to the express request of the individual". This implies that a child of any age may veto disclosure. It has been reported that in 1994 Middlemore Hospital decided not to tell a mother about her 14 year old daughter's miscarriage on the basis that to do so would be a breach of the Privacy Act. The parents were critical of the decision but the hospital respected the capacity of the 14 year old to be treated as an independent person with independent rights of privacy.[33] In connection with this case the Privacy Commissioner commented that doctors have always had their own code of ethics and "have not always revealed all information about children under 16 to their parents".[34]

In a draft paper, *Privacy Issues and Patient Records*[35], the NZMA has the following to say on the subject:

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30 Clause 3(1).

31 M Henaghan "Children and Privacy" Address at Privacy Issues Forum 1995, Wellington, 29 June 1995, 5.

32 See below part VII B 1.

33 Above n 31, 4.

34 "Privacy Laws Just Commonsense: Slane", in *Health Information & Privacy in New Zealand* 88.

35 1995.

> **Children Also Have A Right To Privacy**
> While a parent or guardian has no general right of access to their (sic) children's medical records, a medical practitioner can disclose health information on receiving a request from a parent or guardian where that information is required to provide the child with health services. Medical practitioners must however have regard to the express wishes of the child concerned. Information must be disclosed only to a nominated person or principle care-giver.....

Neither the Code nor the above comments of the NZMA solve the dilemma a doctor would find himself in if a young child does not wish health information to be disclosed to a parent or guardian. The only guideline seems to be the age of 16 years. The Health Act 1956 has been amended so that section 22C(3) now provides that for the purposes of principle 11(d) of the Privacy Act 1993, the disclosure of health information about an individual may be authorised by that individual personally, if he or she has attained the age of 16 years (or by a representative of that individual). This does not solve the problem of how old children younger than 16 years should be in order to deny parents access to health information about themselves. It was hoped that the Privacy Commissioner would address this issue in the permanent code[36], but this was evidently not the case.

B The Law with Regard to Children's Decisions

As long as a child is *prima facie* incompetent to form a relationship of confidentiality, the welfare of such a child is best served by others coming to know what the doctor has learned. Ordinarily it will be the parents who need to know so as to care for their child[37]. This concept of parental autonomy is widely accepted[38], and in the face of this, a doctor would need very strong reasons for not disclosing what has been learned. The "best interests" of the child will

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36 H Patterson "Doctors Come to Grips with Privacy Code" in *Health Information & Privacy in New Zealand* 25.

37 Above n 26, 641.

38 J K Mason and R A McCall Smith *Law and Medical Ethics* (Butterworths,London,1983) 102.

therefore create a strong presumption in favour of disclosure.[39]

The moral dilemma about disclosure occurs when dealing with a child who has the capacity both to consent to treatment and to enter into a confidential relationship. Kennedy and Grubb[40] are of the opinion that a breach of confidence may be justified if the doctor can show that disclosure is in the "best interests" of the child. There is, however, no statutory duty in New Zealand to disclose to parents.[41]

As mentioned above, the dilemma facing a doctor would occur when a child below the age of sixteen requires advice or treatment but does not wish his/her parents to be informed. Issues such as pregnancy or contraception, and more recently, AIDS, would be good examples.

In *Gillick v West Norfolk and Wisbech Area Health Authority*[42] the Court of Appeal in England held that a girl under 16 could not give valid consent to contraceptive treatment without her parents' consent, and ruled that a circular issued by the Department of Health and Social Security to the Area Health Authorities to the effect that a doctor consulted by a girl under 16 would be acting lawfully if he prescribed contraceptives to the girl, was too liberal. This decision was reversed by the House of Lords.[43] As a result of this decision, the GMC revised its guidance to doctors, to the effect that if the doctor is satisfied that the child has the maturity and ability to understand, and the child refuses to allow a parent or such other person to be told, the doctor must decide, in the patient's best medical interest, whether or not to offer advice or treatment, and whether or not to disclose the information learned from the

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39 Above n 26, 641.

40 Above n 26, 642.

41 Above n 31,19.

42 [1985] 1 All ER 533 (CA).

43 [1985] 3 All ER 402. See above n 24, 24.

consultation[44].

The guidance by the GMC is in keeping with good medical ethics as it indicates that the obligation of confidence comes into existence in the case of a competent child - one who is capable of exercising autonomy. In the case of a competent young girl, her parents are third parties and she may legally exercise control over the information she gives to the doctor by binding him to secrecy. In the case of an incompetent young girl, her parents can exercise control over information which the doctor learns from her, in that way, on her behalf, and can prevent him from disseminating it to third parties, such as the press. This right to control arises from the more general right which parents have so as to be able to carry out the duties they have to their children. In this case, the duty is to protect the child's privacy and welfare[45].

The common law position is therefore that a child's capacity to understand the nature of the decision is the determining factor, and not a particular age.

Article 12 of the 1989 United Nations Convention on the Rights of the Child, which New Zealand ratified in 1993, emphasises that where children are able to, they should have a right to express views freely on all matters that affect them, and that due weight should be given to such views in accordance with the "age and maturity" of the child. Article 16 states that no child shall be subjected to arbitrary or unlawful interference with his or her privacy. On the other hand, article 5 also requires respect for the responsibilities, rights and duties of parents or members of the extended family to provide appropriate directions and guidance for the child's exercise of the rights "...in a manner consistent with the evolving capacities of the child".[46] The decision will never be easy for a doctor to

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44 I Kennedy "Confidentiality, Competence and Malpractice" in R Byrne (ed) *Medicine in Contemporary Society* (King's College, London, 1986-1987) 41.

45 Above n 44, 45.

46 Above n 31, 3.

make. In the UK a Dr RJ Brown was charged with improperly disclosing to the father of a 16 year old girl that she had been prescribed an oral contraceptive by the Birmingham Brook Advisory Centre. The dismissal of the charge by the GMC Disciplinary Committee was commented on with approval in an editorial of the *BMJ*[47], as reaffirming that the doctor has an obligation to act in the way he judges to be in the best interests of his patient, but it was later criticised by a senior barrister who insisted that Dr Brown had violated his patient's confidence![48]

Section 3 of the Guardianship Act 1968 defines "upbringing" as including the education and rights of a child. Personal information about a child is part of that child's upbringing. Section 25 gives statutory recognition to the independent decisions of young persons: a young person of 16 years and over can give independent consent to any medical, dental or surgical procedure.[49] Section 25A, however, places no restriction on a female child in respect of her consent or refusal to consent to an abortion.[50]

The Children, Young Persons and Their Families Act 1989 provides that in respect of care and protection, the welfare of the child shall be paramount. Section 5 provides that "the principle that consideration should be given to the wishes of the child or young person so far as those wishes can reasonably be ascertained...having regard to the age, maturity and culture of the child or young person".[51]

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47 "A case of confidence" Editorial (20 March 1971).

48 Above n 25, 62.

49 Cf s 22C(3) of the Health Act 1956, mentioned above part V A. See also V D Plueckhahn and S M Corder *legal Medicine and Forensic Pathology (2 ed Melbourne University Press, 1991)* 98, who point out that in the common law a medical practitioner may not disclose the condition of a child of sixteen years or above to the parents without the child's consent.

50 L O'Reilly "Children's Rights and Privacy - the Impact on Care and Protection" Address at Privacy Issues Forum 1995 (Wellington, 29 June 1995) 2.

51 Above n 50, 3.

The Commissioner for Children, Laurie O'Reilly,[52] feels that children's rights can be reconciled with parental rights and responsibilities, and has suggested that for the purposes of privacy issues, by analogy to the Gillick approach, authority could be given by either the child or the parent acting on behalf of the child. By having regard to the Guardianship Act 1968, the Children, Young Persons and Their Families Act 1989, and the United Nations Convention on the Rights of the Child, the potential for parental input can be considered, but the guiding test must be whether disclosure is in the interests of the child. Henaghan,[53] on the other hand, feels that as long as a young person understands the issues, such a young person has independent status to make the decision and determine his or her own best interests. Once capacity to decide is reached, a young person's decision should be respected.

It must still be conceded that the general law governing the rights of children and the rights and obligations of parents and representatives is rather unclear and unsatisfactory[54]. By giving equal rights of privacy to children, without clearly setting out the circumstances under which a parent or representative's decision may override the wishes of a young child, means that the Code has made the already difficult and nebulous situation worse. It has placed health agencies on a journey between Scylla and Charybdis: on the one hand there is the danger of breaching the Code and on the other hand the danger of depriving the child of the guidance and care of a parent or guardian. "Best interests" is at best a vague concept, but even such guidance, as well as a clear indication of a particular age, such as 14 or 16 years, ought to have been set out in the Code.

VI THE RULE AGAINST DISCLOSURE

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52 Above n 50, 12.

53 Above n 31, 6.

54 Office of the Privacy Commissioner "Health Information Code: Issues Paper No 3. Children-Young Persons-Representatives" in *Privacy: New Zealand* 260.

A Limits on Disclosure of Health Information

Rule 11 of the Code sets out the basic obligation not to disclose health information of an individual to third parties:

> "A health agency that holds health information must not disclose the information...."

This is followed by a list of six qualifying statements ("unless the agency believes, on reasonable grounds...") which are not exceptions (these are enumerated in subrule (2)(a) to (k)), but serve rather to define the scope of the confidentiality:

> (a) That the disclosure is to the individual concerned or the individual's representative. This confirms that confidentiality is concerned with disclosure to a third party and not the individual himself, which is actually self-explanatory.
>
> (b) That the disclosure is authorised by the individual or his representative. Consent obviously releases a health agency from the obligation of confidentiality.
>
> (c) That the disclosure is one of the purposes in connection with which the information was obtained. This would include instances where information is required for aspects of care and treatment[55]. The reasoning is that of presumed consent.
>
> (d) That the source of the information is a publicly available publication. The reasoning here seems obvious. It would be ridiculous to complain that a health agency has disclosed information if that information is already public knowledge!
>
> (e) That the information to be disclosed concerning a patient in hospital consists of only the most basic facts such as location and condition, and the individual has not forbidden such disclosure. This qualification shows that confidentiality does not normally include absolute secrecy as to where a patient finds himself and whether he is dead or alive!
>
> (f) That the information to be disclosed concerns only the fact of death and is by a registered health professional[56] or

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55 Commentary on the Code 31.

56 The Health Information Privacy Code 1994 Amendment No 2 amends the definition of a "registered health professional". It now has the meaning given to it by section 4 of the Health and Disability Commissioner Act 1994. This means that a

> someone authorised by a health agency to a person whom it is reasonable in the circumstances to inform. This is rather obvious, for without such disclosure it might not even be possible to locate the deceased's representative.

Subrule (1) can therefore be seen as a rather lengthy definition of what confidentiality includes or excludes. The qualifications in (a) to (f) are rather obvious, in the sense that they could almost be taken for granted. However, a detailed description is given ex abundanti cautela.

The obligation not to disclose, as set out in rule 11, has always been known as "medical confidentiality". Medical confidentiality previously enjoyed only limited legal protection[57] under medical professional ethics, legislation and the common law.

B Medical Ethical Codes

For doctors, the obligation of confidentiality has mainly been an ethical one embodied in medical ethical codes. The earliest source is contained in the Hippocratic Oath of Ancient Greece, dated around the fifth century BC, and part of it reads as follows:

> Into whatever house I enter, I will go into them for the benefit of the sick. Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge as reckoning that all such be kept secret.[58]

More recent codes have developed from this Hippocratic Oath. The Declaration of Geneva, adopted by the World Medical Association in 1948, is more stringent:

"registered health professional" will now be taken to refer also to certain persons who are receiving training or gaining experience under the supervision of a registered health professional.

57 See below part VIII for the legal protection under the Code.

58 S McLean & G Maher *Medicine, Morals and the Law* (Gower Publishing Co Ltd, Hampshire, 1983) 173.

> I will respect the secrets that are confided in me even after the patient has died.[59]

This was followed by an international code of ethics in 1949,[60] prepared by the World Medical Association:

> A doctor owes to his patient absolute secrecy in all which has been confided in him because of the confidence entrusted to him.[61]

The British Medical Association (BMA) states in its *Handbook of Medical Ethics*:

> A doctor must preserve secrecy on all he knows.

(This injunction is followed by a list of five exceptions).

The New Zealand Medical Association (NZMA) has endorsed each of the international codes, and the obligation of confidentiality is recognised in its 1979 reprint, *Medical Ethics and Etiquette*, which states:

> 5.1.1. The basis of the relationship between a doctor and a patient is that of absolute confidence and mutual respect. The patient expects his doctor not only to exercise professional skill, but also to observe secrecy with respect to the information he acquires as a result of his examination and treatment of a patient.
>
> 5.2.1 It is the practitioner's obligation to observe strictly the rule of professional secrecy by refraining from disclosing voluntarily without consent of the patient (save with statutory sanction) to any third party information which he has learnt in his professional relationship with the patient.

In 1989 the NZMA revised its Code of Ethics. The preamble to the Code states that it is a principle of ethical behaviour to "protect the

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59 M Brazier *Medicine, Patients and Law* (2 ed Penguin Books, 1987) 44.

60 Also 1968 and 1983.

61 Above n 23, 3.

patient's secrets, even after his or her death"[62], and (under the heading "responsibilities to the patient") to "....keep in confidence information derived from a patient or from a colleague regarding a patient, and divulge it only with the permission of the patient except when the law requires otherwise".[63] Although membership of the NZMA is not compulsory, these rules are binding on all doctors because they may be subject to disciplinary procedures involving professional conduct.[64]

C Statutory Obligations of Confidentiality

1 Medical privilege

The common law, as distinct from legislation, provides that doctors can be compelled to give in evidence information they acquire in confidence from their patients.[65] In the UK it has recently been recognised that the common law confers a discretion on Judges to refuse to compel a doctor to disclose confidential information. Medical privilege is the immunity which some medical people have from disclosing in court proceedings certain communications from patients.[66] A doctor can be subpoenaed to give evidence but he can only withhold material from a court where his patient's communications are protected from disclosure by privilege. However, in contrast to the position in the UK, medical privilege in New Zealand has been governed by legislation since 1885.[67] The Evidence Amendment Act (No 2) 1980 provides for medical evidence in the course

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62 Above n 23, 3.

63 V Hammond "Health Records and Information: Access, Disclosure and Confidentiality" LLM Research Paper, VUW, 1992, 8.

64 M Jeffcoat "Medical Confidentiality" LLM Research Paper, VUW, 1985, 60.

65 "Doctors,Drivers and Confidentiality" (1974) 1 *British Medical Journal,* 399.

66 Above n 23, 1.

67 Above n 23, 9.

of legal proceedings.

Section 32 of that Act provides that no registered practitioner or clinical psychologist shall, without the consent of the patient, disclose in any civil proceeding any protected communication which the patient believed to be necessary to enable the registered medical practitioner or clinical psychologist to examine, treat, or act for the patient.[68] This protected communication is narrowed down by the exclusion of communications made for any criminal purpose and those in respect of proceedings in which the sanity, testamentary capacity or life insurance is the matter in dispute. In *Pallin v Department of Social Welfare*[69] Somers J at 276 stressed that a communication made to a medical practitioner could only be protected if the person who made it *believed* the communication to be necessary in order to be examined or treated. He said that such communication must include words and writings and also gestures or signs providing a response to inquiries made of a patient by the practitioner.

Section 33 provides that no registered medical practitioner or clinical psychologist shall, without the consent of the patient, in criminal proceedings, disclose communications made to him by a patient for the purpose of treating drug dependency or any other condition or behaviour that manifests itself in criminal conduct.

Section 35 is a general provision which confers a discretion upon courts in any proceedings to exclude what would otherwise be admissible evidence on the grounds of confidentiality.[70] The court must have regard to the special relationship between the witness and the person from whom the information was obtained, and must also decide whether or not the public interest in having the evidence disclosed outweighs the public interest in the preservation of confidence between persons in the relative positions of the confidant and the witness. Section 35 may be invoked to exclude doctors and

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68 See above n 63, 34.

69 [1983] NZLR 266.

70 Above n 23, 24.

some paramedical people from giving evidence in communications that are not specifically prohibited by sections 32 and 33.[71]

The legal protection offered by medical privilege, as set out above, obviously pertains only to a limited range of confidential communications and only in judicial proceedings. The definition "protected communication" is also restricted to information the patient tells the doctor and does not cover information which the doctor discovers from a physical examination or blood tests.

2 Health workers

Both section 62 of the Hospitals Act 1957 and section 50 of the Area Health Boards Act 1983 contained the basic prohibition (as well as exceptions) that employees (and former employees) of a Hospital Board or an Area Health Board must not disclose information concerning the condition or history of any patient without the prior consent of the patient. This meant that a statutory duty of confidentiality applied to all employees (and former employees) of public hospitals. In 1993 the Area Health Boards Act 1983 as well as large parts of the Hospitals Act 1957 were repealed.

D The Common Law Duty Not to Disclose Information about Patients

1 Breach of confidence

The confidentiality of the doctor-patient relationship is protected by the common law, although there is little in the way of case law where this issue has had to be decided. There are dicta that simply assume that this is correct. In *W v Egdell*[72] Scott J said of the psychiatrist in question: "The question in the present case is not whether Dr Egdell was under a duty of confidence; he plainly

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71 Above n 23, 25; also above n 63, 34.

72 [1990] 1 All ER 835.

was..."[73] Mason and McCall Smith[74] point out that if the Hippocratic principle has the strength of a moral or ethical doctrine, the words of Lord Coleridge CJ[75] may apply: "A legal common law duty is nothing else than the enforcing by law of that which is a moral obligation without legal enforcement". They suggest that the right of the patient then depends upon the court's view of the moral position of the medical profession overseen in the UK by the GMC which has a very great authority based on statute. The alternative would be to view the Hippocratic principle as a mere statement of medical etiquette, offering no protection to a patient.

However, it is generally accepted that the duty which may be owed by the doctor at common law is not the duty which is imposed on him by any code of professional ethics.[76] A doctor who breaches the legal obligation of confidentiality owed to a patient can possibly be liable in damages for breach of confidence. Breach of confidence, an action which has been recognised in English law since the early nineteenth century[77], is not limited to those relationships that are traditionally viewed as involving trust and confidence, such as doctor-patient, solicitor-client, employer-employee, banker-customer, etc. The courts look at the circumstances in which information has been imparted to determine whether such a duty exists, as well as the scope of that duty.[78] In *A.G v Guardian Newspapers (No 2)*[79] Lord Goff said at 658 that equity will intervene to protect confidences when three requirements are met, namely a) the information must have the necesssary quality of confidence about it; b) it must have been

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73 See also M Jones *Medical Negligence* (Sweet & Maxwell, London, 1991) 46.

74 Above n 38, 95.

75 *R v Instan* [1893] 1 QB 450 at 453.

76 RJ Paterson "Aids, HIV Testing, and Medical Confidentiality" (1991) 7 Otago Law Review 390.

77 D Laster "Breaches of Confidence and of Privacy by Misuse of Personal Information" (1989) 7 Otago Law Review 32.

78 Above n 77, 38.

79 [1988] 3 All ER 545.

imparted in circumstances importing an obligation of confidence; and c) there must be unauthorised use of that information to the detriment of the person who communicated it.[80]

The jurisprudential basis of the action for breach of confidence has long been debated. Property, contract, tort and equity have all been suggested as appropriate bases for the action.[81]

2 Negligence

Doctors are considered to have a common law duty of care not to disclose confidential information about their patients (without their consent) to third parties.[82] A breach of this duty of care gives rise to an action in tort for damages. It would, however, have to be foreseeable that disclosure of that information would cause the patient harm. In *Furniss v Fitchett*[83] a doctor was found to be liable in negligence for forwarding a written statement, relating to the patient's soundness of mind, to the husband of the patient. The document was subsequently produced in proceedings between the husband and wife for separation and maintenance. Burrowclough CJ relied upon "the general conception of relations giving rise to the duty of care" to find a duty in tort.[84]

3 Contract

In some instances, it is possible to identify a contractual relationship between a doctor and patient, and an implied term of the contract may be that the doctor shall not disclose confidential

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80 Above n 73, 46.

81 Above n 77, 33.

82 Above n 49, 98.

83 [1958] NZLR 396.

84 Above n 77, 41.

information about the patient.[85] In *Parry-Jones v The Law Society*[86] Diplock LJ said at 180:

> What we are concerned with here is the contractual duty of confidence, generally implied though sometimes expressed between a solicitor and client. Such a duty exists not only between solicitor and client, but, for example, between banker and customer, doctor and patient, and accountant and client.[87]

Likewise, in *Duncan v Medical Practitioners Disciplinary Council*[88] Jeffries J said at 520 that the concept of professional confidence..."on a strict analysis of legal relationships,...is probably contractually based".

The consideration for the contract is the fee which the patient impliedly promises to pay and for which he may be sued.[89] Such a contractual duty would only be able to exist in the case of a fee paying patient in a private consultation, but not between a doctor and patient in a hospital situation.[90] This means that a contractual relationship cannot always be relied upon between doctor and patient.

4 Property

Another possibility is that the duty of confidentiality may be regarded as having a proprietary foundation. This means that the information remains the property of the patient and that breach of confidence consists of the unauthorised dealing with the property of another.[91] It is commonly recognised that patients have a proprietary

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85 Above n 49, 98.

86 [1968] 1 All ER 177.

87 Above n 23, 28.

88 [1986] 1 NZLR 513.

89 Above n 49, 98.

90 Above n 73, 46; see also P Sieghart "Professional Ethics - For Whose Benefit?" (1982) 8 Journal of Medical Ethics 28; see also above n 76, 391.

91 Above n 64, 55.

interest in the information contained in their health records, even though health providers maintain proprietary ownership of the original records.[92]

5 Fiduciary duty (equity)

The fundamental basis of a doctor's duty not to disclose confidential information about patients is the concept of fiduciary obligation [93]. In *Duncan v Medical Practitioners Disciplinary Council*[94] Jeffries J said at 520: "The platform support of a description of medical confidence is to identify the doctor/patient relationship as a fiduciary one". A duty of confidence frequently arises from a relationship between a professional person (such as a lawyer or accountant) and the client. In *Day v Mead*[95] Cooke P, referring to the solicitor-patient context, said at 451 that "breach of confidence is usually classified as a subject of equitable jurisdiction".[96]

6 Invasion of privacy

Apart from breach of confidence there is also an action for invasion of privacy. In 1890, when the American scholars Brandeis and Warren[97] argued for a general right of privacy, they referred to *Prince Albert v Strange*[98] (the earliest case which expressly recognises breach of confidence as well as a right of privacy) to show "that the common law has for a century and a half protected privacy in certain cases".[99] The United States came to recognise a tort for the invasion

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92 Above n 63, 14.

93 Above n 23, 28.

94 Above n 88.

95 [1987] 2 NZLR 443.

96 Above n 76, 391.

97 SD Warren and LD Brandeis "The Right to Privacy" (1890) 4 Harvard Law Review 193.

98 (1849) 1 Mac & G 25; 41 ER 1171.

99 Above n 97, 213.

of privacy as a result of the Brandeis and Warren article. In 1986 invasion of privacy was recognised as a potential tort in New Zealand in *Tucker v News Media Ownership Ltd*[100] and the court relied on American decisions. Tucker sought and obtained an interim injunction against News Media to prevent it from publishing any information about Tucker's prior convictions. At the time Tucker was much in the public eye because of a public fund raising campaign to pay for him to have a heart transplant in Australia. The basis for relief was the tort of intentional infliction of distress and alternatively the tort of invasion of privacy. Jeffries, at 731-732 said:

> I am aware of the development in other jurisdictions of the tort of invasion of privacy and the facts of this case seem to raise such an issue in a dramatic form. A person who lives an ordinary private life has a right to be left alone and to live the private aspects of his life without being subjected to unwarranted, or undesired, publicity or public disclosure...In my view the right to privacy in the circumstances before the Court may prove the plaintiff with a valid cause of action in this country.

7 Has the common law been superseded by the Code?

In *Hobson v Harding and others*[101] Thorp J stressed that the Privacy Act and the Code have not codified the law relating to privacy and have therefore not superseded the common law rights in the same area. He referred to section 115 of the Privacy Act and said that if the Act did replace the common law there would be no need to enact a specific exception to common law liability under principle 6. Section 115(2) refers to "the law relating to...breach of confidence" which acknowledges the continued existence of this common law tort.

It is still possible to pursue compensation through the court system by means of a civil claim based on a common law action[102], but this

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100 [1986] 2 NZLR 716.

101 Unreported,6 March 1995, High Court, Auckland,CP312/94. See also "Privacy Issues in Medicine" Address by Privacy Commisoner to Third Annual Medico-legal Conference, Wellington, 30 March 1995 in *Health Information & Privacy in New Zealand* 101.

102 See above part VI D 1-6 and part VIII B. See also above n 4, 29.

may not now be the best option available because of the availability of an alternative means of pursuing a remedy by lodging a complaint with the Privacy Commissioner.[103]

VII EXCEPTIONS TO THE OBLIGATION NOT TO DISCLOSE

A Statutory Provisions Authorising or Requiring Disclosure

1 Omission from the Code

Rule 11(2) lists a number of exceptions to the basic rule not to disclose information about an individual to third parties. The most obvious exception, namely that of statutory authorisation and duties to disclose, is strangely absent. It does, however, appear in section 7(1) of the Privacy Act, which is relevant to the Code and therefore to rule 11. Section (7)(1) provides that "nothing in principle 6 or principle 11 derogates from any provision that is contained in any enactment and that authorises or requires personal information to be made available". This means that where there is another enactment permitting, authorising or requiring something to be done, that statute will override the relevant rule of the Code[104]. For example, the Health Act 1956 was amended in 1993 and section 22C was added, referring to the Privacy Act and any Code issued under the Act, and permitting providers and purchasers of health and disability services to disclose health information to a number of persons for the purposes of exercising or performing any of those persons' powers, duties or functions. One of the purposes of the Code is to set out the duties of health agencies with regard to the privacy of individuals as clearly as possible, and for this reason it is respectfully submitted that this exception ought to have been included. The provision set out in section 7(1) of the Privacy Act ought to have been repeated in rule 11.

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103 See below part VIII A.

104 Above n 4, 33.

2 Statutes which require medical practitioners to give notice and supply information

There are two classes of statutes that relate to the duty of doctors to disclose information about patients.[105] These statutory provisions applied prior to the Privacy Act and the Code and still continue to apply. There are those which place an obligation on doctors to initiate the supply of information by way of notification, and those which protect doctors if information is elicited from them by persons acting pursuant to a statutory power. Examples of statutes and regulations which oblige doctors to notify are:

Contraception, Sterilisation, and Abortion Act 1977
Maternal Mortality Research Act 1968
Health Act 1956
The Venereal Diseases Regulations 1982 (SR 1982/215)
Births, Deaths and Marriages Registration Act 1995
Hospitals Act 1957
Tuberculosis Act 1948
Transport (Vehicle and Driver Registration and Licensing) Act 1986
Medical Practitioners Act 1968, section 34
Psychologists Act 1981.

3 Statutes and regulations which require medical practitioners to give information on request

Examples of the above are:

Coroners Act 1988
Accident Rehabilitation and Compensation Insurance Act 1992
Social Security Act 1964
Health Act 1956, section 22F
Judicature Act 1908
Medical Practitioners Act 1968, section 61
Medical Auxiliaries Act 1966
Transport Act 1962

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105 Above n 23, 29.

Children, Young Persons, and Their Families Act 1989
Human Tissue Act 1964
Civil Aviation Act 1990

A statutory duty to disclose information has always been an exception to the duty of confidentiality, and this is still the case. It must certainly rank as one of the most important exceptions to the rule against disclosure in the Code, and for this reason, as stated before, it should have been mentioned in rule 11 of the Code.

B Disclosure in Accordance with Recognised Professional Practice

1 Rule 11(2)(b)

Subrule 2(b) of rule 11 allows disclosure of health information by a registered health professional[106] without the authority of the individual to one of three categories of persons, namely, either a person nominated by the individual concerned, or the principal caregiver, or a near relative of the individual "in accordance with recognised professional practice", provided the disclosure is not contrary to the express request of the individual or his or her representative. This rule is obviously designed to cater for the position regarding young children[107], as well as cases where an individual may be too ill to care or make decisions for him or herself and disclosure to a person who is close to the patient may be necessary or helpful. By adding the category "a person nominated by the individual concerned" to that of "a near relative", the Code recognises the fact that a patient may wish to nominate a good friend or live-in-lover to whom information may be disclosed rather than a relative. A traditional question on admission forms at public hospitals in New Zealand was often: "Who is your next of kin?" Apart from omitting the purpose for which this information was collected, the question assumed that patients would nominate a close relative

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106 Above n 56.

107 See above part V A.

as a contact person, whereas in reality this is not always the case.[108] This exception (rule 11(2)(b)) is based on presumed consent and the individual concerned is able to veto such disclosure by means of an express request.

2 Recognised professional practice

The GMC's "Bluebook" *Professional Conduct: Fitness to practise 1991* lists eight exceptions where information about a patient may be disclosed. Exceptions no 3 and no 4 deal with disclosure to relatives or persons close to the patient. No 3 provides that where it is undesirable on medical grounds to seek the patient's consent, information regarding the patient's health may sometimes be given in confidence to a close relative or a person in a similar relationship to the patient. No 4 provides that if, in the doctor's opinion, disclosure of information to a third party other than a relative would be in the best interests of the patient, the doctor must make every reasonable effort to persuade the patient to allow the information to be given. Only in exceptional circumstances may the doctor go ahead and impart such information without the patient's consent.[109] Brazier[110] points out that acting in the patient's best interests is not in itself a defence to breach of confidence, and that the legal justification for talking to third parties without consulting the patient is usually presumed consent.[111]

Subrule (2)(b) makes no mention of a patient's "best interests" which clearly shows that this cannot be the criterion. It also states that an individual may expressly request that information should not be disclosed in accordance with recognised professional practice. In the

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108 B Stewart "The Privacy Act and the Family" Address at the International Year of the Family "Rights and Responsibilities" Symposium, Wellington, 14 October 1994, 3.

109 Above n 73, 49.

110 Above n 59, 51.

111 In contrast to this view, Mason and McCall Smith, above n 38, 98 consider the exception that it is ethical to break confidentiality without the patient's consent when it is in his or her own interests to do so as "unexceptional save to those fanatically opposed to so called professional paternalism".

case of patients moving in and out of psychiatric institutions and the care of a family member or caregiver, the disclosure of information can be a difficult issue. Such a patient may be hostile to his or her caregiver and veto the disclosure of any information.[112] Where a clinician considers a psychiatric patient to lack the mental capacity to give or withhold consent, disclosure may be made to or with the authority of his or her representative according to Subrule (1)(a)(ii) and (b)(ii) of rule 11. However, where a patient does have the necessary mental capacity and forbids disclosure to a family member or caregiver, such a wish must be respected.

One could probably safely say that the legal position was the same prior to the Privacy Act and the Code, but that doctors and other health workers may not have been aware that a patient's "best interests", as perceived by others, may not override the patient's wishes with regard to the disclosure of information.

C Disclosure in the Public Interest

1 Rule 11(2)(d)

Rule 11 (2)(d) provides that information may be disclosed without the individual's authorisation provided

> that the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to:
> (i) public health or public safety; or
> (ii) the life or health of the individual concerned or another individual.

This provision is qualified by subrule (3), namely that disclosure is permitted only to the extent necessary for the particular purpose.

This exception, recognised by professional ethical codes and the

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112 Commentary to the Code 31-32. See also A Zipple "Client Information and the Family's Need to Know: Strategies for Resolving the Conflict" (1990) Community Mental Health Journal 533.

common law, has long been known as a disclosure which is justified on the grounds of public interest and safety.[113] A doctor is considered to have an overriding duty to society and this is the most controversial permissible exception in that it rests on subjective definitions: society is not homogenous and the judgements of individual doctors are bound to differ.[114]

2 Disclosure in the public interest prior to the Code

It has long been recognised that disclosure of information about a patient by a doctor may, in rare circumstances, be justified in the public interest.

In *A.G v Guardian Newspapers Ltd (No 2)*[115] at 545 and 659 Lord Goff said the following:[116]

> ...although the basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure...It is this binding principle which may require a court to carry out a balancing operation, weighing the public interest in maintaining confidence against a countervailing public interest favouring disclosure.

In order to determine whether the public interest exception, as set out in rule 11(2)(d), has brought about any changes whatsoever, one has to look at the scope of this defence in the specific context of the doctor-patient relationship as construed in case law.

(a) *W v Egdell*[117]

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113 Above n 24, 23;see also R Paterson "Blowing the whistle on dangerous patients" (3 March 1994) N Z Doctor 25.

114 Above n 38, 98.

115 Above n 79.

116 Above n 73, 51.

117 [1990] 1 All ER 835.

The scope of the public interest defence in the specific context of the doctor-patient relationship was considered in *W v Egdell*.[118] The question was whether a psychiatrist who had prepared a medical report on a patient was entitled to disclose the contents of the report both to the hospital where the patient was detained and to the Home Secretary. W, diagnosed as being a paranoid schizophrenic, was detained as a patient in a secure hospital, following a conviction for manslaughter of five neighbours, on the ground of diminished responsibility.[119] Ten years after he had been detained, he applied to a mental health review tribunal to be discharged or transferred to a regional secure unit with a view to his eventual discharge. His responsible medical officer, who had diagnosed him as suffering from schizophrenia, which could be treated by drugs, supported the application, but it was opposed by the Home Secretary. His solicitors instructed a consultant psychiatrist to examine W and to produce an independent psychiatric report for the purposes of the tribunal hearing. In his report Dr Egdell strongly opposed W's transfer, and sent the report to W's solicitors in the belief that it would be placed before the tribunal. In view of the contents of the report, W withdrew his application through his solicitors. When Dr Egdell discovered that the application had been withdrawn and that neither the tribunal nor the hospital charged with W's clinical management had received a copy of his report, he contacted the medical director of the hospital, who agreed that the hospital should receive a copy of the report in the interests of W's further treatment. At Dr Egdell's prompting, the hospital sent a copy of this report to the Home Secretary, who, in turn, forwarded the report to the tribunal when referring W's case to them for consideration.

Both Scott J and the Court of Appeal spoke of the danger to the public as a criterion which justified disclosure. The public interest is also a broader concept than simply "danger to the public", and therefore includes danger to a single individual.[120]

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118 Above n 117, ; see also n 73, 51.

119 Above n 26, 649.

120 Above n 73, 54.

The English Court of Appeal first confirmed that Dr Egdell did owe W a duty of confidence. But the duty of confidentiality is not absolute and the public interest in medical confidentiality must be balanced against the public interest in public safety. If Dr Egdell's diagnosis was correct, W remained a source of danger to others, and he was justified in disclosing his report.[121]

The court's decision in *W v Egdell* is consistent with the requirements of rule 11(2)(d), namely that disclosure must be necessary to prevent or lessen a serious and imminent threat to (i) public health or public safety; or (ii) the life or health of the individual concerned or another individual.

(b) *X v Y*[122]

In *X v Y*[123] a tabloid newspaper acquired, in breach of confidence of a health authority employee, information identifying two general practitioners who were continuing to practise after having been diagnosed as HIV positive. The health authority sought an injunction to prevent the publication of the identity of the two doctors. The newspaper argued that the public at large, and the doctors' patients in particular, had an interest in knowing that the doctors were HIV positive. It was held by Rose J that the public interest in preserving the confidentiality of hospital records identifying actual or potential AIDS sufferers outweighed the public interest in the freedom of the press to publish such information. He reviewed the evidence about transmission of HIV from doctor to patient where the doctor had received proper counseling about safe practice, and found that the risk to patients was negligible. There was a far greater risk in the possibility that if they could not rely on confidential treatment, people with AIDS, or those who feared they might have AIDS, would not seek medical help.

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121 Above n 59, 43.

122 [1988] 2 All ER 648.

123 Above n 122.

Once again the decision in this case is consistent with the Code, in that disclosure of the information was in this case not justified because there was no serious and imminent threat to the public health or public safety or the life or health of the individual concerned or another individual.[124]

(c) ***Duncan v Medical Practitioners Disciplinary Committee***[125]

Duncan was a registered medical practitioner in a small rural community. Henry, one of his patients, was a bus driver and had operated a passenger service business for 30 years. Duncan attended Henry on the occasion of two heart attacks, after which Henry underwent a triple coronary artery bypass operation. After the successful operation Henry obtained a medical certificate from the surgeon to enable him to obtain a licence to drive passenger service vehicles. On the day before Henry intended to take his bus to Auckland on a charter trip, Duncan spoke to a prospective passenger and told her that Henry was not fit to drive the bus. Duncan also spoke to Henry and on discovering that he had a licence to drive a passenger service vehicle, sought assistance from a local police constable to have Henry's licence revoked. Later Duncan asked a patient at his surgery to help him organise a petition to have Henry barred from driving passenger service vehicles. Duncan was found guilty of professional misconduct for breach of professional confidence by the Medical Practitioners Disciplinary Committee. Duncan subsequently made a statement to the national news media about Henry's heart condition and his fitness to drive. Once again Henry complained and the Disciplinary Committee found Duncan guilty of professional misconduct by disclosing confidential information to the national news media in breach of his professional responsibilities.

Duncan brought judicial review proceedings in the High Court, seeking a declaration that the Disciplinary Committee's decision was ultra vires, unauthorised and invalid. He also challenged the validity of

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124 Above n 23, 43; see also above n 59, 54.

125 Above n 88.

the charge laid against him by the Proceedings Committee. The High Court found that the framing of a single charge of disgraceful conduct in a professional respect, supported by seven particulars of separate complaints, was invalid. The Proceedings Committee appealed against this and the Court of Appeal held that the proceedings Committee could aggregate a number of different kinds of conduct and formulate an omnibus charge against a practitioner for determination by the Medical Council, provided the doctor was properly informed of what he was charged.

Duncan made three disclosures[126], namely to the prospective passenger, to the police and to the media. The disclosure to the police was not the subject of the complaint, nor was it criticized by the Medical Council or the courts. The Disciplinary Committee's decision included the following reasons for censuring Duncan :".....he breached professional confidence in informing lay people of the personal medical history of his patient". The Committee took the view that professional confidence could only be breached in the most exceptional circumstances and then only if the public interest was paramount.

The Disciplinary Committee found that communication should only be made to the "responsible authority" (in this case the statutory agency having the responsibility to grant or withdraw a passenger service licence). Disclosure to lay people who could not be considered to be responsible authorities was serious and amounted to professional misconduct.

The reference to "public interest" perhaps anticipates that there is a public official that will have the powers to do something about the matter to protect the public interest.[127] In the Duncan case, Jeffries J said at 521: "I think a doctor who has decided to communicate should discriminate and ensure the recipient is a responsible authority."

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126 Above n 4, 31.

127 Above n 4, 31.

If we apply the Code to the facts in the Duncan case, we find that to rely on the exception in rule 11(2)(d), Dr Duncan would have had to believe, on reasonable grounds, that it was not desirable or practicable to obtain Henry's authorisation for the disclosure. Subrule 3 makes it clear that disclosure is permitted "only to the extent necessary for the particular purpose or to satisfy the particular request for information". Duncan thought that the disclosure was necessary to prevent or lessen a serious and imminent threat to public health or public safety. Measured against the Code, if Duncan had disclosed "only to the extent necessary for the particular purpose" he would have disclosed only to the relevant authority so that such authority could take up the matter.

Jeffries J said at 521 that "that qualification [that confidentiality may be breached when another's life is immediately endangered] cannot be advanced so as to attenuate, or undermine, the immeasurably valuable concept of medical confidence." It has been suggested that to acknowledge that a doctor can issue a warning where appropriate, while rigorously maintaining the concept of medical confidence, places an impossible burden on the doctor, as he does need an overt acknowledgement of an accepted corresponding attenuation of this confidence.[128] Such an acknowledgement, which confirms the common law position, is now clearly stated in rule 11(2)(d).

It is important to note that the "public interest" exception to medical confidentiality covers a threat of harm to three possible persons or groups of people, namely the public, the patient concerned, or another individual. The case law discussed above deals with examples of a threat of harm to the public or a third person. The position regarding the patient concerned can be problematic. Where competent adults are involved, breaches of confidence to protect a patient from him or herself usually involve a violation of that individual's autonomy, and are difficult to justify. Beauchamp

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128 Above n 64, 43.

& Childress [129] suggest that possible benefit and prevention of harm to the individual ought to be considered before making such a disclosure. Subrule 2(d), however, makes it clear that only the "prevention of harm" to "prevent or lessen a serious and imminent threat to... the life or health of the individual concerned" may be considered and not the contemplation of any benefit to a patient.

D The Duty to Warn

1 The Code: no duty to warn

Subrule (2)(d) of rule 11 permits disclosure in the public interest but does not enunciate a duty to disclose.[130] In an address[131] in 1994 the Privacy Commissioner said: "I do not intend to attempt to define how far an individual medical practitioner's 'duty to warn' extends." This also explains the deliberate omission in the Code.

2 Is there a common law duty to warn?

In New Zealand the common law has traditionally been reluctant to impose duties of affirmative action. According to Todd et al[132]"...the general principle is..that a person is bound not to inflict damage on another but is not bound to take positive action to prevent injury to..that other". A doctor is under no legal obligation to come to the aid of a stranger, even in an emergency, although the Medical Council of New Zealand confirmed in a statement

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129 TL Beauchamp and JF Childress "The Rule of Confidentiality" in N Abrams and MD Buckner *Medical Ethics: A Clinical Textbook and Reference for the Health Care Professionals* (MIT Press, Cambridge, Massachusetts and London, 1983) 26.

130 K McDonald "Ensuring records are confidential and correct" (8 December 1994) N Z Doctor 35 points out that even though an exception to the rule applies, thereby permitting disclosure, an agency may still decide not to disclose. Rule 11 does not in any way oblige an agency to disclose.

131 Above n 4, 30.

132 SMD Todd et al *The Law of Tort in New Zealand* (The Law Book Co, Sydney, 1991) 132.

in September 1990[133] that a doctor has an ethical obligation to render assistance in an emergency. The position appears to be different if the endangered person is a patient of the doctor, in which case there is perhaps a legal duty of affirmative care based on the special relationship between doctor and patient.[134]

Paul Sieghart[135], commenting on the "Guidance on Ethics for Occupational Medicine of the Royal College of Physicians Faculty of Occupational Medicine 1980", said that a professional code cannot leave it to the individual members of the profession to solve the dilemma as best they can, "after consulting their unguided conscience and perhaps a few respected colleagues". A code must say something about how to approach this kind of problem. Sieghart expresses the opinion that this is not done because "all those who have been given the unenviable task of drafting such codes have found such problems beyond them."

In New Zealand it has not been conclusively resolved whether there is, in rare circumstances, a common law duty upon doctors to disclose information about patients to avoid physical harm to third persons. There are, however, obiter dicta which suggest such a duty, as well as an American decision which may have persuasive influence should such a case come before the courts.[136]

In *W v Egdell*[137] the Court of Appeal indicated that Dr Egdell was justified in disclosing the report, but although it was hinted that a doctor in his position owes a duty to the public, the decision does not suggest that Dr Egdell was under a duty to disclose the report.[138] It has been suggested that this approach is perhaps

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133 "The doctor's obligation to render assistance in an emergency".

134 Above n 76, 396.

135 Above n 90, 31.

136 Above n 23, 41.

137 Above n 117.

138 Above n 73, 55.

indicative of judicial reluctance to impose a positive duty to warn on a psychiatrist faced with the sort of dilemma which confronted Dr Egdell.[139]

In *Furniss v Fitchett*[140] Burrowclough CJ said at 405-406 that a doctor may be justified in breaching patient confidence and hinted at a duty to do so under certain circumstances, when the doctor

> discovers that his patient entertains delusions in respect of another, and in his disordered state of mind is liable at any moment to cause death or grievous bodily harm to that other. Can it be doubted for one moment that the public interest requires him to report that finding to someone.

In yet another obiter dictum, in *Duncan v Medical Practitioners Disciplinary Committee*[141] Jeffries J said at 521:

> There may be occasions, they are fortunately rare, when a doctor receives information involving a patient that another's life is immediately endangered and urgent action is required. The doctor must then exercise his professional judgment based upon the circumstances, and if he fairly and reasonably believes such a danger exists, then he **must**[142] act unhesitatingly to prevent injury or loss of life even if there is to be a breach of confidentiality.

Beauchamp and Childress[143] are of the opinion that one may not breach a confidence except to fulfil another and more stringent duty - either a duty to obey the law or a duty to protect the welfare of the patient or the community. They stress: "There is no right to violate confidences in such cases unless there is also a duty to do so".

In an American case, *Tarasoff v Regents of University of*

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139 Above n 76, 395.

140 Above n 83; see also above n 76, 395.

141 Above n 88.

142 Emphasis added.

143 Above n 129, 25.

California[144] it was held that a psychiatrist had a duty to warn a potential victim of harm that was likely to be inflicted by a patient of the psychiatrist.[145] The psychiatrist employed by the student medical centre at the University of California told the staff of his patient's violent intentions and the staff warned the police, who decided to take no action. The medical centre said nothing to the girl, and she was murdered by the patient soon afterwards. The medical centre was found liable for failing to breach the patient's confidentiality and warn the girl of the threat to her life[146]. Tobriner J said at 337:

> If the exercise of reasonable care to protect the threatened victim requires the doctor to warn the endangered party...we see no sufficient societal interest that would protect unjustified concealment. The containment of such risk lies in the public interest.

and at 347[147]:

> We conclude that the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protected privilege ends where the public peril begins.

English law recognises no general duty to control the actions of another party in an effort to prevent harm being inflicted on third parties. A duty of care has been held to exist only in certain limited situations, namely where a special relationship exists. In *Home Office v Dorset Yacht Co Ltd*[148] the element of control was the determining factor in the relationship between the officers and the boys. In *Holgate v Lancashire Mental Hospitals Board*[149] the

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144 (1976) 551 P 2d 334.

145 Above n 112, 536.

146 Above n 59, 58.

147 See also KC de Haan "My Patient's Keeper? The Liability of Medical Practitioners for Negligent Injury to Third Parties" (1986) Professional Negligence 89.

148 [1970] AC 1004.

149 [1937] 4 All ER 19.

existence of a duty of care owed by the medical officer to the plaintiff was based on the care and control over mental defectives.

In a doctor-patient relationship an element of control is not always discernible, and the source of the recognition of a duty of care owed to third persons can then be sought in the doctor's unique capacity to influence behaviour, either in the treatment he provides or advice he gives patients. Since the decision in *Anns v Merton London Borough Council*[150], the courts have taken a new approach. Having determined the existence of a sufficient relationship of neighbourhood or proximity, it must be considered whether the duty should be negatived, reduced or limited in scope.[151]

Brazier[152] points out, however, that on similar facts to those in the Tarasoff case, an English court would be most unlikely to find a doctor negligent. She quotes *Smith v Littlewood Organisations Ltd*[153] to illustrate that the courts in England are reluctant to make A liable for a wrong committed by B.

3 AIDS and the duty to warn

In Britain the GMC has addressed the difficult conflict between confidentiality and the duty to warn that is potentially raised by finding that a patient is HIV positive.[154] If the patient is in an active sexual relationship, whether in a marriage or with a gay partner, there is a real and identifiable risk posed to the sexual partner of the patient. The doctor who has an HIV positive patient ought first to counsel the patient and discuss the implications for his sexual partner. The GMC states: ".... there are grounds for

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150 [1978] AC 728.

151 Above n 147, 87-88.

152 Above n 59, 58.

153 [1987] 1 All ER 710.

154 General Medical Council, 1988. See A Campbell, G Gillett and G Jones *Practical Medical Ethics* (Oxford University Press, 1992) 125.

disclosing that a patient is HIV positive to a third party without the consent of the patient only where there is a serious and identifiable risk to a specific individual who, if not so informed, would be exposed to infection".[155] The NZMA followed the GMC stand in its 1990 protocol on HIV status and Patient Confidentiality.[156]

It has been suggested[157] that the AIDS pandemic may bring into focus the possibility of a common law duty of care upon doctors to divulge confidential information about patients to third parties. An example much quoted is that of Mr and Mrs A, both patients of Dr B. The husband is diagnosed as HIV positive but he refuses to tell his wife of his condition and will not allow Dr B to inform Mrs A. Dr B surely owes Mrs A a duty of care, but even if she were not his patient, he may have a duty in the public interest. Kennedy and Grubb [158] suggest that one way of determining whether there is a duty on a doctor to breach confidence in the context of HIV infection or any other context would be to ask whether someone infected with HIV by a patient would have a claim in negligence against the patient's doctor.

However, in spite of the opinions of the NZMA, comments of writers and obiter dicta from court cases, in the absence of a court decision to this effect, it cannot be said with certainty that a common law duty to warn, i.e. to disclose information to a third party in the public interest, exists in New Zealand. It is understandable, therefore, that in order to confirm the common law position, no such duty was established in rule 11 of the Code, leaving the position as uncertain as it was before.

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155 See also R Gillon "AIDS and Medical Confidentiality" (1987) 294 British Medical Journal 1676, who says:"..such circumstances will be extremely rare".

156 Policy adopted by New Zealand Medical Association National Assembly, Wellington, 12 September 1990. See above n 76, 380.

157 Above n 23, 41.

158 Above n 26, 665.

E Maintenance of Law and Order

Subrule (2)(i) of rule 11 allows disclosure that is necessary for the maintenance and enforcement of law, including the prevention, detection, investigation, prosecution and punishment of offences or the conduct of proceedings. It can therefore also be seen as a "public interest" exception.

1 Prevention, detection, investigation, prosecution and punishment of offences

(a) Reporting of any crime

Subrule (2)(i)(i) clearly allows disclosure of health information in relation to offences. The wide range of "prevention, detection, investigation, prosecution and punishment" is included.[159] There are two requirements, namely that the health agency would have to believe on reasonable grounds that authorisation from the individual is not desirable or practicable (subrule (2)), and that the disclosure is only to the extent necessary for the particular purpose (subrule (3)).

This exception deals with the disclosure of information that may relate to offences that have been committed or that may be committed in the future. The most dramatic dilemma is posed by the possibility of violent crime. What if the doctor knows that his patient has just committed rape, especially if there is evidence that this is but one of a series of attacks on women? Prior to the Privacy Act and the Code this exception was well known. Britain's GMC lists it as one of the exceptions to a doctor's duty to maintain confidentiality:[160]

> Rarely, disclosure may be justified on the ground that it is in the public interest, which, in certain circumstances, such as, for example, investigation

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159 The Health Act 1956 has been amended and s 22C(2)(f) allows disclosure of health information if that information is required by "any member of the Police, for the purposes of exercising or performing any of that person's powers, duties or functions.."

160 GMC "Bluebook" *Professional Conduct: Fitness to Practise* (February 1991) 18-20.

> by the police of a grave or very serious crime, might override the doctor's duty to maintain his patient's confidence.

Although such disclosure was considered permissible, it was not compulsory. There is case law to the effect that the doctor need not even assist the police by answering their questions concerning his patients.[161] Both medical and legal opinion has been divided on this issue, although published statements are largely confined to the subject of illegal abortion.[162] In 1916 the Royal College of Physicians passed and published resolutions concerning the duties of medical practitioners which included advice to the doctor to urge the patient to make a statement against the person who had performed an illegal operation. However, in the event of her refusal to do so, the doctor was under no legal obligation to take further action.

In Australia a doctor must use his or her own judgement as to whether he should disclose information to the police about a serious criminal offence that has been committed. In Queensland, however, the obligation of the attending doctor in such instances are laid down by statute.[163] Except in Queensland, therefore, there is no duty to disclose information to the police in Australia.

The Code indicates no duty to disclose information of this nature - it merely allows disclosure. This confirms the position prior to the Code.

(b) Child abuse

The reporting of child abuse is discussed here as an exception to the rule against disclosure under subrule (2)(i) of rule 11, but subrule (2)(d)(ii)[164] could also apply, namely "to prevent or lessen a serious and imminent threat to the life and health of the individual

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161 *Rice v Connolly* [1966] 2 QB 414 [1964]2 All ER 649.

162 Above n 38, 99.

163 Above n 49, 101.

164 See above part VII C 1.

concerned..." The reason for this is that child abuse is usually an ongoing process. An offence has already been committed when the doctor detects it, and is more than likely to continue.

Subrule (2)(i) makes it clear that a doctor may disclose such information without breaching the Code. Once again subrule (3) must be adhered to, namely that the disclosure is permitted, only to the extent necessary for the particular purpose. A doctor would therefore disclose such information only to the appropriate authorities.

Section 15 of the Children, Young Persons and Their Families Act 1989 allows "any person who believes that any child or young person has been, or is likely to be, harmed (whether physically, emotionally or sexually), ill-treated, abused, neglected, or deprived" to disclose information in this regard to a social worker or member of the police. Section 16 gives protection to those people who disclose such information from civil, criminal or disciplinary proceedings.

In December 1993 the NZMA commented indirectly upon the temporary Code[165] by submitting a draft version of a privacy code which might be suitable for medical practitioners.[166] Originally the NZMA was informed that it could develop its own code to be endorsed by the Commissioner. This alternative code was, however, ultimately declined by the Commissioner.[167] In this alternative code the NZMA suggested:

> Where a doctor has reasonable grounds to suspect ill treatment or neglect of a child, and the care giver, whether the doctor's patient or not, fails to act responsibly in the particular situation to protect the child, the doctor **should**[168] report to a social worker or the police any ill treatment of a child that comes to the doctor's notice without breaching the privacy of the Code.

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165 The temporary code was replaced by the Health Information Privacy Code 1994 in late 1994. See above part I.

166 "Privacy - A Code of Practice for Medical Practitioners".

167 Letter from NZMA Executive Officer, Jason Dowse, addressed to Louise Freyer, 31 March 1995.

168 Emphasis added.

The NZMA's opinion that doctors ought to report child abuse is merely that - an opinion. There is no statutory provision which compels such disclosure. Likewise the Code does not indicate any duty to disclose, and this confirms the statutory[169] and common law position in New Zealand.[170]

2 Disclosure for the conduct of proceedings before any court or tribunal

The exception in subrule 2(i)(ii) sanctions the disclosure of information necessary for the conduct of court or tribunal proceedings. This subrule is not inconsistent with the common law rule that doctors can be compelled to give in evidence information they acquire in confidence from their patients. However, both these rules are subject to the statutory exceptions (of "medical privilege") which are contained in sections 32, 33 and 35 of the Evidence Amendment Act (No 2) 1980.[171]

F Drug Abusers

Subrule (2)(j) deals with the situation where an individual is or is likely to become dependent upon some drug or prescribed medicine. Such information may be disclosed (only) by a registered health professional[172] to a Medical Officer of Health for the purposes of section 20 of the Misuse of Drugs Act 1975 or section 49A of the Medicines Act 1981. It would then be the officer's task to alert other people, such as the police, pharmacists, hospitals and jails.[173]

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169 S 15 of the Children, Young Persons and Their Families Act 1989, mentioned above.

170 See above part VII D 2.

171 See above part VI C 1.

172 Above n 56.

173 K Scherer "Doctors able to alert others to suspected addicts" in *Health Information & Privacy in New Zealand* 79.

Prior to the Code there was a well-established, but certainly not publicly known, custom that doctors and pharmacists "spread the word" among themselves whenever there was a suspected drug abuser in the neighbourhood.[174] The suspected drug abuser may enter the pharmacy first with a prescription, and the pharmacist may be the one to initiate the disclosure of information, or it may be a doctor whom the drug abuser has approached for a prescription who alerts other doctors and pharmacists. This discreet, grape-vine procedure was effective in preventing the situation where a drug abuser collected a number of scripts from a number of different (and possibly unsuspecting) doctors.

This custom breaches the Code because the disclosure is not to a Medical Officer of Health.[175] In order to disclose this information to a person other than a Medical Officer of Health, doctors and pharmacists will have to meet the requirements of rule 3(1)(c), namely that the individual be made aware of the intended recipients of the information. The commentary to the Code suggests that doctors and pharmacists display warning notices to this effect on their premises.[176] It is doubtful that many doctors or pharmacists would wish to put up such notices, and the custom described above is probably still practised and is likely to continue. Such a breach of the Code is a minor one, in so far as the disclosure may be directly to other health professionals who may be potential health providers of the suspected drug abuser, instead of to the Medical Officer of Health. It will have to be seen how the Privacy Commissioner will deal with a complaint in this regard. It is suggested that such a breach will possibly be dismissed as being one to which the Roman law maxim, "de minimis non curat lex", applies.

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174 The source of this information is confidential.

175 S 22 F of the Health Act 1956 does not apply either, namely that information may be disclosed to a person who is providing or is about to provide health or disability services to the individual. With the "grape-vine" procedure, the disclosure is made prophylactically, in case the suspected drug abuser should approach another health provider.

176 Commentary to the Code 33.

VIII REMEDIES

A Remedies under the Privacy Act 1993[177]

A code of practice under the Privacy Act is a legal document. The statutory basis for codes of practice is found in Part VI of the Privacy Act. It is enforceable through the Privacy Commissioner and the Complaints Review Tribunal (although not usually through the ordinary courts).[178] Part VIII of the Privacy Act deals with complaints regarding breaches of information privacy principles [179]and breaches of a code of practice.[180] A breach of the Code is an action which represents an interference with the privacy of an individual. The following requirements must be met:[181]

> In the opinion of the Commissioner or the Tribunal, the action
>
> (i) Has caused, or may cause, loss, detriment, damage, or injury to that individual; or
>
> (ii) Has adversely affected, or may adversely affect the rights, benefits, privileges, obligations, or interests of that individual; or
>
> (iii) Has resulted in, or may result in, significant humiliation, significant loss or dignity, or significant injury to the feelings of that individual.

A complaint is first lodged, orally or in writing,[182] with the Privacy Commissioner, who investigates the complaint to see whether it has any substance. The role of the Privacy Commissioner is intended to be a conciliatory one[183] and he will therefore try to reach an agreed settlement between the parties. If no settlement is

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177 P Toft "Privacy Act Complaints Procedures" in *Privacy: New Zealand* 47-51.

178 Office of the Privacy Commissioner "Guidance Note on Codes of Practice under Part VI of the Privacy Act" (5 December 1994) in *Privacy: New Zealand* 221.

179 S 66(a)(i).

180 S 66(a)(ii).

181 S 66(b)(i)-(iii); see also Office of the Privacy Commissioner, Fact sheet no. 6 Complaints.

182 S 68(1).

183 S 69(1)(b). See above n 101, 106.

reached, the matter is referred to the Proceedings Commissioner[184] who will refer the case to the Complaints Review Tribunal. If the Privacy Commissioner has refused to investigate a complaint, the complainant may bring proceedings before the Complaints Review Tribunal himself.[185] If the Complaints Review Tribunal is satisfied on a balance of probabilities that there was an interference with the privacy of an individual and the requirements set out above have been satisfied, it has the power to grant any one or more of the following remedies: declarations; restraining orders; orders requiring certain actions to be taken to put things right; and damages up to $200,000.[186]

The Privacy Act 1993 therefore enables an individual to be awarded damages for 1) pecuniary loss suffered as a result of a breach of the Code, 2) the loss of monetary or non-monetary benefit which the individual might reasonably have been expected to obtain if the breach had not occurred, and 3) humiliation and injury to feelings.[187]

It is still possible for a person to bring a common law action in a civil court[188], but this option is not likely to be taken now that the Privacy Act has made it easier and less expensive to obtain redress for damages or detriment suffered as a result of the unlawful disclosure of health information.

B Remedies prior to the Privacy Act 1993

It is said that in the area of privacy there has not traditionally

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184 S 82.

185 S 88.

186 Commentary to Code 37.

187 GE Everard "Health Information and the Privacy Act 1993" (1994) Patient Management 104.

188 See above part VI D 7.

been a remedy for the aggrieved individual for interferences with privacy.[189] Prior to the Privacy Act and the Code, if a doctor breached medical confidentiality, an individual could (and still can after the enactment of the Code[190]) lodge a complaint with the secretary of the Medical Practitioners Disciplinary Committee[191] or the secretary of the Medical Council of New Zealand[192] so that the complaint could be considered by the Medical Practitioners Disciplinary Committee[193]. This could result in disciplinary action against the doctor, but offered no remedy for the complainant. The other option would have been a civil action for breach of duty of care, breach of contract, an action of negligence, or an action of invasion of privacy. However, the expense and difficulty involved in suing someone in a civil action meant that, in effect, there was no remedy for most people who had suffered damage or detriment as the result of an unlawful disclosure of "health information".

It is for these reasons that one can say that the opportunity which the Code affords an aggrieved person to obtain redress for an unlawful disclosure of what is now called "health information" is the most significant difference which has been made to the law relating to this kind of disclosure.

IX CONCLUSION

This paper has endeavoured to show how rule 11 of the Code relates to the law regarding "medical confidentiality" (referring to the duty

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189 Above n 4, 29.

190 The Medical Practitioners Bill, which was introduced to Parliament by the Minister of Health in November 1994, sets out new provisions with regard to the existing procedures for the disciplining of medical practitioners. These provisions are linked to the complaints procedures in the Health and Disability Commissioner Act 1994. See B Yeoman "Peer review in the Medical Profession" LLM Seminar VUW, August 1995, 6.

191 Medical Practitioners Act 1968 s 42A(1).

192 Medical Practitioners Act 1968 s 55(1).

193 The new Medical Practitioners Bill proposes that a complaint will be considered by the Medical Practitioners Disciplinary Tribunal (clause 91).

of doctors and other health workers not to disclose confidential health-related information about individuals to third parties) as it existed prior to the Privacy Act and the Code.

It is concluded that rule 11 reflects the common law as it existed, and still does, in New Zealand. The paper has shown that the common law has not been superseded and that any other statutory provisions authorising or requiring disclosure of health information overrides the provisions of the Privacy Act and the Code.

The Code has, however, made a few additions to the law, and filled small gaps that existed. Firstly, the scope of persons to whom the duty of confidentiality with regard to "health information" applied, has been widened. Secondly, the scope of information which would previously have been regarded as confidential in a medical/health context has also been increased. Thirdly, a twenty year limitation has been added to the disclosure of information concerning deceased individuals.

The Code affords children the same rights of privacy as adults. The common law and statutory provisions with regard to the rights of children are at present rather confusing, and the Code has regretfully added to the confusion by offering no clear guidelines as to when young children's wishes may override the decisions of parents and representatives.

The most important exception to the rule against disclosure, namely disclosure in the public interest, where there is a serious and imminent threat to the health or life of a person or persons, as set out in rule 11(2)(d), enunciates only permission to disclose, but no duty. This omission is deliberate and echoes the uncertainty which currently exists in the common law in New Zealand as to whether there is a duty to act positively to prevent harm to a third party.

In spite of not making significant changes to the law itself, the Code has made a considerable difference. The rules with regard to privacy of health information have been clearly defined and set out

in the Code for those working with such information and who may not previously have known with certainty what the law was and whether it applied to them. Even more important is the fact that the Code is backed by the complaints procedure of the Privacy Act which affords an aggrieved person the opportunity to obtain redress for any interference of privacy which he or she has suffered as a result of a breach of the Code. Prior to the Privacy Act and the Code there may have been many incidents of unlawful disclosure of "health information" which had no consequences. Now such a disclosure is classified as a breach of the Code and there is a remedy at hand for an aggrieved individual.

APPENDIX: Rule 11 of the Health Information Privacy Code 1994

Limits on Disclosure of Health Information

(1) A health agency that holds health information must not disclose the information unless the agency believes, on reasonable grounds:

(a) that the disclosure is to:

(i) the individual concerned; or

(ii) the individual's representative where the individual is dead or is unable to exercise his or her rights under these rules;

(b) that the disclosure is authorised by:

(i) the individual concerned; or

(ii) the individual's representative where the individual is dead or is unable to give his or her authority under this rule;

(c) that the disclosure of the information is one of the purposes in connection with which the information was obtained;

(d) that the source of the information is a publicly available publication;

(e) that the information is information in general terms concerning the presence, location, and condition and progress of the patient in a hospital, on the day on which the information is disclosed, and the disclosure is not contrary to the express request of the individual or his or her representative; or

(f) that the information to be disclosed concerns only the fact of death and the disclosure is by a registered health professional, or by a person authorised by a health agency, to a person nominated by the individual concerned, or the individual's representative, partner, spouse, principal caregiver, next of kin, whanau, close relative or other person whom it is reasonable in the circumstances to inform.

(2) Compliance with paragraph (1)(b) is not necessary if the health agency believes on reasonable grounds that it is either not desirable or not practicable to obtain authorisation from the individual concerned and:

(a) that the disclosure of the information is directly related to one of the purposes in connection with which the information was obtained;

(b) that the information is disclosed by a registered health professional to a person nominated by the individual concerned or to the principal caregiver or a near relative of the individual concerned in accordance with recognised professional practice and the disclosure is not contrary to the express request of the individual or his or her representative;

(c) that the information:

(i) is to be used in a form in which the individual concerned is not identified;

(ii) is to be used for statistical purposes and will not be published in a form that could reasonably be expected to identify the individual concerned; or

(iii) is to be used for research purposes (for which approval by an ethics committee, if required, has been given) and will not be published in a form which could reasonably be expected to identify the individual concerned;

(d) that the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to:

(i) public health or public safety; or

(ii) the life or health of the individual concerned or another individual;

(e) that the disclosure of the information is essential to facilitate the sale or other disposition of a business as a going concern;

(f) that the information to be disclosed briefly describes only the nature of injuries of an individual sustained in an accident and that individual's identity and the disclosure is:

(i) by a person authorised by the person in charge of a hospital;

(ii) to a person authorised by the person in charge of a news medium;

for the purpose of publication or broadcast in connection with the news activities of that news medium and the disclosure is not contrary to the express request of the individual concerned or his or her representative;

(g) that the disclosure of the information:

(i) is required for the purposes of identifying whether an individual is suitable to be involved in health education and so that individuals so identified may be able to be contacted to seek their authority in accordance with paragraph (1)(b); and

(ii) is by a person authorised by the health agency to a person authorised by a health training institution;

(h) that the disclosure of the information:

(i) is required for the purpose of a professionally recognised accreditation of a health or disability service;

(ii) is required for a professionally recognised external quality assurance programme; or

(iii) is required for risk management assessment and the disclosure is solely to a person engaged by the agency for the purpose of assessing the agency's risk;

and the information will not be published in a form which could reasonably be expected to identify any individual nor disclosed by the accreditation or quality assurance or risk management organisation to third parties except as required by law;

(i) that non-compliance is necessary:

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

(ii) for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation);

(j) that the individual concerned is or is likely to become dependent upon a controlled drug, prescription medicine or restricted medicine and the disclosure is by a registered health professional to a Medical Officer of Health for the purposes of section 20 of the Misuse of Drugs Act 1975 or section 49A of the Medicines Act 1981; or

(k) that the disclosure of the information is in accordance with an authority granted under section 54 of the Act.

(3) Disclosure under subrule (2) is permitted only to the extent necessary for the particular purpose.

(4) Where under section 22F(1) of the Health Act 1956, the individual concerned or a representative of that individual requests the disclosure of health information to that individual or representative, a health agency:

(a) must treat any request by that individual as if it were a health information privacy request made under rule 6; and

(b) may refuse to disclose information to the representative if:

(i) the disclosure of the information would be contrary to the individual's interests;

(ii) the agency has reasonable grounds for believing that the individual does not or would not wish the information to be disclosed; or

(iii) there would be good grounds for withholding the information under Part IV of the Act if the request had been made by the individual concerned.

(5) This rule applies to health information about living or deceased persons obtained before or after the commencement of this code.

(6) Notwithstanding subrule (5) this rule applies to health information about any identifiable deceased person, for not more than 20 years after the day of that person's death.

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