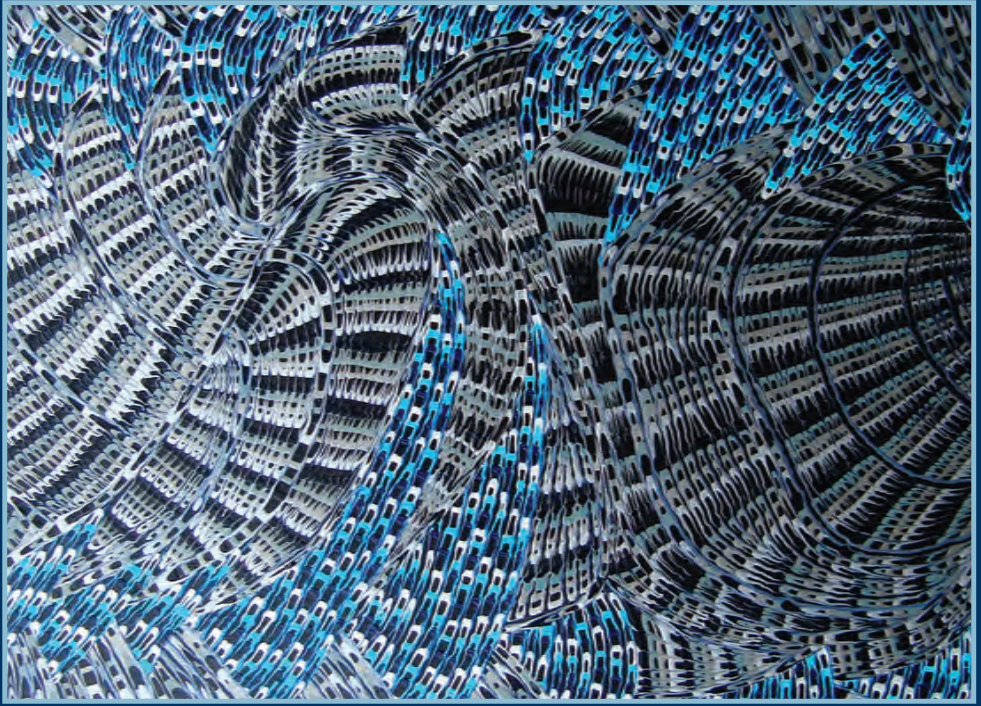


# Health Law in New Zealand



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## PREFACE

This book is a collaborative effort by academics from Auckland and Otago Universities, complemented by Auckland Coroner Morag McDowell. It is fitting that it should emerge from the two New Zealand universities with both law and medical schools, where the intersection of law and medicine has long prompted scholarly debate and enquiry.

It is almost two decades since New Zealand's Code of Patients' Rights (the Code of Health and Disability Services Consumers' Rights) came into effect in 1996. In that time the legal landscape relating to health care and the legislative framework for the public health system has been transformed. In the aftermath of Judge Silvia Cartwright's *Report of the Cervical Cancer Inquiry* (1988) the study and practice of health care law in New Zealand has burgeoned. There has been renewed focus on traditional legal concepts of duty of care, confidentiality, and consent, combined with calls for increased accountability of health practitioners and an emphasis on patient safety and systems analysis. New biotechnologies continue to pose ethical and legal challenges.

In the mid-1980s one of us started a medico-legal course at the University of Otago, and in the early 1990s the other introduced a similar course at Auckland. In both law faculties, specialised courses in law and psychiatry soon followed. We welcomed David Collins' *Medical Law in New Zealand* (1992). Since that pioneering text, developments have followed thick and fast. A raft of legislative reform, notably the Privacy Act 1993 and the Health and Disability Commissioner Act 1994 (and the ensuing Codes), mental health and intellectual disability legislation, the Health Practitioners Competence Assurance Act 2003, accident compensation reforms, and a wave of health reforms, highlighted the need for a new authoritative text for use by legal and health practitioners and students.

What began as a partnership between the two general editors (who developed an interest in the intersection of law and medicine when law students at Auckland University) has become a collaborative endeavour of seven authors, recognising the complexity and diversity of the field. The authors bring a wide range of academic and practical experience to their topics. We have not sought to moderate individual styles, so that authors have been free to bring their own "voice" to their contributions.

In 2006, Thomson Brookers (as the publishers then were) published *Medical Law in New Zealand*. This volume replaces that earlier work. The general editors and many of the authors are the same. However, a change in title was appropriate, given that this volume includes a major new section on public health law. This extends this work well beyond the traditional ambit of medical law.

*Health Law in New Zealand* includes six chapters on topics that did not feature in the earlier work: access to health care (chapter 3), coroners (chapter 24) and public health law (chapters 25–28). The chapters on mental health law (chapters 14, 15 and 16) and

human tissue (chapter 23) have been rewritten in their entirety by new authors (the latter in light of the Human Tissue Act 2008). Other chapters have remained the responsibility of the original authors: all have updated and some have been rewritten to a greater or lesser extent.

The text is divided into 10 parts, covering: the regulation of health care, the Code of Patients' Rights, and access to health care; the standard of care; consent; health information; mental health and intellectual disability; the beginning of life; the end of life; human tissue and coroners; public health; and complaints, discipline and compensation.

A few people are owed special thanks. Co-authors and colleagues in our law faculties provided helpful comments on drafts. Peter Skegg acknowledges assistance from successive research assistants at the Otago Faculty of Law, and in particular Calum Barrett and Stacey Thomson, building on tremendous assistance from almost a decade ago from Jeanne Snelling. Ron Paterson acknowledges research assistance from Philip Arnold and Susan Paul, and helpful comments on parts of the access to health care chapter from Treasa Dunworth, Joanna Manning, Scott Optican, Paul Rishworth, and Hanna Wilberg. Joanna Manning thanks Scott Optican for assistance with the application of privileges and the Evidence Act 2006 in the discipline chapter and Ron Paterson for his review of the civil proceedings chapter. John Dawson thanks Matthew Mortimer for his valuable research assistance. Matthew Mortimer was also of great assistance to Nicola Peart, as was Alison Douglass.

Louise Delany thanks the New Zealand Law Foundation for its generous support of four new chapters on public health law, and Lynda Hagen and Dianne Gallagher of the Foundation for their patient oversight of her project. Helen Curtis provided Louise with able research assistance. For support, review and comment, Louise is grateful to Dr Mark Jacobs, Andrew Forsyth, Sally Gilbert, Paul Prendergast, Frances Graham, Stuart Lillie, Chris Laurenson, Michael Cameron, Geoffrey Roche, and Phil Knipe at the Ministry of Health; Dr Nick Wilson, Dr George Thomson, Dr Michael Baker and Dr Peter Crampton at the University of Otago; and her brother Dr Denis Delany. Morag McDowell acknowledges support from the Office of the Chief Coroner (in particular, research counsel Lily Nunweek and Matthew Mortimer) and thanks Coroners Katharine Greig and Carla na Nagara for their helpful comments on earlier drafts of her chapter.

As general editors, we acknowledge the publishers for encouragement and assistance. In particular, we thank Renay Taylor for her faithful stewardship of this book.

The authors have aimed to state the law as at 30 November 2014, but in a few cases later references have been added.

Peter Skegg

Ron Paterson

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position of trust, if the propriety of charges is questioned. Exploitation (and a breach of right 2) may occur in the absence of any intention to exploit.<sup>73</sup>

### 2.6.3 Standard of care: right 4

Right 4 of the Code deals with standard of care. Four of the provisions begin with the statement, "Every consumer has the right to have services provided". There is, however, no legal duty to provide services, since the parameters of the Code are confined to quality of care, and do not support a right to access care in the first place.<sup>74</sup> Thus these provisions are, in effect, premised by the implicit statement, "Where services are provided".

The duty of "reasonable care and skill" in the provision of services is affirmed in right 4(1). However, the Commissioner is not required to interpret this as limited to the common law *Bolam* test of the standard accepted as proper by a responsible body of professional opinion.<sup>75</sup> On occasion, "reasonable care" for right 4(1) purposes has been interpreted to require a higher standard than currently accepted practice as reflected in expert advice.<sup>76</sup> In areas such as communication, referral and follow-up, the Commissioner may "question accepted practice, to see if it reflects custom rather than care".<sup>77</sup> Even in the areas of assessment, diagnosis and treatment, accepted practice may be found deficient under right 4(1).<sup>78</sup>

71 The fiduciary nature of the doctor-patient relationship was recognised by Jeffries J in *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513 at 521. See also *McInerney v MacDonald* [1992] 2 SCR 138 (SCC) and *Patient A v Health Board X* [2005] BCL 340 (HC). A practice nurse was found to have been in a fiduciary relationship with patients of a general practice in *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC).

72 See, for example, *Chiropractor, Mr B* (Health and Disability Commissioner, Opinion 02HDC09817, 17 January 2003) (sexual and financial exploitation of client by chiropractor).

73 See *Ophthalmologist, Dr C, Southland District Health Board* (Health and Disability Commissioner, Opinion 05HDC12122, 29 June 2007) where an ophthalmologist was found in breach of right 2 in charging for private preoperative and postoperative consultations, in relation to public cataract surgery.

74 See the HDC Act, s 20, in relation to the authorised content of the Code. There may be a duty to provide services in an emergency, if ethical or other relevant standards binding the individual provider so require, since such standards may become enforceable pursuant to right 4(2).

75 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (QB).

76 For a discussion of when the Commissioner may depart from the *Bolam* standard, see Deanne Wong and Ron Paterson "Commissioner's Comment: Ovarian cancer and expert advice" (2005) 32(1) NZ Family Physician 50. See also R Godbold and A McCallin "Setting the standard? New Zealand's approach to ensuring health and disability services of an appropriate standard" (2005) 13(1) JLM 125, advocating a consumer-focused interpretation of right 4; Ron Paterson *The Good Doctor: What Patients Want* (Auckland University Press, Auckland, 2012) for a discussion of the *Bolam* rule and expert advice, at 93-96; José Miola "On the Materiality of Risk: Paper Tigers and Panaceas" (2009) 17 Med L Rev 76, at 93-95, for an excellent discussion of the applicability of the *Bolam* test in the context of the Code.

77 See Deanne Wong and Ron Paterson "Commissioner's Comment: Ovarian cancer and expert advice" (2005) 32(1) NZ Family Physician 50 at 52. See, for example, *General Practitioner, Dr C* (Health and Disability Commissioner, Opinion 99HDC10975, 27 June 2000) (inadequate arrangements for transfer of patient with chest pain from medical centre to hospital); *Midwife, Ms B, and others* (Health and Disability Commissioner, Opinion 09HDC01592, 31 January 2012) (midwife's failure to go above head of obstetric registrar and notify consultant obstetrician re concerning CTG held to be a breach of right 4(1), despite peer midwifery advice that it was reasonable practice not to do so).

Providers are required under right 4(2) to comply with “legal, professional, ethical, and other relevant standards”. This means legal standards underpinned by statute,<sup>79</sup> professional standards set by colleges,<sup>80</sup> ethical standards set by registration authorities,<sup>81</sup> and other relevant standards<sup>82</sup> are potentially legally enforceable via the Code. If a guideline is considered to be aspirational and an expression of best practice, rather than setting a minimum standard, its non-fulfilment is unlikely to lead to a breach of right (2).<sup>83</sup> Relevant also is the status and authority of the body that issued the guidance. If issued by a “responsible authority” under the Health Practitioners Competence Assurance Act 2003 (eg, the Medical Council of New Zealand or Nursing Council of New Zealand), it is likely to be regarded as a minimum standard and binding. The extent of uptake of the guideline among practitioners is another relevant factor.<sup>84</sup> In practice, a breach of right 4(2) arises most often as a result of a provider’s poor record-keeping.<sup>85</sup>

The other parts of right 4 differentiate aspects on the duty of care not previously singled out in the common law. Right 4(3) gives consumers the right “to have services provided in a manner consistent with” the consumer’s needs.<sup>86</sup> Providers are not expected to guarantee a successful outcome,<sup>87</sup> but under right 4(4) services are to be

78 See *Ms A, Midwife, Public Hospital* (Health and Disability Commissioner, Opinion 04HDC14171, 1 June 2005) (failure to assess pregnant woman’s risk of HIV infection held to be an apparent breach of right 4(1), despite evidence that non-assessment was common practice).

79 For example, the Health and Disability Services (General) Standard (NZS 8134.0:2008) issued under the Health and Disability Services (Safety) Act 2001.

80 For example, *The New Zealand College of Midwives’ Standards of Midwifery Practice* (2008), applied by the Commissioner in finding a breach of right 4(2) in *Obstetrician & Gynaecologist, Dr C, Midwife, Ms A, Taranaki District Health Board* (Health and Disability Commissioner, Opinion 12HDC00481, 11 June 2014).

81 For example, *New Zealand Medical Council, Statement on Self Care and Care of Family Members*, applied by the Commissioner in finding a breach of right 4(2) in *General Practitioner, Dr B* (Health and Disability Commissioner, Opinion 03HDC11070, 6 July 2004).

82 For example, contractual obligations and a provider’s own policies such as under a DHB Aged Care Residential Agreement, which was treated as a relevant standard in *Care Manager, Ms D, Registered Nurse, Ms E, A Rest Home* (Health and Disability Commissioner, Opinion 07HDC17744, 16 February 2009) (the Deputy Commissioner stating that “Mrs A was entitled to have services provided that complied with legal, professional, ethical and other relevant standards, including policies and contractual obligations concerning quality of care”).

83 Interestingly, in *Culverden Group Ltd v Health and Disability Commissioner* HC Auckland M1143-SD00, 25 June 2001 at [86], it was suggested that even best practice standards promulgated by an industry group may be “standards that the Commissioner could have regard to”.

84 See *Gynaecologist, Dr B, and others* (Health and Disability Commissioner, Opinion 08HDC07350, 15 March 2010) for an example of the relevance of professional guidelines to determining the appropriate standard of care.

85 See, for example, *General Practitioner, Dr D* (Health and Disability Commissioner, Opinion 09HDC01765, 15 June 2011) (inadequate documentation of each consultation by general practitioner).

86 See *Psychiatrist, Dr C, Clinical Psychologist, Ms D, Public Hospital* (Health and Disability Commissioner, Opinion 00HDC07173, 12 March 2002) (breach of right 4(3) by failure to administer electroconvulsive therapy in a timely fashion). However, right 4(3) does not require a provider to supply services “on demand”; provision of a service in a manner consistent with a patient’s “needs” cannot be equated with according to his or her “wants” (*Practice Nurse, Medical Centre* (Health and Disability Commissioner, Opinion 98HDC16189, 30 June 2000)).

87 This is consistent with the duties imposed on suppliers of services in the Consumer Guarantees Act 1993. See also *F v Medical Practitioners Disciplinary Tribunal* [2005] 3 NZLR 774 (CA) at 36.



provided “in a manner that minimises the potential harm to, and optimises the quality of life of” the consumer. The latter expression is given the following novel definition in clause 4: “to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances”.

Right 4(4) is relevant in situations where the practitioner has exposed the patient to an unnecessary degree of risk or has failed to respond adequately to concerns about a consumer’s care.<sup>88</sup> As the principle of harm minimisation is one aspect of the general duty to exercise reasonable care and skill, the practitioner may also be in jeopardy of a finding of a breach of right 4(1).

In several Commissioner Opinions, where expert advice suggests a provider may have met the *Bolam* standard<sup>89</sup> of “reasonable care and skill” or complied with professional standards, a breach of right 4(4) has nonetheless been found on the basis that a more risk-averse approach was warranted to minimise potential harm to the consumer.<sup>90</sup> Right 4(4) has also been applied in cases where a general practitioner did not have an appropriate bring-up system in place to follow up any tests or investigations ordered when the doctor had reason to suspect a malignancy.<sup>91</sup>

One of the most significant and regularly cited provisions of the Code is right 4(5), which states: “Every consumer has the right to co-operation among providers to ensure quality and continuity of services.” In practice, it is applied in cases where the quality of care coordination is at issue; for example, at handover between nurses<sup>92</sup> or between nursing and medical staff<sup>93</sup> (cooperation between two providers working for one organisation), on discharge from hospital<sup>94</sup> (cooperation between secondary and primary care services) and on referral of patients between district health boards.<sup>95</sup>

88 See *Disability Service Team Leader, Ms B, Nelson Marlborough District Health Board* (Health and Disability Commissioner, Opinion 11HDC00877, 21 June 2013) (Nelson Marlborough DHB failed to respond adequately to concerns of physical and verbal abuse of a young man in the care of disability services).

89 *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.

90 See, for example, *General Practitioner, Dr A* (Health and Disability Commissioner, Opinion 00HDC05372, 14 November 2002) (general practitioner’s non-referral of patient with significant risk factors for heart disease to a specialist failed to minimise the risk of harm and breached right 4(4), but no breach of right 4(1) in light of conflicting expert advice about the standard of reasonable care in such circumstances); Health and Disability Commissioner *Gisborne Hospital 1999–2000: A Report by the Health and Disability Commissioner* (March 2001) (anaesthetist’s reuse of syringes did not minimise harm to patients and breached right 4(4), but did not breach right 4(2) since the practice complied with anaesthetic standards at the time).

91 See, for example, *General Practitioner, Dr C* (Health and Disability Commissioner, Opinion 01HDC08770, 9 April 2003).

92 See, for example, *A District Health Board and others* (Health and Disability Commissioner, Opinion 02HDC08949, 31 March 2005).

93 See, for example, *Bay of Plenty District Health Board, Physician, Dr C, Medical Registrar, Dr D* (Health and Disability Commissioner, Opinion 10HDC00855, 30 April 2013).

94 See, for example, Health and Disability Commissioner *Southland District Health Board Mental Health Services February–March 2001: A Report by the Health and Disability Commissioner* (01HDC11139, October 2002) at 55.

95 See *MidCentral District Health Board, Capital and Coast District Health Board* (Health and Disability Commissioner, Opinion 07HDC20199, 3 October 2008) re the duty of a DHB referring a patient to another DHB, to coordinate the referral by having a system in place to track all referrals.

### 2.6.4 Information disclosure: rights 5 and 6

Several rights are relevant to the issue of information disclosure. Under right 5, the "Right to effective communication", consumers are entitled to receive information in a comprehensible form, language, and manner, and in an environment that enables both parties "to communicate openly, honestly, and effectively". A consumer is entitled to be accompanied by a support person of their choice.<sup>96</sup> Providers must be alert to signs that a consumer has communication needs, and need to ensure both the venue for the consultation and the manner of discussion are appropriate. This may involve talking separately to children and their guardians. Interpreters are not mandatory, but must be provided "where necessary and reasonably practicable".<sup>97</sup>

The title to right 6 – the "right to be fully informed" – is misleading.<sup>98</sup> The text of the provision makes it clear that the duty is to provide sufficient information, a reasonable level of information in the particular situation. Under right 6(1), a consumer is entitled to the information that "a reasonable consumer, in that consumer's circumstances, would expect to receive", including information about their condition, an explanation of the available options (with an assessment of the expected risks, side effects, benefits and costs of each option), and an estimated timeframe for the provision of services. This follows the patient-centred standard adopted by the High Court of Australia in *Rogers v Whitaker*,<sup>99</sup> with its mixture of objectivity ("a reasonable consumer") and subjectivity ("in that consumer's circumstances").<sup>100</sup>

Under right 6(1) consumers are entitled to information even if there is no treatment decision to be made, whereas under right 6(2) information is to be disclosed as a condition precedent to a treatment decision ("[b]efore making a choice or giving consent").<sup>101</sup> In practice, the distinction appears not be important, and both provisions are variously cited in Commissioner Opinions.<sup>102</sup> An important feature of both rights 6(1) and (2) is that they describe the information that a provider is

96 Except when safety may be compromised or another consumer's rights may be unreasonably infringed: right 8. See *Public Hospital, and others* (Health and Disability Commissioner, Opinion 98HDC19009, 19 January 2001), where a public hospital was found not to have breached right 8 in refusing to allow the partner of a woman in pre-term labour to accompany her during a helicopter transfer. Patient safety dictated that two clinicians take the two available seats.

97 See *Dr A, Dr B, Accident and Medical Centre, District Health Board* (Health and Disability Commissioner, Opinion 02HDC04045, 26 May 2004), involving communication with a Samoan patient with limited English language skills, and the responsibility of providers to be alert to communication difficulties, and of employing authorities to provide guidance to staff on accessing interpreter services.

98 The duty to inform under right 6 is further discussed in ch 8.

99 *Rogers v Whitaker* (1992) 175 CLR 479 (HCA).

100 Because of the subjective element of the test, patients who are acutely ill, anxious and stressed may have a right to receive more information, or information more frequently, concerning clinical matters such as their position on a waiting list, than a patient in less serious circumstances (see *Northland District Health Board* (Health and Disability Commissioner, Opinion 09HDC00836, 3 February 2010).

101 In *J v Director of Proceedings* DC Auckland CIV-2004-004-1682, 6 February 2005 at 85, the Judge commented:

"Where there has been a delay of two months between the point where the information was first provided and the point at which consent is sought, in a case where significant surgical intervention is involved, there should be full reiteration of the advice earlier."

## Chapter 10

# HEALTH INFORMATION LAW: GENERAL PRINCIPLES

*JOHN DAWSON*

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### 10.1 Introduction

The next four chapters cover the law on collection, retention and dissemination of health information. This initial chapter distinguishes several kinds of information relationship to which the law applies. The main focus is on situations in which a health professional acquires sensitive information about a patient or their treatment and is therefore under an obligation to respect the privacy and confidentiality of that information unless some other compelling interest justifies its disclosure without the patient's consent. The principal sources of the law are privacy and official information legislation, the law of equity regarding breach of confidence, rules of procedure and evidence governing use of health information in the courts, and other legislation that governs specific information flows.

The main legal principles concern:

- (1) the duty of health professionals to maintain the privacy and confidentiality of information about patients' health and treatment, and to collect, store and use that information in approved ways;
- (2) exceptional situations in which holders of health information have a duty or discretion to disclose such information to a third party, without the patient's consent, because other important public interests must prevail;
- (3) mechanisms for making complaints and seeking remedies available to those who consider they have been the victim of an improper breach of privacy or confidentiality;
- (4) the powers of courts and litigants (including the Police) to obtain access to health information that is relevant to legal proceedings, including judicial powers to make orders for disclosure of information by health professionals,

and to order compulsory medical examinations, the results of which are communicated to the court;

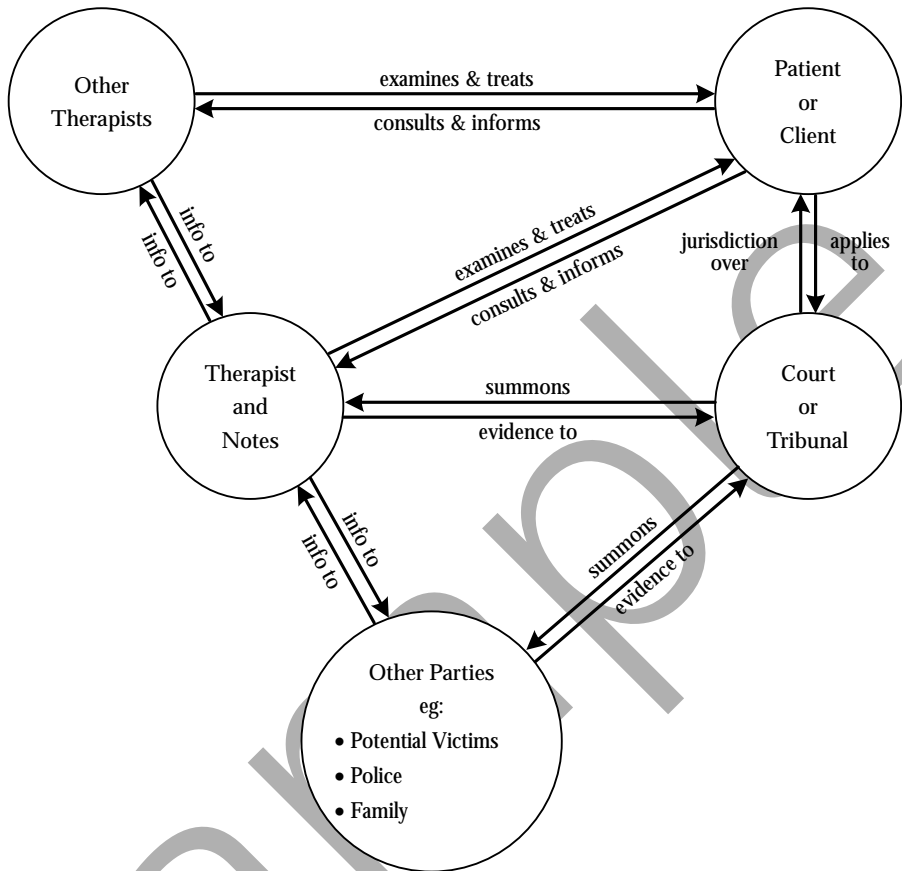
- (5) situations of evidentiary privilege, in which confidential health information relevant to legal proceedings may be withheld from a court (or some other legal process), and analogous situations in which a court may, at its discretion, direct a witness not to produce evidence; and
- (6) the right of the individual to obtain access to health information that others hold about them, and exceptional situations in which access of that kind can be denied.

## 10.2 Disentangling privacy, confidentiality, privilege and the patient's access to records

As that list of principles indicates, the law both limits and authorises health information flows. A relevant metaphor might be the plumbing of a house. It is as if the law has constructed a set of reservoirs, pipes and taps for regulating health information flows. First, the law requires certain sensitive information to be sealed off in discrete reservoirs and stored securely there, and only used for particular purposes; and secondly, the law specifies the circumstances in which certain taps may (or must) be opened or closed, authorising or preventing certain information flows.

To identify the correct legal principles, it is therefore usually necessary to identify: the particular reservoir (or database) in which the relevant information is held; the parties to whom the information might flow; and the particular uses to which it might be put. In the process, it may be useful to map the relationships in a diagram like the one below.

COMMON CONFIDENTIALITY RELATIONSHIPS



Sources of relevant legal rules

- Privacy legislation and the Health Information Privacy Code
- Official information legislation
- Law of equity, contract and professional negligence
- Professional ethical codes and disciplinary procedures
- Privacy legislation and the Health Information Privacy Code
- Law of civil and criminal procedure
- Law of evidence
- Specific legislation prohibiting, permitting or requiring particular disclosures

After the parties to the problem have been identified, the following questions should be addressed:

- (1) Who holds the information in question?
- (2) What kind of information is it?

- (3) How was it acquired, for what purposes, and under what conditions?
- (4) To whom might it be disclosed?
- (5) Has the patient (or their agent) consented to such disclosure?
- (6) If not, does a recognised exception to non-disclosure principles apply?
- (7) If an exception does apply, what information would be minimally adequate to meet the potential recipient's needs; and what conditions should be imposed on circulation or use of the material to prevent it being used in further, unauthorised ways?

If, for example, the information concerned an identifiable patient's health, and it was in the possession of their family doctor, and might be disclosed to that patient at their request, the relevant principles would concern the patient's right of access to their own health records – found in New Zealand in privacy legislation. If, on the other hand, the information might be sent to the Police, without the patient's consent, and might be used as evidence in a trial, different principles would apply, including the law of evidentiary privilege. Alternatively, if a public health researcher hoping to investigate all instances of a particular disease sought access to the information, its disclosure would be covered by principles concerning third party access to health data for bona fide research purposes. In each case, by identifying the position of the holder and the potential recipient of the information, by considering the purposes for which the information was collected and the uses to which it might now be put, and by determining the patient's attitude to its disclosure, a solution can usually be found.

Unauthorised disclosure would be granting third parties access to private or confidential health information without the consent of the patient (or their agent), and without its disclosure being permitted or required by law. Health information relates primarily to the patient, after all. It covers private details of their health and treatment. They therefore have the primary authority to permit its disclosure to proceed.

### 10.3 The evolution of health information law

The law in this area is complex (perhaps too complex), in part due the haphazard manner in which it has developed. New legal principles, like the general concept of information privacy, have often been laid on top of older ones, with the result that several sets of principles come to apply to the same situation. One major example is the concurrent application of privacy and confidentiality principles to many forms of health data. The application of both may be appropriate, as the concepts of privacy and confidentiality protect subtly different legal interests, but it certainly increases the complexity of the law. To unravel such complexity, it often useful to know how the legal principles have developed over time.

#### 10.3.1 Confidentiality

Turning first to the duty to maintain the confidentiality of health records, this has a number of potential legal sources. Such a duty can be imposed by the terms of a contract for health services entered between clinician and patient; it can be considered an aspect of the duty of care owed by clinicians to patients under the law of professional negligence; and, in addition, rules about the confidentiality of certain

kinds of information have existed for centuries, under the law of equity, based on the action for breach of confidence.<sup>1</sup>

These equitable principles about the need to maintain confidences initially emerged in commercial and engineering contexts to prevent the disclosure of financial and manufacturing secrets. They covered information shared between the parties to certain kinds of relationship, like that of employer and employee in a manufacturing enterprise, within which there was an element of trust or reliance and an expectation that commercially sensitive information would not be passed to outsiders without consent. If such information was improperly disclosed, a court could provide a remedy, such as an order suppressing any further circulation of the material.

Subsequently, these general principles of confidentiality have been applied well beyond the original contexts in which they emerged to a wide range of professional relationships, including those of lawyers, bankers and doctors with their clients, the relationship of marriage, and the political relationship between members of the Cabinet.<sup>2</sup> Today, these equitable principles undoubtedly apply to health data collected in the course of confidential therapeutic relationships, and New Zealand courts have awarded damages against health professionals for breach of confidence in recent times.<sup>3</sup>

### 10.3.2 Privacy

The general right to the privacy of personal information, on the other hand, is of much more recent origins in our law, and its scope is not limited to information disclosed within certain categories of relationship. Privacy is probably best understood as an individual human right, one that may be breached by someone with no prior relationship with the individual concerned. The primary function of the right is to permit individuals to control the collection and use of sensitive material about them. A person's diaries or family photographs are usually considered private to them, for instance, and the law will permit them to control their circulation. So, if such material was published in the media, without the person's consent, that could constitute an actionable breach of privacy, even if the information published was true and had come into the possession of the media without any breach of a confidential relationship (after the person dropped their diary in the street, for instance).<sup>4</sup> In such a case, publication could constitute a breach of privacy but not a breach of confidence – indicating the different reach of these concepts.

Until recently, however, no general right to the privacy of personal information was recognised in New Zealand law. Some particular privacy interests had been protected by other legal means. The right not to have one's home, person or property invaded without consent had long been protected, for instance, by the law of trespass. But no general right to the privacy of personal information had been recognised that would

1 See PD Finn *Fiduciary Obligations* (Law Book Co, Sydney, 1977); Francis Gurry *Breach of Confidence* (Clarendon Press, Oxford, 1984); Andrew S Butler and Tim Clarke (eds) *Equity and Trusts in New Zealand* (2nd ed, Brookers, Wellington, 2009).

2 See *Attorney-General v Jonathan Cape Ltd* [1976] QB 752 (QB).

3 See, for example, *JD v Ross* [1998] NZFLR 951 (HC).

4 See the discussion of the new tort of unreasonable invasion of privacy at ch 12 below.

prohibit disclosure of such material without the individual's consent when no trespass had occurred.<sup>5</sup>

That position changed in New Zealand on passage of the Privacy Act 1993 and through subsequent judicial recognition of the new tort of unreasonable interference with personal privacy.<sup>6</sup> The Privacy Act establishes information privacy principles that govern the collection, use, retention, storage and disclosure of personal information, and establishes the Office of the Privacy Commissioner to whom complaints about breach of those principles may be made. It also authorises the Privacy Commissioner to issue specific privacy codes through which the general information privacy principles established by the statute are replaced by special principles (or rules) tailored to particular fields of privacy concern. One of those special codes, of particular relevance to these chapters, is the Health Information Privacy Code 1994.

The new tort of unreasonable interference with privacy, on the other hand, is not based on legislation but on common law principles; it is enforced by the courts, not via the Privacy Commissioner; and it is particularly relevant to the media whose news gathering activities are not covered by the Privacy Act. This tort may cover unauthorised disclosure of health information, and it was applied to restrain disclosure of sensitive mental health data by the media in *P v D*.<sup>7</sup>

The upshot is that both confidentiality and privacy principles may apply simultaneously to certain categories of health information. Patients may pass *private health information* to clinicians *in the course of a confidential therapeutic relationship*. Disclosure of that information to outsiders by the clinician without the patient's consent could then constitute *both* a breach of privacy *and* a breach of confidence, and two distinct complaint processes and sets of remedies would apply. In addition, the health professional could be exposed on a third front, that of professional discipline, as a breach of privacy or confidence can also constitute a breach of professional ethics enforceable through the disciplinary process.<sup>8</sup>

Breach of privacy, breach of confidence and breach of professional ethics are therefore distinguishable though related concepts. They can give rise to different forms of legal proceeding that have different legal sources and histories, and different remedies may be granted against the perpetrator in each case. But all three breaches may occur in a single instance of unauthorised disclosure of health information by a clinician, leaving them exposed to multiple forms of jeopardy. This kind of complexity is a central feature of health information law.

### 10.3.3 Privilege

Another specialised enclave within the general field of health information law concerns relations between courts (and litigants) and those who hold information about a person's health or treatment, when that information may be relevant to the resolution of a legal dispute. In this situation, covered by the law of evidentiary privilege, the public interest in ensuring that all relevant material is put before the

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5 *Malone v Commissioner of the Metropolitan Police* [1979] Ch 344 (Ch).

6 *Hosking v Runting* [2005] 1 NZLR 1 (CA).

7 *P v D* [2000] 2 NZLR 591 (HC).

8 See ch 30 on professional discipline.



court, to permit the fair resolution of the dispute, may conflict with a person's interest in the privacy or confidentiality of their health records. They may not want such material used by the court.

Here the sources of the law lie in procedural rules that establish the powers of courts and litigants to obtain access to information for use in legal proceedings, and in the law of evidence governing the admissibility of such material at a trial. The law of evidence provides, in particular, certain privileges (or immunities) that permit health professionals to hold back information from courts or litigants in some situations, to protect the confidentiality of therapeutic relationships. But because these privileges deny the courts access to relevant evidence, their scope has usually been narrowly defined.

No doubt, as long as courts and tribunals have existed, they have asserted powers to control their procedure and evidence, and to summon witnesses and documents to resolve disputes. Such powers are essential to the fair resolution of proceedings. Evidentiary privileges, on the other hand, that prevent disclosure of relevant information constitute barriers to informed fact-finding. As a consequence, the traditional position within English common law was that no special privilege was recognised that would deny the courts access to relevant health information, regardless of the principle of confidentiality within the health professions, and that is still largely the position in England today.<sup>9</sup> On the other hand, in the civil law jurisdictions of continental Europe, like France, a very different line was taken. There, a strong conception of professional secrecy developed, based on the model of the priest-penitent relationship or the secrecy of the confessional, which prohibited reliance on confidential health material in any legal proceeding. Disclosure of such material could even be considered a crime.<sup>10</sup>

Today, more subtle positions have emerged in many jurisdictions, including New Zealand, concerning the admissibility of such material in legal proceedings. These intermediate positions have been introduced by legislation or by judicial modification of the common law.<sup>11</sup> Beginning in the late 19th century, statutes governing the law of evidence in New Zealand established a privilege that excluded the admission in civil proceedings of certain protected communications made by patients to doctors.<sup>12</sup> Later, a narrower form of privilege was added in criminal proceedings, which applied only to communications made by the accused person to a health professional when seeking treatment for drug addiction or a condition that manifested itself in criminal offending. The apparent purpose was to encourage people to seek therapeutic assistance without fear that what they said to a clinician could be used as evidence to convict them of an offence.<sup>13</sup>

9 See Bankim Thanki and Chloe Carpenter *The Law of Privilege* (Oxford University Press, Oxford and New York, 2006).

10 See, for example, Léo Ducharme *L'Administration de la Preuve* (2nd ed, Wilson and Lafleur, Montreal, 1995).

11 For a brief history of medical privilege in New Zealand, see *C v Complaints Assessment Committee* [2006] NZSC 48, [2006] 3 NZLR 577.

12 Subsequently included in Evidence Amendment Act (No 2) 1980, s 32. This discrete privilege in civil proceedings was abolished on passage of the Evidence Act 2006.

Furthermore, in the mid-20th century a more general common law judicial discretion emerged, which permitted a court to excuse a potential witness from giving evidence, or producing a document, to protect the confidentiality of certain relationships in the wider public interest.<sup>14</sup> That discretion was in turn placed on a statutory footing in New Zealand in 1980.<sup>15</sup> In addition, the privilege that covers communications between lawyers and clients can cover medical reports prepared for lawyers about their clients.

So a range of evidentiary privileges may now be asserted to resist the compelled production of health information in legal proceedings, despite the barrier this may pose to fair resolution of a dispute. As a consequence, the power of a court to order a stay of its proceedings, as a means of preventing unfairness in the trial process, has emerged into greater prominence to mediate the potential conflicts between the parties. The availability of this remedy means that the party asserting a privilege, who wants to hold back relevant information, may be forced to choose between disclosing it to the court, to ensure all relevant evidence is available, and withholding the material, with the result that the proceedings will be stayed to prevent unfairness to the other party.

This area of law was the subject of an important decision of the Supreme Court of New Zealand, in *C v Complaints Assessment Committee*<sup>16</sup> That decision expanded somewhat the boundaries of medical privilege in New Zealand, and may signal the adoption of a more expansive judicial approach to the interpretation of medical or therapeutic privileges, influenced by the notion that personal privacy is an important human right. The law of evidentiary privilege was then comprehensively reformed by the passage of three new statutes: the Evidence Act 2006, the Criminal Disclosure Act 2008 and the Search and Surveillance Act 2012. The rules in these statutes therefore constitute the central focus of chapter 13 below, which is specifically directed at disclosure of health information in legal proceedings.

#### 10.3.4 The patient's access to their health records

A further enclave within this general field concerns the patient's right to obtain access to their own health records held by others. Here the issue is not, strictly speaking, one of privacy or confidentiality because, in most cases, no threat to the patient's privacy or the confidentiality of clinical relationships is posed by giving a patient access to information about their own health care. It is information about them, after all. But the patient's right of access to their health records is still an important aspect of health information law, particularly because it permits the patient to check the accuracy of information others hold about them. In New Zealand the relevant principles are found in privacy legislation, notably in rule 6 of the Health Information Privacy Code 1994. This provides patients with a general right of access to their own health records. It is not an unqualified right, however. Some kinds of information may still be held back, even from the person concerned.

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13 Subsequently included in Evidence Amendment Act (No 2) 1980, s 33; see now Evidence Act 2006, s 59.

14 *D v National Society for the Prevention of Cruelty to Children* [1978] AC 171(HL).

15 Evidence Amendment Act (No 2) 1980, s 35; now see Evidence Act 2006, s 69.

16 *C v Complaints Assessment Committee* [2006] NZSC 48, [2006] 3 NZLR 577.

The patient's right of access to their own health records was originally established in New Zealand by an amendment to the official information (OI) legislation in 1987.<sup>17</sup> But the scope of the OI regime has never extended beyond information held in the public sector, so, when first established, the patient's right of access covered only records held by public sector health providers. Most hospital record-keeping systems in New Zealand were covered, as most hospitals were publicly run, but that OI regime did not extend to records held by general practitioners or other private sector providers. The patient's right of access was then extended in 1993 to records held in the private sector, when the relevant provisions were shifted to the Privacy Act 1993, which extends to both public and private domains.

With some limited exceptions, the Privacy Act requires that all health providers must grant patients access to their own records and permit them to copy those records. It even requires health providers to permit the patient to place a statement on their record about information the patient considers incorrect. So patients in New Zealand now have a general right of access to their medical records in all health care settings unless there is good reason, established by law, for the material to be withheld.

### 10.3.5 Specific statutory exceptions

Finally, alongside these general features of the law, a wide array of statutory provisions has been enacted to prohibit, permit or require specific information flows. Generally, these specific provisions prevail over the principles established by the privacy and official information regimes.

Some of these provisions require the disclosure of health information to designated people. Those people may only be permitted to use that information for limited purposes, however, and they may not be permitted to pass it to others not authorised to receive it under the statutory scheme. Statutes concerning monitoring of the public health, for instance, often require limited disclosures of that kind.<sup>18</sup>

Some other statutes are to opposite effect: they throw an extra cloak of confidentiality or privacy over certain data. There is legislation, for instance, that throws such a cloak over the formal quality assurance activities of the health professions. Here the aim is to encourage the free discussion by clinicians of adverse medical events in specific cases, in quality assurance forums, to permit lessons to be drawn to improve patient care. Information shared in such forums is sealed off from disclosure without the consent of the clinicians involved. It cannot be disclosed even to the Coroner investigating a patient's death.<sup>19</sup> Similarly, admissions made by health practitioners

17 From this time, hospital and area health boards were covered by the vital Official Information Act 1982, sch 2 that lists the range of public organisations to which official information principles apply. Some health information held by government departments and by hospitals run by the then Department of Health, such as Lake Alice psychiatric hospital, had been covered by the OI regime since its introduction in 1982. Parallel legislation covers local government: see the Local Government Official Information and Meetings Act 1987.

18 An example is the legislation giving evaluators access to the health data of women who contract cervical cancer, regardless of the women's consent to its disclosure, for the purpose of auditing the national cervical screening programme: see Health Act 1956, pt 4A.

19 See the quality assurance provisions in Health Practitioners Competence Assurance Act 2003, ss 52–63.