Professional Practice Guideline 17

Access and use of clinical information for medico-legal report writers in New Zealand

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The Royal Australian & New Zealand College of Psychiatrists

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Purpose

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed this professional practice guideline to assist psychiatrists in New Zealand. The RANZCP has provided medico-legal guidance pertaining to the practice of psychiatry and this guideline provides specific advice on managing the privacy implications when accessing and using privileged health information in the New Zealand medico-legal setting. This guideline applies to reports ordered under the Criminal Procedure (Mentally Impaired Persons) Act 2003, Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, Sentencing Act 2002, and Parole Act 2002.

Key messages

- Clinical records should not be viewed without consent.
- Written consent should be obtained to access confidential health records.
- The consent discussion should cover relevant issues including the lack of confidentiality with Court proceedings to ensure that the consent is valid.
- The signed consent form or proxy form if verbal consent is given or a legal guardian consents, should be included when clinical information is requested from relevant agencies.
- For competent persons, if consent to view the records is declined, the report writer may request access to view the clinical record and document the appropriate *Health Information Privacy Code 1994* exception being applied.
- For competent persons, if consent to view the records is declined and the records are not accessed this should be recorded and the clinical implications discussed in the report.
- If the person is incapable of giving informed consent this should be documented in the report.
- If a legally appointed guardian exists for a subject incapable of giving consent, written consent should be sought from the guardian.
- If the subject is incapable of giving consent, no guardian exists, and the report writer needs to access the clinical files, then access to the records can again be requested using the appropriate exceptions.

Introduction

This guideline has been developed by the RANZCP to provide guidance to report writers working in the New Zealand medico-legal environment. This guideline should be read in conjunction with Professional Practice Guideline 11: Developing Reports and Conducting Independent Medical Examinations in Medico-Legal Settings (PPG 11). [1] PPG 11 notes that a practitioner must observe relevant legislation within their jurisdiction but does not specifically address the issue of accessing clinical information for the purpose of medico-legal reports.

The New Zealand Subcommittee of the Faculty of Forensic Psychiatry (NZFFP) considers that access and use of clinical information in medico-legal reports can be a potentially challenging area of practice for psychiatrists. The NZFFP has become increasingly aware of the dilemma experienced by report writers who access privileged health information in order to complete medico-legal reports. These guidelines seek to clarify the privacy implications of accessing and using privileged health information within medico-legal settings in New Zealand.

Definitions

Court-ordered reports in New Zealand are not subject to medical privilege. The lack of confidentiality and limits on privilege of these reports is specified in section 59(1)(b) of the Evidence Act 2006:

> Privilege in criminal proceedings for information obtained by medical practitioners and clinical psychologists…does not apply in the case of a person who has been required by an order of a Judge, or by other lawful authority, to submit himself or herself to the medical practitioner or clinical psychologist for any examination, test, or for any other purpose.

PPG 11 also notes in points 6.3 and 6.5:

> Psychiatrists conducting an examination for medico-legal purposes should inform the examinee that their primary role is to provide a report to enable decision making by a Court, Tribunal or other decision maker…Psychiatrists must always explain the limits of confidentiality to the person being examined. Psychiatrists must indicate that medico-legal report contents are not confined to the usual standard of a patient-treating doctor clinical interview.

The other parts of section 59 of the Evidence Act 2006 do however specify that health information gathered outside of court-ordered assessments remains medically privileged.

Background

No part of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP) states that clinical, or privileged, health information is required to complete a court-ordered report.

There are strongly held opinions that clinical information gathered for the purpose of health care should not be used in medico-legal reports as the reports will be presented in open court and remain on the court file. [2] Confidentiality of the health information cannot therefore be guaranteed in these circumstances.

If a medico-legal report is ordered there is an obligation on report writers to provide relevant information to assist in the process of justice. Review and inclusion of appropriate medically privileged material is frequently required to meet this obligation. Although health information can be gathered from the individual during the non-privileged assessment, cross-checking the validity of the information provided can be crucial to allow for informed deliberation of the matter at hand.

There has now been sufficient case law in New Zealand to endorse a common law tort of unreasonable interference or invasion of privacy. The key question therefore for medico-legal report writers is could a civil case be brought, and remedies sought, if medically privileged health information is provided in reports? This has not occurred to date to the NZFFP's knowledge. Regardless, the following guidance on access and use of clinical information may assist in creating a standard approach to this issue and reduce the potential risk for report writers working in New Zealand.

Recommendations

- The guidance from the NZFPP is that the clinical records should not be viewed without consent from the patient. It is however acknowledged that a brief viewing of the clinical records may be required if significant safety concerns have been highlighted prior to the assessment for example via court liaison or prison services.
- Written consent should be obtained to access confidential health records. If written consent is unable to be obtained, for example due to a videoconference assessment, verbal consent to view the files should be documented, preferably with a witness present.
- The consent discussion should cover relevant issues including the lack of confidentiality with Court proceedings to ensure that the consent is valid.
- The signed consent form, or proxy form if verbal consent is given or a legal guardian consents, should be included when clinical information is requested from relevant agencies.
- For competent persons, if consent to view the records is declined, the report writer may request access to view the clinical record. The exception being applied to disclose medically privileged information without consent should be documented in both the covering letter to the holding agency and medico-legal report.
- For competent persons, if consent to view the records is declined and the records are not accessed this should be recorded and the clinical implications discussed in the report.
- If the person is incapable of giving informed consent this should be documented in the report.
- If a legally appointed guardian exists for a subject incapable of giving consent, written consent should be sought from the guardian.
- If the subject is incapable of giving consent, no guardian exists, and the report writer needs to access the clinical files, then access to the records can again be requested using the appropriate exceptions.

General Principles

1.1 Obtain Written Consent to Access the Personal Health Information

The NZFFP recommends that written consent should be requested from the subject to access their health records. The initial written consent to view the files could be obtained when the report is ordered, for example by court liaison staff, however the consent should be specifically discussed again at the time of the clinical interview.

It is acknowledged that it may not be possible to obtain written consent from the subject. In these cases, documenting verbal consent to view the files is recommended, preferably with a witness present.

For consent to be valid the subject must be aware that the information being accessed is privileged and will be used in a public forum. The NZFFP recommends that services ensure the written consent form covers the relevant issues so the signed consent is informed. The report writer should also document the aspects of consent that have been discussed in the report.

It is important to clarify the subject's understanding of consent and ensure the subject is competent to give consent, see PPG11. [1]

Where a competent subject does not give consent, and the records are not then accessed, this should be recorded in the report, noting the limitation and consequent effect on the opinion provided.

If the person is incapable of giving informed consent this should be documented in the report.

If the person has a legal representative, for example a welfare guardian, then written consent should be obtained from this person.

1.2 Accessing Personal Health Information

The NZFFP recommends that the signed consent, or proxy form if verbal consent is given or a legal guardian consents, is included when requesting information from relevant agencies.

If consent from a competent person is declined, the requesting letter should include appropriate explanations as to why the report writer is over-ruling the subject's reasons for declining consent to access their clinical files.

The NZFFP recommends that information not obtained from the subject should be specified in the report.

If the clinical notes are viewed without consent from the subject, the exception used to disclose medically privileged information without consent (e.g. due to refusal or a lack of capacity) should be documented in the report.

The Health Information Privacy Code 1994 (HIPC) [3] provides guidance on the use and disclosure of health information. The following exceptions exist under the HIPC on the limits on use of health information:

> Rule 10(1)(d) that the use of the information for that other purpose is necessary to prevent or lessen a serious threat to: (i) public health or public safety; or (ii) the life or health of the individual concerned or another individual;
>
> Rule 10(1)(f) that non-compliance is necessary: (i) to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution, and punishment of offences; or (ii) for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation).

Disclosure of health information without consent is specified in the following relevant clauses:

> Rule 11(2)(d) that the disclosure of the information is necessary to prevent or lessen a serious threat to: (i) public health or public safety; or (ii) the life or health of the individual concerned or another individual;
>
> Rule 11(2)(i) that non-compliance is necessary: (i) to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution and punishment of offences; or (ii) for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation).

The NZFFP also recommends that medico-legal report writers are aware of the limits on disclosure as per HIPC Rule 11 subrule 3 '[d]isclosure under subrule (2) is permitted only to the extent necessary for the particular purpose.' This is consistent with point 7.4 in PPG 11. [1]

If any issues or conflicts arise related to accessing personal health information, then these are the responsibility of the holding agency to resolve. Medico-legal report writers should acknowledge any limits related to obtaining relevant information in their reports.

Footnote

This guideline focuses specifically on Rules 10 and 11 of the HIPC [3] and how these apply to medico-legal reports. The Office of the Privacy Commissioner has also stated that clinicians must be aware of the entire HIPC [3] and that Rules 2, 4 and 8 may apply when information is collected during these assessments. In order to comply with privacy legislation, clinicians should also be guided by Rules 5, 6, 7 and 9. The current consolidated version of the HIPC is available online from the Office of the Privacy Commissioner.

References

1. Royal Australian and New Zealand College of Psychiatrists. *Professional Practice Guideline 11: Developing Reports and Conducting Independent Medical Examinations in Medico-Legal Settings*. 2015. Available at: https://www.ranzcp.org/files/resources/college_statements/practice_guidelines/ppg11-developing-reports-and-conducting-independen.aspx
2. Dawson J. *Medical Privilege and Court-Ordered Psychiatric Reports*. *NZULR.* 2012 Dec; 25(2): 239–69.
3. Office of the Privacy Commissioner. *The Health Information Privacy Code.* 1994 (NZ) Available at: https://privacy.org.nz/assets/Files/Codes-of-Practice-materials/Consolidated-HIPC-current-as-of-28-Sept-17.pdf

Further reading

1. *Hosking v Runting* (2005) 1 NZLR 1.
2. *P v D* (2000) 2 NZLR 591.
3. Royal Australian and New Zealand College of Psychiatrists. *Code of Ethics.* 2018. Available at: https://www.ranzcp.org/files/about_us/code-of-ethics.aspx
4. *Tucker v News Media Ownership Ltd* (1986) 2 NZLR 716.

Disclaimer

This information is intended to provide general guidance to practitioners and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances, information or material that may have become subsequently available.

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