Confidentiality: Medico-legal Aspects*

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Curriculum vitae

Dennis Davis is Associate Professor of the Department of Commercial Law at the University of Cape Town. He holds a BA LLB from the University of Cape Town and obtained a M. Phil in Criminology at Cambridge University where he taught for one year. He has co-authored several text books and written over thirty articles on tax, estate planning, jurisprudence and labour law. He is presently engaged in co-authoring a book entitled "Beyond Apartheid" and is a columnist for Finance week.

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Summary

The rules of conduct of the SA Medical and Dental Council together with decisions of South African law courts, make it clear that both ethically and legally a medical practitioner is required to keep the confidence of his patient. South African practitioners, like their overseas counterparts, are confronted with a legal position in which, unlike the lawyer/client relationship, there is no absolute privilege for communication between physician and patient. The paper explores the definition of the limited privilege rule and arguments for an amendment thereof. It also examines the question of the moral and legal obligation of the practitioner to make disclosures to a third party or agency. In this connection the paper considers the problem of the duty to disclose illnesses such as AIDS to persons other than those for whom the patient has granted consent. In a more indigenous context, the paper examines the controversy relating to the behaviour of doctors who, during the unrest of 1985 and 1986, co-operated with the police in pointing out patients who had suffered certain injuries resulting in patients being arrested and taken to police cells.

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I swear by Apollo the physician, by Aesculapius, Hygeia and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgement the following Oath:

"All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will *keep secret and will never reveal*...".

In terms of South African law, a medical practitioner is required to keep the confidence of his patient (Parkes v Parkes 1916 CPD 702; Botha v Botha 1972 (2) SA 559 (W)). This position is confirmed by Rule 16 of the SA Medical and Dental Council which prohibits the disclosure of any information, whether orally or in writing in respect to a patient's condition which should not be disclosed save for the disclosure with the express consent of the patient or in the case of

a minor, with the permission of a parent or guardian or in the case of a deceased, with the permission of the nearest relative or executive.

The rules note that in a court of law, the rule about professional confidentiality can be broken but only under protest when ordered to do so by the presiding legal officer. Hence unlike the lawyer/client relationship there is no absolute privilege for communication between patient and doctor. Consequently a refusal by the medical practitioner to comply with a court order to disclose certain information can result in a prosecution for contempt of court. In this connection the practitioner is in a cleft stick as disclosure of such information to a court can result in an action for invasion of privacy, defamation or possibly breach of contract.

However, comparative precedent suggests that the patient's remedy is more formal than substantive. For example, the Scottish courts were confronted with this issue on two occasions in the similarly named AB v CD cases (1851) 14D 177 (CT of Sess) and 1904 (7) F72).

In the first AB v CD the Court of Session considered an action for damages brought against a doctor who had disclosed to a church minister that the pursuer's wife had given birth to a full-term child six months after marriage. The Court held that there was a duty on the part of the doctor not to reveal confidential information about his patient unless he was required to do so in court or if disclosure were 'conducive to the ends of science' — but, in that case, identification of the patient would be improper. In the second AB v CD the pursuer was seeking a separation from her husband. Having been examined by the defendant at the suggestion of her lawyers, she was later examined by the same doctor who was, then, acting on behalf

"As regards confidentiality, the doctor's role is not an easy one".

of her husband. The doctor disclosed to the husband certain information he had obtained in the course of his first examination and the wife argued that this constituted a breach of confidentiality. Once again, the court accepted that there was a duty on the part of a doctor not to disclose confidential information about his patient but stressed that not every disclosure would be actionable. As Lord Frayner pointed out,

some statements may be indiscreet but not actionable; there might be, for example, an actionable breach if the disclosure revealed that the patient was suffering from a disease which was a consequence of misconduct on his part.

As the contemporary commentators have noted, 'this really amounts to no more than saying that the patient is entitled to protection against defamatory statements, a protection which is hardly adequate.' (McCall Smith of 137)

Apart from being forced to disclose confidential information by a court, there are a number of other exceptions to the rule, some of which also raise a range of difficulties.

These are well set out in the United Kingdom's Handbook of Medical Ethics (1981) which noted that 'a doctor must preserve secrecy on all he knows'. There are five exceptions to this general rule:

i) **Consent to Publish**

This is perhaps the easiest of the exceptions in that if the patient consents to a relaxation of secrecy, he allows a doctor the right to release information.

ii) **Patient's interests**

In this connection it is ethical to break confidentiality without a patient's consent when it is in his own interests to do so and when it is undesirable on medical grounds to seek such consent. Thus a properly considered clinical decision cannot be unethical when it proves right or wrong and, in the event of disciplinary or legal action, the fact that it was a justifiable breach would offer a complete defence both in court and before the Medical and Dental Council.

iii) **The Doctor's duties to Society**

This is undoubtedly the most controversial of the exceptions. As Mason and McCall Smith put it, "society is not homogenous but consists of groups amenable to almost infinite classification — regional, political, economic, by age and so on: it follows that what one man regards as a duty to society may be anathema to another. Individual doctors are bound to weigh the scales differently in any particular instance while, in general, all relative weighting must change from case to case". (AT 125)

A medical practitioner is under no obligation to divulge information to a policeman who arrives at a hospital.

A number of dilemmas can be raised in this connection:

a) *The question of violent crime.*

If a doctor knows his patient has committed rape, particularly where there is evidence that this is one of a series of attacks on women, the question arises as to his duty to disclose such information. In the UK there is case law to the effect that a doctor need not even assist the police by answering their questions concerning his patients although he cannot give false or misleading information (Rice v Connolly (1966) 2 QB 414).

b) *The Disclosure of Contagious Disease*

In a recent English case of Gillick v West Norfolk and Wisbech Health Authority (1985) 2 WLR 413 in which the issue was whether contraceptive advice or treatment can be given by a doctor to a girl aged under 16 without the knowledge and consent of her parents. Eveleigh LJ said:

"I would add a word on confidentiality. A doctor's position is *not an easy one*. The courts recognise this ... arguements which we have heard as to the difficulty which the duty of confidentiality imposes upon a doctor. *The alleged duty must be subject to exceptions* ...".

The principle of confidentiality should remain paramount, save when society has primacy of claim.

The fact that the duty is not absolute and that this recognized by the court perhaps fortifies the doctor in the following scenario. A homosexual blood donor is subsequently diagnosed by his doctor to be suffering from AIDS (auto-immune deficiency syndrome). The doctor knows of his patient's donor activities. Should he tell the blood transfusion authorities, in face of lack of patient consent and absence of any separate statutory compulsion, in order to prevent further donations and try to track down existing ones? In the US case of Simonsen v Simonsen (1926) 104 NCB 244, the court held that a physician was not liable for revealing to the patient's spouse that the patient was suffering from venereal disease.

c) *Co-operation with the police*

There is an interesting published decision of the Medical and Dental Council relating the Rule 16 which is of particular relevance in this connection. A practitioner asked whether he could provide information to the South African police for the purposes of a departmental enquiry. The policeman in question had been a patient of the practitioner and the latter had diagnosed that he suffered from acute alcoholic poisoning as a result of which he was hospitalised for 10 days. It was decided by the committee in the light of the provisions of rule 16 that the practitioner could not make a disclosure of his diagnosis (EC report Sept 1970 item 81).

This ruling is of particular significance given the recent

unrest in the country. In a paper delivered some two years ago Professor J P Van Niekerk of UCT's medical school drew attention to the fact that confidentiality had become a major issue during the civil disturbances in the Cape in mid-1985. "Public confidence in the medical profession was reported to be at a low ebb as a result of a belief that medical personnel at major hospitals were required to inform police of the injuries of casualties treated. This was certainly not the case at Groote Schuur Hospital, but despite reassurances, informal casualty clinics were established in the community to deal with the injured so that they did not have to be sent to hospital. Unfortunately, this meant that seriously injured and innocent people were deprived of quality treatment to which they were rightfully entitled." (AT 53).

Professor Van Niekerk's observations were an accurate reflection of the perception held of members of the medical community by township dwellers caught in the turbulence of the period. In an article in the SA Journal of Human Rights, Gilbert Marcus, a senior research officer at the Centre for Applied Legal Studies at Wits noted that information emanating from the Eastern Cape indicates that there has been a persistent pattern of behaviour on the part of certain doctors in provincial hospitals charged with the treatment of victims of unrest. The police appear to have operated on the assumption that a person injured by a bullet or by buck-shot is presumed to have been engaged in acts of public violence. Such an injury usually results in automatic arrest and incarceration pending trial. Marcus argues that apart from certain statutory exceptions, like the duty to report notifiable diseases in terms of the Health Act of 1977, there is no general duty in South African law imposed upon a medical practitioner to divulge information concerning the commission of an offence nor to report bullet wounds to the police. Thus he submits that in the absence of a well-founded apprehension of the suspected commission of an offence, a medical practitioner is under no obligation whatsoever to divulge information to a policeman who arrives at a hospital on a 'fishing

expedition' in search of people wounded in situations of unrest.

In South Africa, the only section of the Criminal Procedure Act which is remotely applicable to confidentiality is s 47 which places an obligation upon anyone between the ages of 16 and 60 to assist the police, if requested, in the apprehension of a criminal. This section cannot however be used to justify reporting bullet wounds to the police.

Consequently I would argue that reporting bullet wounds to the police is a breach of confidentiality — see Rule 16; certainly this is so if the 1970 Ruling is taken into account.

Marcus's argument goes further, however. He suggests that in respect of cases of detention the practitioner does have a duty to disclose information. Thus he deems that it is not a sufficient answer for a doctor to disclaim responsibility for the treatment of a patient simply because that patient has been removed from the hospital by virtue of a warrant of arrest. At the very least, a doctor would be obliged to compile a medical history of the patient detailing treatment administered as well as recommendations for future treatment. This information should then be made known to the arresting officer, and more importantly, to the district surgeon for the area. This would at least ensure that the district surgeon, who would then assume responsibility for the treatment of the patient, was fully appraised of the treatment already received by the patient, as well as of indications for future treatment. This would effectively cast the obligation upon the district surgeon to ensure that the patient continued to enjoy proper medical care.

The doctor's dilemma is his relationship to his patient vis-a-vis society.

d) *Confidentiality within the family*

Mason and McCall Smith raise the issue of matrimonial violence under this heading. In respect of violence between spouses they conclude that, in the end, it is clear that an adult woman of sound mind is entitled to her autonomy; she has the opportunity of reporting to the police or, often more usefully, she has access to one of the many voluntary shelters which are now being established. She now has far greater protection under the law. All the doctor can effectively do is to advise and, in this, he may be able to help by arranging for treatment of the offender — 'wife battering' is markedly associated with alcoholism and neurotic symptoms in the husband. The position is different when the form of familial violence takes the form of child abuse. Given a defenceless victim, the authors suggest that parental autonomy should be forfeited on the grounds of impropriety and the doctor should be able to rely upon the defence of necessity, either by assuming consent on the part of one who is unable to consent, or to save life.

It is of course possible that a doctor who mis-diagnoses child abuse can find himself the defendent in a defamation case.

e) The final exception has already been canvassed above, namely the obligation to disclose as a result of a court order. In some countries (New Zealand, Israel, Newfoundland and Quebec, for example) a statutory medical privilege has been introduced. Certainly the policy basis of according privilege to lawyers and not to medical practitioners can only be justified on the link between the lawyer and the court, but that should not be enough to permit such a distinction.

Conclusion

The problem of confidentiality will seemingly always be an issue fraught with moral and legal difficulty. I would argue that the principle of confidentiality should remain paramount save where an uncontested principle of society has primacy of claim. Such a principle can only find its intellectual roots in the common good of the society and not of a segment of that society. Perhaps the difficulty concerning confidentiality is illustrated by the criticism of Lord Moran, Churchill's surgeon, not because he disclosed information about Churchill's health once he had died but because of failure to draw attention to the physical state of his patient during life. As Mason and McCall Smith note, this brings one back to "the dilemma of the doctor's relationship to his patient vis-a-vis society. After all, we did win the Second World War!"

References

1. Marcus G. The Abdication of Responsibility: The Role of Doctors in the Uitenhage Unrest. South African Journal of Human Rights 1985; 1: 151.
2. Mason J K and McCall Smith A. Law and Medical Ethics 1987; Butterworths; London.
3. Van Niekerk J P de V. Professional Codes: Some Current Issues In: Benetar S (ed). Ethics and Moral Issues in contemporary Medical Practice 1985: UCT.

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