

## Medical Law

**Topic 3** (of 10); **Lecture 1** (of 2):

### Confidentiality: Its Nature, Legal Basis and Permissible Breaches

**Aim:**

To outline the nature of confidentiality and to examine the circumstances under which the GMC permits a registered medical practitioner to breach a patient's confidences.

**Objectives:**

After careful study of this topic you should be able to:

1. Explain the nature and role of confidentiality in the Dr - patient relationship;
2. Explain the circumstances under which a patient's confidences could and/or should be broken;
3. Explain the impact of the *Data Protection Act 1998*, the *Human Rights Act 1998* and the current (2004) version of: '*Confidentiality: Protecting and Providing Information*' on maintaining patient confidentiality.

#### (I) Basic Principles of Confidentiality.

##### (1) The Nature of Confidentiality

*Beauchamp & Childress (Principles of Biomedical Ethics, 4/e 1994, p420)* note that:

Confidentiality is present when one person discloses information to another, whether through words or an examination, and the person to whom the information is disclosed pledges not to divulge that information to a third party without the confider's permission. In schematic terms, information, [S] is confidential if and only if [X] discloses [S] to [Y], and [Y] refrains from disclosing [S] to [Z] without [X's] consent.

In relation to the doctor-patient relationship, *Gillon (Philosophical Medical Ethics)* says that:

It seems clear that two conditions are necessary to create a moral duty of confidentiality: one person [the doctor] must undertake - that is explicitly or implicitly promise - not to disclose another's secrets and that other person [the patient] must disclose to the first person information that he considers to be secret. Thus, there can be no transgression of confidentiality if the information is not regarded as secret by the person giving it; equally it is only because doctors have undertaken not to disclose patients' secrets that they have acquired a duty of confidentiality.

**MacLean and Maher** (*Medicine, Morals and the Law*) add that:

... confidentiality is simply a consequence of the place of consent in medical practice. If the moral autonomy of the patient is to be respected, then the patient must consent to all aspects of it, including the divulgence or withholding of information concerning himself.

In essence, MacLean and Maher have merely noted the moral basis that underpins the common law rule expressed by **Boreham J** in *Hunter v Mann* [1974] QB 767 @772 that:

...the doctor is under a duty not to disclose, without the consent of the patient, information which he, the doctor, has gained from his professional capacity.

Moreover, in *Ashworth Security Hospital v MGN* [2001] 1 WLR 515, @ 627, **Lord Phillips MR** was under no doubt that:

It is well settled that there is an abiding obligation of confidentiality as between doctor and patient and, in my view [the patient] is entitled to be confident that details about his condition and treatment remain between himself and those who treat him.

Thus, the principle of medical confidentiality is generally regarded as being both a moral and legal obligation of fundamental importance. Moreover, it is another illustration of **Coleridge LCJ's** dictum in *R v Instan* (1893) that: 'every legal duty is founded on a moral obligation'.

Codes of ethics affirming the significance of confidentiality include: The *Hippocratic Oath* and (in its 'updated' form) *The Declaration of Geneva*; & The World Medical Association's *International Code of Medical Ethics*.

Part of the *Hippocratic Oath* affirms: "Whatever in connection with my professional practice or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all should be kept secret."

**Knight** (*Legal Aspects of Medical Practice*) points out that: "Even if a medical graduate does not formally affirm this Oath at qualification, he accepts its spirits and intentions as his ideal standard of professional behaviour."

Thus, in the doctor/patient relationship there is an accepted obligation on the part of the doctor not to make any improper disclosure concerning his patient's illness or of information of which he has become aware owing to the special relationship between doctor and patient. A principal reason for this is that confidences belong to the patient and **not** to the doctor who is merely their custodian.

## **(2) Approaches to the Justification of the Ethical Duty of Medical Confidentiality**

There are two distinct approaches to the principle of confidentiality. **MacLean and Maher** note that: "The two modes of understanding confidentiality can be appreciated in terms of

the difference in perspective of the two sides of the doctor-patient relationship”.

1. “First, ... *the perspective of the patient*. His concern with confidentiality is that his involvement with a doctor to some extent threatens his autonomy in that he divulges information about himself. [and, as noted above:]

If the moral autonomy of the patient is to be respected, then the patient must consent to all aspects of it, including the divulgence or withholding of information concerning himself. ... The patient’s perspective on confidentiality ... emphasises the idea of respect for persons as moral ends in themselves.

The moral theory which focuses on a duty towards a person as a moral end in himself is Kant’s non-religious *deontological* theory. [N.B.: A theory which has more than one absolute principle, i.e. more than one principle that appears without exception, is generally known as a *pluralist theory of autonomy-based ethics*. Kant’s theory is monist].

2. “A quite different view of confidentiality ... might be called *the doctor’s perspective*. ... Since the doctor is treated as the expert in the field of medicine, certain matters are for him alone to know, and not the proper concern of anyone else. The basic value underlying confidentiality as viewed from this perspective is that of the professional autonomy of the doctor. If doctors were required to divulge all information derived from relationships with their patients, then such autonomy would be threatened, and doctors would find their freedom of clinical judgment to be in danger, perhaps to the extent that medical decisions could no longer be made.”

A theory which is based on the nature of the consequences of [a doctor’s] actions or proposed actions is known, simply, as a *consequentialist* theory. *Utilitarianism* is the best known example.

(Deontological and consequentialist theories were explained in Topic 2: Introduction to Medical Ethics).

### **(3) The Legal Bases of Confidentiality**

As recently as 1987, *Mason & McCall Smith* (*Law and Medical Ethics*, 2/e) noted that:

“There is very little *legal* support for the doctrine of strict confidence between patient and doctor.” Moreover, they suspected that: “... in the era of priestly medicine, the principles of confidentiality were rather less than patient orientated - it is more than likely that the maintenance of a closed profession was the overriding concern”. They cited *Thomson* as maintaining that this also applied to the Hippocratic School. Accordingly, basing what is accepted as altruistic ethics upon the Hippocratic Oath is tantamount to building upon sand.

(N.B.: In addition to the doctor/patient relationship, professional codes of nurses and professions supplementary to medicine also include provisions about maintenance of *secrecy* concerning individual patients.)

Pre-1988 there was also very little case law illustrating a legal basis on which a doctor would be liable for damages or an injunction as a result of improper disclosure of a patient’s confidence. Nevertheless, in *Kitson v Playfair* (1896), a doctor’s revelations to his family about his sister-in-law’s pregnancy cost him, £12,000! However, following the

decision in *A-G v Guardian Newspapers* (No.2) (1988), firmer legal bases of confidentiality have developed (see below); and a breach of professional confidence will almost certainly result in disciplinary action by the GMC and hence possible erasure from the medical register.

In *Legal Aspects of Nursing*, 4/e, 2005, *Dimond* says that the *common law* legal duty of confidentiality may arise:

1. From the duty of care in negligence;
2. From the implied duties under a health care professional's contract of employment in which (s)he has a responsibility to the employer to keep information acquired from work confidential; and
3. From the duty to keep information which has been passed on in confidence, confidential, even when there is no pre-existing relationship or legally enforceable contract between the parties. This duty is based in equity: *Phipps v Boardman* (1967); *Stephens v Avery* (1988). (In *W v Egdell* (1990), it was claimed that the duty of confidence was also based in implied contract).

*A-G v Guardian Newspapers* decided that there was a public interest in giving legal protection to confidences imparted under explicit or implicit notices of confidentiality and *Stephens v Avery* confirmed the existing common law rule that for a breach of confidentiality to be established there must be:

1. the necessary quality of confidence attached to the information imparted;
2. the information must have been imparted in circumstances importing an obligation of confidence; and
3. there must be an unauthorised use of that information to the detriment of the party communicating it.

More recently, the focus has been on statutory provisions that protect a patient's confidences, viz; *Arts.8* and *10* of the *European Convention on Human Rights* as given the force of law from the 1<sup>st</sup> October 2000 by the *Human Rights Act 1998*; and provisions of the *Data Protection Act 1998*, implementing *EC Directive 95/46*, in force as from 1<sup>st</sup> March 2000.

*Art.8 European Convention on Human Rights* provides that:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interest of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The applicability of Art.8 to the concept of confidentiality in respect of information disclosed by a patient was noted by the *European Court of Human Rights* in *Z v Finland* (1988) where the Court said that:

The protection of personal data, not least *medical data*, is of fundamental importance to a person's enjoyment of his or her right to respect for private and family life as guaranteed by Article 8 of the Convention ... Without such protection, those in need of medical assistance may be deterred from revealing such

information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even, from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community.

**(N.B.:** In *R v. Dept of Health, ex p. Source Informatics* (2000), the Court of Appeal decided that, at that time, privacy was at the foundation of medical confidentiality).

Undoubtedly, provisions of the *European Convention on Human Rights* have now become of prime importance in underpinning the legal basis of confidentiality. Indeed, the leading case of *Campbell v MGN* (2004) has focused on **Art. 8** (respect for private life) and balanced it against **Art.10** (freedom of expression):

### **Campbell v MGN [2004] 2 AC 457**

The fashion model Naomi Campbell had been photographed leaving a meeting of Narcotics Anonymous. The photographs accompanied an article in the Daily Mirror that praised her fight against drug addiction and gave details about her treatment. In hearing the claim for breach of confidence, it fell to be decided by the House of Lords if her attendances at meetings of Narcotics Anonymous were confidential and, if so, was there a greater (public) interest in protecting the freedom of the press so sanctioning the breach?

**Held:** The majority of the House decided that the time, place and nature of the drug therapy were confidential, hence the taking of the photographs and the publication of the article constituted a breach of confidence. The public interest element involved a ‘balancing exercise’ between the right to a private life, as provided for in Art.8 ECHR and the right to freedom of expression under Art.10 ECHR. First, as Campbell had made public statements proclaiming she did not take drugs, either she had waived confidentiality or, in the alternative, the public interest justified the press in publishing an article to correct Campbell’s misleading statements. However, as there was little public interest in the story, her private life prevailed over the right to freedom of expression. In essence, the breach of confidence occurred because of the publication of the *nature* of the information as opposed to any pre-existing relationship between Naomi Campbell and the newspaper. The relatively small sums she was awarded in damages and aggravated damages came as no surprise given that Baroness Hale had said the case was, in essence, ‘a prima Donna celebrity against a celebrity-exploiting newspaper’.

However, the more significant aspects of the case focus on some of the opinions expressed in the House. For example, in paragraph 17 of the report, **Lord Nicholls** stated:

The time has come to recognize that the values enshrined in **Arts.8** and **10** are now part of the cause of action for breach of confidence.

Moreover, Lord Nicholls was of the opinion that the “essence of the tort is better encapsulated now as *misuse of private information*”. However, if this is equivalent to a breach of an equitable obligation of confidence, it adds nothing.

**Baroness Hale** noted the special nature of medical information, saying:

It has always been accepted that information about a person’s health and treatment for ill health is both private and confidential. This stems not only from the

confidentiality of the doctor-patient relationship but from the nature of the information itself.

Baroness Hale then sought to answer the question of: “ ... the nature of the freedom of expression which was being asserted by [MGN]”. As part of the balancing act (between Arts.8 and 10 ECHR), Her Ladyship noted (at para.157):

The weight to be attached to the various considerations is a matter of fact and degree. Not every statement about a person’s health will carry the badge of confidentiality or risk doing harm to that person’s physical or moral integrity. The privacy interest in the fact that a public figure has a cold or a broken leg is unlikely to be strong enough to justify restricting the press’s freedom to report it. What harm could it possibly do? ... in this case there was, as the judge found, a risk that publication would do harm. *The risk of harm is what matters at this stage*, rather than the proof that actual harm has occurred. Blundering in when matters are acknowledged to be at a ‘fragile’ stage may do great harm.

Art.8(1) ECHR, which recognizes a right to respect for ‘private and family life’ has been interpreted as “the ability to conduct one’s life in a manner of one’s own choosing”: *Pretty v UK* (2002) 35 EHRR 1, para.62

Of course, the rights may be overridden by the provisions of Art.8(2) providing they are “in accordance with the law and .. necessary in a democratic society ...”. This limited infringement is in line with proportionality being recognized as a well-established general principle of European Community (hence English) law. It would seem that this provision also supports the decision in *W v Egdell* (1990) (infra)

{**N.B.** The incorporation of Arts.8 and 10 ECHR into English law has **NOT** meant that English law has developed a tort of *infringement of privacy*: *Wainwright v Home Office* [2004] 2 AC 406 }

## **(II) Medical Confidentiality: An Important but not an Absolute Principle**

There is inconsistency in the approach to medical confidentiality: the moral obligation to maintain a patient’s confidences isn’t always upheld in practice. Confidentiality appears to be an absolute requirement in the *International Code of Medical Ethics* (1949) where it is stated that: ‘A doctor *shall* preserve absolute secrecy on all he knows about his patient because of the confidence entrusted to him.’ Furthermore, as *Mason & McCall Smith* note: ‘Medical confidentiality in France and Belgium is absolute and is protected in the criminal code.’ Indeed, *Gillon* adds:

In France so strict is the obligation of medical confidentiality that it is apparently enshrined in law as an absolute medical privilege which no one, including the patient, is allowed to override, even when to do so would be in the patient’s best interest.

However, the principal ethical codes contain implied qualifications on confidentiality being regarded as an absolute duty of secrecy. The qualification in the *Hippocratic Oath* is: ‘Whatever ... I see or hear which ought not to be spoken of abroad, I will not divulge ...’ which implies that some disclosure is permissible. The same implication may be read into

the *Declaration of Geneva* where a doctor undertakes to: ‘... respect the secrets which are confided in me even after a patient has died’. However, ‘respect’ for a patient’s confidence would appear to be less than a strict duty to maintain it.

17 years ago, instances where it is deemed permissible to break the professional confidence were contained in ‘*Professional Conduct: Fitness to Practise*’ - the *Blue Booklet* - GMC, January, 1993 (subsequently replaced by ‘*Confidentiality: Guidance from the GMC*’. London: GMC, 1995 { See, now, ‘*Confidentiality: Protecting and Providing Information*’. GMC, April 2004}). In the 1993 publication, doctors were permitted to disclose information in the following cases.

1. Waiver i.e. the patient or his legal adviser gives written consent to the publication of the information disclosed.
2. Information is shared with other doctors, nurses or health professionals participating in caring for the patient.
3. Where on medical grounds it is undesirable to seek the patient’s consent, information regarding the patient’s health may sometimes be given in confidence to a close relative.
4. When in the doctor’s opinion disclosure of information to some third party other than a relative would be in the best interests of the patient, the doctor must make every effort to get the patient’s consent. Only in exceptional circumstances may the doctor go ahead and impart that information without the patient’s consent.
5. Information may be disclosed to comply with a statutory requirement, for example notification of an infectious disease.
6. Information may be disclosed where it is so ordered by a court.
7. ‘Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by the police of a grave or very serious crime, might override the doctor’s duty to maintain his patient’s confidence.’
8. Information may also be disclosed if necessary for the purpose of a medical research project approved by a recognized ethical committee.

That there were eight possible exceptions to the principle of medical confidentiality led *Maclean and Maher* to note that: ‘... [they] render the principle of confidentiality ... almost meaningless’. *Siegler* condemned the apparent discrepancy between what medical practitioners preached and what they practised. He was of the opinion that: ‘Confidentiality in medicine is a decrepit concept compromised systematically in the course of routine medical care.’

## **Analysis of the 1993 exceptions updated to 2009**

### **(1) Where a sick patient consents to the disclosure of significant information.**

In its most dramatic form this could be a ‘death bed confession’. A ‘death bed’ confession of whatever nature should be recorded if at all possible and then read over and signed by the patient. Where the patient knows that he is in imminent danger of death, any statement that he makes may be admissible in legal proceedings.

*Kennedy & Grubb* (*Medical Law Text and Materials*, 2/e, 1994) point out, however, that waiver is not really an exception to the obligation of confidence: it is merely a recognition

by the patient that the doctor is no longer under an obligation to keep the confidence since it defeats the *existence* of an obligation. They also note that written consent isn't necessary: that such a requirement simply confuses *proof* with legal *validity*.

## **(2) Information is shared with other doctors, nurses, etc.**

Caring for a hospital patient is, essentially, a 'team responsibility', though the more people who have access to the patients records the more difficult it becomes to maintain the concept of confidentiality. In a survey, *Siegler* was "astonished to learn that at least 25 and possibly as many as 100 health professionals and administrative personnel ... had access to the patient's record and all of them had a legitimate need, indeed a professional responsibility, to open and use that chart". (This led to his describing confidentiality as a decrepit concept). When this finding was reported to the patient whose concern had prompted the enquiry, the patient asked Dr *Siegler* to explain 'just what you people mean by confidentiality'.

## **What information needs to be shared and by whom?**

*Downie and Calman* (*Healthy Respect: Ethics in Health Care*) clearly identify the problems that arise under this heading and note that: 'Clinical practice is concerned with dealing with whole patients, not just the physical problems, but with social, psychological, emotional and spiritual problems. ... [this] ... requires that a team approach is adopted, and that there is communication between members of the team. This raises the fundamental problem of confidentiality in the health care professions: How do you share confidential information without losing trust?' *Downie and Calman* focus on the two areas of control which can effectively prevent breach of confidence: information and people. The first involves four levels of information and the second involves four categories of health care personnel / other people.

### **Levels of information**

Some information relating to a patient is generally freely available to members of a health care team: for example, name and sex. As information becomes progressively more detailed, however, disclosure becomes a matter of clinical judgment. The levels of information are: *Identification*: Name, address, sex, marital status and primary disease.

*Medical information*: Disease, extent of disease, treatment investigations, past medical information, drug information.

*Social information*: Housing, work, family, social relationships.

*Psychological information*: Anxiety, stress, sexual problems, emotional state.

### **The personnel might be categorised as:**

1. Those who must know;
2. Those who should know;
3. Those who could know;
4. Those who shouldn't know.

The lists of levels of information and of personnel indicate what levels of information and by whom information about the individual *might* be shared: it will be a matter of fact and clinical judgment in each case.

This apparent breaking of a patient's confidence seems to depend on the paternalistic assumption that to do so without consulting the patient will be in the patient's best interests. Such a disclosure is a matter of clinical judgment, however. Indeed, in some circumstances a patient might suffer if information known to a doctor wasn't passed on to other health care professionals: for example, if a pharmacist and a nurse weren't told of a patient's allergy to a certain medication or allowed to see a patient's records, they would be unable to ensure that the patient was given the proper medication.

In *R v Dept of Health, ex p. Source Informatics* (2000), the Court of Appeal decided that anonymised patient data that had been obtained by pharmacists and doctors from prescription forms for the purpose of being used in the creation of a database for pharmaceutical companies, did not breach any patient's confidentiality. The reasoning has been heavily criticized, however. Instead of the Court of Appeal basing their decision on the fact that anonymised data<sup>1</sup> would not be against the patients' interests (how could it be if it were anonymised?) they decided that patient privacy was not about to be violated because, *inter alia*, a reasonable pharmacist's conscience 'would not be troubled by the proposed use made of patients prescriptions'. *Mason & Laurie*<sup>2</sup> are very critical of the Court's reasoning, arguing that: "This decision challenges the law of confidence at its very core [since] it shifts the basis of the duty of confidence from the public interest to the question of fairness of use". By contrast, *Stauch, Wheat and Tingle*<sup>3</sup>; *Montgomery*<sup>4</sup>; and *Brazier & Cave*<sup>5</sup> note the decision without making such critical commentary. With respect, it appears that *Mason & Laurie* have exaggerated this 'shift' at the expense of the 'balancing exercise' – the latter being an issue they discussed in detail - and very clearly - in paras.8.21-8.24 of their book.

### (3) Where ... information ... may be given to a close relative

The general rule is that the confidence of an autonomous person who does not consent to disclosure of information must not be breached. However, if (say) the relatives of an elderly patient are to care for that patient eventually, there may be information which they need to know for the patient's own safety. In the circumstances, disclosure might be in the patient's best interests. Whereas this is a debatable point, both *Lord Bridge* and *Lord Brandon* said in *Re F* (1989), in respect of *incompetent patients*, that it would be bad law that prevented such patients being cared for properly simply because they could not consent to it. See now *ss.2-5 Mental Capacity Act 2005*:

- s.2 – a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter ...
- s.3 – an inability to make decisions: in essence, a statutory enactment of the *Re C* (1994) criteria;
- s.4 – determination of a person's best interests ..
- s.5 – acts in connection with care or treatment.

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<sup>1</sup> See the next lecture on the concept of 'Caldicott guardians' in conjunction with the DPA 1998.

<sup>2</sup> *Mason, JK, and Laurie, GT. Mason & McCall Smith's Law and Medical Ethics, 7/e, 2005. Para.8.56*

<sup>3</sup> *Stauch, M, Wheat, K, and Tingle, J. Sourcebook on Medical Law, 2/e. London: Cavendish, 2002, p246.*

<sup>4</sup> *Montgomery, J. Health Care Law, 2/e. Oxford: OUP, 2002, p258.*

<sup>5</sup> *Brazier & Cave, Medicine, Patients and the Law, 4/e. London: Penguin, 2007, p72*

#### **(4) Disclosure to a third party other than a relative . . .**

A simple example under this heading would be the disclosure by a company doctor to his employer of medical information relating to a company employee. This may take the form of a periodical health check on an employee who (say) is frequently exposed to radiation. The report would be a legitimate business communication and any early diagnosis of disease would (hopefully) be in the patient's best interests.

#### **(5) Statutory duties of disclosure**

##### **The general position**

Provisions of statute law requiring notification of certain facts about a patient to be disclosed to the authorities are: *s.269 NHS Act 2006*, which requires each registrar of births and deaths to notify the Primary Care Trust within 36 hours of the birth; and a particularly controversial obligation placed on a doctor is that under *s.172(2) Road Traffic Act 1988* which requires that (s)he has to reveal the identity of a patient treated following a road accident: this is sometimes difficult to equate with the general rule of no obligation being put on a doctor to inform the police of his knowledge of his/her patient's criminal offences - but see (7) below. Note also: the *Abortion Regulations 1991, SI 1991/499, Reg.5, which provides that* . . . any information furnished to a Chief Medical Officer in pursuance of these Regulations shall not be disclosed *except* that disclosure may be made –

- (d) pursuant to a court order, for the purposes of proceedings which have begun; or
- (e) for the purposes of bona fide scientific research; or
- (f) to the practitioner who terminated the pregnancy; or
- (g) to a practitioner, with the consent in writing of the woman whose pregnancy was terminated; ...

#### **(6) Information may be disclosed where it is so ordered by a Court**

*Brazier (Medicine, Patients and the Law)* says: 'The circumstances in which doctors may choose to disclose information about their patients may worry patients and create problems for doctors. The doctors' legal dilemma is solved when the law compels him to disclose information.'<sup>6</sup> She adds: 'Privilege in the sense of being free to refuse to give evidence relating to professional dealings with clients, is something usually enjoyed by lawyers alone and not shared by any other professional colleagues. ... The only protection for medical confidentiality lies in the judges discretion'. (See *D v. NSPCC*):

##### **D v NSPCC [1977] 1 All E.R. 589**

P sought an order to compel the N.S.P.C.C. to disclose who had mistakenly accused her of child abuse.

**HELD:** The order was refused. The public interest in people feeling free to approach appropriate authorities to protect young children outweighed the private rights of the affected party.

#### **(7) A justifiable disclosure in the public interest**

As *Mason & McCall Smith* point out 'the doctor's over-riding duty to society represents what is arguably the most controversial permissible exception in so far as it rests on

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<sup>6</sup> *Brazier, M and Cave, E. Medicine, Patients and the Law*, 4/e. London: Penguin, 2007, p87

subjective definitions’.

The general position is that a doctor knowing that a *criminal* offence has been committed is under no obligation in law to inform the police. The case of *Rice v Connolly* (1966) also illustrates that a doctor need not even assist the police by answering their questions concerning his patients although he must not give false or misleading information.

The major exception to this general rule was provided for in *s.18 Prevention of Terrorism (Temporary Provisions) Act 1989*<sup>7</sup>. s.18 made it an offence for *any person* having information which he believed may be of material assistance in preventing terrorism or apprehending terrorists to fail without reasonable excuse to give that information to the police.

Apart from such exceptional circumstances, then, the position of a doctor is that the criminal law will not penalise him for not informing the police of his knowledge of criminal conduct, whereas if he does inform them he might be in breach of confidence.

However, while a doctor in England and Wales might escape criminal liability, in America the non-disclosure of a patient’s confidence has led to an action in negligence for breach of a duty of care:

**Tarasoff v Regents of the University of California (1976)**

The student medical centre at the University of California was sued in negligence by the parents of a murdered girl, T, for failing to warn T of the risk posed to her by one of their patients, P. P. had confided his intention to kill T in a psychologist employed at the centre. The staff informed the campus police who briefly detained P but then released him when he appeared rational. The medical centre passed no information to T who was murdered by P soon afterwards.

**HELD:** There was a breach of duty to exercise reasonable care to protect T.

*Brazier* (*Medicine, Patients and the Law*, 4/e, pp86-87) is of the opinion that a similar action under English law may *not* succeed. She says:

First the court would have to determine whether in the special circumstances of medical confidentiality a duty to breach confidence could be countenanced. ... The doctor is faced with a stark conflict of duty. If the doctor *may* lawfully breach his patient’s confidence, does he have a duty to do so to safeguard the individual at risk? The courts in England are reluctant in effect to make A liable for a wrong committed by B. ... At the highest the doctor’s duty may be set as an obligation to consider and assess the risk to the third party. The Californian medical staff did their best. They informed the police. The extent of the doctor’s duty to third parties in England would appear to be this. He must not ignore any risk to other people created by his patient. He must weigh his duty to his patient against his duty to society and other individuals. If he acts reasonably on the evidence before him in this most awesome of dilemmas, the court will not penalise him if he ultimately proves to be wrong.

Currently, issues in cases involving AIDS and HIV are amongst the most controversial to be considered as possible disclosures in the public interest:

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<sup>7</sup> See now, *s.19 Terrorism Act 2000*

### **X v Y [1988] 2 All ER 648**

Two doctors were being treated in hospital for AIDS. Their names were passed to a newspaper by a health authority employee. The health authority succeeded in obtaining an injunction to prevent the newspaper publishing details of the doctors. *Rose J* said:

I keep in the forefront of my mind the very important public interest in freedom of the press. And I accept there is some public interest in knowing that which the defendants seek to publish ... But in my judgment those public interests are substantially outweighed when measured against the public interests in relation to loyalty and confidentiality both generally and with particular reference to AIDS patients' hospital records ... The deprivation of the public of the information sought to be published will be of minimal significance if the injunction is granted.

In the second case, however, the applicant was substantially, but not wholly, successful in his application for an injunction:

### **H (A Healthcare Worker) v Associated Newspapers Ltd and N (A Health Authority) [2002] LI Rep Med 210**

H, a healthcare worker, was HIV positive. He obtained an order in the Court of Appeal preventing a newspaper disclosing the identification of the health authority, by whom he was employed, but not of his (H's) speciality, since the risk that such information would reveal his identity was so low as not to warrant a fetter on the freedom of expression enjoyed by the newspaper. (Note: In this case, by contrast with *Campbell v MGN* (2004), the influence of Art.10 ECHR prevailed over Art.8).

At present *AIDS is not notifiable* under the *Public Health (Control of Disease) Act 1984* but the Secretary of State can order hospitalisation and, if necessary, detention of sufferers: *Public Health (Infectious diseases) Regulations 1985; S. I. 1985 / 434*.

### **(8) Breach of Confidentiality for the purpose of a medical research project**

A patient who has failed to respond to 'conventional' treatment may, as a last resort, be given a drug which is on clinical trial / has not previously been used to treat the particular disease from which the patient is suffering. The close monitoring of the patient's condition will determine the drug's (un)suitability for future use. While the intention is to benefit the patient's health, the administration of the drug may well be undertaken without the patient's *informed* consent. Thus the patient's autonomy is ignored in the name of therapeutic privilege. See now: *ss.30-34 MCA 2005*:

*s.30* – explains what is meant by intrusive research;

*s.31* – expresses the requirements to be met for approval to be given to a research project;

*s.32* – provisions on consulting carers, etc;

*s.33* – provisions for additional safeguards;

*s.34* – provisions relating to loss of capacity during a research project.

### **Confidentiality: Protecting and Providing Information. (GMC, April 2004)**

Given that this latest publication merely requires that doctors who are requested to provide

information should: (1)(c) keep disclosures to the minimum necessary; and that they ‘... must always *be prepared to justify* [their] decisions in accordance with this *guidance*’ (my emphasis), there appears to be no reason to think that any of the 1993 ‘approved exceptions’ referred to earlier would no longer command ethical support or to think that they could not be defended in court.

### **Conclusion**

While respect for the principle of autonomy is an ethical concept of fundamental importance, this is not reflected in the duty of medical confidentiality. The concept of confidentiality is ill-defined, having a doctor’s perspective as well as a patient’s perspective. There are instances when autonomy yields to other moral demands, such as the rights of others, and also to legal demands, such as statutory duties of disclosure. These exceptions appear to be specified without being justified.

### **References**

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*Gillon, Philosophical Medical Ethics*, 1986. Chichester: Wiley, Ch.17;  
*Mason & Laurie, Mason & McCall Smith’s Law and Medical Ethics*, 7<sup>th</sup> edn., 2005. Oxford: OUP, Ch.8;  
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*Siegler, Medical Confidentiality - a decrepit concept*, (1982) 302 *New England Journal of Medicine*, 1518;

### **Workshop / Potential Examination Questions**

1. Confidentiality in medicine is a decrepit concept, compromised systematically in the course of routine medical care. (Siegler).

Discuss.

2. To what extent, if at all, do you agree that the equitable obligation of confidence is becoming established as the foundation of the law relating to medical confidentiality and that this trend is to be welcomed?