Pugmire and the dilemma of disclosure

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Neil Pugmire's disclosures that law changes meant the release into the community of potentially dangerous patients have assumed heroic proportions. Judging by the volume of support he received and the abuse heaped on his employer for taking disciplinary action against him, many people see Mr Pugmire as a knight on a white charger, saving the public from peril at the hands of the deranged. However, the Privacy Commissioner has launched an investigation into possible breaches of the Health Information Privacy Code, and Mr Pugmire's employer, despite reaching an out of court settlement with Mr Pugmire, continues to insist that he had no right to disclose patient information. The circumstances of Mr Pugmire's disclosure have provoked strong human reactions. How does the law balance a patient's expectation of confidentiality against a perceived need to prevent harm to others?

Mr Pugmire wrote to the Minister of Health in mid-1993 detailing concerns about the Mental Health (Compulsory Assessment and Treatment) Act 1992. The Act, he said, redefined who could be compulsorily detained. Some people would now be discharged whom he thought were very dangerous. As an example, he said that responsible mental health professionals thought a named patient about to be discharged was highly likely to commit very serious sexual crimes against little boys. The Associate Minister responded saying that "mental health legislation should not be used to justify the detention of difficult or dangerous individuals", and that the situation was being actively monitored. Some months later, a person who had been discharged from a mental hospital in the circumstances about which Mr Pugmire had expressed concern committed a sexual offence involving a two year old boy, and was charged, convicted and sentenced to imprisonment. This person was not the person whom Mr Pugmire had named in his letter to the Minister. Mr Pugmire then communicated with Mr Goff, an opposition MP, and sent him a copy of his letter to the Minister. Mr Goff then released the letter publicly, but with material identifying the patient deleted. The individual Mr Pugmire named has since been publicly identified (but not by Mr Pugmire nor by Mr Goff), but has not since his discharge been charged with any sexual offence.

This note looks at the law surrounding disclosures of patient information. When may (and sometimes when must) health professionals disclose information that they have acquired in the course of their professional relationships with someone to whom they have provided services? To whom may they disclose? What sanctions exist for unjustified disclosures?

There are three main ways in which the law might govern situations like Mr Pugmire's. I will canvas the three options, and then discuss a possible new development that the Pugmire case has provoked, "whistleblowing" legislation.

The law of confidence

Mr Pugmire owed a duty of confidentiality to the patient he named in his letter to the Minister. This duty is one shared by all health professionals. Most health professionals' ethical codes recognise a duty to keep confidential information about their patients/clients. The law will protect this duty in the action for "breach of confidence". Generally speaking, a duty of confidence arises, to use the words of a judge in a leading case, "when confidential information comes to the knowledge of a person (the confidant) in circumstances where he has notice, or is held to have agreed, that the information is confidential, with the effect that it would be just in all the circumstances that he should be precluded from disclosing the information to others." It is plain that this duty arises in health contexts. The reason for this, as another judge graphically put it, is that "patients will not come forward if doctors are going to squeal on them" (for doctors, one could read health professionals generally). However, in a case like Mr Pugmire's it is not the existence of a duty of confidentiality that is at issue, but the breadth of that duty. Does it preclude disclosure in all circumstances, or can there be occasions when a person in Mr Pugmire's situation might be justified in disclosing his concerns about the patient, and to whom might he disclose?

The courts have recognised that the public interest in the protection of confidences might be outweighed by some other countervailing public interest in disclosure. A court has to assess, in any given case, where the line is to be drawn between protecting confidence and disclosure justified in the public interest. One of the circumstances where courts have recognised that doctors may reveal a confidence is if the public safety is at risk. However, as the health professional owes the duty of confidentiality to the patient/client, it is for the health professional to show that he or she is excused from it. This would mean that the professional would have to demonstrate in the particular case that the circumstances do pose a real, immediate and serious risk. He or she also has to show that disclosure will substantially reduce the risk, and that disclosure goes only so far as is reasonably necessary to minimise the risk. The last point relates to the question of to whom it is proper to disclose the otherwise confidential information. A recent English case (*W v Egdell* [1990] 1 Ch 359) upheld the decision of a doctor to disclose, contrary to the wishes of a compulsorily detained psychiatric patient who had earlier killed five people, to the Home Secretary (the relevant statutory authority) details of the doctor's concerns about the risk

that the patient's transfer to a less secure institution would pose. The court said that it would have been wrong for the doctor to have publicised his concerns in the news media, or to have gossiped with friends, but it was proper to communicate with the Home Secretary. He was a responsible authority with power to act. The circumstances of the killings gave rise to the gravest concern for the safety of the public, the court said, and so the authorities responsible for his treatment and management were entitled to the fullest relevant information concerning his condition.

The court in *W v Egdell* accepted that the doctor necessarily would make a subjective assessment of the risk that the release of the patient might pose. However, if made in good faith, and on the basis of sound professional judgment, the court would accept the doctor's opinion of the risk, even if it differed from that of other professionals involved in the case. But it is for the court to determine that the public interest in breaching the confidence outweighs the public interest in keeping it.

It was relevant in this case for the psychiatrist to disclose to the Home Secretary because he had statutory powers to maintain the compulsory detention of the patient. In the case of Mr Pugmire's disclosures, the Minister had no power, as the Associate Minister made clear in her reply to Mr Pugmire, to detain or to influence the further detention of the patient. What Mr Pugmire was arguing for in his letter was a change in policy. He highlighted the need for change, as he saw it, by illustrating his argument with details of the patient's case. This is the point which makes the Pugmire case finely balanced. If a court took the view that Pugmire, as a responsible health professional with knowledge concerning the allegedly dangerous patient, disclosed in good faith information to responsible authorities in circumstances where the disclosure was justified in the interests of the safety of the public, then he would be excused the breach of confidence. If, however, the court decides that any of those elements is not satisfied, then the breach is not justified. It is arguable whether the Minister, Mr Birch, constituted a "responsible authority". Unlike the Home Secretary, he had no powers available to him as the law stood. He was, however, probably the person best placed to decide that the law should be changed, and to promote a bill through Parliament. Whether this is sufficient to make the Minister someone to whom confidential information can properly be disclosed is doubtful. Even if the Minister is seen as a responsible authority, it is unlikely that a court would regard Mr Goff as one. (Mr Goff himself is unlikely to face liability for breach of confidence because he took steps to ensure that the patient's name was not publicly disclosed.)

Contrast however, this situation with the well-known Californian case of *Tarasoff*. A student killed Tatiana Tarasoff in 1969. He had earlier told a psychotherapist that he wanted to kill her; the therapists predicted that he would. Miss Tarasoff's family successfully sued the psychotherapists and their employer for failing to warn them of the risk. The court said that privacy ends where the public peril begins. The health professional was in this case not only justified in breaching the patient's privacy or expectations of confidentiality, but was in fact required to do so. This decision provoked controversy. Many psychiatrists argued that a duty to warn victims threatens the basic trust that underlies the relationship between a patient and the therapist. A patient, they said, would be reluctant to tell their doctor everything that might be relevant if the doctor cannot offer a complete assurance of confidentiality, and that this reduces the prospects of successful treatment with a consequent increase in the risk to society that such potentially dangerous people might pose. However, the case implicitly rejects that argument. The court is saying that it is not right for a person's life to be put in jeopardy in order to help psychiatric patients.

In *Tarasoff*, the victim was clearly identified, and should have been warned of the threat to kill her. In the Pugmire case, the concern was less specific; no potential victim was identified (Pugmire said in his letter to the Minister that the patient admitted to a continuing feeling of wanting to commit sexual acts with little boys - he had been detained for attempting to rape and strangle two boys seven years previously). And many people may be at large in society with unlawful and dangerous desires. As well, it is often very difficult to predict individual patients' behaviour with any reliability. Ordinarily the law's force is imposed on those who have committed acts of violence; threats only attract criminal sanctions where identified individuals are at risk.

These cases together say that where the risk is so clear and immediate (known victim - *Tarasoff*) or the past behaviour coupled with good faith concern on the part of the professional borne out of qualified professional judgment makes the risk too great to contemplate (five deaths - *Egdell*), a health professional with knowledge of the circumstances is justified in and may be required to disclose confidential information. However, in *Tarasoff* the need to disclose was to reduce the risk to the victim, and in *Egdell* for the Home Secretary to exercise powers over the patient. In the Pugmire case, neither of those factors is present. And because the purpose of the disclosure was to urge a change in mental health policy, it is not clear that disclosure was justified. It would be difficult to say that Mr Pugmire would be safe in assuming that he would succeed in a breach of confidence action brought against him.

A tort of privacy

The patient whose details Mr Pugmire disclosed to the Minister may possibly have a common law action for breach of privacy. Such a tort is at an embryonic stage in New Zealand. Judicial comment has been tentative so far, and few cases have progressed to a point where the elements of the tort are clearly identifiable. It appears, however, that the courts may compensate a plaintiff whose private life has been publicly disclosed without justification. Judges have, however, suggested that a protectable right to privacy has to be balanced against the right of the public to be informed. It is probable that similar factors that would justify a disclosure in a breach of confidence action would operate to defeat a claim for breach of privacy.

The Privacy Act and the Health Information Privacy Code (Temporary)

Under the Health Information Privacy Code (Temporary), issued by the Privacy Commissioner, Mr Bruce Slane, under the Privacy Act, agencies holding health information may disclose it under defined

circumstances. Mr Slane's investigation, noted above, is to ascertain whether a justified disclosure has occurred. It is clear that Mr Pugmire is a health agency in terms of the Code and that the information he disclosed concerning the patient was health information.

The relevant Rule in the Code says that a health agency may ordinarily only disclose health information with the authorisation of the individual concerned (or from his/her representative where the individual is unable to give authority (sic)). In the present case, however, a health agency may also disclose an individual's health information

- where it is not desirable or practicable to obtain authorisation to disclose from the individual or his or her representative;
  and
- disclosure is necessary to prevent or lessen
- a serious and imminent threat
  - to public health or public safety or
  - to the life or health of an individual.

One question which Mr Slane will have to consider in his investigation is whether the nature of the threat, and the necessity of disclosure to prevent or lessen that threat, is to be evaluated at the time of the disclosure, or in the light of events that occur afterwards. How relevant is it, for example, that in the six or so months since the discharge of the patient he has not committed (or more accurately not been charged with) any offences of the type that Mr Pugmire warned about?

If Mr Slane finds that Mr Pugmire has breached the Code and that this constitutes "an interference with the privacy" of the patient, then GoodHealth Wanganui, Mr Pugmire's employer, might also be liable, unless it took steps reasonably practicable to prevent Mr Pugmire from making the disclosures. His employer suspended him for unauthorised disclosure of confidential patient information, which was defined as a matter of "serious misconduct" in a document known as "Disciplinary Procedures and Rules of Conduct". In the Employment Court, Mr Pugmire claimed that his superiors at Lake Alice knew of and approved of his sending the letter to the Minister (his employer took action over the disclosure to Mr Goff). The Crown health enterprise's internal rules would probably count as a "step reasonably practicable" to prevent Mr Pugmire from making the disclosure, but the sanction that Mr Pugmire's superiors allegedly gave to the first disclosure might counter this. It is not apparent that the employer actively took steps to prevent disclosure to one politician but not to another.

Possible "whistleblower" legislation

Mr Goff is sponsoring a private member's bill to provide protection for individuals who bring information concerning corrupt, illegal or harmful activity to the attention of relevant authorities. Two government Ministers (Messrs East and Graham) have indicated their general support for some form of legislation. Overseas experience is that employees who "blow the whistle" are frequently vilified, especially by employers. Mr Goff's bill would provide protection to a person who discloses to a statutory authority information which he or she reasonably believes to be true, relating to any conduct or activity which, among other things, constitutes a "significant risk or danger, or is injurious to, public health or public safety". The statutory authority can then investigate and where appropriate refer the matter to an enforcement authority or for corrective action by the agency involved. This might not include, on the bill as worded, an inquiry into the need for legislative change such as Mr Pugmire was calling for.

The "New" New Ethics Committees

Since the establishment of a new ethics committee structure in 1989 there have been a number of changes to ethics committee structure and function culminating in the latest set of guidelines.

In 1991 a revision of the National Standard for Ethics Committees was issued. Then when the health reforms were introduced replacing Area Health Boards (AHBs) with RHAs and CHEs, it became obvious that a new structure for ethics review, not tied to the old AHB structure, had to be devised. A working party called the Interim Taskgroup on Health and Disability Service ethics was convened to consider this problem and report to the minister. The Interim Taskgroup reported in February and the Ministerial decision was announced in June.

The new arrangement was that there should be regional ethics committees funded but not controlled by RHAs. They would be accountable to RHAs for their budget and to a new National Advisory Committee on Health and Disability Service Ethics (NACHDSE) for their functioning and their decisions. Their role still embraces both research and clinical issues. They will be accredited either by the HRC or by the Director General of Health on advice from the National Advisory Committee. They will comprise at least seven members, half lay and half professional and with three Maori members. They are primarily responsible to ensure the protection of patients when research or innovative treatment occurs but they are also to have a proper interest in any matter that raises ethical issues in relation to Health Care. There will be an accredited committee for every region in New Zealand and only review by such a committee will constitute adequate ethical approval for a research or treatment protocol (in terms of the ARCI Act, research funding, or professional conduct requirements).

The net effect of these changes is to provide a comprehensive national structure within which ethical review of Health Care research and services can be carried out. In addition to local and national committees, the system is expected to function in close liaison and working relationships with the HRC, with a National Committee on Assisted Reproductive Technologies (which will probably be a subcommittee of the NACHDSE even if the membership is different). The informal `networking' meeting of Ethics Committee chairpersons is to continue to serve that valuable function and there is to be a national meeting of Maori members on a similar basis.

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