Late-term abortion: what can be learned from *Royal Women's Hospital v Medical Practitioners Board of Victoria*?

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ABSTRACT

- In 2001, the Medical Practitioners Board of Victoria received a complaint from an Australian Government Senator regarding a late-term abortion carried out in February 2000 at the Royal Women's Hospital, Melbourne.
- Five years later, the complaint of professional misconduct was finally dismissed by the Board as being frivolous and vexatious.
- The action highlights a number of deficiencies in the way medical practitioner boards deal with complaints against medical practitioners; in particular, the Board's lack of discretion to deal with complaints lacking substance.
- Early mediation of the dispute between the Royal Women's Hospital and the Medical Practitioners Board could have avoided a great deal of suffering and expense.
- As a result of this case, it is likely that the Victorian Medical Practitioners Board will be given additional powers in the future to deal with complaints without merit.

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In 2004, the *MJA* published an important article by de Crespigny and Savulescu that gave a comprehensive summary of Australia's current abortion laws.[1] Their contribution was timely; it followed a controversial public debate about a late-term abortion carried out in February 2000 at the Royal Women's Hospital (RWH) in Melbourne. de Crespigny and Savulescu stated that: "The termination of a 32-week pregnancy on the grounds of probable dwarfism in the fetus raises profound and divisive ethical issues." While no one can take issue with that statement, it was not relevant to the facts of the case under discussion — a pregnant woman attending RWH's emergency department, threatening to kill herself unless her fetus was aborted. The threat was taken seriously by all the clinicians who saw her. The clinical consensus was that a refusal to terminate her pregnancy was likely to result in the death of both the woman and her baby.

My object in revisiting this case is to remind doctors that, in some circumstances, the common law will compel them to reveal confidential information if they are subpoenaed as witnesses in proceedings before a court or medical tribunal. This is a cautionary tale of how terribly wrong things may go when, as in the case outlined below, the two warring parties fail to heed this simple fact.

Events leading up to the abortion

In late January 2000, a 40-year-old woman (Ms X) was referred to RWH by her general practitioner, having been advised that an ultrasound examination indicated that her 31-week-old fetus might have skeletal dysplasia. Accompanied by her supportive husband, she arrived at the emergency department in a state of great agitation, becoming "hysterical and suicidal, demanding that her pregnancy be terminated".[2]

After a further ultrasound confirmed the diagnosis of fetal skeletal dysplasia, Ms X was referred to an ultrasonologist, a geneticist, a genetic counsellor, an obstetrician, and a psychiatrist. All confirmed that she was acutely suicidal and would most likely kill herself unless her fetus was aborted. Having rejected all other management options, including adoption of the child, all agreed that an abortion was the only feasible alternative. On the known facts, there was thus never any doubt that this late-term abortion was lawful, undertaken to preserve the woman from serious danger to her life and mental health.

The abortion was carried out in early February 2000 and Ms X delivered a stillborn baby girl. Although she refused an autopsy, a photograph of the baby showed features of achondroplasia.[1]

Events that followed the abortion

The case came to the attention of Dr John De Campo, the Chief Executive Officer of RWH, in late June 2000 when the ethical issues involved in the case were discussed at a hospital meeting.[1] This led to Dr De Campo dismissing the ultrasonologist and suspending several other specialists on the staff without discussing the facts of the case (the suspended specialists were subsequently reinstated).[1] In my opinion, the purported dismissal and suspensions would appear to be unlawful, being contrary to Section 41(2) of the *Health Services Act 1988* (Vic), which provides that:[3]

> The board of a public hospital . . . must not dismiss or suspend any registered medical practitioner employed or engaged by the hospital unless the board
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> (a) where there has been an allegation against the registered medical practitioner, inquires into any matter alleged; and
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> (b) gives the registered medical practitioner an opportunity to be heard.

Dr De Campo then referred the case to the Victorian State Coroner, enclosing Ms X's file.

Some 18 months after the referral, the Deputy Coroner concluded, on 23 January 2002, that a coronial inquiry was limited to investigating reportable *deaths*, and that *stillbirths* fell outside its jurisdiction. This meant that the Coroner had been provided with confidential medical records to which his office could claim no possessory title, and they should have been returned to the hospital.

Call for an investigation

Meanwhile, in May 2001, Julian McGauran (an Australian Government Senator and anti-abortion lobbyist) had reported the case to the Medical Practitioners Board of Victoria. Subsequently, he requested details of the case from the Coroner.

The Chief Coroner, rather than returning Ms X's medical records to the hospital, forwarded copies of them to Senator McGauran without the patient's consent. In my opinion, the Coroner's action in releasing confidential information was not only injudicious and beyond the Coroner's authority, but was in breach of Victoria's privacy legislation.

In February 2002, Senator McGauran made a formal complaint to the Medical Practitioners Board, enclosing some of Ms X's medical records, and claiming that the abortion carried out at RWH, involving five named clinicians, was illegal, and that the diagnosis of dwarfism was wrong. The material supplied to the Board did not include a report of the psychiatrist at RWH, which stated that failure to terminate the patient's pregnancy would constitute a serious risk to her mental health, nor the findings of the hospital's subsequent internal investigation, which concluded that all the clinicians involved in the termination "had acted in good faith and that the management followed was determined by those involved to be the most appropriate". In my opinion, if the Board had been provided with *all* the medical records, these would have become part of its preliminary investigation and would, in all probability, have resulted in the Board dismissing the complaint at that time, as well as clearing the doctors of alleged improper conduct.

On 13 March 2002, Senator McGauran delivered a speech in the Australian Government Senate concerning Ms X's termination, claiming: "... there was a misdiagnosis of the child's disability of dwarfism. The baby did not have dwarfism but was found to be normal on delivery."[4]

Medical Practitioners Board investigation

Senator McGauran's speech seemed to stir the Board into action. Section 25 of the *Medical Practice Act 1994* (Vic) compels the Board to investigate a complaint if it concerns the professional conduct of a medical practitioner if (i) the complaint has not been dealt with by the Health Services Commissioner and (ii) the Board has not determined the complaint to be frivolous or vexatious. On 18 April 2002, the Board delegated its powers to conduct a preliminary investigation into the McGauran complaint to a subcommittee of three members of the Board. The subcommittee was satisfied that the complaint was frivolous and vexatious and recommended that no investigation was warranted. However, the Board rejected this recommendation. Insisting on a full investigation into the complaint, the Board wrote to RWH on 8 May 2002 seeking full details concerning Ms X's treatment.

Ms X, having been consulted by RWH, instructed her solicitors to advise the Board on 24 May 2002 that she did not wish to have any involvement in the investigation and did not consent to the release of her medical records. Given this stalemate, the Board made no attempt to question any of the medical specialists named in the complaint regarding Ms X's treatment, presumably on the assumption that they would follow the hospital's lead and claim privilege. If that was the Board's assumption, it was seriously misguided.

In an attempt to clarify the law on this matter, I published an article in the *MJA* in 1999 entitled *Confidentiality and the courts*,[5] emphasising that a doctor has no right to refuse to disclose confidential information in the course of judicial or quasi-judicial proceedings, such bodies having the power to override a claim of privilege.[6] I quoted an extract from Lord Denning's famous dictum, to the effect that courts will respect medical confidences and will not direct a doctor to answer a question unless it is not only relevant, "but also it is a proper, and indeed necessary question in the course of justice to be put and answered".[7] In *re Buchanan*,[8] the Full Court of the Supreme Court of New South Wales adopted a similar approach.

Doctors should be reminded that medical boards are quasi-judicial tribunals, given a wide jurisdiction under the various state and territory Acts. In Victoria, this power extends to reviewing the professional performance of all medical practitioners registered in Victoria, to imposing fines, to suspending from practice, and to cancelling a medical practitioner's registration. It also has coercive powers to compel the attendance of a medical practitioner who is the subject of a complaint at a preliminary conference (Medical Practice Act, Section 48B). For good measure, Section 49 of the Act confers a discretion on the Board to hold its investigative proceedings in camera (ie, closed to the public) whenever "the hearing is taking evidence of intimate ... matters", and to withhold the identity of the practitioner(s) who is the subject of the proceedings.

It is my view that the Board could — and should — have sought the attendance of the various named specialists involved in the termination. Having been compelled to appear before the Board, these doctors would claim privilege, but, if their submission was overruled, they would have been required to answer all relevant questions relating to the treatment of their patient. On the facts of this case, the Board's probing of the various specialists would have established that Ms X was considered by all clinicians, including a psychiatrist, to be acutely suicidal. This would have cleared them of any alleged professional misconduct and terminated the Board's investigation.

Instead, having failed to obtain Ms X's medical records from RWH, the Board made a request on 8 May 2003 to obtain her records through the *Freedom of Information Act 1982* (Vic). This process was doomed to fail, as the hospital could — and did — in the absence of the patient's consent for their release, legally resist the request. (Any document released under freedom of information [FOI] is open to public inspection.)

The FOI action having failed, the Board obtained a search warrant from the Magistrates' Court for evidence to see whether there was any basis for suspending or cancelling the registration of the five named medical specialists. The Board executed the search warrant on 18 November 2003 and seized a number of documents from RWH.

Legal processes initiated by Royal Women's Hospital

RWH, objecting to the seizure of its records, made an application to the Magistrates' Court on 18 November 2003 for an order that the seized documents be returned. This application was heard on 15 March 2004. The major issue argued before the Magistrate turned on the validity of the search warrant and its execution.

RWH's principal arguments were (i) that the production of medical records was protected by privilege, in reliance on Section 28(2) of the *Evidence Act 1958* (Vic); and/or (ii) the production of the documents was subject to the protection of Section 141(2) of the Health Services Act;[3] and (iii) that the handing over of the documents would be contrary to the public interest and public immunity existing in relation to Ms X's records held by the hospital, and accordingly were immune from production.

The Magistrate rejected all RWH's legal submissions and dismissed the application with costs, ordering that the documents seized pursuant to the search warrant be released to the Board. The hospital was ordered to pay the Board's costs. The hospital lodged an appeal with the Supreme Court of Victoria. This caused the Board to put its preliminary investigation "on hold".

RWH's appeal to the Supreme Court came before Gillard J, who dismissed the appeal on 29 June 2005 with costs. A further appeal to the Victorian Court of Appeal was likewise dismissed on 20 April 2006, with costs against the hospital.

Having exhausted the appeals process, RWH finally provided the Board with Ms X's file, consisting of notes made by various doctors and nurses, as well as the hospital's internal investigation. After an examination of these notes, the Board dismissed the complaint on 15 September 2006, finding no evidence of professional misconduct, and thereby ending the considerable stress caused to five doctors by the protracted nature of the proceedings.

In relying on "public interest immunity", RWH submitted that medical records of patients in public hospitals belong to a class of documents that are protected from disclosure, given the link between government and public health. This argument was rejected at every stage on the basis that public interest immunity was limited to decision making at the highest government level. Applied to the instant facts, and doing what was described as a "balancing exercise", the courts held that the public interest in the proper investigation of complaints made against registered medical practitioners outweigh the public interest in the confidentiality of documents identified as a class, "namely the medical records of women patients in public hospitals seeking advice and treatment about women's health and reproduction, and in particular obstetrics and gynaecological advice".[2] This somewhat narrow view may be contrasted with decisions in the United States and England, where sensitive health records have been held immune from disclosure, holding that breaches of confidentiality would discourage the public from seeking appropriate medical care.[9]

Before the Court of Appeal, the argument based on medical confidentiality became almost a side issue, the President (Maxwell P) noting that concerns about confidentiality were not limited to the doctor–patient relationship. Comparing the position of patients with that of taxpayers, his Honour observed that:

> The understandable desire for privacy is not, however, met by denying the Commissioner the right to obtain information by compulsory process, but rather by the imposition of stringent secrecy provisions prohibiting disclosure of any information so obtained.
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> To remove any misapprehension in this regard, the Board has declared from the outset that it will do whatever is necessary to ensure that the information is kept confidential. It is vitally important that this be done. Once it is appreciated that there will not be — indeed, was never proposed to be — any public disclosure of the information, the adverse consequences foreshadowed by the Hospital seem far less likely to occur.
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> Given that confidentiality issues of this kind inevitably arise when the Board is conducting investigations, I would have expected the *Medical Practice Act* — which gives the Board its investigatory duties and functions — to have imposed a strict secrecy regime. Surprisingly, the Act is silent on this subject. This omission should be corrected as a matter of urgency.[2]

Given that the Board has the discretion to hold any hearing in camera, and having advised RWH that any information in this case would be kept confidential, I submit that the "adverse consequences" which the hospital feared could arise from public disclosure of Ms X's records were largely academic.

What can be learned

This case reveals a number of deficiencies in the manner in which complaints against medical practitioners are investigated in Victoria. It may well be that the recommendation of Maxwell P that the Medical Practice Act should be amended to impose a strict secrecy regime will avoid the confrontational approach adopted by the Board in this case. However, having set out the existing statutory regime, doctors will no doubt be surprised that a complaint by someone having no "standing" could have led to such protracted litigation. If nothing else, the case has brought into sharp focus the need for tighter controls on who can make a complaint to the Board. Dr Mark Yates, the Australian Medical Association's Victorian President, has foreshadowed that from July this year, the Board will have additional powers to refuse to deal with complaints that are misconceived, lacking in substance, or where the notification does not warrant investigation. Such amendment will no doubt be welcome.

The cognitive dissonance that persuaded the Coroner to release a patient's private information led to the Law Reform Committee of the Parliament of Victoria reviewing the *Coroners Act 1985* (Vic). In its final report, the Committee was critical of the Coroner's action in releasing Ms X's confidential record and recommended that the Act be amended to provide better protection of patient privacy in future.

This case has reaffirmed that the common law does not afford absolute privilege to information in a doctor–patient relationship and, in some circumstances, may compel its disclosure to courts and quasi-judicial tribunals. Doctors should be aware that medical tribunals regulating medical practice are able to enforce the obligation to give confidential information, as well as compel the production of documents pursuant to discovery or subpoena, or the reach of a search warrant.

The case highlights a grey area of the law in relation to the crime of child destruction. Neonatal technology has made such significant advances that some premature babies now survive that could have been legally aborted. It follows that it will become increasingly difficult to determine at what stage of development a fetus will be capable of being born alive and sustained by medical technology.

The case also draws attention to the limited choice available to Australian women requesting abortion after 20 weeks, even with severely anomalous fetuses. While Victorian law is silent with regard to the termination of pregnancies performed solely because the fetus has a serious abnormality, this stands in stark contrast to the laws of the Australian Capital Territory, which has removed abortion from its criminal statutes, and legislation in South Australia and the Northern Territory that makes it lawful to terminate a pregnancy in a prescribed hospital if two doctors believe that there is a substantial risk that the child, if born, would be seriously handicapped, either physically or mentally. However, no guidelines are provided to assess the child's quality of life. This may be contrasted with the Royal College of Obstetricians and Gynaecologists in England, which has adopted the guidelines of The Netherlands. These prescribe an assessment that includes the extent to which the affected child would be: able to communicate; self-aware; dependent on medical support; self-sufficient in the future; and expected to suffer.

Postscript

In July 2005, Senator McGauran included Ms X's name in material he sent to *The Age* (Melbourne), despite a suppression order made on 8 December 2004 by Master Wheeler of the Victorian Supreme Court on the publication of the names of Ms X and any treating medical practitioners involved in the termination. This persuaded the Victorian Health Services Commissioner to refer Senator McGauran to the Privacy Commissioner, where the issue is still current.

As the legal processes were grinding slowly to their final dénouement in September 2006, Senator McGauran sent Ms X's records to the Health Services Commissioner (who took no action).

After the case was dismissed by the Board, the Senator released a statement that the Board's investigative powers were so *restricted* that "a possible breach of Victorian criminal law, relating to child destruction, could not be addressed . . . This case was one with no complications. It represented a test case for late-term abortions in Victoria."[10]

Competing interests

None identified.

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