Confidentiality, privacy and the reporting by health professionals of a patient's unfitness to drive: legal dilemmas

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Abstract

The NRTC is currently revising the *Medical Examinations of Commercial Vehicle Drivers*[1] with the intention of combining it with *Assessing Fitness to Drive: guidelines and standards for health professionals in Australia*[2]. One of the issues raised in this review concerns the potential liability of a health professional who reports to the driver licensing authority that a patient whom she or he has assessed is medically unfit to drive. This paper will address laws relating to the issues of confidentiality and privacy, as well as the duty to report. Examples will be drawn from various jurisdictions. Further exposition of the law will be provided through the use of case studies, which are designed to illustrate the application of particular aspects of the law to relevant fact situations.

Introduction

Health professionals have several overlying legal obligations with respect to the information they obtain from their patients. Whilst there are also various professional codes, for example the Australian Medical Association's *Code of Ethics*, this paper will concentrate on the legal obligations. There is a duty of confidentiality existing in both common law and in the jurisdictions of individual States and Territories, and an obligation to maintain privacy imposed by statute at a Commonwealth level which has been adopted variously in some States and Territories. At the same time, exceptions to these obligations operate in various ways, including where a patient consents to the information being communicated. Where reporting to driver licensing authorities about a patient's unfitness to drive, a statutory defence exists in the Australian Capital Territory, New South Wales, Queensland, Tasmania and Victoria. A statutory duty to report currently exists in the Northern Territory and South Australia.

Keeping information confidential under the common law

Health professionals have a duty of confidence with respect to all information received in the course of a health-care relationship. Whilst this duty has found expression in common law (that is, case law developed over time in the courts), it is more clearly expressed in statute (that is, law made by Parliament). Under the common law, there appear to be few cases in which a patient has sued a doctor for breach of confidentiality and there is no direct Australian authority[3]. The obligation has been recognised in equity[4] (equity, being a system of law developed over time in courts, which were originally separate to the common law courts, to modify the harshness of the common law). Other jurisdictions have found the duty to exist in various ways. In the United Kingdom, the duty to maintain confidentiality has been found to exist in contract[5]. Whereas, in New Zealand, the duty has been *suggested* to exist in contract[6]. The duty of confidentiality has, however, been found to exist in tort in New Zealand, as part of the doctor's duty of care in the law of negligence[7].

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[1] *Medical Examinations of Commercial Vehicle Drivers*, National Road Transport Commission and Federal Office of Road Safety, Melbourne, 1997.
[2] Austroads, *Assessing Fitness to Drive: guidelines and standards for health professionals in Australia*, Austroads, Sydney, 2001.
[3] Loane Skene, *Law and Medical Practice: Rights, Duties, Claims and Defences*, Butterworths, Sydney, 1998, p. 198.
[4] *Smith Kline & French Laboratories (Aust) Ltd v Secretary, Department of Community Services and Health* (1920) 95 ALR 87, affd (1991) 99 ALR 679; *Breen v Williams* (1996) 186 CLR 71; see Loane Skene, above n. 3, p. 200. See also, John Devereux, *Medical Law: Text, Case and Materials*, Cavenish Publishing, Sydney, 1997, pp. 207–9
[5] *Parry-Jones v Law Society* [1969] 1 Ch 1at 7 and 9; *Duchess of Argyl v Duke of Argyl* [1967] Ch 302 (Ch D); see Loane Skene, above n. 3, p. 199. See also, Meg Wallace, *Health Care and the Law*, Law Book Co., Sydney, 2001 (3rd ed.), pp. 275–6.
[6] The High Court in *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513; *Furniss v Fichett* [1958] NZLR 396; see Loane Skene, above n. 3, p. 199. For extracts of the judgement, see 274–5. See also, Peter MacFarlane, *Health and Medical Law: Commentary and Materials*, The Federation Press, Sydney, 2000, pp. 180–1.
[7] *Furniss v Fichett* [1958] NZLR 396; see Loane Skene, above n. 4, pp. 199–200. See also, Meg Wallace, above n. 4, pp. 277–8. For extracts of the judgement, see Peter MacFarlane, above n. 6, pp. 169–72. See also, John Devereux, above n. 4, pp. 209–11.

One exception to a breach of confidentiality is where the patient has given explicit consent. This exception applies under both common law and statute. Where there is no consent, another potential exception is the public interest exception. In considering this exception, the courts balance two public interests, the public interest in maintaining professional confidences and the public interest in protecting the public. It is not a case of balancing the patient's private interest in confidentiality against a broader public interest[8]. The use of the public interest exception to justify breaching the duty of confidentiality towards a patient is a potentially fraught area and will depend very much on the facts of the case. Issues to be considered are the circumstances of the risk, the severity of the risk and the person/s at risk. In addition, the circumstances of the disclosure must also be considered; for example whether disclosure is to the relevant authority or to the public in general (the latter of which is frowned upon) and those who are potentially at risk. Courts in the United Kingdom and New Zealand have applied the public interest exception in different ways.

The English case of W v Egdell [1990] Ch 400 involved a psychiatric assessment by Dr Egdell of a patient, W, who had been diagnosed with paranoid schizophrenia. The patient had been detained for an unlimited period in a secure hospital after being convicted of manslaughter for killing five people. The doctor had been asked by the patient's solicitors to provide a report on him to support his application to be removed to a less secure facility. The report did not support the removal and the patient's solicitors withdrew the application. The doctor sent a copy of the report to the hospital and two other relevant authorities. The patient sought an injunction on the disclosure of the information contained in the report as well as damages for breach of confidentiality. The court found that the doctor did owe a duty of confidentiality to the patient, but that he had an overriding duty to the public to place the report before the proper authorities if the public interest so required[9].

In *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513, the court held that a breach of confidence was only justified in exceptional circumstances, such as to protect another person's life, and then only to the relevant authority. This case involved a bus driver who had had a triple coronary bypass operation. The patient had obtained a certificate from his treating surgeon stating that he was fit to drive. Dr Duncan, who was the patient's general practitioner, formed a different opinion, and approached the local police with a view to having the patient's driver licence revoked. The doctor also told other people in the community about the patient's medical condition and warned them not to travel on the bus. The complaint against the doctor was upheld[10].

Case study 1: Dr W is examining Patient A as part of an on-going therapeutic relationship. During the consultation, Dr W forms the view that Patient A is medically unfit to drive. On the one hand, Dr W is aware of the duty of confidentiality that she has towards her patient. On the other hand, Dr W is aware that should Patient A drive, than he may be a danger to himself and potentially other motorists or pedestrians. Dr W raises her concerns with Patient A, suggesting that Patient A report the matter to the driver licensing authority or that Dr W could do so. Patient A rejects both suggestions. Should Dr W decide to report her opinion to the driver licensing authority in reliance on the common law exception of public interest, she may be open to proceedings on the basis of breaching confidentiality. Assuming the court allows the action to proceed, it would probably consider the extent of the risk if Patient A were permitted to drive, as well as the circumstances of the breach. It is probably more prudent for Dr W to rely on exceptions provided in statute, where applicable.

Case study 2: Dr X examines Patient B for the purposes of assessing her fitness to drive for the driver licensing authority. During the examination, Dr X forms the view that Patient B is unfit to drive in specific circumstances. By presenting for the examination that has been required by the driver licensing authority, Patient B has provided implicit consent for the information to be reported to the driver licensing authority. In addition, explicit consent may be sought in the form provided by the driver licensing authority for the purposes of the medical examination.

[8] *W v Egdell* [1990] 1 All ER 835; *AG v Guardian Newspapers Ltd (No. 2)* [1988] 3 All ER 545; see Loane Skene, above n. 3, p. 209. For particular extracts of the judgement, see Peter MacFarlane, above n. 6, p. 178–9. See also, John Devereux, above n. 4, pp. 218–19.

[9] For more detailed discussion see Loane Skene, above n. 3, p. 208–9. See also, Meg Wallace, above n. 5, pp. 280–1. For extracts of the judgement, see Peter MacFarlane, above n. 6, pp. 177–80. See also, John Devereux, above n. 4, pp. 217–20.

[10] For more detailed discussion see Loane Skene, above n. 3, p. 207.

Maintaining privacy – the Commonwealth approach

Privacy law in Australia operates at both Commonwealth and State or Territory levels[11]. Every jurisdiction is covered by privacy law in one way or other. In most cases, there are layers of regulation, so that both Commonwealth and the relevant State or Territory regulation apply. Such regulation applies in a general sense to prevent the personal information of an individual being collected or disclosed except in specific circumstances.

At the Commonwealth level two regimes are in operation. First, there are the Information Privacy Principles established by the *Privacy Act 1988*, which are applied to Commonwealth government agencies as well as having certain application to the credit providers. Second, there are the National Privacy Principles that apply to specific parts of the private sector and which are also now part of the *Privacy Act 1988*. The application of these principles depends on whether the health provider falls within the public or private health sector. The Information Privacy Principles apply to any Commonwealth public sector health providers. The National Privacy Principles apply to all private sector health providers, including individuals and bodies corporate etc. (section 6C and 6D).

This leaves State and Territory public sector health providers to be dealt with by State and Territory laws. There are separate legislative or administrative privacy measures in most States and Territories. Legislative measures have been adopted in the Australian Capital Territory, New South Wales and Victoria[12]. More detail is provided on the Victorian legislation below. Administrative measures have been adopted in South Australia, Tasmania and Queensland. In the Northern Territory, a draft bill has been released for public comment[13]. This only leaves Western Australia to be solely covered by the Commonwealth law.

Both the Information Privacy Principles (IPPs) and the National Privacy Principles (NPPs) essentially deal with the collection, use and disclosure of personal information. The focus in this paper will be on disclosure since that applies to the circumstances concerned, namely the communication by a health professional of information about a patient's unfitness to drive. Under Information Privacy Principle 11, there are limits on the disclosure of personal information held in a record (definitions include a document or database: section 6), which would include a medical opinion about a person's unfitness to drive. A number of exceptions apply, including where the individual concerned has consented to the disclosure or where the disclosure is required or authorised by or under law (IPP 11 1(b) and (d)). Disclosure will also be permitted where the record-keeper believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or of another person (IPP 11 1(c)).

Under National Privacy Principle 2, an organisation must not disclose personal information about an individual for a purpose (the *secondary purpose*) other than the primary purpose of collection. There is an important distinction in National Privacy Principle 2 between a primary purpose and a secondary purpose. Where the health professional is examining the patient for the purpose of providing a report to the driver licensing authority, the disclosure of information relating to the patient's unfitness to drive would be allowed under NPP 2.1. Matters become more complicated where the health professional is examining the patient as part of the on-going therapeutic relationship and forms the view that the patient is unfit to drive. Disclosure under these circumstances would amount to disclosure for a secondary purpose, which would only be allowed under certain exceptions. As with the IPPs, if the patient consents, disclosure is allowed (NPP 2.1. (b)). Another similar exception operates where the disclosure is required or authorised by or under law (NPP 2.1. (g)). And again, there is an exception if the organisation reasonably believes that the disclosure is necessary to lessen or prevent a serious and imminent threat to an individual's life, health or safety or a serious threat to public health or public safety (NPP 2.1 (e)).

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[11] See also, Loane Skene, above n. 3, pp. 196–8, although note that some of the discussion on the Information Privacy Principles is outdated, as the amendments to the *Privacy Act 1988* (Cth) came effect on 21 December 2001 (see note 8, below).

[12] The *Privacy Act 1988* (Cth) applies government agencies in the Australian Capital Territory. Health records, whether in public or private hands, are dealt with by the *Health Records (Privacy and Access) Act* 1997 (ACT), although from 21 December 2001, the *Privacy Act 1988* (Cth) will apply in the ACT. In NSW, the *Privacy and Personal Information Protection Act 1998* (NSW) applies. NSW has also established its own Office of the Privacy Commissioner. For further discussion, see Office of the Federal Privacy Commissioner, *Privacy in Australia*, October 2001.

[13] See Northern Territory Attorney-General's Department, *Discussion Paper: Information Bill*, Darwin Northern Territory, 2001. In addition, the Northern Territory Department of Health and Community Services released a discussion paper on *Protecting the Privacy of Health Information in the Northern Territory* in March 2002.

Keeping information confidential and maintaining privacy – Victorian example

Various State and Territory legislation requires health providers to maintain confidentiality. In Victoria, for example, general confidentiality is provided by the *Health Services Act 1988* (Vic), section 141 (2)[14]:

> *A person to whom this section applies must not, except to the extent necessary –*
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> *(a) to carry out functions under this or any other Act; or*
> *(b) to exercise powers under this or any other Act in relation to a relevant health service; or*
> *(c) to give information he or she is expressly authorised, permitted or required to give under this or any other Act –*
>
> *give to any other person, whether directly or indirectly, any information acquired by reason of being a person to whom this section applies if a person who is or has been a patient in, or has received health services from, a relevant health service could be identified from that information.*

The application of this section includes a person who is (or who has been) engaged or employed in or by a public or denominational hospital, a private hospital, a multi purpose service, a day procedure centre or a community health centre: section 141 (1). There are exceptions to the duty to maintain confidentiality under the *Health Services Act 1988* that apply, including where the person (to whom the information relates) consents to the giving of the information: section 141 (3).

In addition, there is the *Health Records Act 2001*, the purpose of which is to promote fair and responsible handling of health information by (among other things) protecting the privacy of an individual's health information that is held in the public and private sectors (section 1). The act establishes eleven Health Privacy Principles to deal with health information. Health information is defined very broadly and includes information or an opinion about an individual's physical, mental or psychological health (at any time) that is also personal information (section 3). Personal information is defined broadly but essentially means information or an opinion about a person (whether true or not) who can be identified (section 3). The important point, therefore, is that the information relates to the health of an individual who can be identified. Such information would include information about the physical or mental health of an identifiable individual that might impact on his or her ability to drive.

Disclosure of health information is dealt with under Health Privacy Principle 2. Like the Commonwealth National Privacy Principle 2, an organisation must not disclose personal information about an individual for a purpose (the *secondary purpose*) other than the primary purpose of collection. Exceptions include where the individual consents to the disclosure (HPP 2.2(b)) or where the use or disclosure is required, authorised or permitted, whether expressly or impliedly, by or under law (HPP 2.2(c)).

Case study 3: Dr Y works in the Victorian public health sector. He has examined Patient C and formed the view that Patient C, who holds a driver's licence, is unfit to drive. Since he operates in the public health sector in Victoria, he is not subject to the Commonwealth privacy legislation. He is, however, subject to the statutory duty to maintain confidentiality, as expressed in the *Health Services Act 1988* and is required not to breach Patient C's privacy under the *Health Records Act 2001*. Dr Y discusses the matter with Patient C, who insists that the matter not be reported to the driver licensing authority.

Statutory defences

Where no consent has been provided and the health professional reports his or her concerns to the driver licensing authority, albeit in good faith, she or he may be open to proceedings on a legal basis. A defence, however, may be provided by legislation. In Victoria, for example, statutory protection is provided under section 27 of the *Road Safety Act 1986*. There are two possible protections that could apply. The first protection applies narrowly where a test has been required by relevant authority[15] to test the health or competence to find out if a person is unfit to drive or if it is dangerous for that person to drive. In such circumstances no action may be taken against the person who carries out the test and makes a report to the relevant authority based on the results of the test. The second protection applies much more broadly. It applies to a person who reports in good faith to the relevant authority any information which discloses or suggests that a person is unfit to drive or that it may be dangerous to allow that person to hold or to be granted a driver licence, a driver licence variation or a permit. Similar defences are also provided in the Australian Capital Territory, New South Wales, Queensland

[14] For other examples see Meg Wallace, above n. 5, pp. 274–5. See also, Peter MacFarlane, above n. 6, pp. 175–7. See also, John Devereux, above n. 4, pp. 211–16.

[15] Legislation in the various jurisdictions refers to the road transport authority, the Authority, the Registrar, the chief executive, the Corporation and the Director General.

and Tasmania, but not in Western Australia[16]. The provision of such defences does not mean that health professionals must report, but that is they do so, they have a statutory protection. In contrast, both South Australia and the Northern Territory impose a positive duty to report.

Case study 3 continued: Dr Y is strongly of the view that should Patient C continue to drive, there is a very high likelihood of Patient C becoming incapacitated while driving a vehicle, which could result in a vehicle collision. Dr Y is aware that Patient C is bus driver, which makes the consequences of a potential collision more serious. Having formed the view that Patient C is unfit to drive, Dr Y reports the matter to the driver licensing authority, relying on the statutory defence provided under the *Road Safety Act 1986* (Vic). He should be protected by the defence in these circumstances.

Duty to report in statute – South Australian example

The existing duty to report in South Australia is under review in light of comments made by the South Australian Coroner in the findings of the inquest into the death of a young girl[17]. The coroner in that inquest found that there was a lack of awareness of the existing duty by a number of the health professionals involved. In South Australia, certain health professionals are under a duty to report to the relevant authority under certain circumstances. Under section 148 of the *Motor Vehicles Act 1959* (SA), a legally qualified medical practitioner, a registered optician, or a registered physiotherapist who has reasonable cause to believe that:

- *a person whom he or she has examined holds a driver's licence or a learner's permit; and*
- *that person is suffering from a physical or mental illness, disability or deficiency such that, if the person drove a motor vehicle, he or she would be likely to endanger the public,*

... is under a duty to inform the Registrar in writing of the name and address of that person, and of the nature of the illness, disability or deficiency from which the person is believed to be suffering.

There are three elements to this duty. First, it is imposed on legally qualified medical practitioners, registered opticians, or registered physiotherapists. These parties will be described collectively as the health professional. Second, the health professional must have reasonable cause to believe that a person whom he or she has examined holds a driver's licence or a learner's permit. Third, the health professional must also have reasonable cause to believe that the person is suffering from a physical or mental illness, disability or deficiency such that, if the person drove a motor vehicle, he or she would be likely to endanger the public. If each of these elements is satisfied then the health professional is under a duty to inform the relevant authority in writing of the name and address of the person, and of the nature of the illness, disability or deficiency from which the person is believed to be suffering. The health professional must also then notify the person to whom the information relates of that fact and of the nature of the information furnished. There is no civil or criminal liability incurred in carrying out the duty imposed.

Case study 4: Dr Z examines Patient D as part of an on-going therapeutic relationship and forms the view that he is not fit to drive. Dr Z discusses her concerns with Patient D, who is adamant that the matter should not be reported to the driver licensing authority. Both parties are located in South Australia. Dr Z is aware that Patient D holds a driver's licence and believes that he is suffering from a physical illness that means that the public are likely to be in danger if he drives. Therefore, Dr Z is under a duty to provide this information to the South Australian Registrar in writing. Dr Z is also required to inform Patient D that she has done so.

Conclusion

The law imposes rigorous duties on health professionals to keep information obtained from or about their patients confidential and private. Such duties are, however, ameliorated by various exceptions that also operate. Exceptions include where the patient has provided consent and where another law permits or authorises disclosure of the information. In Victoria, the Australian Capital Territory, New South Wales, Queensland and Tasmania, statute law allows disclosure of information relating to a person's unfitness to drive to the driver licensing authority. In South Australia and the Northern Territory, statute law requires a health professional to report to the driver licensing authority if the health professional is of the opinion that the patient is unfit to drive. As Western Australian law is silent on the matter, any exception would need to be derived from the exceptions under the Commonwealth privacy legislation. Given the potential confusion for both doctors and patients, a more nationally consistent approach would be preferable, one that balances the need to preserve the relationship of trust between the health professional and patient with the need to ensure that drivers are fit to drive.

[16] *Road Transport (General) Act 1999* (ACT), s. 230; *Road Transport (General) Act 1999* (NSW), s. 49; *Transport Operations (Road Use Management) Act 1995* (Qld), s. 142; *Vehicle and Traffic Act 1999* (Tas), s. 63.
[17] Inquiry No. 12/01 (0325/1999), p. 29.

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