

Position Statement 89

Patient–psychiatrist confidentiality: the issue of subpoenas

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The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is increasingly concerned about patient–psychiatrist confidentiality being undermined by the use of subpoenas to gain access to clinical records.

When compared to other common law countries, Australian law offers less protection for patients against access to their clinical records and the protection that does exist varies greatly across the federal, state and territory jurisdictions. As a result, patient records in both the private and public sectors may be subject to subpoena in both criminal trials and civil litigation. This has become a common event in court proceedings, even when the disclosure of these records appears to serve little evidentiary purpose and is likely to have severe effects on former, current and potential patients.

Therefore, the RANZCP urges Australian governments to undertake law reform that recognises the importance of confidentiality in mental health care, confining breaches to rare cases where an overriding medical or legal purpose is served, such as ensuring patient safety. Overseas models can serve as a guide to law reform – in particular, the stronger protections available under New Zealand law. If this model is not enacted, the RANZCP recommends the uniform adoption of existing provisions in Australian law that protect information obtained in professional confidential relationships.

The RANZCP acknowledges that many people with lived experience of mental illness prefer the term ‘consumer’; however, this position statement uses the term ‘patient’ to reflect the terminology commonly used in legislation.

Ethics

Effective diagnosis and treatment often requires a patient to disclose intensely personal matters to their doctor. Patients must be able to trust that these matters will not be disclosed to third parties. Recognition of this truth is as old as the medical profession itself, as evident in the Hippocratic Oath. The Good Medical Practice Guidelines in Australia and New Zealand restate the ethical duty to ‘treat information about patients as confidential’ (Medical Board of Australia, 2016; Medical Council of New Zealand, 2013).

Confidentiality takes on an even larger role in the psychiatric context. At its core, psychiatry involves developing a trusting relationship, listening carefully to people’s most personal thoughts and feelings, understanding their mental state and working with them to identify and implement appropriate treatments, including therapy. Therefore, patients need to feel comfortable discussing relationships, emotions, memories and impulses of the most sensitive kind with their psychiatrist; to do so, they must feel confident that they are in control of what is disclosed and who it is disclosed to.

Quite often, this includes sensitive information about third parties such as family members who may be unaware that it has been communicated to the psychiatrist. The information often contains feelings towards family members, descriptions of interactions (including details of intimate relations or of sexual assaults) and highly subjective opinions and judgements about the personalities of

family members. These notes are susceptible to misinterpretation when used outside of the therapeutic context.

The RANZCP Code of Ethics upholds the duty of psychiatrists to maintain the confidentiality of patients and their families. The Code sets out detailed guidelines for handling sensitive information; these include narrow exceptions where disclosure without consent is permitted:

Principle 4.3: A breach of confidentiality may be justified on rare occasions in order to promote the best interests and safety of the patient or other people. Psychiatrists may have a duty to inform the intended victim(s) and/or relevant authorities.

Impact of forcible disclosure on patients

When their clinical records are disclosed against their will, patients frequently feel ashamed, helpless and stigmatised. Successful therapy may become impossible in such circumstances; the relationship of trust with the psychiatrist may be permanently damaged, and in some cases, patients may be re-traumatised by the forcible disclosure. Actual or threatened disclosure can be particularly harmful for psychiatric patients, as they have an acute need for supportive, reliable, and trusting relationships.

When facing the prospect of legal proceedings, these impacts can be compounded by the rigours of the trial itself and the frequent impossibility of receiving effective ongoing therapy – a state of affairs that judicial authorities have recognised. In a Canadian case considering the use of subpoenas to gain access to the clinical records of sexual assault victims, the following was acknowledged:

‘At a time she would normally find support in the therapeutic relationship, as during the trial, she finds herself without support. In the result, the patient’s treatment may cease, her distrustfulness be exacerbated, and her personal and work relations be adversely affected... She is doubly victimised, initially by the sexual assault and later by the price she must pay to claim redress...’ (*M. (A) v. Ryan*, 1997).

Unwanted disclosure of patient records may not only impair therapy, it can also raise questions about the fairness of court proceedings that use clinical records as evidence:

‘[R]outine disclosure of medical records and unrestricted cross-examination upon disclosure threaten to function very unfairly against anyone who has undergone mental or psychiatric therapy, whatever the precipitating event or nature of the treatment, as compared to other members of the public. Such persons would be subject to an invasion of their privacy not suffered by other witnesses who are required to testify. They may have to answer to details of their personal life reflected in their records and effectively overcome a presumption, most often entirely unfounded, that their medical history is relevant to their credibility and ability to testify on the matter in issue’ (*Osolin*, 1994).

Similar issues arise in many legal contexts such as family law, where the clinical records of ex-spouses are regularly sought in custody disputes. Documented instances exist where a parent has used this information to try to damage the relationship between the other parent and their children (SMH, 2014; Women’s Legal Service NSW, 2016). Again, judges have recognised that this is a potential danger arising from the compelled disclosure of clinical records:

‘Made public and taken out of context, the disclosure of notes from therapy sessions could have devastating personal consequences for the patient and his or her family, and the threat of such disclosure could be wielded to unfairly influence settlement negotiations or the course of litigation. Especially in the context of matrimonial litigation, the value of the therapist–patient relationship and of the patient’s privacy is intertwined with one of the most important concerns of the courts – the safety and wellbeing of children and families’ (*Kinsella*, 1997).

The very possibility of disclosure may lead patients to restrict what they say to psychiatrists – thereby increasing the possibility of misdiagnosis – or to avoid seeking treatment altogether (Levy et al., 2014). Many empirical studies have confirmed that prospective patients are more likely to censor themselves if they cannot be assured of confidentiality (Paruch, 2009).

Current status of clinical records under Australian law

The cost of issuing a subpoena to gain access to clinical records is negligible (Levy et al., 2014). The process of objecting to a subpoena, however, is frequently difficult, costly and uncertain, for a variety of reasons. As a result, conflict can occur between the needs of psychiatric patients and the legal system.

Australian common law does not recognise the need to protect clinical records from disclosure in court (ALRC, 2005; *Fritze*, 2005). The protection that does exist is contained in statute – primarily, the federal, state and territory Evidence Acts (the Acts). In this regard, the Acts remain far from uniform and Commonwealth law contains no protections at all (although state and territory evidence laws apply to Federal Court proceedings).

The Victorian, Tasmanian and Northern Territory Acts have varied regimes for protecting medical communications. These regimes are subject to numerous exceptions and only apply in civil proceedings.

Except in the case of Queensland, all states and territories restrict access to communications between counsellors (including health professionals) and victims of sexual assault. In Victoria, for example, the party seeking to disclose those communications in a civil or criminal proceeding must:

- obtain leave from the court before issuing a subpoena
- prove that the evidence will have substantial probative value to a fact in issue
- prove that the public interest in preserving the confidentiality of confidential communications and protecting a protected confider from harm is substantially outweighed by the public interest in admitting the evidence.

The underlying policy rationale is that confidentiality is necessary to encourage victims to both seek counselling and report the crime (ALRC, 2005). However, it is also acknowledged that the purpose of counselling is therapeutic, not investigative; consequently, the notes taken will often be unfit for the purpose of settling facts in issue during court proceedings and may instead be used to cast unwarranted doubts upon the credibility and character of victims (NSW Parliamentary Debates, 1997). The RANZCP shares this view and believes that it would be inconsistent to deny this protection to all other psychiatric patients.

Evidence Acts in New South Wales, Tasmania and the Australian Capital Territory also contain provisions addressing protected confidential professional relationships. The discretion allows judges to exclude evidence if it would disclose a communication made in confidence to a person acting in a professional capacity, where the professional is under an obligation to maintain confidentiality. Judges must give this direction if it is likely that harm will be caused by admission of the evidence and if the nature and extent of the harm outweighs the desirability of the evidence being given. In deciding whether to exercise this discretion, judges must consider a long list of factors, among them the public interest in protecting confidential relationships.

Although the discretion may be sought by patients or granted on the judge's own initiative, it is often the psychiatrist who assumes the burden of arguing for its use. The existence of the discretion makes it possible to resist unwanted access to clinical records, but – in the RANZCP's view – it falls far short of what is needed to enable psychiatrists to meet their ethical duties. This is for a number of reasons, including the following:

- the Acts require patients and/or psychiatrists to prove – on the balance of probabilities – that disclosure might cause harm to the patient (Merrill, 2015). Where psychiatric patients are concerned, we believe harm should instead be presumed on the basis of the known harmful impact of forcible disclosure on patients
- the Acts also require patients and/or psychiatrists to prove that the nature and extent of this harm outweighs the desirability of the evidence being given. We believe that the party issuing the subpoena should bear the burden of arguing that the forensic value of the records outweighs the harm caused by their disclosure. Currently, the issuing party only needs to establish the relevance of the records sought
- harm is narrowly defined in the New South Wales and Tasmania Acts: actual physical bodily harm, financial loss, stress or shock, damage to reputation or psychological harm (such as shame, humiliation and fear). This definition does not fully encompass the damage that can be done to the therapeutic relationship. As noted, patients sometimes feel betrayed by a psychiatrist who has been forced to disclose clinical records; it may be impossible to restore that trust and consequently impossible for the patient to receive effective treatment
- the Acts list 10 factors that judges regard in turn when deciding whether to grant the privilege. The sequence emphasises matters related to the trial and sets a low priority on the needs of the patient in question and the practice of psychiatry more broadly. The likelihood of harm, and the nature and extent of harm that would be caused to the protected confider is the fifth factor listed. The public interest in preserving the confidentiality of protected confidences is the ninth factor listed; this is the point at which the deterrent effect on potential patients becomes a legal issue.

In regard to clinical records, Australian judicial authorities have held that '[the] professionally mandated ethical value of confidentiality, with no legislative or common law recognition [is not] likely to be regarded as significant in litigious processes' (Harricks, 2014). While judges have used their discretion to prevent disclosure in individual cases, it has been held that as a general rule the public interest in excluding records '[does not] at this point in time extend to or include protection of a clinician–patient or counsellor–client relationship. That may be regrettable on many levels. But it is the current state of the law' (Duffy, 2015).

When judges deem it necessary to admit clinical records into evidence, they are still able to modify courtroom procedures to reduce the harm caused to patients. By hearing the clinical evidence in a closed court that excludes the public, judges can administer justice in a way that helps avoid needless pain and suffering. Australian judges have recognised that the open-justice principle can be curtailed to protect victims of crime (John Fairfax, 1991). Therefore, a strong argument exists to extend that protection to others who may be gravely harmed by the invasion of privacy in court proceedings such as patients whose confidential and sensitive medical records are the subject of subpoenas. The International Covenant of Civil and Political Rights recognises that closed courts may be appropriate 'when the interest of the private lives of the parties so requires' (Article 14). Although Australia has ratified this fundamental human rights treaty, Australian courts rarely apply this provision (Davis, 2001).

Practical challenges involved in objecting to a subpoena

In the view of the RANZCP, patient confidentiality is poorly served by current laws and judicial practice, and the practical challenges faced when defending patient confidentiality are considerable. To object to a subpoena, a psychiatrist must, at short notice, copy and examine what may be a substantial body of material accumulated over several years. The psychiatrist may then have to cancel appointments to attend court and face cross-examination on the grounds for objection. Cancelled appointments can have major impacts on patients. Frequently, patients need urgent assessment and medication and cannot be transferred to other practitioners at short notice.

The RANZCP considers that it is unreasonable to expect psychiatrists to undertake this process every time patient records are subpoenaed. Despite their ethical commitments, the pressure to comply with subpoenas is immense, leading to a position some psychiatrists have described as 'learned helplessness' (Levy et al., 2014).

Law Reform Commissions in Australia have long recognised:

‘an ongoing tension between the codes of ethics and professional duties of many professions in Australia and the legal duty to reveal to the courts information said in confidence... there is a clear public interest that can be demonstrated in protection of a confidence, such as the encouragement of people to seek treatment’ (ALRC, 2005).

To address these competing public interests, the Australian Law Reform Commission (ALRC) recommends that all Evidence Acts adopt the NSW discretion to protect confidential relationships (ALRC, 2005). The RANZCP supports this proposal, but notes shortcomings in the NSW model that would need to be addressed in order to adequately protect the confidentiality of psychiatric patients.

Current status of clinical records under New Zealand law

By contrast, the New Zealand Evidence Act (the New Zealand Act) contains a strong privilege that operates in criminal proceedings to protect communications between patients and health professionals when patients are being treated for drug dependency or any other condition that may lead to criminal conduct (s59). No balancing test applies. The rationale is that ‘the broader aim of securing due compliance with the law is more likely to be achieved through medical treatment than through prosecution. This is particularly true of drug addiction, where legal sanctions have little effect’ (NZLC, 2013).

Where this privilege does not apply, courts still have a general discretion to exclude evidence obtained in a confidential setting in both criminal and civil proceedings (s69).

The RANZCP considers that the New Zealand Act better accommodates the needs of patients than its Australian counterparts because it:

- recognises that confidential clinical practice may assist the broader goals of the justice system. This is evident in the strong protection for clinical records made when treating conditions that may lead to criminal behaviour
- emphasises the public interest in protecting vulnerable patients and ex-patients. When judges consider whether to exclude the evidence, the first factor they must regard is the likely extent of harm that may result from the disclosure. Later, they must also consider the sensitivity of the evidence and society’s interest in protecting the privacy of the victims of offences and, in particular, victims of sexual offences
- preserves the particular therapeutic relationship in question and ensures that potential patients are not deterred from seeking help either. One of the factors that may outweigh the court’s need for evidence is the value of ‘maintaining activities that contribute to or rely on the free flow of information’.

The RANZCP notes that this legislative scheme has been in operation since 1980 and protections for confidential communications were strengthened when the new Evidence Act was introduced in 2007. All political parties expressed support for the new Act, and none raised any concern about these provisions (NZ Hansard, 2005–7). The New Zealand Law Commission ‘has not been made aware of any situations where the discretion... has failed to adequately protect information disclosed in the course of consultation with a health professional that did not attract medical privilege’ (NZLC, 2013).

Court proceedings do not appear to have been impaired by these provisions either. Although additional protections for confidentiality have been added since 1992, the essential scheme has not changed. In that year, it was evaluated in the following terms by the New Zealand Department of Justice: ‘the provisions... dealing with protected communications have not given rise to any particular problems’. Ultimately, the scheme ‘strikes the right balance’ (WALRC, 1992).

Overseas models

Australian courts have acknowledged that it is easier to protect patient confidentiality on public interest grounds in other Commonwealth countries (*Kirby*, 2014). Patient and counselling records receive even stronger protection in the United States of America. Termed the psychotherapist privilege, it has been enacted in every state and the Supreme Court held it to be part of US common law (*Jaffee*, 1996).

The court held the privilege to be necessary because ‘the mental health of our citizenry, no less than its physical health, is a public good of transcendent importance’ and ‘the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.’ The price of denying access to clinical records was held to be ‘modest’ because, if the privilege were rejected:

‘confidential conversations between psychotherapists and their patients would surely be chilled, particularly when it is obvious that the circumstances that gave rise to treatment will probably result in litigation. Without a privilege, much of the desirable evidence... is unlikely to come into being.’

To ensure certainty that confidences will be kept, and to prevent inconsistent rulings, the court rejected the application of a case-by-case test that balances the patient’s need for confidentiality with the court’s need for evidence. Most Commonwealth countries still favour the balancing exercise in some form, however. For this reason, the RANZCP believes that the New Zealand framework offers a model that would be suitable for guiding Australian law reform on this issue.

Recommendations

The RANZCP reaffirms the commitment of the psychiatric profession to confidentiality in clinical practice. We advocate law reform that recognises the therapeutic value of confidentiality and respects the privacy of patients. The RANZCP therefore:

- urges all Australian governments to draw on international examples to offer comparable protections against unwarranted access to clinical records
- seeks to highlight the stronger protections available for patient confidentiality in comparable common law countries
- wishes to draw attention to the protections offered by the New Zealand Evidence Act. The Act recognises the therapeutic value of confidentiality in a number of ways, serving as an example of how the needs of justice can be balanced with the needs of mental health care
- supports the ALRC recommendation to allow judges a discretion to protect confidential professional relationships. We note that Evidence Acts in New South Wales, Tasmania and the Australian Capital Territory have already been amended to provide this discretion. However, we hold serious concerns about the current design of these provisions and ask governments to include the RANZCP in consultations to make sure the Acts protect the needs of patients
- urges judges to use their discretion to close courts when the contents of psychiatric records are being discussed to minimise distress and potential harm for patients. International law recognises that the principle of open justice must sometimes give way to respect for privacy
- will actively engage with the legal profession to raise awareness of the harmful impacts of disclosing clinical records without patient consent. We will advocate for the protection of the patient–doctor confidential relationship
- will work closely with all parties seeking law reform that protects patients’ confidentiality. Such parties include allied professions that provide mental health counselling – including psychologists and social workers – and organisations representing mental health consumers.

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