

**THE LAW RELATING TO CONFIDENTIALITY OF DATA
ACQUIRED BY RESEARCHERS IN THE BIOMEDICAL
AND SOCIAL SCIENCES**

by

PAUL BRAVENDER-COYLE*

Introduction

The Privacy Bill 1986 (Cth.), which was introduced into Parliament late last year, will *inter alia*, prohibit researchers employed by federal agencies such as C.S.I.R.O. and the Australian National University, from engaging in acts or practices which constitute an interference with privacy. The Bill, which is based on the recommendations of the Australian Law Reform Commission contained in its report on privacy,¹ is designed: (1) to establish a comprehensive set of rules to regulate the collection, handling and use by federal departments and agencies of personal information so as to provide individuals with a level of privacy consistent with efficient government administration; and (2) to provide an efficient means for compliance with those rules.² Principles 10 and 11 of the Information Privacy Principles (contained in clause 13 of the Bill) permit the disclosure of personal information in certain circumstances, including, situations where such disclosure is necessary or desirable for medical research that is being conducted in a manner that is consistent with 'prescribed medical research guidelines' (*i.e.*, guidelines for the protection of privacy in the conduct of medical research). The National Health and Medical Research Council is authorized to issue such medical research guidelines. The expression 'medical research' is defined to include epidemiological research.

Although the Bill does not preclude a person from seeking existing administrative law remedies such as mandamus, prohibition or injunction, or remedies under the *Administrative Decisions (Judicial Review) Act 1977* (Cth.), against interferences with privacy by federal agencies, clause 16 (2) provides that such interference will not, of itself, permit

* Faculty of Law, Monash University. Barrister and Solicitor of the Supreme Court of Victoria, and a member of the Berlin-based Committee on Medicine and the Law of the International Bar Association.

1 Australian Law Reform Commission, *Privacy*, Vol. 2, Canberra, Australian Government Publishing Service, 1984.

2 Second reading speech: Lionel Bowen (Attorney-General), House of Representatives, *Hansard*, 23 October 1986, 2656-2658; second reading speech: Senator Walsh (Minister for Finance), Senate, *Hansard*, 17 November 1986, 2310-2311; second reading debate, House of Representatives, *Hansard*, 14 November 1986; 3133-3146; Bill read a second time: House of Representatives, *Hansard*, 14 November 1986, 3146; Senate, *Hansard*, 10 December 1986, 3762; Bill read a third time: House of Representatives, *Hansard*, 14 November 1986, 3146.

the person to recover damages. However, when reporting a finding that an interference with privacy has occurred, the Data Protection Agency (established under the Bill) will be able to make a recommendation for compensation to the person affected by the interference. The Bill also modifies the common law by extending the availability of damages for breach of confidence: (1) under the law of the Australian Capital Territory; or (2) by federal agencies and officers under State or Territory law.

Thus the proposed legislation will protect, *inter alia*, research subjects from interference with their privacy by researchers employed by federal agencies: (1) by permitting them to seek existing administrative law remedies against the federal agency concerned; and (2) by means of the existing common law remedies for breach of confidence. However, the majority of researchers in the biomedical and other human-related sciences are outside the ambit of the proposed legislation, and they continue to be subject to professional codes of conduct and common law rules relating to confidentiality. The latter, together with aspects of the law of defamation, copyright and passing off, constitute the principal methods for the prevention of unauthorized disclosure of personal information.

This article will examine the existing controls and regulatory mechanisms available to preserve the confidentiality of personal data acquired by researchers in the biomedical and other human-related sciences; the standards set by professional codes of conduct; the common law relating to breach of confidence; and, finally, policies, practices and procedures for maintaining confidentiality.

Conceptual classification

Before proceeding to a detailed examination of existing controls on such research, it may be useful to make some preliminary conceptual classifications.

Existing controls can be classified into four types, and the researchers themselves can be classified into two categories.

A. Codes of professional ethics

These consist of codes of behaviour or conduct prescribed by professional bodies such as the American Medical Association, the British Medical Association, the Australian Medical Association, the American Psychological Association, the American Psychiatric Association, the Australian Psychological Society, to mention just a few. Failure to comply with such a code may result in disciplinary action being taken against the member by the professional body to which he or she belongs. Usually these codes of professional behaviour are relevant in legal proceedings where they may constitute evidence of the standard of professional care or ability required of members of that profession. Supplementary rules, often called guidelines, are sometimes issued by these professional bodies from time to time prescribing procedures to be followed in certain areas of research.

B. Institutional guidelines

These consist of guidelines issued by an institution, such as C.S.I.R.O. or a university or the ethics committee of a hospital, and they usually require that research procedures carried out at the institution concerned must comply with those guidelines.

C. Government funding guidelines

These consist of guidelines issued by government funding bodies such as the Medical Research Council in the U.K. or the National Health and Medical Research Council in Australia. Compliance with the guidelines is usually a condition of receiving funding, and non-compliance may result in termination of that funding.

D. Legal controls

Such controls include legislation, regulations and the common law. They also include rules and regulations issued by statutory disciplinary tribunals such as the General Medical Council in the U.K. or its equivalent in the Australian States.

Researchers can be classified into two main categories:

1. Those researchers who are members of professional bodies such as those referred to in category D above and who are bound by that body's code of professional ethics.
2. Those researchers who do not fall into category 1. This would usually include researchers who do not belong to any professional association and might probably include postgraduates, research assistants and technicians in university faculties of medicine and science, as well as some economists and sociologists belonging to research institutions.

Accordingly, in the case of government-funded research, the controls on both categories of researchers would be as follows:

	Researcher Type 1	Researcher Type 2
A. Codes of Professional Ethics	*	
B. Institutional Guidelines	*	*
C. Government Funding Guidelines	*	*
D. Legal Controls	*	*

In the case of privately-funded research, the controls may be represented as follows:

	Researcher Type 1	Researcher Type 2
A. Codes of Professional Ethics	*	
B. Institutional Guidelines	*	*
D. Legal Controls	*	*

Codes of Professional Ethics

The classic enunciation of confidentiality of information obtained in a professional or biomedical research relationship is contained in the Hippocratic Oath:³

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 should be kept secret.⁴

The non-disclosure of that 'which ought not to be spoken of abroad' clearly 'indicates that there are some things which may be published'.⁵ The Declaration of Geneva adopted by the World Medical Association at its meeting in Geneva in 1948 and amended at its meeting in Sydney in 1968, modifies this prohibition⁶ to: 'I will respect the secrets which are confided in me, even after the patient has died.' The International Code of Medical Ethics prepared by the World Medical Association in 1949 states: 'A doctor shall preserve absolute secrecy on all he knows about his patients because of the confidence entrusted to him.' Similar provisions are contained in the codes of ethics of the various national medical associations. The Australian Medical Association Code of Ethics, for instance, interprets the Hippocratic Oath as follows: 'To keep secret anything learned as the outcome of professional relationship with a patient which should not be divulged', and states that:

It is the practitioner's obligation to observe strictly the rule of professional secrecy by refraining from disclosing without the consent of the patient (save with statutory sanction) to any third party information which he has learnt in his professional relationship with his patient,

while the Canadian Medical Association Code of Ethics states:

An ethical physician will keep in confidence information derived from his patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except where the law requires him to do so.

But, perhaps, the best description of the exceptions to non-disclosure is contained in the British Medical Association's handbook, which lists five exceptions to the rule of professional secrecy.⁷ These are:

- (1) *Consent*. The patient gives his or her consent to disclosure;
- (2) *Interests of the patient*. It is ethical to break confidentiality where 'it is undesirable on medical grounds to seek a patient's consent,

3 J. Edelstein, *Der Hippokratische Eid*, Zurich and Stuttgart, Artemis-Verlag, 1969, 5; P. Deichgaber, *Der Hippokratische Eid*, 3rd ed. Stuttgart, Hippokrates-Verlag, 1972, 8-10.

4 J. K. Mason and R. A. McCall Smith, *Law and Medical Ethics*, London, Butterworths, 1983, 251; D. Giesen, *Medical Malpractice Law: A Comparative Law Study of Civil Responsibility Arising from Medical Care*, Bielefeld, Geiseking-Verlag, 1981, 425; E. J. Picard, *Legal Liability of Doctors and Hospitals in Canada*, Toronto, Carswell, 1978, 25.

5 Mason and McCall Smith, *supra* note 4, at p. 96.

6 *Ibid.*

7 British Medical Association, *Handbook of Medical Ethics*, London, British Medical Association, 1981, 12-15.

but it is in the patient's own interest that confidentiality should be broken';

- (3) *Duty to society.* This exception permits disclosure where the doctor has an 'overriding duty to society';
- (4) *Medical research.* Disclosure may be permitted where the information is required for approved medical research;
- (5) *Due legal process.* This exception permits disclosure when the information 'is required by due legal process', *i.e.* by legislation or in court.

The first exception is, of course, not really an exception to the principle of confidentiality since, strictly speaking, where consent has been given no transgression of confidentiality occurs.⁸ Of the remaining four exceptions, the third (duty to society) and the fourth (medical research) are obviously the most important ones in the context of the confidentiality of data acquired by biomedical researchers, though, of course, the final exception (due legal process) will be considered later in the context of legal controls. Of course, this is not to suggest that the first exception is totally irrelevant since it has been suggested that there may be situations where the pressures to consent to disclosure 'are virtually irresistible and truly autonomous consent is impossible [. . .]'⁹

The second exception — that it is ethical to disclose confidential information without the patient's consent when it is in the patient's interests and when it is undesirable on medical grounds to seek such consent — is unexceptional. Such a decision rests, 'by definition, on clinical judgment — a properly considered clinical decision cannot be unethical whether it proves right or wrong,'¹⁰ and consequently it would be considered as a justifiable breach of confidence in any legal proceedings or before a professional conduct committee.¹¹

The third exception — where there is an 'overriding duty to society' to disclose — is certainly the most difficult, and its extent most uncertain, of the five exceptions. It permits the disclosure of confidentiality in the interests of promoting the benefit of, or preventing harm to, others¹² in society.

The fourth exception — disclosure of information required for approved medical research — is the only one of the five exceptions to patient-doctor confidentiality which is not recognised in law. In this context, the Australian Medical Association's guidelines on the disclosure of research data requires its members, in the absence of legislation, 'to ensure that the patient's identity is never compromised and that the patient's privacy is not invaded unless with his informed knowledge and consent'.¹³

8 Editorial, 'Medical Confidentiality' (1984) 1 *J. Med. Ethics* 3.

9 Mason and McCall Smith, *supra* note 4, at p. 97.

10 *Ibid.*

11 *Ibid.*

12 Editorial, *supra* note 8, at p. 4.

13 Australian Medical Association, *Policies of the Australian Medical Association*, Sydney, Australian Medical Association, 1980, para 35.

The fifth exception — disclosure under compulsion of law — can be sub-divided further into (a) disclosure under statute or common law and (b) disclosure in court. There are an increasing number of Acts of Parliament and subordinate legislation requiring that certain information gained in treatment must be notified. These include 'notifiable diseases' and venereal disease, to mention just a few. A physician may also be required to divulge confidential information while being cross-examined in the witness-box. Fortunately, a number of jurisdictions have legislation which grants professional privilege to doctors in civil, but not criminal,¹⁴ proceedings.¹⁵ The privilege, of course, belongs to the patient, not the physician.

Many other codes of professional ethics embody similar, if not identical, categories of exceptions.¹⁶ It will be seen later that all these categories of exceptions to non-disclosure, except the fourth one, are analogous to the legal categories of disclosure. As mentioned above, the fourth exception is not recognised by law.

However, generally speaking, since researchers are more usually confronted by the third (duty to society) and fourth (research) exceptions, these two exceptions will subsequently be examined in greater detail.

Institutional Guidelines

Some institutions have written guidelines or unwritten conventions for the disclosure of confidential information. These may vary from institution to institution, and are usually imposed by the ethics committees of individual institutions.

Nevertheless, a study in 1984 revealed that record keepers at some institutions disclosed the identity of subjects despite being warned to preserve the subjects' privacy. However, it appears from the study that those institutions such as teaching hospitals which received many such requests from researchers invariably protect the identity of subjects.¹⁷ One assumes that this was because of their greater experience in handling such requests,¹⁸ as a consequence of which they had probably developed either written guidelines or unwritten conventions for handling them.

14 Kirby M.D., 'Should Doctor's Records Be Privileged?' (1981) 2 *Med.J. Aust.* 115-116.

15 *Evidence Act 1958* (Vic.) s. 28 (2), (3); *Evidence Act 1910* (Tas.) s. 96 (2), (3); *Evidence Act 1937* (N.T.) s. 12 (2), (3).

16 American Medical Association, *Principles of Medical Ethics* (1957) s. 9; *Summary Report of the Task Force on Confidentiality of the Council on Professions and Associations of the American Psychiatric Association* (1975); American Psychological Association, *Ethical Standards of Psychologists 1968*; Australian Psychological Society, 1970, 77; Australian Association of Social Workers, *Code of Professional Ethics 1981*, Principle 8. A brief review of these codes is given in R. F. Boruch and J. S. Cecil, *Assuring Confidentiality of Social Research Data*, University of Pennsylvania Press, 1979, 19-22.

17 J. W. Donovan, 'An Experiment in Privacy Protection' (1984) 141 *Med.J. Aust.* 648-649.

18 *Ibid.* 649. See also N.S.W. Department of Health, *Confidentiality of Health Records in Hospitals and Community Health Services*, Circular No. 82/369.

Government Funding Guidelines

The two major bodies which issue such guidelines are the National Health and Medical Research Council in Australia and the Medical Research Council in the U.K. Compliance with the guidelines of these bodies is usually a condition of receiving funding, and non-compliance may result in termination of that funding.

The National Health and Medical Research Council permits the exchange of information between researchers. It states:

subject to maintenance of confidentiality in respect of individual patients, all members of research groups should be fully informed about projects on which they are working.¹⁹

The Medical Research Council goes even further and states that

subject to certain safeguards, medical information obtained about individual patients should continue to be made available without their explicit consent for the purpose of medical research.²⁰

Legal Controls

As stated earlier, these legal controls may include not only legislation, regulations and the common law, but also rules and regulations issued by statutory bodies such as the General Medical Council in the U.K., or its equivalent in the Australian jurisdictions.

The General Medical Council, however, recognizes that information may be disclosed for research purposes. According to the G.M.C.,

[i]nformation may also be disclosed for the purpose of a medical research project which has been approved by a recognised ethical committee.²¹

Clearly, the relationship of physician and patient, social worker and client, and psychotherapist and patient, are professional relationships, and consequently 'the law implies a term into the contract whereby a professional man is to keep his client's affairs secret'.²²

But does the relationship of researcher and subject come within its ambit? The answer is that it clearly does, either because it is (1) a professional relationship like that of doctor and patient;²³ (2) a confidential relationship analogous to that of employer-employee or lecturer-student;²⁴ or (3) a confidential relationship based, 'not so much on property or on contract, but rather on the duty to be of good faith'.²⁵

19 National Health and Medical Research Council, *Statement on Human Experimentation and Supplementary Notes*, Canberra, N.H.M.R.C. rev. 1982, para 12.

20 Medical Research Council, 'Responsibility in the Use of Medical Information for Research' (1973) 1 *Br.Med.J.* 213-216.

21 General Medical Council, *Professional Conduct and Discipline: Fitness to Practise*, London, General Medical Council, 1983, 20.

22 *Parry-Jones v. Law Society* [1969] 1 Ch. 1, 9, per Lord Denning M.R.

23 *Furniss v. Fitchett* [1958] N.Z.L.R. 396 at p. 400; P. D. Finn, 'Confidentiality and the "Public Interest"' (1984) 58 *A.L.J.* 497, at p. 501; *A.B. v. C.D.* (1851) 14 *Dunl. (Ct. of Sess.)* 177; *A.B. v. C.D.* (1904) 7F (Ct. of Sess.) 72.

24 *Slavutych v. Baker* (1975) 55 *D.L.R.* (3d) 224; *Putzman v. Taylor* [1927] 1 *K.B.* 637, at p. 641. *Abernethy v. Hutchinson* (1825) 3 *L.J. Ch.* 209.

25 *Fraser v. Evans* [1969] 1 *All E.R.* 8, at p. 11, per Lord Denning; *Duchess of Argyll v. Duke of Argyll* [1967] *Ch.* 302; *Taylor v. Blacklow* (1836) 3 *Bing. (N.C.)* 235; 135 *E.R.* 401.

The latter category may be illustrated by *Foster v. Mountford & Rigby Ltd.*²⁶ where an injunction was placed on the sale in the Northern Territory of the book *Nomads of the Australian Desert* on the grounds that it contained confidential information about sacred sites and rituals given to the researcher by tribal aborigines. They had taken the researcher into their confidence, said Muirhead J., and 'whilst there is no evidence by document or conversation or indeed by recognized legal relationship of the manner in which the confidence was reposed',²⁷ he was satisfied that the book revealed some secrets which it was understood would not be revealed when the trust was imposed. He agreed that the case involved 'many issues, some involving matters of public policy, including one's right to disseminate the results of scientific or anthropological research',²⁸ but that nevertheless it was 'well established that the law will act to prevent a breach of faith, a breach of confidence'.²⁹ As Lord Justice Denning stated in *Fraser v. Evans*, '[n]o person is permitted to divulge to the world information which he has received in confidence, unless he has just cause or excuse for doing so'.³⁰

Confidentiality in research may not only be imposed by the common law, but sometimes also by statute, as, for example, the *Epidemiological Studies (Confidentiality) Act 1981* (Cth.), which imposes a statutory duty of confidentiality in relation to epidemiological studies of physical, mental, or behaviour disorder conducted by, or on behalf of, the Commonwealth.

Unauthorized disclosure of confidential information could result in proceedings against the researcher for breach of contract, negligent disclosure, or breach of confidence, depending on the circumstances of disclosure.³¹ It could even, in some situations, result in the researcher being sued for defamation, deceit, or negligent misstatement.³²

If the researcher belongs to a professional association, or is subject to a statutory authority governing his profession (e.g. the General Medical Council), that body may take disciplinary proceedings against him for conduct unbecoming a physician³³ and he could be reprimanded, suspended or even struck off the register.³⁴

26 (1976) 14 A.L.R. 71.

27 *Ibid.*, 73.

28 *Ibid.*, 76.

29 *Ibid.*, 74.

30 [1969] 1 All E.R. 8, at p. 11.

31 Mason and McCall Smith, *supra* note 4, at pp. 107-108; V. D. Plueckhahn, *Ethics, Legal Medicine and Forensic Pathology*, Melbourne, Melbourne University Press, 82; R. G. Fox, 'Ethical and Legal Principles of Confidentiality of Psychologists and Social Workers' in M. Nixon, *Issues in Psychological Practice*, Melbourne, Longman Cheshire, 1984, 161-163; Australian Law Reform Commission, *Privacy*, Vol. 1, Canberra, Australian Government Publishing Service, 1983, 420.

32 Fox, *supra* note 31 at pp. 161-163; Australian Law Reform Commission, *supra* note 31, at pp. 419-420.

33 *Medical Practitioners Registration Ordinance 1930* (A.C.T.) s. 30; *Medical Practitioners Registration Act 1980* (N.T.) s. 30; *Medical Practitioners Act 1938* (N.S.W.) s. 27; *Medical Act 1939* (Q.) ss. 35, 37A; *Medical Practitioners Act 1983* (S.A.) ss. 54, 58; *Medical Act 1959* (Tas.) s. 25; *Medical Practitioners Act 19.0* (Vic.) s. 17; *Medical Act 1894-1968* (W.A.) s. 13.

34 *Cf R. v. General Medical Council* [1930] 1 K.B. 562.

Exceptions

The law, however, permits, and in some cases compels, disclosure in certain circumstances. These circumstances may be categorized as follows:³⁵

- disclosure is made with the express or implied consent of the confider;
- disclosure in the interests of the public;
- disclosure is made in the interests of the confidant;
- disclosure under compulsion of law.

It is sometimes claimed that there is also a further category: disclosure in the interests of the confider.

Disclosure with consent

This category corresponds to the first exception examined while considering codes of professional ethics.

Clearly disclosure may be made with the express or implied consent of the confider.³⁶ Although express consent creates few problems, the question of when consent can be implied is a little more difficult.

Where a subject is being interviewed by a researcher and the subject is aware that the researcher is part of a team undertaking the study, it is probably true to say that the subject has consented to that information being exchanged with the other researchers in the team, or if the researcher is a junior one (*e.g.*, a student), that the subject has consented to the information being made available to the senior researcher or research supervisor. Such consent could more readily be implied where the subjects are students, and thus generally aware of the character of research projects. Where the subject is a member of the general public, then more consideration would be required before assuming that the subject had so consented. The correct procedure would, of course, be to discuss the situation with the subject himself.

According to Professor Robert Hayes, Australian Law Reform Commissioner, some legal practitioners have been advising researchers that implied consent may constitute an exception justifying the disclosure of research data. Commenting on this, he states that

[s]uffice it [is] to say that the courts have been cautious about *implied* consent; and even in the context of the confidential relationship between banker and customer, there has been no authoritative legal pronouncement that such a well-known custom as a banker's opinion is legally justified in all circumstances. There will be many situations in the hospital context in which persons beyond the group of attending health professionals will be lawfully entitled to have access to medical records on the basis of implied consent. But epidemiologists should be careful not to push this too far, particularly when access to hospital records is sought by outside

35 Australian Law Reform Commission, *supra* note 31, at p. 394.

36 *C. v. C.* [1946] 1 All E.R. 562.

epidemiologists, or when epidemiologists, on the basis of access to hospital records, seek to follow them through into unconnected educational or work places.³⁷

Disclosure in the interests of the confider

This category corresponds to the second exception examined while considering codes of professional ethics.

It has been argued by some that disclosure

may be justified as something to which the person confiding would have consented had he or she been in a position to comprehend the necessity of the occasion and been capable of expressing views on the matter. This applies particularly in relation to mentally disordered persons. The person may not pose an imminent danger to themselves or others but the worker may nevertheless wish to release information about them to preserve their health and to provide for their welfare.³⁸

This view has been doubted, even where the individual is, in fact,³⁹ a danger to himself, for example,

an old man who lives alone, refusing to accept any social help or support and who is at great risk of contracting hypothermia.⁴⁰

Disclosure in those circumstances 'might not be justifiable under the current law' either on the grounds of public interest⁴¹ or by reference to implied consent.⁴²

Disclosure in the public interest

This category corresponds to the third exception examined while considering codes of professional ethics.

This category is the most difficult and problematic of all. It

has been criticised as too imprecise. But it may be that its flexibility is desirable, allowing it to accommodate changes in perceptions of the public interest, and developments of medical predictability.⁴³

In *Cartside v. Outram*,⁴⁴ a case which concerned fraud in commercial dealings, Wood V.C. stated:

The true doctrine is that there is no confidence as to the disclosure of iniquity. You cannot make me the confidant of a crime or a fraud, and be entitled to close up my lips upon any secret which you have the audacity to disclose to me relating to any fraudulent intention on your part; such a confidence cannot exist.⁴⁵

37 R. Hayes, 'Epidemiological Research and Privacy Protection' (1984) 141 *Med. J. Aust.* 621, at p. 623.

38 Fox, *supra* note 31, at p. 180.

39 Australian Law Reform Commission, *supra* note 31, at p. 419.

40 A. Samuels, 'The Duty of the Doctor to Respect the Confidence of the Patient' (1980) 20 *Med. Sc. Law* (1) 58, at p. 63.

41 Australian Law Reform Commission, *supra* note 31, at p. 419.

42 *Ibid.*

43 *Ibid.*

44 (1857) 26 L.J.Ch. 113.

45 *Ibid.*, 114.

The ambit of this category was widened in *Initial Services Ltd. v. Putterill*,⁴⁶ where the manager of the company disclosed to the Press certain practices of the company which were contrary to the *Restrictive Trade Practices Act 1956* (U.K.). Lord Denning M.R. said:⁴⁷

In *Weld-Blundell v. Stephens*,⁴⁸ Bankes, L.J. rather suggested⁴⁹ that the exception is limited to the proposed or contemplated commission of a crime or a civil wrong. But I should have thought that was too limited. The exception should extend to crimes, frauds and misdeeds, both those actually committed as well as those in contemplation, provided always — and this is essential — that the disclosure is justified in the public interest. The reason is because ‘no private obligations can dispense with that universal one which lies on every member of the society to discover every design which may be formed, contrary to the laws of the society, to destroy the public welfare’: see *Annesley v. Anglesea (Earl)*.⁵⁰

In *Commonwealth v. John Fairfax & Sons Ltd.*,⁵¹ which concerned publication of government documents dealing with Australia’s policy towards East Timor, Mason J. said:

It has been acknowledged that the defence applies to disclosures of things done in breach of national security, in breach of law (including fraud) and to disclosure of matters which involve danger to the public.⁵²

However, in that case it did not cover advice given by public servants ‘with a view to exposing what is alleged to have been the cynical pursuit of expedient goals, especially in relation to East Timor’.⁵³

Crimes and proposed crimes are also encompassed by this category since ‘the detection and prosecution of criminals, and the discovery of projected crimes, are important weapons in protecting the public interest’.⁵⁴

It appears that courses that contain ‘dangerous material’, e.g. ‘medical quackeries of a sort which may be dangerous if practised behind closed doors’⁵⁵ are also encompassed by this category. Disclosure may also be in the public interest where there is evidence that the organizations who confided the information ‘have been protecting their secrets by deplorable means such as is evidenced by [their] code of ethics’,⁵⁶ e.g. if there was an implication

that here was an organisation which had laid down a criminal code of its own and by the criminal code it treated, and required its adherents to treat, persons as outlaws deprived of any protection

46 [1968] 1 Q.B. 396.

47 *Ibid.*, 405.

48 [1919] 1 K.B. 520; 35 T.L.R. 245, C.A.; aff’d [1920] A.C. 956.

49 [1919] 1 K.B. 520, at p. 527.

50 (1741) 1 Br. P.C. 289, 1 E.R. 573, 17 State Tr. 1139, reported in a note in (1869-70) L.R. 5 Q.B. 317.

51 (1981) 55 A.L.J.R. 45.

52 *Ibid.* at p. 51.

53 *Ibid.*

54 *Malone v. Metropolitan Police Commissioner* [1979] 2 All E.R. 620, at p. 646, per Megarry V.C.

55 *Hubbard v. Vosper* [1972] 2 Q.B. 84, at p. 96, per Lord Denning M.R.

56 *Ibid.* at p. 101, per Megaw L.J.

or sanction so far as the scientological organisation was concerned if they have been guilty of 'suppressive acts'; and no Scientologist was to be condemned, under the ethical code of Scientology, for any action — I repeat any action — which he might take against such 'fair game'.⁵⁷

However, it appears that civil wrongs, such as libellous statements are not encompassed by this category,⁵⁸ provided there is no public interest in disclosure which overrides the public interest in maintaining confidentiality.⁵⁹ Although the last clause of the preceding sentence may have a tautological ring about it, we have in fact arrived at the balancing of public interests test, *i.e.* the balancing of interests test enunciated in *Science Research Council v. Nassé; B.L. Cars Ltd. (formerly Leyland Cars) v. Vyas*.⁶⁰

On the other hand, there is an *obiter dictum* by Warrington L.J. in *Weld-Blundell v. Stephens*⁶¹ that a criminal libel may come within the ambit of this category. The ambit of this category was widened even further in *Lion Laboratories Ltd. v. Evans*^{61a} in which the Court of Appeal held that, contrary to the suggestion in *Gertside v. Outram*, the defence of disclosure in the public interest does not depend upon any 'iniquity', but merely that the information is so important to the public as to outweigh the competing public interest in the maintenance of confidentiality. In that case, the Court held that the first public interest prevailed because doubts about the accuracy of a speed measuring device meant that there was a possibility of innocent people being punished for offences they may not have committed.

Tarasoff Case

The question of disclosure of confidential information also arose in *Tarasoff v. Regents of the University of California*.⁶² In that case, Poddar, a voluntary outpatient receiving therapy at a hospital forming part of the University of California at Berkeley, informed Moore, a psychologist who was his therapist, that he was going to kill an unnamed girl, readily identifiable as Tatina, when she returned from spending the summer in Brazil. Moore, with the concurrence of two psychiatrists at the hospital, decided that the patient should be committed for observation in a mental hospital. Moore orally notified two campus policemen that he would request commitment, and he sent a letter to the Police Chief requesting the assistance of the police department in securing

57 *Ibid* at p. 100, per Megaw L.J. See also *Church of Scientology of California v. Kaufman* [1973] R.P.C. 627 (int. proceedings), 635 (trial), Ch.D.

58 *Weld-Blundell v. Stephens* [1919] 1 K.B. 520, C.A

59 *Distillers Co. (Biochemicals) Ltd. v. Times Newspapers Ltd.* [1972] 1 Q.B. 613, at pp. 623-625, per Talbot J.

60 [1979] 3 All E.R. 673; [1979] 3 W.L.R. 762.

61 [1919] 1 K.B. 520, at p. 533.

61a [1985] 1 Q.B. 526.

62 131 Cal. Rptr. 14 (1976); 551 P. 2d 334 (1976); J. G. Fleming and B. Maximov, 'The Patient or His Victim: The Therapist's Dilemma' (1974) 62 *Cal.L.Rev.* 1025.

the patient's confinement. Three officers took the patient into custody but, satisfied that the patient was rational, released him on his promise to stay away from Tatina. The director of psychiatry at the hospital then asked the police to return Moore's letter, directed that all copies of the letters and notes that Moore had taken as therapist be destroyed, and ordered that no further action be taken to detain the patient.

Two months later, the patient killed Tatina. Her parents brought an action in the Supreme Court of California. Tobriner J., delivering the majority judgment, said that the cause of action could be amended to allege that Tatina's death proximately resulted from the defendants' negligent failure to warn Tatina or others likely to apprise her of her danger. He continued:

Although [...], under the common law, as a general rule, one person owed no duty to control the conduct of another, the courts have carved out an exception to this rule in cases in which the defendant stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct. Applying this exception to the present case, we note that a relationship of defendant therapists to either Tatina or Poddar [the patient] will suffice to establish a duty of care [...].⁶³

Although the California decisions that recognize this duty have involved cases in which the defendant stood in a special relationship *both* to the victim and to the person whose conduct created the danger, we do not think that the duty should logically be constricted to such situations. Decisions of other jurisdictions hold that the single relationship of a doctor to his patient is sufficient to support the duty to exercise reasonable care to protect others against dangers emanating from the patient's illness. The courts hold that a doctor is liable to persons infected by his patient if he negligently fails to diagnose a contagious disease or, having diagnosed the illness, fails to warn members of the patient's family.⁶⁴

Turning to the question of confidential information, the Court looked at s. 9 of the Principles of Medical Ethics of the American Medical Association (1957), which stated that a physician may not reveal such confidences 'unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community', and s. 1024 of the Californian Evidence Code, which stated that there was no privilege 'if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger'. The Court stated:

We realize that the open and confidential character of psychotherapeutic dialogue encourages patients to express threats of violence, few of which are ever executed. Certainly a therapist should not be encouraged routinely to reveal such threats; such disclosures could seriously disrupt the patient's relationship with

63 Ibid, 343.

64 Ibid, 344.

his therapist and with the persons threatened. To the contrary, the therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger.⁶⁵

The Court concluded 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 protective privilege ends where the public peril begins.⁶⁶

It is clear, however, that such a duty does not apply *mutatis mutandis* to all relationships, since the Court in *Tarasoff* held that the campus police who, at the request of Moore and the psychotherapists, briefly detained the patient but released him when he appeared rational did 'not have any such special relationship to either Tatina or to Poddar [the patient] sufficient to impose on such defendants a duty to warn respecting Poddar's violent intentions'.⁶⁷

One writer, commenting on this Californian decision, has stated that the courts in the U.K. and Australasia 'have not yet held a psychologist or social worker is under any duty to protect third parties from possible risk disclosed in the course of providing therapeutic services' since at 'the present time he has a *right* to disclose in such circumstances, but it has not been raised into a *duty* to do so'.⁶⁸ While it is true that there have been no court decisions concerning these two professions, it is very doubtful whether the last statement is correct when considered in the light of *Weld-Blundell v. Stephens*,⁶⁹ where Bankes L.J. stated that in the case of 'confidential communications to a professional adviser as to the proposed commission of a crime, or as to the proposed commission of a civil wrong upon an individual', a

contract to keep such a communication secret may well be considered as an illegal contract, and the *duty* to the public to disclose the criminal or illegal intention may properly be held to override the private duty to respect and protect the client's confidences.⁷⁰

Later in the same case, Warrington L.J. stated that

if the document in question revealed a contemplated crime, the commission of which its disclosure might prevent, I think there would be a *duty* owing to the public which would override any private obligation.⁷¹

65 *Ibid*, 347.

66 *Ibid*. See also the Summary Report of the Task Force on Confidentiality of the Council on Professions and Associations of the American Psychiatric Association 1975.

67 *Tarasoff v. Regents of the University of California*, 551 P 2d 334, at p. 349.

68 Fox, *supra* note 31, at pp. 161-162.

69 [1919] 1 K.B. 520.

70 *Ibid* 527 (emphasis added).

71 *Ibid* 533 (emphasis added). Perhaps their honours were influenced by the offence of misprision of felony.

Since that case involved disclosure of a confidential statement which resulted in the confider being sued for libel, the above statements might be regarded as *obiter dicta*. It is interesting to observe, however, that Bankes L.J. considered that 'the *proposed* commission of a civil wrong upon an individual' [emphasis added] could be disclosed, and he later distinguished between that situation and the case 'where the wrong is completed before the communication is disclosed', and which should not be disclosed. He believed that the case he was dealing with came within the latter category.

Quite apart from whether his statement ('the wrong is completed before the communication is disclosed') is correct in the context of the law of libel, his distinction between a contemplated crime or civil wrong and crimes or civil wrongs which have actually been committed⁷² was questioned by Lord Denning M.R. in *Initial Services Ltd. v. Putterill*. In that case Lord Denning observed:⁷³

In *Weld-Blundell v. Stephens*,⁷⁴ Banks, L.J. [...] suggested that the exception [to non-disclosure of confidential communications] is limited to the proposed or contemplated commission of a crime or a civil wrong. But I should have thought that was too limited. The exception should extend to crimes, frauds and misdeeds, both those actually committed as well as those in contemplation, provided always — and this is essential — that the disclosure is justified in the public interest. The reason is because 'no private obligation can dispense with that universal one which lies on every member of the society to discover every design which may be formed, contrary to the laws of the society, to destroy the public welfare': see *Annesley v. Anglesea*.

There is much to be said for Lord Denning's view, since an examination of the passage of the judgment of Bankes L.J. reveals that the distinction arose from a conceptual difficulty, as he cited the solicitor-client relationship as the basis for his distinction: 'a person who is charged with attempting to commit suicide tells his solicitor that he did so attempt and asks him to defend him'. Bankes L.J. appears to have confused the solicitor-client relationship, which as we know is a special exception — legal professional privilege — with a general rule involving all professional communications.

There is some uncertainty as to disclosure of illegal abortions. In 1896 Hawkins J. stated that there was no duty to report to the authorities 'whenever they thought that a crime had been committed',⁷⁵ but, even here, he drew a distinction between abortion and murder.⁷⁶ However, Avory J. in 1914 stated that there 'are cases where the desire to

72 Ibid 527.

73 [1968] 1 Q.B. 396, at p. 405.

74 [1919] 1 K.B. 520, C.A., aff'd [1920] A.C. 956.

75 *Kitson v. Playfair* (1896) *The Times*, 28 March 1896, 22 Digest (Reissue) 457, (1896) 1 *Brit.Med.J.* 882.

76 Mason and McCall Smith, *supra* note 4, at p. 99, fn. 12.

preserve that confidence must be subordinated to the duty which is cast on every good citizen to assist in the investigation of serious crime [...]'⁷⁷

In the New Zealand case of *Furniss v. Fitchett*, which concerned the negligent disclosure of confidential information by a physician, Barrowclough C.J. stated:

I cannot think that [the duty of non-disclosure] is so absolute as to permit, in law, not the slightest departure from it. Take the case of a doctor who discovers that his patient entertains illusions 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? Take the case of a patient of very tender years or of unsound mind. Common sense and reason demand that some report on such a patient should be made to the patient's parent or other person having control of him. But public interest requires that care should be exercised in deciding what shall be reported and to whom [...]. That which will justify a departure from the general rule must depend on what is reasonable professional conduct in the circumstances under consideration in the particular case, and as such is a question for the jury.⁷⁸

What if the researcher discovers that his subject has a contagious or infectious disease and the subject works in a public place such as a swimming pool or a hotel? In practice 'such questions are now a matter of history because modern therapy sterilises infected persons rapidly save in very exceptional circumstances'.⁷⁹ But what if the subject has contracted AIDS? Here the researcher may feel that he has a moral duty to disclose,⁸⁰ but would he be protected under the category of public interest if he does so? The Australian Law Reform Commission, in its review of the law in this area, took the view that if the subject (i) was about to commit, or had committed, a serious crime; (ii) was a child abuser; or (iii) the victim of a serious crime, the researcher might be justified in disclosing the information to the appropriate authorities.⁸¹ It should be noted in passing that there is legislation in most jurisdictions governing the reporting of child abuse⁸² and that the Queensland *Medical Act* 1939-1981, s. 35 (ix)-(xi), in effect, compels a medical practitioner to disclose to the police any information he receives concerning an attempted or completed crime, or when he attends the victim of criminal attack (even though the victim did not consent to disclosure).

The Australian Law Reform Commission took the view, however, that disclosure (i) that a subject had a genetically transmissible disease;

77 'Medical Etiquette and Criminal Abortion': charge to the jury, Birmingham Autumn Assizes. 1 December 1914 (1914) 78 J.P. 604; (1914) 49 L.J. 713. His Honour was probably influenced by the existence of the offence of misprision of felony.

78 [1958] N.Z.L.R. 396, at pp. 405-406.

79 Mason and McCall Smith, *supra* note 4, at p. 99.

80 Plueckhahn, *supra* note 31, at p. 84.

81 Australian Law Reform Commission, *supra* note 31, at p. 418.

82 See note 94 *infra*.

(ii) that he represented a danger to the public, such as a barman who develops a chancre or open tuberculosis, or a bus driver whose blood pressure is rising over 200; or (iii) the subject is a danger to himself, as for example, an old man who lives alone, refusing to accept any social help or support and who was at great risk of contracting hypothermia, might not be justifiable under the current law.⁸³ In such a situation, every effort should be made by the researcher to persuade the subject to agree to disclose the information.⁸⁴ However, the decision of the Court of Appeal in *Lion Laboratories Ltd. v. Evans*^{84a} may mean that (i) and (ii) could be disclosed.

Consequently, the advice given by some lawyers that certain forms of research, such as epidemiological research, would come within the 'public interest' exception to the duty of confidentiality is probably not tenable in the light of judicial decisions.⁸⁵

Exceptions

In summary then, the legal exceptions to non-disclosure of confidential communications are:

- A. Disclosure under compulsion of law or where there is a statutory obligation to disclose.
- B. Disclosure with the consent, either express or implied, of the confider.
- C. Disclosure in the public interest:
 - crimes, including criminal libel;
 - fraud;
 - proposed or contemplated crimes;
 - statutory obligations to disclose;
 - possibility of innocent people being punished for offences which they may not have committed;
 - doubts about devices upon the accuracy of which a person's livelihood or liberty may depend;
 - courses that involve dangerous material or medical quackeries which may be dangerous to the public;
 - secrets of an organization which are protected by deplorable means by that organisation, thereby constituting a danger to the public;
 - activities involving a breach of law generally (e.g. Trade Practices legislation); or
 - anything else within the all encompassing phrase: 'matters which involve danger to the public'.

83 Australian Law Reform Commission, *supra* note 31, at p. 419.

84 Plueckhahn, *supra* note 31, at p. 84.

84a [1985] 1 Q.B. 526.

85 R. Hayes, 'Epidemiological Research and Privacy Protection' (1984) 141 *Med.J.Aust.* 621, at p. 623.

These are all within the ambit of disclosure in the public interest, but civil wrongs on their own, *i.e.* not involving the public interest, are not within its ambit.

Disclosure in the interests of the confidant

A researcher might seek to avail himself or herself of this defence if 'proceedings are brought against them and it is necessary for the proper defence of those proceedings [. . .]'⁸⁶

The existence of this exception as a *separate* category has, however, been doubted,⁸⁷ since it could really belong to the category of disclosure in court proceedings.⁸⁸

Disclosure under law

This category corresponds to the fifth exception examined while considering codes of professional ethics. This category can be further sub-divided into: (a) disclosure under statute;⁸⁹ (b) disclosure under common law; and (c) disclosure in court proceedings.⁹⁰

There exist statutory requirements for reporting of infectious diseases (including venereal diseases),⁹² misuse of drugs,⁹³ child abuse,⁹⁴ statistical purposes,⁹⁵ as well as requiring that confidential reports be furnished in certain circumstances.⁹⁶ The Queensland *Medical Act* 1939-1981, s. 35 (ix)-(xi), referred to earlier, states that a medical practitioner shall be guilty of 'misconduct in a professional respect' if he fails to disclose to the police any information he receives concerning an attempted or completed crime, or when he attends the victim of a criminal attack. Provisions in road traffic legisla-

86 Australian Law Reform Commission, *supra* note 31, at p. 418.

87 *Ibid*, 395.

88 See *infra*.

89 Plueckhahn, *supra* note 31, at 84; Australian Law Reform Commission, *supra* note 31, at 416-417; Mason and McCall Smith, *supra* note 4, at p. 105; Fox, *supra* note 31, at pp. 172-173; Giesen, *supra* note 4, at p. 184.

90 Plueckhahn, *supra* note 31, at pp. 83-84; Australian Law Reform Commission, *supra* note 31, at p. 421; Mason and McCall Smith, *supra* note 4, at p. 107; Fox, *supra* note 31, at pp. 174-175; Giesen, *supra* note 4, at p. 184.

92 *Venereal Diseases Act* 1917 (U.K.); *Health Act* 1958 (Vic.) s. 137; *Public Health Act* 1902 (N.S.W.) s. 29 (1A); *Health Act* 1937 (Qld.) ss. 29, 30, 51 (3), 54 (2), (5); *Health Act* 1935 (S.A.) s. 128; *Public Health Act* 1962 (Tas.) ss. 27, 41; *Health Act* 1911 (W.A.) Part IX, Div. 2; *Public Health (Infectious Diseases) Regulations* 1968 (U.K.), S.I. 1968/1366, reg. 6 (2); *Venereal Diseases Ordinance* 1956 (A.C.T.) ss. 6, 6A; *Public Health (Infectious and Notifiable Diseases) Regulations* (A.C.T.) regs. 4, 4A; *Public Health (Tuberculosis) Regulations* (A.C.T.) reg. 3; *National Health Service (Venereal Diseases) Regulations* 1974 (U.K.), S.I. 1974/29; See also R. v. Gordon (1923) 54 O.L.R. 355.

93 *Misuse of Drugs (Notification of and Supply to Addicts) Regulations* 1973 (U.K.), S.I. 1973/799, reg. 2.

94 *Child Welfare Act* 1939 (N.S.W.) s. 148B (3); *Community Welfare Act* 1972 (S.A.) s. 91; *Health Act* 1937 (Qld.) s. 76K; *Child Protection Act* 1974 (Tas.) s. 8 (2), (3).

95 *Abortion Regulations* 1968 (U.K.), S.I. 1968/390, reg. 4; *Abortion (Scotland) Regulations* 1968 (U.K.), S.I. 1968/505, reg. 4.

96 *Social Security Act* 1947 (Cth.) s. 135TF.

tion may require the disclosure of confidential information if the information is requested by the police.⁹⁷ Other provisions in road traffic legislation, while not being mandatory in character, may provide an indemnity against civil proceedings for disclosing the information.⁹⁸

Disclosure may also be required under the old common law offence of misprision of felony, which still subsists in New South Wales, South Australia and the Australian Capital Territory.⁹⁹ Thus, if a researcher in those jurisdictions discovers that a felony is being planned or committed, or has been committed, and without consenting to it, conceals or procures the concealment of the crime, or fails to disclose it to the responsible authorities (*i.e.*, the police) within a reasonable time after having had a reasonable opportunity for doing so, he is guilty of misprision of felony.¹⁰⁰ Lord Denning in *Sykes v. Director of Public Prosecutions* thought that it might not apply in the case of relationships such as those of doctor-patient and lawyer-client.¹⁰¹ However, it is unlikely that the ambit of Lord Denning's exception is sufficiently wide to encompass the relationship of researcher and subject.

Finally, a researcher may be compelled to produce documents and to testify in court unless he can claim privilege. As mentioned earlier, some jurisdictions grant professional privilege to doctors in civil, but not criminal,¹⁰² proceedings.¹⁰³ Even then, since the researcher is not 'attending' a 'patient',¹⁰⁴ he could not claim professional privilege. Nor would the relationship of researcher and subject itself found a basis for claiming privilege, since, as Dixon J. stated in *McGuinness v. Attorney-General of Victoria*, except for restricted categories of relationships established by statute or the common law, an inflexible rule had been

established that no obligation of honour, no duties of non-disclosure arising from the nature of a pursuit or calling, could stand in the way of the imperative necessity of revealing the truth in the witness box.¹⁰⁵

Of course, the researcher could still claim privilege on the same grounds available to any other individual (*e.g.*, privilege against self-incrimination, public policy in not revealing the identity of an informant, etc.).

97 *Road Traffic Act 1972* (U.K.), s. 168 (2); *Hunter v. Mann* (1974) 2 All E.R. 414.

98 *Transport Act 1972* (Que.), s. 86; *Motor Vehicle Act 1960* (B.C.), s. 208; *Highway Traffic Act 1970* (Ont.), ss. 142-144; *Motor Vehicle Administration Act 1975* (Alta.), s. 14 (2), (3).

99 The offence has been abolished in the U.K.: *Criminal Law Act 1967* (U.K.), s. 5 (5); and replaced in Victoria by the offence of concealing an offence: *Crimes Act 1958* (Vic.) s. 326.

100 *R. v. Crimmins* [1959] V.R. 270; *R. v. Wilde* [1960] Crim.L.R. 116; *Sykes v. Director of Public Prosecutions* [1962] A.C. 528; *R. v. Stone* [1981] V.R. 737; *King* (1965) 49 Cr.App.R. 296; *Lovegrove and Kennedy* (1983) 33 S.A.S.R. 332, (1984) 8 Crim.L.J. 188.

101 [1962] A.C. 528, at p. 564.

102 M. D. Kirby, 'Should Doctor's Records be Privileged?' (1981) 2 *Med.J. Aust.* 115-116.

103 See *supra*, note 15.

104 *Hare v. Riley* [1974] V.R. 557, at p. 582.

105 (1940) 63 C.L.R. 73, at pp. 102-103.

Freedom of Information

Both the Commonwealth of Australia and Victoria have enacted legislation allowing public access to documents in the possession of government departments and prescribed authorities. The term 'prescribed authority' encompasses many Commonwealth and Victorian research institutions such as C.S.I.R.O., public universities, public teaching hospitals, and most medical research institutes.

Consequently, a member of the public could obtain access to research data or reports belonging to these institutions, unless it is an exempt document.

Section 41 (1) of the *Commonwealth Freedom of Information Act* 1982 provides that a document is an exempt document if its disclosure would involve the unreasonable disclosure of information relating to the personal affairs of any person, while section 45 of the same Act states that a document is an exempt document if its disclosure would constitute a breach of confidence.

Similar provisions exist in the Victorian Act. Section 33 (1) of the Victorian *Freedom of Information Act* 1982 is identical to s. 41 (1) of the Commonwealth Act, while s. 35 (1) of the Victorian Act provides that a document is an exempt document if its disclosure would divulge any information or matter communicated in confidence to an agency or Minister, and, *inter alia*, the disclosure of the information would be contrary to the public interest by reason that the disclosure would be reasonably likely to impair the ability of the agency or Minister to obtain similar information in the future.

Exchange of Information

Perhaps the commonest infraction of strict confidentiality is the sharing of information about subjects,

not only among different members of the medical profession but also between different members of the 'health care team' — receptionists, nurses, secretaries, recordkeepers, physiotherapists, radiologists, social workers, psychologists, chaplains and perhaps even teachers, police, and assorted voluntary workers.¹⁰⁶

Obviously, this is particularly the case when research is being carried out at a large teaching hospital, which may result in the information 'being available to other doctors, nurses, students, ancillary medical staff, administrators and the like'.¹⁰⁷ A concept of *extended confidentiality* has developed which is assumed to cover the exchange of information between various members of the clinical health care team.¹⁰⁸

Coincident with this has been the rapidly increasing availability, capacity and sophistication of computers,¹⁰⁹ resulting in research data

106 Editorial, *supra* note 8, at p. 3.

107 Plueckhahn, *supra* note 31, at p. 5.

108 *Ibid*, at p. 86.

109 D. F. H. Pheby, 'Changing Practice on Confidentiality: A Cause for Concern' (1982) 8 *J.Med.Ethics* 12.

becoming not only more centralized, but also more readily accessible in remote terminals.¹¹⁰

It was in the light of these technological and other developments which threaten confidentiality that the World Medical Association adopted the following two resolutions at its 27th World Medical Assembly in 1973. The first resolution reaffirmed the vital importance of confidentiality. In the second resolution, the World Medical Association, while drawing attention to the great advantages resulting from the use of computers and electronic data processing, requested all national medical associations to take all possible steps to assure confidentiality, and all member countries of the W.M.A. to reject all attempts having as a goal legislation authorising procedures which could endanger or undermine the confidentiality, and expressing the strong opinion that medical data banks should only be available to the medical profession and not linked to other central data banks.¹¹¹

Students

In its report on privacy, the Australian Law Reform Commission, after conducting fieldwork and interviews with physicians and medical students, concluded that when medical students are placed in teaching hospitals, which generally begins in the third or fourth year of their university studies,

they have virtually unlimited access to patients' medical records. Students' knowledge of the law about privacy and confidentiality, at this stage, is generally based upon the folk law of the medical profession, rather than upon any concrete information about the legal context in which they operate. The general attitude is that only disclosures to members of the lay public provide cause for concern.¹¹²

It has also been observed that some institutions 'simply have no guidelines for students to follow'.¹¹³ Similarly, others 'do not cover the topic at all in their curriculum or do so belatedly — after the student is already in field placement'.¹¹⁴

In the absence of specific guidelines, it has been recommended that students, at least in their pre-clinical years, should not have access to research data unless the names of subjects and relatives are altered or replaced by initials or fake names. If names are changed rather than simply erased or obliterated, a notation should appear clearly indicating that this has been done. If the material concerns a highly unusual or much-publicized situation that could be identified easily even after the subject's name has been altered or erased, then certain identifying information may need to be altered.¹¹⁵

110 Plueckhahn, *supra* note 31, at p. 86.

111 British Medical Association, *supra* note 7.

112 Australian Law Reform Commission, *supra* note 31, at p. 142.

113 S. J. Wilson, *Confidentiality in Social Work: Issues and Principles*, New York, The Free Press, 1978, 35.

114 *Ibid.*

115 *Ibid.*, 35-36.

Benefits of Research

There can be little doubt that research generally, but particularly medical research, both retrospective and prospective, has produced great benefits for mankind.¹¹⁶

Not only does the approach help to identify the existence and incidence of a disease, to determine symptom development and disease consequence, but it is essential in laying out the array of possible origins of the disease. Longitudinal methods in this sector have been considerably more efficient over the last forty years with the development of survey sampling technology. And when coupled to other methods, such as randomized experiments, the approach can be dramatically effective in identifying whether and how well particular treatment programs work.¹¹⁷

This can be illustrated by the example of research into coronary heart disease. Early investigations with autopsy studies provided evidence necessary to justify longer-term, longitudinal studies. Because the ability to describe and predict based on longitudinal studies 'does not necessarily yield unequivocal information on the causes of heart disease, long-term experimental tests of different treatment programs' were mounted.¹¹⁸

The best of these tests generally involve large samples tracked over long periods of time and, moreover, randomized assignment of individuals to one of the competing treatments.¹¹⁹

Unfortunately, these studies 'raise logistical problems more serious than those engendered by longitudinal research alone', and consequently, pilot studies were undertaken which

furnished data on the practical difficulty of field tests and somewhat less equivocal small-scale data on the impact of diet control on heart disease. Such short-term studies have paved the way for longer-term studies that focus on the more plausible causal mechanisms [. . .]¹²¹

Thus, the 'systematic tracking of both the healthy and the ill remains a basic weapon in the medical research armamentarium'.

However, the Australian Law Reform Commission, in its report on privacy, stated that

[s]ubject to the general rules authorising disclosure, a doctor cannot publish or otherwise disclose for research purposes any confidential information obtained about patients where the use or disclosure identifies or renders identifiable the patients in question.¹²³

116 Plueckhahn, *supra* note 31, at p. 86.

117 R. F. Boruch and J. S. Cecil, *Assuring the Confidentiality of Social Research Data*, University of Pennsylvania Press, 1979, 39.

118 *Ibid.*, 39-40.

119 *Ibid.*, 40.

120 *Ibid.*

121 *Ibid.*

122 *Ibid.*, 39.

123 Australian Law Reform Commission, *supra* note 31, at p. 416.

Procedures for Maintaining Confidentiality

Most research institutions have developed procedures for the deletion of patients' names. Such a procedure has been recommended by the Medical Research Council and the Australian Medical Association.¹²⁴

A second requirement has also been recommended.¹²⁵ For example, the Lindo Committee on Data Protection in the U.K. recommended that not only should the research data be in such a form that individuals are not identifiable, but also that such information should only be released for *bona fide* epidemiological or clinical research.¹²⁶

A third requirement is often recommended. For example, an individual may feel that his privacy is being invaded even though he remains quite anonymous to the researcher¹²⁷ and consequently, wherever possible, both consent and anonymity should be sought [...]¹²⁸ Thus, disclosure of data under the United States' *Privacy Act* 1974¹²⁹ must fulfil all three requirements, *viz.* (1) it must be in a form not individually identifiable; (2) it can only be made upon the written consent of the individual; and (3) it must be for a purpose compatible with the purpose for which it was originally collected.¹³⁰ The U.S. Code of Federal Regulations specifies additional regulations for researchers conducting research on human subjects, including, *inter alia*, the informed or knowing consent of the participant or legal guardian without 'undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion'.¹³¹

The Australian Medical Association's guidelines on confidentiality also lay down that a patient's privacy must not be invaded 'unless with his informed knowledge and consent'.¹³²

The requirement of *informed* consent before disclosure of confidential research data has arisen because of 'some abuses and rather free interpretations of the term "consent"'.¹³³

The term 'informed consent', in the context of the release of confidential research data, has been defined as the subject or legal guardian not merely consenting, but also understanding 'what information is to be given, to whom, and for what purpose'. This extended definition of consent has been employed by organizations such as the American National Red Cross in order to avoid the abuses inherent in blanket consent forms which are used widely in many hospitals. In contrast to

124 Medical Research Council, *supra* note 20; Australian Medical Association, *supra* note 13.

125 Editorial, *supra* note 8, at p. 4.

126 Pheby, *supra* note 109, at p. 12.

127 O. M. Ruebhausen and O. G. Brim, J., 'Privacy and Behavioural Research' (1965) 65 *Colum.L.Rev.* 1184, at p. 1201.

128 *Ibid.*

129 Pub.L. No. 93-579, 88 Stat. 1896.

130 D. G. Carter, J. J. Harriss III, and F. Brown, 'Privacy in Education: Legal Implications for Educational Researchers' (1976) 5 *J.L. & Ed.* 465, at p. 471.

131 45 C.F.R. 46 (Protection of Human Subjects).

132 Australian Medical Association, *supra* note 13; N.S.W. Privacy Committee, *Research & Confidential Data Guidelines for Access* (May 1935), 2.1-2.3.

133 Wilson, *supra* note 113, at p. 56.

informed consent forms, blanket consent forms authorize the release of 'any and all information' which the institution possesses on the subject, and that the 'question of privacy' between the institution and the subject 'is waived'.¹³⁴

The Australian Law Reform Commission has stated that the first requirement (*viz.*, disclosure of data in a form which does not identify subjects) is the one that is required by law. The other requirements may be necessary in the U.S.A., which, unlike the U.K., Australia and New Zealand, has a developed law of privacy. However, even this minimum requirement has not been met by researchers because, according to the Commission,

in practice, confidential information about identifiable subjects is systematically exchanged by medical researchers in breach of the legal rules, the medical research fraternity asserting that its own self-disciplinary mechanisms provide sufficient protection for the subject.¹³⁵

Thus, at present,

the rules which balance the rights of the subject whose personal data is used, and those which protect him from misuse of such data, or alert him to any possible harm he may suffer, exist only in the ethical practice and morality of those researchers having access to his medical records.¹³⁶

Unfortunately, the ethical practices of some researchers leaves much to be desired. Australian Law Reform Commissioner, Professor Robert Hayes, cited the example of a researcher who had approached a potential subject seeking his co-operation in a study of his disease. The prospective subject, who was extremely sensitive about his disease and feeling considerable pain and anxiety, refused. 'This researcher literally went behind the patient's back and approached the treating doctor for the health information and got the information.'¹³⁷

He described one practice which was becoming increasingly common: an epidemiologist notices that a group of patients have a particular disease in common. Checking their medical records, he discovers they have the same kind of job. The researcher then contacts their employers to see their employment records. According to Hayes, the legality of that was 'certainly questionable and yet it was a vital technique from the researcher's point of view'.¹³⁸

Researchers, on the other hand, have argued on philosophical grounds that '[s]ociety has a vital stake in epidemiologic and other medical research' and that

134 *Ibid* at pp. 55-65.

135 Australian Law Reform Commission, *supra* note 31, at p. 416.

136 Plueckhahn, *supra* note 31, at p. 86; Briefing, 'Confidentiality, Records, and Computers' (1979) 1 *Br.Med.J.* 698-699; Editorial, 'Confidentiality of Medical Records — A Factless Debate' (1980) 2 *Lancet* 1230-1231.

137 P. McIntosh, 'Researchers fight off Curbs to Patient Data', *Age* (Melbourne) 11 January 1985.

138 *Ibid.*

[t]he social contract that facilitates the existence of individuals within social groups requires that each individual occasionally yields some of his rights, including privacy and freedom of action, for the benefit of society as a whole.¹³⁹

They argue that many such studies in the past would not have been possible had the actual consent of the numerous patients, to use their records, been required.¹⁴⁰

They maintain that the solution offered by the Australian Law Reform Commission, *viz.*, that patients should be advised at the time of compilation of medical records that the information may be used for research purposes, would not solve the problem for a number of reasons.¹⁴¹

First, because it is unlikely to be implemented at the point of collection of *all* medical records, and completeness is the essence of validity and generalization of such medical research. Second, because it would prevent the use of historical information or information collected outside the health system where this practice does not apply (for example, information on industrial exposure to chemical hazards). Third, because it is not at all certain that this prospective, and essentially uninformed, consent would, in the event of legal challenge, prove to be adequate.¹⁴²

Consequently, if the Australian Law Reform Commission's assessment of the case law (case law *not* involving medical research) is correct, then 'a substantial amount of research [...] will be, or already is, outlawed [...]'¹⁴³ According to the Presidents of the four Royal Colleges in Australia, this would constitute a serious threat to the continuation of medical research.¹⁴⁴

It is also argued that since such research is in the public interest, and since epidemiological research in particular is conducted by registered medical practitioners who are vulnerable to complaint, investigation and deregistration, and who are all subject to codes of professional conduct, then they should be allowed to proceed without the consent of identifiable living subjects.¹⁴⁵ Hayes, on the other hand, argues that the threat of deregistration is unreal in some jurisdictions because of extreme delays and a very low rate of deregistration of unprofessional practitioners, and that one concern which he had about ethics committees and codes of professional accountability

is that they might, whether through ignorance or blindness born of their own professionalism, endorse practices which, in fact, might depart from the requirements of the substantive law.¹⁴⁶

139 L. Gordis and E. Gold, 'Privacy, Confidentiality and the Use of Medical Records in Research' (1980) 207 *Science* 153.

140 Plueckhahn, *supra* note 31, at p. 86.

141 B. K. Armstrong, 'Privacy and Medical Research' (1984) 141 *Med.J.Aust.* 620.

142 *Ibid.*

143 *Ibid.*

144 P. M. Elliot, R. T. Finch, J. B. Hickie, *et al.*, 'A Plea for Medical Research' (1984) 141 *Med.J.Aust.* 484.

145 Hayes, *supra* note 37, at p. 623.

146 *Ibid.*

He also maintained the 'floodgates argument', namely, that broad 'public interest' exceptions to the legal standards 'might encourage less reputable groups than the medical research fraternity to stake their claims for special consideration'.¹⁴⁷

Researchers, however, have argued that the Australian Law Reform Commission, in its rejection of the 'public interest' defence for medical research, 'relied on case law which has no direct relevance to the use of medical research'.¹⁴⁸

It has been pointed out that other reports have taken a different view. For example, the United States' Privacy Protection Commission took the view that biomedical or epidemiological research projects should constitute an exception to the general requirement of consent by the prospective subject before access to his or her medical records is permitted,¹⁴⁹ but that such disclosure should be subject to a number of safeguards, *i.e.*,

first, the discloser can not violate any limitation under which the information was collected; second, the disclosure in individually identifiable form must be necessary to the research; third, the institution or practitioner must be satisfied that the importance of the research is such that it warrants the risk to the individual in the exposure of the information to the researcher; fourth, the institution or practitioner must be satisfied that the researcher has established adequate safeguards to protect the disclosed information from unauthorized use, including a programme for removal and destruction of identifiers; and fifth, the institution or practitioner must retain the authority to consent in writing to any further use or redisclosure of the information in individually identifiable form.¹⁵⁰

In Canada the Commission of Inquiry into Confidentiality of Health Information has recommended that hospitals could disclose medical records to a qualified researcher with the approval of a human experimentation ethics committee which included at least one representative of the public, such disclosure being subject to certain safeguards.¹⁵¹

Finally, one must mention two statements which appear to recognise that disclosure of confidential research data may be in the public interest, and which have been cited both in the report of the Younger Committee on Privacy in the U.K.,¹⁵² and by Morison in his report on the law of privacy in New South Wales,¹⁵³ especially as both statements have been referred to by researchers as acknowledging a 'public interest' exception for the disclosure of research data¹⁵⁴ on the grounds that both 'took the

147 Ibid.

148 Armstrong, *supra* note 141, at p. 621.

149 W. J. Curran, 'The Privacy Protection Report and Epidemiological Research' (1978) 68 *Am.J.Public Health* 173.

150 Armstrong, *supra* note 141, at p. 621.

151 J. Hollobon, 'The Krever Report on Confidentiality' (1981) 124 *Can.Med. Assoc.J.* 330-336.

152 United Kingdom, *Report of the Committee on Privacy* (Younger Report) London, 1972, Cmnd. 5012, at p. 110.

153 W. L. Morison, *Report on the Law of Privacy*, Sydney, Parliament of New South Wales, 1973, Parl. Pap. No. 170, at p. 33.

154 Armstrong, *supra* note 141, at p. 621.

view that public health considerations could justify abridgement of the privacy of the individual and this clearly is taken to include research into the causation of disease'.¹⁵⁵

The Nordic Conference of International Jurists on the Right of Privacy at Stockholm in 1967 concluded that 'the protection of health may justify reasonable measures taken to combat or to prevent the outbreak of an epidemic or the spread of communicable diseases',¹⁵⁶ while, although Article 8 (1) of the European Convention on Human Rights and Fundamental Freedoms 1950¹⁵⁷ protects the right to privacy, Article 8 (2) goes on to state that that right may be abridged if it is necessary 'in the interest of [. . .] public safety [or . . .] for the protection of health [. . .]' It is clear, however, from an examination of these declarations that they do not justify the disclosure of confidential research data for ordinary or routine research purposes. On the contrary, such disclosure is only justifiable when the health and safety of the public is in peril.

Conclusion

Two situations which may confront the researcher have been considered. First, what should a researcher do when he receives confidential information from a subject that a crime is being planned or has been committed, or that some other matter is afoot which, while not necessarily criminal, may involve danger to the public? Clearly, under the public interest exception to confidentiality such information could be disclosed to the proper authorities without the consent of the subject, such disclosure being sanctioned both by codes of professional conduct and by the common law.

Second, should a researcher who has received confidential data from a subject disclose that information to a third person for research purposes? Although this may, in some cases, be sanctioned by codes of professional conduct, it may constitute an actionable breach of confidence at common law. Ideally, therefore, a researcher should (i) obtain the informed and knowing consent of the subject before releasing the research data; (ii) ensure that the information will be used only for *bona fide* research purposes; and (iii) ensure that all identifying references are deleted from the research data. As an absolute minimum, requirement (iii) should be complied with.

Of course, there will be situations in which even (iii) cannot be complied with without blocking off important lines of research¹⁵⁸ as, for example, when it is necessary to identify the subject with certainty or to interview him.¹⁵⁹ As the Medical Research Council told the Younger Committee,

155 Morison, *supra* note 153, at p. 33.

156 *Conclusions of the Nordic Conference of International Jurists on the Right of Privacy*, Stockholm, 1967.

157 E.T.S. No. 5; U.K.T.S. 70 (1950); Cmd. 8969.

158 Morison, *supra* note 153, at p. 33.

159 *Report of the Committee on Privacy*, *supra* note 152, at p. 111; N.S.W. Privacy Committee *supra* note 132, at 3.1-3.3.

[i]n research on clinical and population genetics there was no alternative to methods involving personal contact with the subjects and their relatives, if there was to be adequate warning of specific genetic diseases or understanding of genetic mutations caused by environmental hazards. In industrial medicine also the proper assessment of a health risk would often require the linking of personal medical and industrial records, and access to medical records could also be vital in research designed to evaluate treatment.¹⁶⁰

The modification of the common law to accommodate the needs of such researchers could best be achieved by legislation similar to the provisions in the Queensland *Health Act* 1937-1981 (ss. 154M, 154N, which may authorise scientific research and studies for the purpose of reducing morbidity or mortality, and s. 101I, under which the Director-General can release perinatal statistics to researchers) and the South Australian *Health Act* 1935-1975 (ss. 146r, 146s, which may authorize scientific research and studies for reducing morbidity and mortality), but of wider ambit, along the lines recommended by the United States' Privacy Protection Commission or the Canadian Commission of Inquiry into the Confidentiality of Health Information.