

Medical Privilege in New Zealand

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Many are the articles one reads in which the writer examines an area of the common law and finds it deficient in the light of modern thought and conditions. And with equally monotonous regularity, the writer, having exposed the illogicalities and tortuities of his subject, terminates his thesis with the pious platitude that "it is high time that the matter was dealt with by the legislature". So it may come as somewhat of a surprise to those staunch believers in the omniscience of parliamentary wisdom that there are spheres of the common law in which the invasion of the legislator, together with his trusty cohort, the draughtsman, has been less than beneficial. Such a sphere in New Zealand is found in the law of evidence, more particularly in the rights of medical practitioners to refuse to answer questions in judicial proceedings. It is with this topic that this paper intends to concern itself.

It may be thought with reason that medical privilege is too esoteric a branch of the law to be of any great import to the practising lawyer, especially at a time when it is becoming fashionable to exchange medical reports before an action is heard¹ or even to have an agreed medical expert.² But cases still arise in which the subject rears itself in its most acute form, and in so doing reveals the disturbing features

¹ See, e.g., *Vose v. Barr* [1966] 2 All E.R. 226, where a plaintiff in a personal injuries action was penalised in costs for his unreasonable refusal to disclose a medical report to the defendant. And in *Bird v. Hammond* [1960] N.Z.L.R. 466, a stay of proceedings was ordered in a claim under the *Deaths by Accident Compensation Act* 1952 until a plaintiff agreed to submit himself to a medical examination in order that an excessive sum in respect of his expectation of working life might not be awarded. Northern Ireland courts have taken a similar stand: *Anderson v. Irwin* [1966] N.I. 156; *Irvine v. Freeland* [1967] N.I. 146; and comment by D. B. Murray Q.C. in [1967] N.I.L.Q. 65, 68.

² At least in custody and wardship cases: *Re S. (Infants)* [1967] 1 W.L.R. 396, 407; *Re R. (P.M.)* [1968] 1 W.L.R. 385, 387-8; *B. (M.) v. B. (R.)* [1968] 1 W.L.R. 1182, 1185 (C.A.).

of relatively certain, yet flexible, principles impeded in their development, and moreover, rendered completely uncertain and illogical by legislative intervention.

This paper intends, first, to examine the policy underlying medical privilege; secondly, to examine the common law position; thirdly, to examine the position in New Zealand; fourthly, and perhaps inevitably, to recommend reform.

The term "medical privilege" as used herein is intended to describe the rights, if any, a medical man has, to insist on withholding from a judicial tribunal information in his possession which might assist the tribunal to ascertain facts relevant to an issue upon which the tribunal is adjudicating. The rights include those in respect of interlocutory proceedings, such as discovery, interrogatories and inspection, as well as the giving of evidence and the production of documents at the hearing.³

1. Policy Underlying Medical Privilege

The foundation for the privilege has sometimes been considered as resting upon an implied contractual term that the doctor is to keep the patient's affairs secret.^{3A} But this, however, is not the most satisfactory base because difficulties arise when the consultation is intended, for one reason or another, to be free, and also because the implied term is always stated to be subject to some such exception as that no disclosure is permitted except for "just cause",^{3A} which, of course, begs the crucial question of what amounts to just cause.

The reasons most forcefully advanced by doctors in favour of a form of medical privilege are connected with the Hippocratic Oath, by which every doctor holds himself honour-bound, whether he has sworn it formally or not.

"Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of man, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret."⁴

The purpose of the oath is primarily that of preserving the confidential relationship inherent when a person consults a medical man. But it is recognised, both by the legislature and by the courts, and even by doctors, that this need to preserve secrecy is not an absolute value. Certain statutes have made inroads into the relationship;⁵ and it has been held that if a patient requests his doctor to reveal to a nominated person confidences entrusted to the doctor by the patient, the doctor

³ Law Reform Committee, 16th Report, "Privilege in Civil Proceedings", (1967) para. 1, p. 3. See also the excellent article by Nokes (1950) 60 L.Q.R. 88.

^{3A} *Tournier v. National etc. Bank* [1924] 1 K.B. 461, 480-1, per Scrutton L.J.

^{3B} *ibid.*; *Parry-Jones v. Law Society* [1968] Ch. 195

⁴ Cf. the International Code of Medical Ethics: "A doctor shall preserve secrecy on all he knows about his patient because of the confidence entrusted to him."

⁵ *Human Tissues Act* 1964 s.6 (3); *Maternal Mortality Research Act* 1968 s.11.

is not entitled to refuse to do so.⁶ Some doctors, too, are frequently placed in the dilemma whether or not they should report a crime obviously committed by or upon a patient to the authorities.⁷

This brings us to the second aspect of the policy underlying the privilege, and one which appears to lie on a surer foundation, namely, that the privilege is that of the patient, rather than that of the doctor.⁸ It is essential that a patient should be able to confide unreservedly and with the utmost candour in his doctor such matters as may be relevant to the diagnosis, e.g., his past physical or mental history, or that of his family. This argument may, of course, be used in support of the creation or extension of a privilege in respect of other professional relationships. But it is well established that accountants⁹, bankers,¹⁰ priests (at common law only),¹¹ journalists,¹² and members of a family¹³ have no privilege in similar circumstances. Indeed, only the legal profession enjoys a "privileged" status.¹⁴

It is possible to discern a further reason behind the privilege in the tendency of the law to look unfavourably upon admissions (even though quite likely true) which are the result of pressure or suffering.¹⁵ In *National Mutual Life Association of Australasia v. Godrich*,¹⁶ Isaacs J. said of a statute creating medical privilege:

"... The State, setting private obligation against private obligation refuses to be a participant in the breach of a personal trust, probably the result of physical suffering or the fear of death."¹⁷

This notion, however, cannot be elevated to the status of a principle because of the bountiful exceptions to it.¹⁸

Doctors have often argued in favour of a privilege as wide as that given to legal advisers. But the argument by analogy is always dangerous, no less so here where the differences between the two professions and between the very nature and purpose of the communications entrusted to them are so great. The one profession deals with the securing

⁶ *Garner v. Garner* (1920) 36 T.L.R. 196; *C. v. C.* [1946] 1 All E.R. 562.

⁷ Many doctors refuse to report criminal abortions except to prevent a clumsy amateur causing serious harm to unsuspecting women.

⁸ *Pacyna v. Grima* [1963] V.R. 421, 428.

⁹ *Parry-Jones v. Law Society* [1968] Ch. 195.

¹⁰ *Tournier v. National etc. Bank* [1924] 1 K.B. 461, 479. See also the *Banking Act* 1908, s.20; *R. v. Wm. Bacon and Co. Ltd.* [1969] N.Z.L.R. 228; *A.N.Z. Bank Ltd. v. Ryan* (1968) 88 W.N. (Pt. 1) (N.S.W.) 368, 372-3.

¹¹ *Normanshaw v. Normanshaw* (1893) 69 L.T. 468. They have in N.Z.: see *Evidence Act* 1908, s.8(1). Cf. *Cook v. Carroll* [1945] I.R. 515.

¹² *McGuinness v. A.-G.* (1940) 63 C.L.R. 73; *A.-G. v. Clough* [1963] 1 Q.B. 773; *A.-G. v. Mulholland* [1963] 2 Q.B. 477.

¹³ *Wheeler v. Le Marchant* (1881) 17 Ch.D. 675, 681.

¹⁴ *C.I.R. v. West-Walker* [1954] N.Z.L.R. 191.

¹⁵ *R. v. Williams* [1959] N.Z.L.R. 502; Cf. *R. v. McKay* [1967] N.Z.L.R. 139.

¹⁶ (1909) 10 C.L.R. 1.

¹⁷ *Ibid.*, 33-4.

¹⁸ *Evidence Act* 1908 s.20; *Deokinan v. R.* [1968] 3 W.L.R. 83.

of property rights and with litigation, actual or imminent, where by reason of the adversary system confidential admissions are part of the daily routine.¹⁹ The other deals with physical cures where disclosure would rarely occur, and even more rarely be sought after by third parties for their own advantage. It is true that in the United States, the State legislatures have been active in passing privilege-creating statutes to the point where some 37 states and the District of Columbia have medical privilege in one form or another.²⁰ However, American law seems to favour the protection of confidential relationships much more so than does English law,²¹ a view which has not escaped criticism from prominent American commentators.²²

Having looked briefly at the policy behind medical privilege, we are now in a position to examine the common law approach to claims of such privilege.

2. Common Law Position

The heads of privilege at common law were initially established by the judges' view of what was best in the interests of the State. No doubt public policy is an unruly steed to ride, but in this area of the law as, in others, it is an essential and even overriding consideration.

The common law has always proceeded on the basis that all evidence which has a material bearing on the question which the Court has to decide should be put before it, for only with a full knowledge of the facts can the tribunal be satisfied that it has sufficient information before it to work justice. Lord Sumner stated this attitude with his customary clarity in *Russell v. Russell*:²³

"In the administration of justice nothing is of higher importance than that all relevant evidence should be admissible and should be heard by the tribunal charged with deciding according to truth. To ordain that a court should decide upon the relevant facts and at the same time that it should not hear some of those relevant facts from the person who best knows them and can prove them at first hand seems to me to be a contradiction in terms. It is best that truth should out and that truth should prevail."²⁴

The law's attitude towards privileges in general has therefore been that they constitute a fetter upon truth and accordingly should be narrowly

¹⁹ Wigmore develops this point more fully: see v., *Wigmore on Evidence* (2nd ed., 1923) para. 2380, pp. 208-9.

²⁰ Bernfeld, "Medical Professional Secrecy with Special Reference to Venereal Diseases", (1967) 43 British Journal of Venereal Diseases, p. 53, 54.

²¹ Wigmore contemptuously cites a state statute protecting communications passing between employer and typist: *op. cit.* It is noteworthy that the first medical privilege statute in common law jurisdictions was enacted in New York in 1828: Wigmore, *op. cit.*, pp. 202-4.

²² E.g. Wigmore. Others are noted by Bernfeld, *op. cit.*

²³ [1924] A.C. 687.

²⁴ *Ibid.*, 748. This has been put another way by saying that a Court will not encourage fraud: *Lucena v. N.M.L.* (1911) 31 N.Z.L.R. 481, 495, per Williams J. See also *N.M.L. v. Godrich* (1909) 10 C.L.R. 1, 28, per O'Connor J.: "Prima facie every litigant is entitled to bring before the Court all evidence material to the proof of his case."

construed. This attitude has strongly influenced the interpretation placed upon statutes conferring or extending privileges.

The position at common law in respect of medical privilege has not been in real doubt since 1776.²⁵ A practitioner may be compelled to give evidence of all matters arising out of the professional relationship, whether the matters relate to what the patient told him or to what the practitioner observed, diagnosed, prescribed, or told the patient. The rule applies both to criminal and civil proceedings.²⁶ The leading case is the *Duchess of Kingston's Case*,²⁷ where, in a bigamy trial, a physician who had attended the accused and her "husband" was asked whether he knew from the parties of any marriage between them. Upon the physician's taking objection to the question on the grounds that such information came to him in confidence in his professional capacity, Lord Mansfield C.J. said:

" . . . A surgeon has no privilege, where it is a material question in a civil or criminal cause to know whether parties were married or whether a child was born, to say that his introduction to the parties was in the course of his profession and in that way he came to the knowledge of it . . . If a surgeon was voluntarily to reveal these secrets, to be sure, he would be guilty of a breach of honour and of great indiscretion; but to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever."

This position has invited the occasional judicial lament that the medical profession should have the same privilege as the legal profession,²⁸ but the rule as laid down by Lord Mansfield has nevertheless been generally applied to material questions down to the present day and represents the modern law.²⁹ The rule extends to both written and oral information acquired by the practitioner.³⁰ So medical records,

²⁵ *Duchess of Kingston's Case* (1776) 20 St. Tr. 355.

²⁶ *Ibid.*; *Witt v. Witt* (1826) 3 Sw. & Tr. 143.

²⁷ (*Supra*), note 25.

²⁸ See *Wilson v. Rastall* (1792) 4 T.R. 753, 760, per Buller J.; *Greenough v. Gaskell* (1831) 1 My. & K. 38, 103, per Lord Brougham L.C. The impassioned plea of Garrow B. in *Earl of Falmouth v. Moss* (1822) 11 Price 455, 470-1, repays reading as a quaint piece of Victoriana.

²⁹ *McTaggart v. McTaggart* [1949] p. 94, 97; *A.-G. v. Mulholland* [1963] 2 Q.B. 477; *R. v. Beynon* [1963] N.Z.L.R. 635, 638. *Biok v. C.C. Wakefield and Co. Ltd.* [1962] N.S.W.R. 1447, 1448.

³⁰ Nokes, (1950) 66 L.Q.R. 88, 91. *Witt v. Witt* (1892) 3 Sw. & Tr. 143 cannot be supported insofar as it appears to draw a distinction between a written communication describing the patient's symptoms, which the learned Judge Ordinary decided was privileged, and oral communications, which he appears to have thought were not. A deaf and dumb person might have to describe his symptoms in writing or by signs; is there any reason why such communications should be excluded, whilst a similar verbal description by a normally endowed patient would not be?

and reports, if not covered by some other head of privilege,³¹ may be ordered to be produced on a *subpoena duces tecum*.³² No problem arises if the patient himself calls the doctor to give evidence or consents to his doing so. Just as the privilege between legal adviser and client is the client's, so any medical privilege is that of the patient.³³ If the patient expressly or impliedly waives the privilege, the doctor cannot refuse to give evidence, or, indeed, to reveal any information acquired from the doctor-patient relationship to any person nominated by the patient.³⁴

In *C. v. C.*,³⁵ Lewis J. ruled that a doctor was not justified

"in refusing to divulge confidential information to a patient or to any named persons when asked by the patient to do so."

Two features of the rule should particularly be noted. Firstly, as the statement by Lord Mansfield indicates, the question put to the doctor in Court must be relevant before it need be answered. Otherwise, it would, on general principles, be inadmissible.³⁶ To be relevant in the sense required by law, the question must be directed towards proving a fact in issue.³⁷ It seems, too, that the question must be necessary in the interests of justice in the circumstances of the particular case. In one of the cases in which a journalist unsuccessfully invoked privilege, Donovan L.J., extending his remarks to medical privilege, observed that the question put to the witness

"ought to be one the answer to which will serve a useful purpose in relation to the proceedings in hand . . ."³⁸

It seems, therefore, that if substantial and credible evidence upon a particular issue has already been given, the Court may refuse to order a doctor to give evidence which is co-extensive and only confirmatory of previous evidence, if the doctor would otherwise have to disclose facts acquired in his professional character. The question would serve no "useful purpose in relation to the proceedings in hand"; to allow it would be to breach a confidence.

Secondly, the judge has a discretion whether or not to admit evidence the disclosure of which would breach a professional confidence. The case law indicating the manner in which this discretion is exercised is

³¹ E.g., legal profession privilege: *Anderson v. Bank of British Columbia* (1876) 2 Ch.D. 644; or Crown privilege: *Gain v. Gain* [1961] 1 W.L.R. 1469, although this head should rarely be claimed in the case of routine medical reports after *Conway v. Rimmer* [1968] 2 W.L.R. 998, H. L. Privilege may attach also to communications attempting marital reconciliation: *Theodoropoulos v. Theodoropoulos* [1964] 311.

³² *Report of the Committee on Personal Injuries Litigation* (1968; Cmd. 3691), p. 87, para. 304.

³³ *Pacyna v. Grima* [1963] V.R. 421, 428.

³⁴ *Garner v. Garner* (1920) 36 T.L.R. 196.

³⁵ [1946] 1 All E.R. 562, 563.

³⁶ *Koruma v. R.* [1955] A.C. 197, 203.

³⁷ *R. v. Hartz* [1966] 3 All E.R. 433, 449.

³⁸ *A.-G. v. Mulholland* [1963] 2 Q.B. 477, 492.

sparse, but a number of broad guide-lines stand out. The Court will weigh up, on the one hand, the interests of the community that justice be done between the parties, and, on the other, that professional confidences should be respected.³⁸ If more harm than good would result from compelling the doctor to disclose confidential information, then the Court may exercise its discretion against the reception of such evidence.

"The judge [has] a wide discretion to permit a witness, whether a party to proceedings or not, to refuse to disclose information where disclosure would be in breach of some ethical or social value and non-disclosure would be unlikely to result in serious injustice in the particular case in which it is claimed."⁴⁰

Suppose, for example, a party sought to call a practitioner to give evidence of what a patient said while under a state of hypnosis or narcosis induced by the practitioner for treatment purposes. A Court would almost certainly refuse to receive such evidence. It would not be in the public interest to admit it, for otherwise patients in need of such treatment might refuse to undergo it through fear that what they might say while under treatment could be disclosed elsewhere to their prejudice.⁴¹ Similar considerations apply to communications in the course of psychiatric therapy.⁴² Matters unrelated to the patient's health not uttered in the course of and inseparable from the treatment ought not to be refused admission. If a practitioner were called to testify to information which he had acquired in his capacity as a medical adviser, but which consisted of matters irrelevant to the patient's health or treatment, such information would be outside the doctor-patient relationship and would be proffered to the doctor merely in his capacity as friend or third party. The law certainly gives no protection to statements merely because they are made to friends.⁴³

In criminal proceedings, especially for serious charges,⁴⁴ or in civil matters of some moment, the Court's discretion will more likely be exercised in favour of disclosure. In relatively trifling cases, the Court will lean more favourably towards the respecting of medical confidences,

³⁹ *A.-G. v. Mulholland (supra)*, p. 490, per Lord Denning M.R.

⁴⁰ Law Reform Comm., 16th Report, para. 1, p. 3.

⁴¹ Such evidence might equally be rejected upon the ground that it is too unreliable at present for a Court of law to act upon: *R. v. McKay* [1967] N.Z.L.R. 139, 150, 152 (truth drugs).

⁴² In *Nuttall v. Nuttall* (1964) 108 So.Jo. 105, a psychiatrist was summoned by the petitioner (not his patient) and questioned about a confession of adultery the respondent had made to the psychiatrist while under treatment. The Court ruled that the psychiatrist must answer. The Law Reform Committee thought that if the evidence was for the purpose of furnishing grounds for divorce, it should not have been admitted; *aliter* if the respondent's mental condition was in issue, e.g., was her anxiety caused by her husband's cruelty or by her own adultery? (16th Report, para. 51, p. 22).

⁴³ *Wheeler v. Le Marchant* (1881) 17 Ch.D. 675, 681 per Jessel M.R.

⁴⁴ *R. v. Gibbons* (1823) 1 C. & P. 97 (murder).

even though thereby a litigant may be hard pressed to prove his case.⁴⁵

If no more substantial principles can be formulated, it is because of the infinite combination of fact situations which may arise in which medical privilege may be sought. In the pragmatic tradition of the common law, no attempt will be made to predicate these. Their solution will be left to judicial discretion exercised on the broad principles outlined above.⁴⁶

Although the categories of privilege are not closed,⁴⁷ the English courts are extremely unlikely to extend such privilege as is already accorded to medical advisers. Nor does there appear to be any real demand from the British medical profession that they should do so. Representations made by their national body to the Law Reform Committee which recently investigated the subject of medical privilege indicated that doctors had little quarrel with the way in which judges had exercised their discretion in this respect.⁴⁸

3. New Zealand Position

Section 9 of the Evidence Further Amendment Act 1895 created a form of medical privilege in New Zealand, apparently based on a similar provision introduced in Victoria in 1857. The New Zealand provision was re-enacted in identical terms to s.9 in 1905 and is now enshrined in s.8(2) and (3) of the Evidence Act 1908. To obtain a fuller understanding of some of the difficulties of interpretation inherent in the provision, it is necessary to set s.8 out in full.

8. Communications to clergymen and medical men

- (1) A minister shall not divulge in any proceeding any confession made to him in his professional character, except with the consent of the person who made such confession.
- (2) A physician or surgeon shall not, without the consent of his patient, divulge in any civil proceedings (unless the sanity of the patient is the matter in dispute) any communication made to him in his professional character by such patient, and necessary to enable him to prescribe or act for such patient.
- (3) Nothing in this section shall protect any communication made for any criminal purpose, or prejudice the right to give in evidence any statement or representation at any time made to or by a physician or surgeon in or about the effecting by any person of an insurance on the life of himself or any other person.

Two early cases indicated that the Courts might adopt a wide construction in interpreting s.8(2). In *Godfrey v. Godfrey*,⁴⁹ an undefended petition for divorce upon the grounds of adultery, the petitioner sought to tender the evidence of a medical officer who had attended the res-

⁴⁵ As in *Witt v. Witt* (*supra*); although it is not suggested that divorce is a trifling matter within the rule. See also *ex p. Pritchard* [1953] 2 All E.R. 766, 772.

⁴⁶ *A.-G. v. Mulholland* [1963] 2 Q.B. 477, 492 per Donovan L.J.

⁴⁷ *A.-G. v. Clough* [1963] 1 Q.B. 773. But good cause must be shown: *Earl of Falmouth v. Moss* (1822) 11 Price 455, 471.

⁴⁸ Law Reform Comm., 16th Report (1967), para. 51, p. 22.

⁴⁹ (1904) 6 G.L.R. 289.

pondent wife at a public hospital for the results of a miscarriage. The officer was quite prepared to give evidence and took no objection to his being asked questions to prove the matter. However, Edwards J. *suo motu* took the point that the officer's evidence was inadmissible by virtue of the present s.8(2). He went on to say that the medical profession should acquaint itself with the provision and that doctors were under a duty to take the objection, especially if their patient was not represented in Court.⁵⁰

The following year a similar situation arose in *Stack v. Stack*,⁵¹ another undefended divorce petition. The petitioner called a doctor to give evidence relevant to the issue of the husband's adultery, *viz.*, that the doctor had prescribed for a venereal disease from which the husband was suffering. Upon the judge's drawing attention to s.8(2), counsel submitted that he intended only to elicit what the doctor saw, not what the patient said. Denniston J. ruled that

“the tendering of any part of his person for examination, with a view to medical treatment to a physician was a communication within the section.”

and refused to admit the evidence.⁵²

Both these decisions plainly regarded the privilege conferred as beneficial and accordingly gave a liberal interpretation to the provision.⁵³ “Communication” was given a wide meaning to include both what the patient said to the doctor and what the doctor himself observed during the attendance.⁵⁴

This liberal approach was short-lived. Six years after the decision in *Stack v. Stack*, the Court of Appeal was called upon to consider the subsection upon a Case Stated by Edwards J. in the leading case of *Lucena v. National Mutual Life Association of Australasia Ltd.*⁵⁵ The plaintiff, the executrix of the deceased Lucena's will, sued the defendant insurance company for moneys due under a policy taken out by the deceased. The defendant resisted the claim on the basis that the deceased had made a false statement in relation to his health in the proposal, and for this purpose sought to examine a number of doctors who had attended or operated upon the deceased during his lifetime. The question arose of what part, if any, of the doctors' evidence was admissible in the light of s.8(2). Section 8(3) was irrelevant as being applicable only to examinations specifically for the purpose of the doctor reporting to an insurer of the patient's medical condition

⁵⁰ *Ibid.*, 290.

⁵¹ (1905) 25 N.Z.L.R. 209.

⁵² *Ibid.*, 210.

⁵³ No doubt keeping in mind the forerunner of *Acts Interpretation Act* 1924. s.5(j).

⁵⁴ *Stack v. Stack* was in fact approved in *N.M.L. v. Godrich* by four of the judges who sat in that case: see (1909) 10 C.L.R. 1, 17–18; 31, 37, 41.

⁵⁵ (1911) 31 N.Z.L.R., 481.

prior to the issue of a policy.⁵⁶ The Court of Appeal, over the dissent of Edwards J., refused to adopt a liberal approach to the construction of the provision.⁵⁷ Stout C.J. called it "an alteration or invasion of the common law".⁵⁸ The Court adopted as the correct guide to its interpretation the following passage from the judgment of O'Connor J. in *N.M.L. v. Godrich*:⁵⁹

"It is a well-known principle of interpretation that where a statute infringes a common law right it will be taken, in the absence of express words to the contrary, that the legislature did not intend to interfere further with the right than was necessary to effect the object of the enactment. *Prima facie*, every litigant is entitled to bring before the Court all evidence material to the proof of his case. In respect of doctors' evidence, where a statute under certain circumstances abridges that right it should be so interpreted as not to extend the exception or privilege beyond the limits which the language, fairly interpreted, has expressly marked out. The Courts have always been careful to keep such privileges within their limits."

As a result of this interpretation, the Court laid down the following principles based on the provision:

(1) The legislature used the words "communication made to [the physician or surgeon]"; whereas in the corresponding Victorian statute, the words used were "information acquired in attending the patient". Accordingly, the word "communication" must be given a restrictive meaning, certainly more so than the word "information", which under the Victorian statute had been held to include both what the patient said and what the doctor saw and said.⁶⁰ In the New Zealand provision, "communication" comprised only what the patient communicated to the physician by means of writing, words or signs. The submission of his body by the patient to the doctor's ministrations was not a communication.

(2) "Communication" does not include what the doctor himself saw when examining the patient; nor what the doctor himself communicated to the patient, including his diagnosis; nor what he found during an operation. The doctor may give evidence of all these matters.

(3) The communications are further restricted by the concluding words of s.8(2). They must be clearly referable to the doctor-patient relationship. They must be made to the physician "in his professional character" and they must be "necessary to enable him to prescribe or act for such patient". Whatever the patient says which cannot fairly be related in these ways carries no privilege.

(4) The privilege continues despite the patient's death. The death of the patient does not unseal the physician's lips as to the matters which were privileged in the patient's lifetime.

⁵⁶ *Ibid.*, 484, per Edwards J., *arguendo*.

⁵⁷ Edwards J., though clearly dissatisfied with the other opinions, did not dissent on the substantive points.

⁵⁸ *Ibid.*, 488.

⁵⁹ (1909) 10 C.L.R. 1, 28.

⁶⁰ *N.M.L. v. Godrich* (1909) 10 C.L.R. 1.

(5) Medical records concerning the patient made at a hospital will, in the absence of evidence to the contrary, be presumed to contain communications by the patient to his physician or surgeon, and will accordingly carry privilege.

The decisions of *Godfrey v. Godfrey* and *Stack v. Stack* can no longer, therefore, be regarded as good law upon the substantive points they purported to decide, although the judgments of the Court in *Lucena* do not expressly overrule them, or, indeed, even mention them.⁶¹

The decision in *Lucena* was followed shortly afterwards by *Re the St. Helen's Hospital*,⁶² where it was held that the privilege extended to proceedings of a tribunal constituted under the Commissions of Inquiry Act 1908. Cooper J. also expressed the view that what a doctor repeated in the course of his duty of his patient's communications to a nurse or other member of the hospital staff remained privileged.⁶³

There has been no further reported decision on medical privilege in New Zealand, with the exception of *R. v. Beynon*.⁶⁴ This decided the point that s.62 Hospitals Act 1957, which forbids any person employed by a hospital board from giving information concerning the condition or treatment of a patient without that patient's consent, did not prevent such an employee from giving evidence in a Court of law.⁶⁵ Turner J., in the course of his short oral judgment, referred to *Lucena* without in any way casting doubt on that decision.⁶⁶ Indeed, after the passage of some 57 years since the decision in *Lucena*, without any amendment of s.8(2), it would be difficult to argue successfully that the decision could be reviewed.⁶⁷

The New Zealand decisions, however, have left unresolved a number of difficulties in the provision, which we shall now endeavour to clarify. "Proceeding"

It is clear enough that the privilege does not extend, in view of the clear contradistinction of the word "proceeding" in s.8(1) and "civil

⁶¹ *Cross on Evidence* (N.Z. ed.), 277. Denniston J. said, *arguendo* in *Lucena* that his decision in *Stack* was obiter. *Sed quare.*

⁶² (1913) 23 N.Z.L.R. 682.

⁶³ *Ibid.*, 685.

⁶⁴ [1963] N.Z.L.R. 635, C.A. The question also arose incidentally in *Bird v. Hammond* [1960] N.Z.L.R. 466 in a motion to stay proceedings until the plaintiff agreed to submit to a medical examination. Opposing counsel argued that a stay should not be granted because, *inter alia*, the doctor's evidence would be inadmissible by virtue of s.8. Barrowclough C.J. at pp. 468-9 dismissed the argument, relying upon the principles enunciated in *Lucena*, but without specifically referring to that case.

⁶⁵ A decision which seemed obvious in view of s.62(4).

⁶⁶ *Ibid.*, 639.

⁶⁷ *Royal Court Derby Porcelain v. Russell* [1949] 2 K.B. 417, 429; *Re Manson* [1964] N.Z.L.R. 257, 271-2. Cf. the robust approach in *R. v. Bow Road JJ.* [1968] 2 Q.B. 572.

proceeding" in s.8(2), to criminal proceedings.⁶⁸ The civil proceedings in which the privilege may be invoked include any action, trial, inquiry, cause, or matter, depending or to be inquired of or determined in any Court,⁶⁹ whether final or interlocutory.⁷⁰ "Court" is defined as including the Court of Appeal, the Supreme Court, and Magistrate's Court, and any Court of summary jurisdiction. The use of the word "includes" in both the definition of "proceedings" and "Court" indicates that these definitions are not exhaustive.⁷¹ Accordingly, tribunals and arbitrations may be encompassed, although it is highly improbable that executive acts would.⁷²

"Patient"

There should be little difficulty in practice in ascertaining who is a patient within the meaning of the provision. The Shorter Oxford Dictionary defines a "patient" as "one who is under medical treatment".⁷³ So a patient must be a person under the medical treatment of the physician in question. It is unnecessary that the person must *knowingly* be under treatment; a person who is unconscious as a result of an accident and is treated at that time by a physician, whether or not the person's regular physician, may still be the former's patient.⁷⁴ The fact that a person needing treatment goes to a doctor will in most cases lead to the inference that such person is the doctor's patient,⁷⁵ although this inference is rebuttable, as is pointed out below. It is unnecessary that payment be contemplated for the attendance, for the privilege should extend to rich and poor alike.⁷⁶ If the patient goes to a hospital on the physician's advice, the relationship of doctor and patient may nevertheless still exist. It is equally possible that a person may be the patient of several physicians or surgeons simultaneously, so that communications to any of them may be privileged.⁷⁷ The Court is entitled to place some weight upon the doctor's opinion and medical opinion in general as to whether a person is a patient.⁷⁸

A person may attend a physician for the purpose of obtaining a report in anticipation of litigation. He may not be a patient within

⁶⁸ *R. v. Beynon* [1963] N.Z.L.R. 635.

⁶⁹ *Evidence Act* 1908, s.2.

⁷⁰ *R. v. Legal Aid Committee, ex p. Rondel* [1967] 2 Q.B. 482, 491, per Lord Parker C.J.

⁷¹ *Dilworth v. Comm. of Stamps* [1899] A.C. 99, 105; *Pickens v. Franssen* [1964] N.Z.L.R. 606, 613; *Hawken v. C.I.R.* [1965] N.Z.L.R. 979, 984.

⁷² *C.I.R. v. West-Walker* [1954] N.Z.L.R. 191, 209.

⁷³ P. 1448.

⁷⁴ *Carroll v. Warrnambool Racing Club* [1953] Argus L.R. 1160, 1161.

⁷⁵ *Godrich's case*, 28.

⁷⁶ *Lucena's case*, 487, *arguendo*; Cf. *Hedley Byrne v. Heller* [1964] A.C. 465, 517 per Lord Devlin.

⁷⁷ *Godrich's case*, p. 28.

⁷⁸ *Ibid.*, 15; *Blakely v. De Lambert* [1959] N.Z.L.R. 356.

s.8(2) and the report may not be covered by medical privilege.⁷⁹ The lifting of the privilege in the case of examinations for insurance purposes in s.(8)3 seems to contemplate that the person might otherwise be a patient, although as a whole s.8(3) appears to be one of those provisos "which may have been inserted for the purpose of allaying unfounded fears but were not in fact necessary".⁸⁰ In *Carroll v. Warrnambool Racing Club*,⁸¹ Lowe J. ruled that a person examined at the request of the opposite party was a patient. However, the learned judge expressly proceeded on the basis that the provision, being remedial, ought to be given a wide construction. This view is, with respect, untenable in the light of *Godrich*,⁸² a decision of the High Court of Australia, and, having regard to *Lucena*,⁸³ would almost certainly not be followed in New Zealand. Indeed, in *Graham v. Smith*, Sholl J. held that a person for whom a doctor did not intend to prescribe was not a patient.⁸⁴

It is submitted, therefore, that if a physician or surgeon does not intend to prescribe or act for a person or to send him to someone who will, then such a person is not a "patient" within the provisions of s.8(2).⁸⁵

"Physician or Surgeon"

Throughout this paper, the terms "medical adviser" "medical officer", "doctor", "medical practitioner", "practitioner", and "physician" have been used more or less interchangeably at the risk of some slight inaccuracy. Clearly, a registered medical practitioner must be included within the term "physician or surgeon" as used in s.8(2).⁸⁶ Nor is there any reason why an unregistered practitioner should be excluded in certain circumstances. Suppose, by an oversight, a practitioner's renewal of registration was delayed by a day, so that he might for that day be technically unregistered. Would there be any reason to say that communications made to that practitioner on that day would not be privileged simply because of the collateral reason of lack of

⁷⁹ It might, however, be covered by legal privilege: *McGuinness v. Fairbairn Lawson Ltd.* (1966) 110 So. Jo. 870, C.A.

⁸⁰ *News Media (Ak.) Ltd. v. Police* [1969] N.Z.L.R. 37, 41.

⁸¹ [1953] Argus L. R. 1160.

⁸² (*Supra*).

⁸³ (*Supra*).

⁸⁴ 19th July 1954, unreported: see J. A. Keely, "Exclusion of Medical Evidence", (1954) 28 A.L.J. 343. In *Bird v. Hammond* [1960] N.Z.L.R. 466, Barrowclough C.J. found it unnecessary to rule whether *Carroll's* case was good law in N.Z.

⁸⁵ *X. v. Y. (No. 1)* [1954] V.L.R. 708, 711-2. Cf. *Lucena*, 486, *arguendo*: "... 'Patient' means anyone intentionally under the care of a doctor for curative purposes". "Intentionally" must refer to the doctor's intention, not the patient's, for an unconscious person may nevertheless be a patient: *Carroll v. Warrnambool Racing Club* [1953] Argus L.R. 1160, 1161.

⁸⁶ *Medical Practitioners Act* 1968, s.74.

registration?^{86A} On the other hand, communications to quacks would not be privileged for the simple reason that they are not included in the term "physician or surgeon" as used in s.8(2).

A physician may be described as a registered practitioner who specialises in medicine or a practitioner who is undertaking general practitioner work. Similarly, a surgeon is a practitioner who specialises in surgery. Loosely speaking, a general practitioner may describe himself as either a physician or a surgeon, although it is rare that he describes himself as both.⁸⁷ So, hospital orderlies and nurses to whom a patient may communicate directly cannot claim privilege. Nor should such persons as midwives, chiropodists and dental surgeons. And it may be that a nurse present in the room who overhears the communications made to a doctor may not plead the privilege.⁸⁸ Communications through an interpreter, if necessary, would probably carry privilege.⁸⁹

It is unlikely, and the dearth of authority suggests, that this particular problem will arise in any acute form.

"Without the consent of the patient"

That the privilege is that of the patient and not that of the physician is made clear by the fact that the patient's consent may remove the privilege. But what do the words "without the consent of the patient" mean in this context? Insofar as waiver does not amount to consent, it is sufficient to remove the privilege.⁹⁰ However, the subsection does not say "No evidence given without consent shall be admissible . . ."⁹¹ It directs its mandate to the physician: "No physician or surgeon shall divulge . . ." Consequently, where the patient is present in court either personally or by counsel, and takes no objection to evidence protected by s.8(2), the evidence, if otherwise admissible, may be received.⁹² In cases where the patient is dead or not so present, the Court may itself protect the patient's interests by refusing to admit the evidence.

" . . . The Courts will be astute to protect the interests of unrepresented persons by giving effect to objections which those persons might have taken, and to protect medical men against possible penalties for inadvertent breach of the section."⁹³

Whether or not consent has been given will be answered on general principles familiar to other branches of the law.⁹⁴ Consent might be

^{86A} Cf. *Bear v. Ward* (1821) Jac. 77.

⁸⁷ *Jenkins v. Reid* [1948] 1 All E.R. 471, 475–6.

⁸⁸ Cf. *Calcraft v. Guest* [1898] 1 Q.B. 759.

⁸⁹ *Du Barre v. Livette* (1791) Peake 108.

⁹⁰ *Godrich*, 39; *X. v. Y.* [1954] V.L.R. 708, 710; *Taylor v. Taylor* [1956] Tas. S.R. 84, 87.

⁹¹ *X. v. Y. (supra)*, Cf. *Domestic Proceedings Act* 1939, s.5(4): no statement or admission, "shall be received in evidence in any Court whatsoever".

⁹² *Godrich*, 26, 28–9, 39–41; *X. v. Y.*, 710.

⁹³ *X. v. Y.*, 710.

⁹⁴ See, e.g., *Stephen's Digest of Criminal Law* (9th ed., 1919), p. 257.

implied by the bringing of a malpractice action against the doctor.⁹⁵ On the other hand, the mere fact that the patient gives otherwise privileged evidence, does not lift the privilege so far as the doctor is concerned.⁹⁶

One serious problem which has arisen is whether consent may be given by a patient's personal representative after the patient's death. The preponderance of opinion in the United States, and, it is submitted, the better view on the wording of s.8(2), is that the personal representative may give consent.⁹⁷ The Australian decisions tend to the opposite conclusion.⁹⁸ But in *Pacyne v. Grima*,⁹⁹ Sholl J. held that an executor, if a party to the proceedings, could waive the privilege. Unfortunately, the decision in *Andasteel Constructions Pty Ltd. v. Taylor* in the following year compounded confusion by holding the opposite where an executor was not a party.¹⁰⁰ The distinction is illogical, and nothing in the subsection supports it. It is submitted that the subsection allows a personal representative to waive the privilege, for, after all, he is the watchdog of the estate and supposedly the best person to assess the deceased's interests insofar as they affect the estate. Any other construction might work injustices.¹

“Communication”

We have already canvassed the interpretation of “communication” in *Lucena’s* case, and have noted the restrictive construction placed upon the word. We have seen that the words of the section indicate that the communications must be made by the patient to be privileged. Suppose, however, that an elderly, perhaps senile person was brought by another person to the doctor and that other person gave the doctor the information necessary for him to prescribe. Such communications may be privileged on the basis that the person is an agent of the patient for this purpose.²

“Necessary to enable him to prescribe”

These words would exclude statements of a casual nature not referable to the doctor-patient relationship. “Necessary” should be construed

⁹⁵ 5 Wigmore, para. 2399, p. 226; Fricke, “Medical Privilege”, Int. Bus. & Law Symposium (1968), 24; *X. v. Y.* (*supra*).

⁹⁶ *Taylor v. Taylor* [1956] Tas. S.R. 84.

⁹⁷ 5 Wigmore, para. 2391, p. 226.

⁹⁸ *Warnecke v. Equitable Life Assnse Soc.* [1906] V.L.R. 482, 487; *Godrich*, 24, 39, 42.

⁹⁹ [1963] V.R. 421.

¹⁰⁰ [1964] V.R. 112.

¹ E.g., in *Maine v. Maryland Casualty Co.* 178 N.W. 749 (1920) a widow was unable to recover because of the inability to reveal the result of an examination of the deceased in his lifetime: 5 Wigmore, para. 2380, pp. 207–8. In *Doe d. Marriott v. Hertford* (1849) 19 L.J.Q.B. 526, 528 Erle J. thought, in a case where the executor was not a party, that a client's heir and executor could waive legal professional privilege. *Bullivant v. A.-G.* [1901] A.C. 206.

² *Russell v. Jackson* (1851) 9 Hare 387, 390.

liberally but objectively.³ A patient may say many things which he may *bona fide* believe to be necessary to enable the doctor to prescribe, but which are in fact entirely superfluous. No doubt the patient's belief should be taken into account and given some weight, as ought the doctor's. However, it is submitted that, in the final analysis, the Court should decide whether what the patient communicated was in fact necessary, giving the patient as a lay person a wide latitude, for the doctor to prescribe or act.

Exceptions

There are three cases where no privilege exists by virtue of s.8(2) and (3):

- (1) If the sanity of the patient is the matter in dispute;
- (2) If the communication was made for any criminal purpose;
- (3) If the statement or representation was made at any time to or by a physician or surgeon in or about the effecting by a person of an insurance on the life of himself or any other person.

The third exception seems largely self-explanatory, and provides a measure of, though not full, protection against frauds directed against insurance companies.⁴

So far as (1) is concerned, it should not be very difficult to ascertain whether the sanity of the patient is in dispute. This cannot mean the sole matter in dispute, otherwise a party could deliberately complicate a case by raising a number of issues in order to retain the privilege. If the sanity of the patient is in issue as one of the matters, then the exception applies.⁵ The issue will arise fairly and squarely in committal proceedings, but may equally arise as to who is a fit and proper person to have custody of a child.⁶ Sanity in this context does not entail a consideration of the *McNaughten* rules, since s.8(2) applies only to civil proceedings.⁷

So far as (2) is concerned, this appears to have been inserted *ex abundanti cautela*.⁸ It is more apposite to the privilege extended by s.8(1) to ministers of religion, for it would be impossible to say that a communication made to a doctor for a criminal purpose could be made to him "in his professional character" and be "necessary to enable him to prescribe or act". The communication would be wholly outside the doctor-patient relationship and thus not privileged. *A fortiori*, if the

³ *Lucena*, 981, *arguendo*; *Godrich*, 8–9, per Griffiths C. J.

⁴ Cf. *Lucena* and *Godrich*; also *Warnecke*: see note 98.

⁵ *X. v. Y.* [1954] V.L.R. 708; *Taylor v. Taylor* [1956] Tas. S.R. 84.

⁶ *Taylor v. Taylor* (*supra*).

⁷ To which the *McNaughten* rules (1843) 10 Cl. & F. 208 should not apply: *Williams v. Williams* [1964] A.C. 698, 750–2, per Lord Pearce; *Morriss v. Marsden* [1952] 1 All E.R. 925, 927; *Beals v. Hayward* [1960] N.Z.L.R. 131; *Imperial Loan Co. v. Stone* [1892] 1 Q.B. 599.

⁸ *News Media (A.k.) Ltd. v. Police* [1969] N.Z.L.R. 37, 41.

doctor knows it is for a criminal purpose, since he might thereby become an accessory.⁹ It is submitted that the words "for any criminal purpose" mean "in the furtherance of any criminal object".¹⁰ Confessions or admissions of crime or civil fraud would probably not come within the meaning of the phrase since the criminal purpose would already have been accomplished. However, such communications could hardly be said to be necessary for the doctor to prescribe, and thus would be outside the privilege in any case extended by s.8(2).

However, if this view be incorrect or incomplete, when can it be said that communications have been made for a criminal purpose? How does one positively know that communications have been so made without first removing the privilege? It is submitted that, by analogy with the rules in respect of legal privilege, there must be a definite charge that the communication itself was a step in the commission of a crime or preparatory to or in aid of the commission of a crime.¹¹ The Court may look at the pleadings, affidavits and documents already produced and may then decide whether the party so charging makes his claim honestly and that there is a sufficient probability of substantiation of such charge.¹² The risk is run that once the communication is given in evidence, no criminal purpose may be established, but, on the other hand, any other rule might mean the possible suppression of a crime.¹³

Miscellaneous

So far as conflicts of law are concerned, the law seems relatively clear. The privilege is a question of evidence, or, possibly, procedure, and as such is governed by the *lex fori*.¹⁴

Finally, there is one area of medical privilege in New Zealand which has, it is submitted, been inadequately explored. Once one reaches the position that a particular statement is not privileged by reason of it falling outside the provisions of s.8(2), then *prima facie* that statement is admissible in evidence. In other words, the same position is reached as at common law, namely, that the statement carries no privilege from disclosure. At common law, as we have seen, the admissibility of the statement is then subject to an overriding discretion vested in the Court to exclude the statement in the public interest. None of the New Zealand cases dwell on this aspect, probably because of the preoccupation with the complexities of s.8(2). However, it is submitted that this same overriding discretion exists in New Zealand and that, accordingly, s.8(2) does not cover the entire field of medical privilege.

⁹ *Varawa v. Howard Smith Ltd.* (1910) 10 C.L.R. 382, 390

¹⁰ *R. v. Cox and Railton* (1884) 14 Q.B.D. 153.

¹¹ *Ibid.*, 167.

¹² *Bullivant v. A.-G* [1901] A.C. 196.

¹³ *Hall v. Guardian Trust* [1939] N.Z.L.R. 993, 1000-1.

¹⁴ *Godrich*, 26, 39, 42, 14, 24; *Re Fuld* [1965] 3 All E.R. 776, 779; *Re Duncan* [1968] Ch. 306.

Conclusion

Whatever one's views on the desirability of medical privilege, it may be said with confidence that the New Zealand position is unsatisfactory. Section 8(2), if originally intended as an adequate privilege creating provision, is confusing and arbitrary. The comments of Edwards J. in *Lucena* are hard to resist:

"Whatever the object of the Legislature, it is obvious that it has failed to use words which are of any practical value for the protection of a patient who consults a medical practitioner. On the other hand, it certainly has used words which, while of no practical value for the protection of the patient, may in some cases render it difficult to define the boundary between what is admissible in evidence and what is inadmissible. Thus if the enactment ever proves to be of practical value to any one, the person to profit is much more likely to be a member of the legal profession than any one else."¹⁵

His Honour's prophesy that the subject would be one of considerable future litigation has, fortunately not eventuated. However, this fact, even when coupled with the apparent indifference of New Zealand medical opinion to the matter, is no reason for removing what is a discreditable piece of drafting from the statute-book.

It is submitted that it is unnecessary to provide a sweeping privilege for doctors which protects all information they receive in their professional capacity, for the American experience in this respect has proved that this can cause acute injustice.¹⁶ On the contrary, it is submitted that the discretionary principles of the common law, with their concomitant flexibility, operate most satisfactorily in this area. No evidence is available that anyone in the United Kingdom is hindered from consulting a doctor by the knowledge that the occasion carries no privilege. The report of the English Law Reform Committee recommends no change in the existing law in England on the subject.

"To replace this wide judicial discretion by a more comprehensive and rigid statutory classification of privileges with detailed provisions in which each of them could or could not be claimed would, we think, be more likely to defeat than to promote the interests not only of justice but also of those social values which it is the object of a privilege to protect."¹⁷

It is submitted that a simple repeal of the New Zealand provision namely s.8(2) and that part of s.8(3) dealing with the subject would remove much of the uncertainty and artificiality inherent in its drafting and in the decisions upon the provision. The vacuum created by such repeal would automatically be filled by the common law, bringing order, flexibility and commonsense to bear upon the subject of medical privilege in New Zealand.

¹⁵ *Lucena v. N.M.L.* (1911) 31 N.Z.L.R. 481, 496.

¹⁶ 5 Wigmore, pp. 200 *et seq.*

¹⁷ Law Reform Comm., 16th Report, para. 1, p. 3.