

Confidentiality: Medico-legal Aspects*

— D Davis



Prof Dennis Davis BA LLB, M.Phil. Crim
Dept of Law
University of Cape Town
Rondebosch
7700

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.

*Paper presented at the 6th General Practitioners Congress

KEYWORDS: Confidentiality; Physician-Patient Relationship; Human Rights

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

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.

S Afr Fam Pract 1988; 9: 362-6

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 Frayne pointed out,

SCHEDULING STATUS:
PROPRIETARY NAME:

[84]

RENITEC*5 Tablet

COMPOSITION
Each RENITEC 5 tablet contains 5 mg enalapril maleate, MSD.
Each RENITEC 20 tablet contains 20 mg enalapril maleate, MSD.

PHARMACOLOGICAL CLASSIFICATION
A.7.1.3 Vascular medicines - other hypotensives

PHARMACOLOGICAL ACTION
RENITEC (enalapril maleate, MSD) is the maleate salt of enalapril, a derivative of two amino acids, L-alanine and L-proline. Following oral absorption, RENITEC is hydrolysed to enalaprilat, which is a specific, long-acting, non-sulphydryl angiotensin converting enzyme inhibitor.

INDICATIONS
RENITEC is indicated in:
all grades of essential hypertension
renovascular hypertension
congestive heart failure

CONTRA-INDICATIONS
Pregnancy and lactating mothers.
Hypersensitivity to the product or its components.

DOSE AND DIRECTIONS FOR USE
ORAL: Since its absorption is not affected by food, RENITEC tablets may be administered before, during or after meals. The usual daily dosage ranges from 10 to 40 mg in all indications. RENITEC may be administered once or twice a day. The maximum dose studied in man is 80 mg daily.

In the presence of renal insufficiency and cardiac failure, lower doses and/or less frequent administration of RENITEC may be required (see **SIDE EFFECTS AND SPECIAL PRECAUTIONS**).

Essential Hypertension

The initial dose is 10 to 20 mg depending on the degree of hypertension and is given once daily. In mild hypertension the recommended initial dose is 10 mg daily. For other degrees of hypertension the initial dose is 20 mg daily. The usual maintenance dose is one 20 mg tablet taken once daily. The dosage should be adjusted according to the needs of the patient.

Concomitant Diuretic Therapy in Hypertension

Symptomatic hypertension may occur following the initial dose of RENITEC; this is more likely in patients who are being treated currently with diuretics.

Caution is recommended, therefore, since these patients may be volume or salt depleted. The diuretic therapy should be discontinued for 2-3 days prior to initiation of therapy with RENITEC. If this is not possible, the initial dose of RENITEC should be low (5 mg or less) to determine the initial effect on the blood pressure. Dosage should then be adjusted according to the needs of the patient.

Renovascular Hypertension

Since blood pressure and renal function in such patients may be particularly sensitive to ACE inhibition, therapy should be initiated with a lower starting dose (e.g. 5 mg or less). The dosage should then be adjusted according to the needs of the patient. Most patients may be expected to respond to one 20 mg tablet.

RENITEC*20 Tablet

taken once daily. For patients with hypertension who have been treated recently with diuretics, caution is recommended. (See paragraph above.)

Dosage in Renal Insufficiency

Generally, the intervals between the administration of enalapril should be prolonged and/or the dosage reduced.

Renal Status	Creatinine-Clearance ml/min	Initial Dose mg/day
Mild impairment	<30 >30	5
Moderate impairment	<30 >15	2.5
Severe impairment	<10	2.5 mg on dialysis days†

†Enalapril is dialysable. Dosage on non-dialysis days should be adjusted depending on the blood pressure response.

Congestive Heart Failure

Blood pressure and renal function should be monitored closely before and after starting treatment with RENITEC (see **Precautions**) because hypotension and consequent renal failure have been reported. In patients with CHF, the usual maintenance dose is 10-20 mg daily, given in single or divided doses. The initial dose of RENITEC in patients with CHF (especially renally impaired or sodium- and/or volume-depleted patients) should be lower (5 mg or less), and it should be administered under close medical supervision to determine the initial effect on the blood pressure. If possible, the dose of diuretic should be reduced before beginning treatment. The appearance of hypotension after the initial dose of RENITEC does not imply that hypotension will recur during chronic therapy with RENITEC and does not preclude continued use of the drug.

In the absence of, or after effective management of symptomatic hypotension following initiation of therapy with RENITEC in CHF, the dose should be gradually increased, depending on the patient's response, to the usual maintenance dose (10-20 mg) given in a single or divided dose. This dose should be performed over a 2-4 week period, or more rapidly if indicated by the presence of residual signs and symptoms of heart failure.

SIDE EFFECTS AND SPECIAL PRECAUTIONS

Dizziness and headache were the more commonly reported side effects. Other side effects occurred and included fatigue, asthma and hypotension, orthostatic hypotension, syncope, nausea, dizziness, muscle cramps, rash, cough and angioneurotic oedema.

Hypersensitivity/Angioneurotic Oedema

Angio-oedema has been reported in patients treated with RENITEC. Hypersensitivity reactions such as angioneurotic oedema with swelling of the face, the tongue, and the glottis together with serious shortness of breath have been reported in individual cases. In such instances RENITEC should be discontinued and appropriate medical measures should be initiated immediately.

Clinical Laboratory Test Findings

Increases in blood urea and serum creatinine, usually reversible upon discontinuation of RENITEC, have been seen. These are

most likely to occur in the presence of bilateral renal artery stenosis, especially in patients with renal insufficiency.

Transient increase in blood urea and serum creatinine may occur in patients without evidence of pre-existing renal impairment, especially in patients taking diuretics. Slight decreases in haemoglobin, haematocrit and white cell count, as well as elevation of liver enzymes, have been reported.

Symptomatic Hypotension

This has occurred following the initial dose of RENITEC. It is most likely to occur if the patient has been volume-depleted, e.g. by prior diuretic therapy, dietary salt restriction, dialysis, diarrhoea or vomiting. In patients with heart failure, symptomatic hypotension is most likely to occur in those patients with more severe degrees of heart failure, as reflected by the use of high doses of loop diuretics, hyponatraemia or functional renal impairment. Should hypotension develop, the patient should be placed in a supine position. Volume repletion with oral fluids or intravenous normal saline solution may be required. Treatment with RENITEC may usually be continued following restoration of effective blood volume and pressure.

In some patients with congestive heart failure who have normal or low blood pressure, additional lowering of systemic blood pressure may occur with RENITEC. This effect is anticipated, and usually is not a reason to discontinue treatment. If hypotension becomes symptomatic, a reduction of dose or discontinuation of RENITEC may be necessary.

Impaired Renal Function

Patients with renal insufficiency may require reduced and/or less frequent doses of RENITEC. (See **DOSE AND DIRECTIONS FOR USE**.) In some patients with bilateral renal artery stenosis or stenosis of the artery to a solitary kidney, increases of blood urea and serum creatinine, reversible upon discontinuation of therapy, have been seen. This is especially likely in patients with renal insufficiency.

Some hypertensive patients with no apparent pre-existing renal disease have developed minor and usually transient increases in blood urea and serum creatinine when RENITEC has been given concomitantly with a diuretic. Dosage reduction of RENITEC and/or discontinuation of the diuretic may be required.

Surgery/Anaesthesia

In patients undergoing major surgery or during anaesthesia with agents that produce hypotension, enalapril blocks angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Paediatric Use

RENITEC has not been studied in children.

Drug Interactions

The combination of RENITEC with other antihypertensive drugs may increase the antihypertensive effect, especially in combination with diuretics.

The combination of RENITEC with beta-adrenergic blocking agents and methylglucoside improves the efficacy of lowering the blood pressure.

Ganglionic blocking agents or adrenergic blocking agents, combined with RENITEC, should only be administered with careful observation of the patient.

Because of lack of experience, concomitant treatment of RENITEC with calcium antagonists is not recommended.

The lithium elimination may be reduced. Therefore the lithium levels of serum should be carefully compared if lithium salts are to be administered.

Serum Potassium

In patients with renal failure, the administration of RENITEC may lead to elevation of serum potassium. Potassium supplements, or potassium sparing diuretics such as spironolactone, furosemide or amiloride are usually not recommended, particularly in patients with impaired renal function, since they may lead to significant increases in serum potassium. If concomitant use of the above-mentioned drugs is deemed appropriate, they should be used with caution and with frequent monitoring of serum potassium.

KNOWN SYMPTOMS OF OVERDOSEAGE AND PARTICULARS OF ITS TREATMENT

Limited data are available with regard to overdose in humans. The most likely manifestation of overdose would be hypotension, which can be treated, if necessary, by intravenous infusion of normal saline solution.

Several hypertensive patients in clinical studies have received as much as 80 mg of enalapril intravenously over a fifteen minute period. No adverse effects, other than those associated with recommended dosages, were observed.

Enalaprilat may be removed from the general circulation by haemodialysis.

CONDITIONS OF REGISTRATION

Advertising to the professions only.

IDENTIFICATION

RENITEC 5 is a white, barrel-shaped, biconvex, 7 x 6 mm tablet, one side engraved "RENITEC", other side scored.

RENITEC 20 is a peach coloured, barrel-shaped, biconvex, 7 x 8 mm tablet, one side engraved "RENITEC", other side scored.

PRESENTATION

RENITEC tablets are available in packs of 30 (with desiccant).

STORAGE INSTRUCTIONS

Store the tablets with desiccant in a dry place below 25 °C. Protect from light.
KEEP OUT OF REACH OF CHILDREN.

REGISTRATION NUMBERS

RENITEC 5: T/7.1.3/164

RENITEC 20: T/7.1.3/166

NAME AND BUSINESS ADDRESS OF THE APPLICANT
LOGOS PHARMACEUTICALS (PTY) LTD, Old Pretoria Main Road, Halfway House 1685, Republic of South Africa.

DATE OF PUBLICATION OF THIS PACKAGE INSERT
18 September 1986

†Registered Licensed User of Trademark

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

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

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 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 ... arguments 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

SALBUTAMOL

S2 VENTEZE Respiator Solution. Each ml contains Salbutamol Sulphate equivalent to 5 mg Salbutamol. Reg. No. U102.1/1B7

Perfect balance of speed and endurance.

The Swallow. The greatest traveller in the animal kingdom. He migrates over 8000 kilometers at high speed, requiring a perfect balance of speed and endurance and exceptionally high performance from his tiny lungs.



Venteze Respiator Solution can help your asthmatic patient get greater performance from their lungs.

- Provides rapid bronchodilation.
- Selectively relaxes bronchial


smooth muscle.

- Makes respiration more efficient.

Give your asthmatic patient that balance of rapid and sustained action — prescribe Venteze Respiator Solution.

VENTEZE 

TRIED AND TRUSTED SALBUTAMOL EFFICACY

 **LENNON LIMITED** Quality medicine you can afford to trust



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 apprised 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 defendant 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.

*Please address all
correspondence to:*

**The Editor
SA Family Practice
PO Box 40447
ARCADIA
0007**