
Privacy and the Health Industry

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Abstract

This article examines confidentiality and freedom of information in the health industry and access to medical records in both the public and private sector. In particular, it considers changes to the access of medical records in the private health sector after the amendments to the *Privacy Act 1988* (Cth) in 2003.

Introduction

This article will consider the impact of common law rules of confidentiality and the effect of Freedom of Information and Privacy legislation on ownership of and access to medical records.

The area of confidentiality and access to medical records raises complex issues and is further complicated by the widespread use of advanced information technology in health service facilities and the increased use of multi-team and multi-facility health care. Any discussion concerning disclosure of confidential information and privacy in the health industry immediately raises the possibility of a conflict of interest. On the one hand the general public has a right to be protected from communicable diseases and other health threats and there is an obligation on the part of governments to provide such protection. On the other hand individuals have a right to privacy.

Further, these competing interests exist in an environment where antibiotic resistant organisms abound and incurable communicable diseases such as HIV/AIDS, SARS and the Ebola virus exist. Of even greater concern is the increase in diseases with no known cure, for example SARS, and the fact that more

and more organisms are becoming resistant to antibiotic treatment.

At the same time, due to the rapid development of technology and diagnostic procedures, an increasing amount of personal information concerning the health of patients is available. Consumers in the health industry are constantly demanding more protection of their rights particularly in the areas of confidentiality, privacy and access to personal information.

Generally, doctors and health workers have an ethical obligation to patients not to disclose personal information that they have obtained from them during the course of treatment. However, this duty is not absolute and there are some exceptions. Apart from their ethical obligations, health professionals also have legal obligations to maintain confidentiality concerning any information they have gathered from their dealings with their patients.

The rules relating to confidentiality are far reaching and apply even after death. Possible causes of action for breach of confidentiality include breach of contract, negligence and defamation. In equity it is possible to seek an injunction to restrain a breach of confidence.

Breach of confidence occurs when information that has been discovered through a relationship of trust is disclosed.

In her article, Danuta Mendelson,¹ a lawyer, explored the legal and ethical position of doctors who were requested to disclose information obtained from their patients under confidential circumstances. In particular she considered the legal and ethical dilemma arising from a letter sent by the Medical Board and Victoria Police asking doctors to disclose the identity of any patient they suspected may be 'Mr Cruel'. 'Mr Cruel' was believed to have been responsible for the abduction and sexual assault of a number of young girls in Melbourne and also for the murder of Karnein Chan.

From the ethical perspective, she concludes that especially when dealing with suspicions in contrast to actual statements or confessions, the duty of the medical practitioner is to act in the best interests of his or her patient. In her opinion this would be in a non-judgemental or speculative manner.

In assessing the legal situation she noted that:

In Australia, neither the common law nor the statutes construe the duty of medical confidentiality in absolute terms – the confidential information has to be disclosed under statutory or judicial compulsion. At the same time, in all States and Territories..., a breach of the patient's confidentiality, which cannot be justified under common law or statute, may expose the medical practitioner to a civil action, professional disciplinary proceedings and in particularly notorious cases, to criminal charges.²

Confidentiality

Health care professionals owe a common law duty not to disclose information about patients whom they have treated. In the health industry, this duty mainly arises

under contract and in negligence. For example, in one case³ a doctor disclosed information about his patient's psychiatric state to her husband. The husband used this information in matrimonial proceedings against her. The court held that the doctor was negligent, as he had owed the patient a duty of care and had breached the required standard of care by disclosing information that may have caused her damage. Although the rule is clear and forms the basis for professional confidence it is not absolute and there are a number of exceptions to the general rule.

The main justification for authorising or permitting disclosure of certain information is that it will best serve the patient's interests and their treatment. Disclosed information is usually given to other health professionals who are involved with treating the patient. Information that is disclosed to other health professionals for the patient's benefit must relate to the treatment of that patient. The following are the main exceptions:

Consent of the patient

A patient may give express or implied consent. Express consent occurs when a patient expressly permits disclosure of information relating to them. Implied consent is less clear as it is assumed that a patient, by admitting themselves to hospital, consents to a free exchange of medical information. However, this exception does not extend, for example, to the disclosure of a patient's HIV status when the purpose of the disclosure is to protect health workers in an occupational capacity rather than for the therapeutic benefit of the patient.

Information to relatives

Implied consent may also cover the situation where a doctor informs a close relative of a patient's sudden or urgent admission to hospital. In less urgent situations, where concerned relatives make enquiries concerning a

¹ D. Mendelson, "'Mr Cruel' and the Medical Duty of Confidentiality' (1993) 1 *Journal of Law and Medicine* 120.

² *Ibid* 125.

³ *Furniss v Fitchett* (1958) NZLR 396.

patient's health it would appear that any discussion about a patient's health without their express consent would be regarded as a breach of confidentiality. This principle is subject to any statutory exceptions and in limited cases where a doctor believes disclosure of information is for the benefit of the patient.

Patient's benefit

Health professionals may disclose information about the patient to other health professionals provided it is related to the treatment of the patient and not simply for the benefit of another member of the health care team. Permitted information includes information about the patient's medical condition, other related aspects of the patient's life and the fact that the person is a patient at all, especially in the case of psychiatric care.

Disclosure required by law

A statutory duty to disclosure overrides the common law duty to maintain a confidence. Only information covered by the statute can be disclosed, for example, specific disease notification of certain infectious diseases. Often the name of the individual is not required. All jurisdictions of Australia, except Western Australia, make it an offence for specified professionals to fail to report a suspected child abuse case to the relevant authorities. The Australian Capital Territory, New South Wales, Queensland, South Australia, Tasmania and Victoria all have legislation that provides, where a person acts in good faith in voluntarily reporting suspected child abuse cases, that it is not considered to be a breach of privacy laws and that person cannot be sued for defamation. In other jurisdictions professionals have an option to report, however are not protected from legal action such as defamation.

Where disclosure is required by statute, courts of law may compel health professionals to disclose information either by request or subpoena. In this case

there is no medical professional privilege. In one case⁴ a doctor who was under investigation for medi-fraud refused to produce patient records. The court held that the law, a statute, *Health Insurance Act 1973* (Cth), required disclosure.

Court orders

If a court orders a health professional to produce documents or attend court as a witness, failure or refusal to do so may result in contempt proceedings and a prison sentence. This is so, even if the required information about the patient would otherwise be confidential.

In the case of *NJ v Australian Red Cross Society*,⁵ the Supreme Court of Victoria ordered the Australian Red Cross to name two people who had recently donated hepatitis B infected blood after several people were infected by contaminated blood transfusions. The court however protected the donors from any legal action and made the plaintiff's suitors give an undertaking not to disclose names or identifying details to anyone else.

Medical research

Consent is usually required before any personal information about a patient is released. However there is a limited exception in the case where medical information from a patient's files is to be used by other health professionals for approved medical research. In the event that consent is difficult to obtain or is refused, an ethics committee may decide that in the circumstances it is proper for that information to be provided for medical research.

Public interest

This exception is the most difficult. The public interest exception enables a doctor to give information about a patient, which would otherwise be confidential, in circumstances where a doctor's duty to the public

⁴ *Hill v Howe* (1991) 30 FCR 272.

⁵ Unreported No 6498/94, 26 June 1996, Vic SC.

outweighs his duty of confidentiality to his patient. This exception applies both where a doctor is sued in negligence and contract. Seemingly, it would appear to be limited to cases involving a patient's criminal or illegal activity or to prevent potential harm to the public.

In the New Zealand case of *Duncan v Medical Practitioners Disciplinary Committee*,⁶ a bus driver had undergone a triple bypass operation on his heart and then applied for a bus driver's licence. Dr Duncan was the patient's general practitioner who referred him for surgery. Dr Duncan tried to have the bus driver's licence revoked, told people in the community not to ride in his bus as it was too dangerous and complained to the police and media. The court held that Dr Duncan was in breach of his duty of confidence to his patient. The surgeon who was treating the patient considered the patient fit and had certified the patient as fit to drive a bus. Jefferies J said that it did not appear to have been a case in which '...a doctor receives information involving a patient that another's life is immediately endangered and urgent action is required.'⁷ Jefferies J also said that the doctor should ensure that the '...recipient (of any such information) is a responsible authority.'⁸ In this case, for example, if Dr Duncan had made his complaint to an appropriate authority that was responsible for granting bus drivers' licences or controlling standards for bus drivers, it is possible his disclosure may have satisfied the public interest exception. However, in this case the doctor's vitriolic attack on the bus driver in the above circumstances was unacceptable.

In the English case of *W v Egdell*,⁹ a patient who suffered from schizophrenia murdered five people. Dr Egdell sent a report recommending against the patient's discharge. In this case, the court said that the

disclosure of information to benefit the public interest outweighed the duty of confidentiality to the patient.

The American case of *Tarasoff v Regents of the University of California*¹⁰ highlights the difficult situation where a patient informs his psychotherapist that he intends to kill a *particular* woman. In this case the patient later killed the woman and the victim's father sued the therapist for negligent failure to warn his daughter of the imminent risk to her. The plaintiff succeeded. Although the *Tarasoff* decision has not been applied in Australia, it certainly does raise the issue of whether in certain circumstances there is a duty to warn an *identifiable* third party of the risks of any serious, imminent danger.

To date no Australian court has recognised a duty to warn on the part of a doctor although it would appear that public authorities in certain circumstances do have a duty to warn. In her article, Mendelson¹¹ explores the common law exception of public interest and in particular the positive duty of disclosure at law in respect to a dangerous patient. She refers to the '*Tarasoff Two* principle', that 'the public interest in preventing the risk of harm posed by a potentially dangerous patient should generally override the public interest in the protection of the patient's confidences...'¹² and notes that the High Court of Australia has not considered this issue. However, in *Sutherland Shire Council v Heyman*,¹³ the High Court did impose a *prima facie* duty to rescue, safeguard from or warn another person of foreseeable injury. The High Court did not, however, recognise a positive duty to act or prevent injury as found in the *Tarasoff* case.

⁶ [1986] 1 NZLR 513.

⁷ Ibid p.521.

⁸ Ibid p 521.

⁹ [1990] 1 All ER 835 (CA).

¹⁰ (1976) 17 Cal 3d 425; 551 P 2d 334.

¹¹ D. Mendelson, "Mr Cruel" and the Medical Duty of Confidentiality' (1993) 1 *Journal of Law and Medicine* 120.

¹² Ibid 126.

¹³ 157 CLR 424.

Ownership of medical records

The general rule has been that health records are created to assist the health professional only and therefore the traditional view is that medical records remain the property of the doctor.

In the case of *Breen v Williams*,¹⁴ the High Court held that the medical record documents remained the property of the doctors. The facts of this case are that a woman, Ms Breen, had silicone breast implants inserted in 1977. She later developed capsules in her breasts and consulted a plastic surgeon, Dr Williams, who compressed the capsules. Dr Williams was not the doctor who had inserted the implants. In 1984 a third doctor diagnosed a lump from leaking silicone gel in Ms Breen's breast and performed a partial mastectomy. Ms Breen then decided to participate in a class action in the United States of America against the manufacturer Dow Corning Corporation. She asked Dr Williams for copies of the records he held concerning her condition and treatment and he refused to give them to her. The High Court said that medical records are owned by the person who prepares them and that person has copyright in those documents.

As such, doctors have the discretion to decide whether to keep the records, show the patient the records or even destroy the records. However, the court would not allow those records to be used for profit or permit disclosure to unauthorised persons.

The decision of *Breen v Williams* only applies to private doctors, hospitals and institutions. The decision did not apply to public hospitals because freedom of information legislation in most jurisdictions overrides the common law decision of *Breen v Williams*.

Access to and release of medical records

Under legislation dealing with freedom of information and various health department guidelines, patients can

access medical records and information pertaining to themselves from public hospitals. A patient also has a legally enforceable right under contract to see their medical records that they have paid for, for example X-rays or diagnostic tests. Access to medical records from private hospitals and institutions is not covered by freedom of information legislation.

In 2003, *Privacy Amendment (Private Sector) Act 2000* (Cth) was enacted.¹⁵ This legislation extended the operation of the *Privacy Act 1988* (Cth) to cover all health care providers in the private health sector throughout Australia. The effect of this legislation was to override the decision in *Breen v Williams* denying private patients access to their medical records. It introduces a general right of access for all consumers, both public and private, to their own health records and also requires health service providers to provide documentation clearly setting out their particular policies for management of the consumer's personal information.

The legislation recognises the sensitive nature of health information and the need for confidentiality. The Act also provides enforcement mechanisms for dealing with breaches. The main objective of the law is to encourage clear and open communication between the health service provider and the health consumer.

The Act operates within a framework of ten National Privacy Principles.¹⁶ The National Privacy Principles represent the minimum privacy standards that are required for the disclosure of patients' personal health information.

The new legislation also empowers the Privacy Commissioner to issue guidelines.¹⁷ These guidelines are advisory and are not legally binding. The guidelines are intended as a reference to the new

¹⁴ (1996) CLR 186.

¹⁵ <http://www.privacy.gov.au/>

¹⁶ *Privacy Act 1988* (Cth) Schedule 3.

¹⁷ *Privacy Act 1988* (Cth) s 27(1)(e).

privacy legislation for the health care industry and to assist health service providers in meeting their obligations under the National Privacy Principles of the Act. Throughout Australia, private health service providers have developed privacy information guidelines for patients explaining the obligations of the health care provider under the National Privacy Principles. The guidelines essentially set the standards for the ways in which private organisations handle personal information. They explain how private health care providers may collect, use and disclose certain types of personal information that they obtain from or about a patient. They also ensure that the information is kept secure and advise patients on how they can obtain access to that information.

If a patient believes that a health provider has interfered with their privacy, complaints can be made to the Privacy Commissioner.¹⁸

Conclusion

The law of confidentiality remains unclear and is mainly framed by cases and common law rules and principles. The law is clear that health providers and, in particular, doctors have a duty not to disclose confidential information. The exceptions, however, reduce the effectiveness of the general rule to the point where there may be a duty on a health professional to disclose personal information about a patient and warn of risks to third parties in certain circumstances.

The new amendments to the privacy legislation complement the law of confidentiality regarding the handling of health information and promote greater openness between health professionals and consumers.

¹⁸ *Privacy Act 1988* (Cth) s 40(1A).