

# Medical privilege in the law of evidence in Aotearoa New Zealand

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When can information obtained in the course of medical examination or treatment be admitted and used in criminal proceedings? How is the law working in practice? Is reform necessary or desirable? These are some of the questions Te Aka Matua o te Ture | Law Commission is seeking submissions on as it examines the law on medical privilege as part of its third (and final) statutory review of the *Evidence Act 2006*.

The *Act* sets out what evidence can be admitted and used in court proceedings. As the rules of evidence determine what information is presented in court to establish the facts of a case, they are of critical importance to securing just processes and outcomes and, ultimately, a fair, efficient and effective justice system. Since its enactment, the Commission has been tasked with carrying out an operational review of the *Act* every 5 years—identifying potential issues in practice and, where necessary or desirable, making recommendations for reform.

## Medical privilege—purpose, origins and scope

Section 59 of the *Act* creates a privilege in criminal proceedings for communications made to, and information obtained by, medical practitioners and clinical psychologists in the course of the examination, treatment or care of a person in relation to drug dependency or other conditions or behaviour that may manifest in criminal conduct.

A privilege is an exception to the general legal rule that all relevant evidence should be available to a court. It arises in situations where another public interest outweighs the general public interest in ensuring a court has all the information it needs to arrive at a correct decision.<sup>1</sup>

The public interest underlying medical privilege is the interest in maintaining confidentiality in healthcare practitioner-patient relationships. The original policy grounds for recognising medical privilege in statute were that:<sup>2</sup>

- Society has an interest in encouraging people to seek medical attention, and for them to communicate openly and honestly with healthcare professionals when they do so;
- Individuals generally prefer and expect that the information they do share will be kept private; and
- In cases involving drug dependency or other conditions that may manifest in criminal behaviour, compliance with the law is more likely to be achieved through medical treatment than through criminal prosecution.

## Medical privilege in practice

The Commission's initial research and engagement with stakeholders has identified two potential issues with the operation of section 59 in practice, and we take these in turn, below.

Our preliminary view is that section 59 could benefit from reform—both to give greater effect to the policy justifications underlying the existence of a medical privilege, and to ensure that the *Act* reflects contemporary medical practice. We have not reached a firm conclusion on this, however, or on how reform could best be achieved. We are seeking submissions to inform our recommendations to the Government. Our *Issues Paper* sets out our analysis and options for reform in more detail and is open for consultation until 30 June 2023.

## Exceptions to medical privilege

Section 59 is already narrowly defined, but section 59(1)(b) creates an exception to medical privilege in cases where a person is required, either by a court or another lawful authority, to submit themselves to a medical practitioner or clinical psychologist for “any examination, test, or for any other purpose”. This means that information obtained by a medical practitioner or clinical psychologist during a court-ordered assessment (for example, assessing a person's fitness to stand

trial) is not privileged.

The first issue we explore in our *Issues Paper* relates to uncertainty as to whether this exception applies to court-ordered *treatment*. It is not clear, for example, whether it applies to information obtained during a counselling programme that a person has been directed to attend as a condition of their parole, extended supervision order or a community-based sentence. A related issue is then whether, once information has been obtained through a court-ordered assessment, it can be repurposed and used for another, unrelated purpose—for example, to support criminal charges for unrelated offending.

We believe it is unlikely that the exception was originally intended to apply to court-ordered treatment. The first mention of such an exception can be found in the *Evidence Further Amendment Act 1895* and clearly states that privilege attaches to information obtained by a medical practitioner “*unless the sanity of the patient be the matter in dispute*”.<sup>3</sup> This suggests that the initial intention of limiting medical privilege was to ensure that information required to reach a legal determination (for example, to reach a view on whether a person was fit to stand trial) remained available to the court.

We also question whether allowing the exception to apply to court-ordered treatment—or permitting information obtained through court-ordered assessment to be used for another, unrelated purpose—is consistent with the policy justifications for medical privilege. Such a broad carve-out from medical privilege could inhibit patients from engaging honestly and openly in assessment processes or treatment programmes. It could also have far-reaching consequences for information obtained during compulsory treatment under mental health legislation, which were unlikely to have been intended.

In our *Issues Paper*, we present two possible options for reform to clarify the circumstances in which the exception to medical privilege applies, and how information obtained can be used. The first is to remove the words “*for any other purpose*”. The second is to limit the exception so that it only applies where the information obtained will be used for the same purpose for which it has been ordered.

## Professions covered by medical privilege

The second issue we explore in our *Issues Paper* relates to the status of disclosures made to health professionals other than medical practitioners

and clinical psychologists.

Section 59(5) states that the privilege extends to people “*acting in a professional capacity on behalf of*” a medical practitioner or clinical psychologist. There is some uncertainty as to who and what is covered by the wording “on behalf of”. The courts have held that this covers nurses acting at the direction of a medical practitioner or clinical psychologist working in a hospital,<sup>4</sup> but not a counsellor working in a programme for sexual offenders to whom the defendant had been referred by a psychologist for further treatment.<sup>5</sup>

A further consideration is whether the approach under section 59(5) is consistent with contemporary healthcare provision. We note that an increased focus on multi-disciplinary team (MDT) working means patients will come into contact with a range of professionals working together to deliver comprehensive care and treatment. It may be less clear-cut when professionals are working “on behalf of” a medical practitioner or clinical psychologist, and when they are working autonomously. In a case from 2009, the court held that a person can only be said to be acting “on behalf of” a medical practitioner or clinical psychologist if the practitioner or psychologist has already initiated examination, treatment or care. It is unclear how often this will be the case in MDT working.<sup>6</sup>

We are also conscious of the increased use of remote healthcare and digital technologies in healthcare provision. Whether some individuals working in these areas are “acting on behalf of” a medical practitioner or clinical psychologist is not yet clear. A recent case involved an argument that a call-taker working for a mental health helpline was acting “on behalf of” a medical practitioner—but this issue was not determined by the Court of Appeal<sup>7</sup> and, although the Supreme Court accepted that this was potentially an issue of “public importance”, leave to appeal was declined since it was not an appropriate case to consider the issue.

For these reasons, we present two possible options for reform. First, to amend section 59(5) to clarify what it means to “act on behalf of” a medical practitioner or clinical psychologist. Alternatively, the privilege could be extended to a broader range of healthcare professionals, beyond medical practitioners and clinical psychologists.<sup>8</sup>

## Next steps

To ensure the Commission’s recommendations to the Government are fully informed, it is crucial that we hear from clinicians and other health-

care professionals with experience in this area, and those who may be affected by any reforms. If you are interested in making a submission to us, you can find out more at [www.lawcom.govt.nz/our-projects/the-third-review-evidence-act](http://www.lawcom.govt.nz/our-projects/the-third-review-evidence-act) or by contacting the review team at [evidence@lawcom.govt.nz](mailto:evidence@lawcom.govt.nz).

govt.nz. Submissions are open until 30 June 2023.

The feedback we receive through this process will inform our analysis and the recommendations for reform of the Act we make to the Government. We will deliver our final report to the Minister of Justice in February 2024.

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**COMPETING INTERESTS**

Nil.

**CORRESPONDING AUTHOR INFORMATION**

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**REFERENCES**

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4. *R v Rapana* [1995] 2 NZLR (HC).
5. *R v Gulliver* 9 June 2005 CA51/05.
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