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Medical Confidentiality against Disclosure in the Public Interest: Should such protective privilege ends when ***public*** peril begins?

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A. Introduction

The integrity of the doctor-patient relationship is based on safeguarding patient's confidential information. ***Medical*** ethics stress the importance of ***confidentiality*** based on the assumption of an individual's right to privacy and on the assumption that the consequences of breaching this right to privacy normally outweigh possible benefits. As stated in the *Hippocratic Oath*, 'All that may come to my knowledge in the exercise of my profession … I will keep secret and never reveal.' However, the duty of ***confidentiality*** is by no means an absolute concept. The patient's ***interest*** in his privacy must be balanced with other potentially conflicting interests. In providing care, ***medical*** professionals often find themselves trapped between conflicting duties and obligations.

B. Definition of *confidentiality*

Confidentiality refers to the legal or ethical duty to keep private the information gathered during the course of a professional relationship. Literally speaking, ***confidentiality*** means to keep secret that is not to be divulged.[1]

C. Justifications for *confidentiality*

Confidentiality serves various purposes in medicine. First of all, ***confidentiality*** gives recognition to patient autonomy. It acknowledges respect for the patient's sense of individuality and privacy. Patient's personal, physical, and psychological secrets are kept confidential in order to decrease the sense of shame and vulnerability that would surface if the information would be revealed. Secondly, ***confidentiality*** protects doctors' integrity, which is important in improving the patient's health. ***Confidentiality*** permits individuals to trust that information given to their doctors will not be dispersed further. In doing so, communication will become honest and straightforward. Gillon aptly said that 'if patients did not believe that doctors would keep their secrets then either they would not divulge embarrassing but potentially medically important information, thus, reducing their chances in getting the best ***medical*** care.'[2] In many psychiatric cases, ***confidentiality*** is essential to psychiatric treatment. Without the assurance of complete secrecy, patients would be less inclined to enter treatment and those already in therapy would be unwilling to disclose important material. Therefore, violating ***confidentiality*** would seriously affect the care of the mentally ill, to the detriment of patients and society alike.

D. The Duty of *Medical Confidentiality*

Medical professionals are generally obligated to hold in confidence information obtained about their patients. The source of this obligation can be found in the common law, principles of equity, various statutory provisions, and in the ethical codes governing health care professionals. The *International Code of* ***Medical*** *Ethics* mentions that 'a doctor shall preserve absolute secrecy on all he knows about his patients because of the confidence entrusted in him.' Similarly, the *Declaration of Geneva* requires doctors to promise to 'respect the secrets that have been confided in me, after the patient has died'. Similarly, under the *Malaysian* ***Medical*** *Council Code of Professional Conduct*, the ethical duty of can be found in *paragraph 2.22 on Abuse of Confidence* which states that '[a] practitioner may not improperly disclose information which he obtains in confidence from or about a patient.'[3]

At common law, the duty of ***confidentiality*** can be found in both contract law and in tort law. Every contract between a patient and ***medical*** professional gives rise to an implicit agreement that the professional will preserve the patient's confidences, and breach of this obligation could give rise to an action for breach of contract. A patient may also have a remedy in the tort of negligence ***against*** a ***medical*** professional, if negligent ***disclosure*** of confidential information gives rise to some foreseeable injury to the patient. In *AG v Guardian Newspapers (No 2)*,[4] Lord Goff stated that '… a duty of confidence arises when confidential information comes to the knowledge of a person (the confidant) in circumstances where he has notice, or is held to have agreed, that the information is confidential, with the effect that it would be just in all the circumstances that he should be precluded from disclosing the information to others…'. His Lordship further added that there are several limitations to this duty. The first limitation is that 'the principle of ***confidentiality*** only applies to information to the extent that it is confidential.'[5] Thus, once the information has entered the ***public*** domain, it can no longer be regarded as confidential. The second limitation is that 'the duty of confidence applies neither to useless information, nor to trivia…'.[6] The third limitation is of far greater importance and is basically the subject-matter of this paper. Although the duty of ***confidentiality*** protects ***public interest*** but the duty can be overridden by 'some other countervailing ***public interest***, which favours ***disclosure***.'[7]

E.Justifications for breaching *confidentiality*

As mentioned by Lord Goff, the duty of ***confidentiality*** is not absolute. The law recognises several justifications for breaching the duty of ***confidentiality***. The justifications include:

i. *Disclosure* with patient's consent

Patient may give express or implied consent. To give a legally valid consent, patient must have the mental competence,[8] sufficient understanding of the treatment proposed[9] and by with their own free will. It other words, there must not exist any duress or undue influence.

ii. *Disclosure* allowed by statutes

A number of statutory provisions provide for the ***disclosure*** of information by ***medical*** practitioners. There are several legislations in Malaysia that requires ***medical*** practitioners to disclose patient information to the relevant authorities, for example, the Prevention and Control of Infection Diseases Act 1988 (Act 342),[10] the Poisons Act 1952 (Act 366)[11] and the Criminal Procedure Code (FMS Chapter 6).

iii. *Disclosure* in the *public interest*

Public interest includes matters which affects the life and even the liberty of members of the society.[12] If it can be shown that the ***public*** has serious and legitimate ***interest*** in the ***disclosure*** then it may be demonstrated that there is a just cause or excuse in breaking confidence. The importance of secrecy is weighed ***against*** the ***public interest*** in ***disclosure***. ***Public interest*** was raised as a defence in the case of *X v Y*[13] which concerned doctors who were believed to be continuing in practice despite having developed Acquired Immune Deficiency Syndrome (AIDS). The court held that the ***public interest*** in preserving the ***confidentiality*** of hospital records identifying actual or potential AIDS sufferers outweighed the ***public interest*** in the freedom of the press to publish such information because victims of the disease ought not to be deterred by fear or discovery from going to the hospital for treatment. Furthermore, free and informed ***public*** debate about AIDS could take place without publication of the confidential information. Amongst other examples of ***public*** interests, which may outweigh the competing ***public interest*** in maintaining confidences are ***disclosure*** in the interests of national security, ***disclosure*** to prevent harm to third party and ***disclosure*** to prevent crime. For the purposes of this article, discussion will be restricted to the last two examples.

(a) *Disclosure* to prevent harm to third party

Medical professionals including psychiatrists may, at times, find it necessary to reveal confidential information disclosed by the patient in order to protect the patient or third parties from imminent danger.

Although this area has not been thoroughly explored by the English and Malaysian courts, there are several American cases,[14] which have held that a positive legal duty was owed to a third party in such a circumstances. In these cases, it was decided that the harm sustained by the third party outweighs the duty of ***confidentiality*** owed by the doctor to the patient. In the landmark case of *Tarasoff v Regents of the University of California*,[15] a student, Prosenjit Poddar, was receiving outpatient psychiatric treatment at the University California Hospital. He has been pathologically obsessed with Tatiana Tarasoff, a student he had met at a dance. Poddar had tape-recorded conversations with the Tarasoff and spent hours replaying the tapes in order to ascertain her feeling for him. He informed his therapist, Dr Gold, an employee of the University of his fantasies of harming, and perhaps even killing Tarasoffs. Dr Gold informed the campus police of Poddar's intentions and police detained him temporarily for questioning. Dr Gold however, did not warn Tarasoff or her family members of Poddar's intentions. After Poddar's release, he stabbed Tarasoff to death. Tarasoff's parents sued Dr Gold and the University in negligence claiming that Dr Gold had a legal duty to warn Tarasoff of the threat by Poddar. It was held by the Supreme Court of California that a duty was owed to the Tarasoffs; in the circumstances the ***confidentiality*** due to the patient was outweighed by the duty to the third party. Mr Justice Tobriner delivering the majority opinion said:

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim ***against*** such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to appraise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.[16]

This phrase in Mr Justice Tobriner judgment has the effect of imposing a positive duty of doctors towards third parties. Mr Justice Tobriner further held that the existence of such duty depends on the existence a special relationship between the doctor and the dangerous person or to the potential victim. Since the relationship between a therapist and his patient satisfies this requirement, this is sufficient to create a duty to exercise reasonable care to protect a potential victim of another's conduct.

The decision in *Tarasoff* has two major criticisms. Firstly, the doctor has to assess the seriousness of the patient's mental problem and this will lead to the unreliability of predicting future violence. Secondly, this decision obviously damages the doctor and patient relationship with regards to the duty of ***confidentiality***. However, it is widely felt in America that the existence of serious danger to others outweighs the violation of the duty of ***confidentiality*** as 'the protective privilege ends where the ***public*** peril begins.'[17]

The English courts have treated imposing a duty to control the actions of a third party with hostility. For instance, in the case of *Hill v Chief Constable of West Yorkshire,*[18] the mother of Peter Sutcliffe's last victim claimed damages ***against*** the Chief Constable in whose area most of the offences had taken place, claiming that the police had failed to exercise reasonable care in their investigations. The basic issue that arose before the court was whether the police owed a duty to a member of the ***public*** who suffered injury through activities of a criminal. The court held that such duty does not exist unless there is a special relationship between the parties, which is over and above ordinary relationship based on foreseeability. In arriving at this decision, the court approved its earlier decision in *Home Office v Dorset Yacht Co Ltd*,[19] where some Borstal boys who were under the supervision of prison officers while camping on an island off which yachts were moored, boarded and damaged one of the vessels. The House of Lords held that the Home Office were liable as there was a special relationship between the officers and the boys, by virtue of which the officers were responsible for controlling the individuals in their charge. The court in *Hill* felt that such special relationship that was present in *Dorset Yacht* was clearly lacking in the former case, as Peter Sutcliffe was not under police custody at the time of the killing. However, the court in *Dorset Yacht* did not delve deeply into the meaning of 'control' so as to determine the existence of a special relationship. Does control mean having physical custody of the person or is it sufficient if one is able to influence or sway another's thoughts and actions? This question is still left unanswered by the English courts, as Peter Sutcliffe was not under police custody

at that time. On the other hand, supposing the Sutcliffe had been under therapy at that time and had informed the therapist of his plan to kill, a scenario, which is similar to *Tarasoff*, how would the English courts have reacted? Looking at the English courts close guarded principle of foreseeability and proximity, it seems at the very least, that in order to impose liability, an identifiable victim would be an essential requirement together with a special distinctive risk in relation to the victim, which ought or have been foreseen by the defendant.

Protecting third parties even if no potential crime is threatened

In *Re C (A Minor) (Evidence: Confidential Information)*[20], the English Court of Appeal had to deal with a novel point of law by considering whether it is necessary to protect third parties even though there is no threat of harm. This case involved the proposed adoption of a one year old baby. The mother withdrew her consent a day before the adoption hearing. At an adjourned hearing, the adopting parents' solicitor produced an affidavit sworn voluntarily by the mother's GP, containing evidence of her mental condition and fitness to bring up a child. The mother objected to the admissibility of the evidence as it was a breach of ***confidentiality***. She was unsuccessful in the lower court and appealed. Sir Stephen Brown, delivering the leading judgment, called this an unusual case and opined that the case rests on its own very special facts. Although there was no previous authority directly in point, the court held that no breach of confidence had taken place. Sir Stephen Brown stated that:

> … I believe that a judge, if carrying out some balancing exercise, would be fully justified in coming down clearly in favour of admitting the evidence. It should also be recognised that the ***disclosure*** of the material contained in this affidavit was the subject of a restricted ***disclosure***. It was being made available only to the judge who had to decide the application, and to those who were also bound by the ***confidentiality*** of the hearing in chambers. Accordingly, I have no hesitation in reaching the conclusion that the judge was correct to rule that this evidence was admissible and that it should be admitted.[21]

(b) *Disclosure* to prevent crime.

Disclosure may be justified on the basis of the need to protect those at risk of death or serious harm. The protection of ***public*** from crime was considered in *W v Egdell*,[22] which provides an interesting insight into the dilemma faced by the court in such situation. In 1974, W shot four people and drove off in his car throwing out homemade bombs. Later that day he shot two others. Five of his victims died and two other required major surgery. He pleaded guilty to manslaughter on the grounds of diminished responsibility. He was diagnosed as suffering from paranoid schizophrenia. He was ordered to be detained in a secure hospital indefinitely and could only be released by the order of the Home Secretary if he was found to be no longer a danger to ***public*** safety. In 1984, W made an application to a mental health tribunal to review his condition and hope that this will lead to an early discharge. Dr Egdell, a consultant psychiatrist, was asked by W's solicitors to prepare a psychiatric report on W. After examining W, Dr Egdell's opined that W is still highly dangerous and showed persistent ***interest*** in explosives. Upon receiving the report, W's solicitors withdrew his application to the mental health review tribunal. However, Dr Egdell believed that the contents of his report should be made available both to the ***medical*** director of the hospital that was caring for W and the Home Office. This is to warn those who are involve in caring for W at the hospital and to ensure that the ***public*** was in no way endangered by his early release. W applied to the court for an injunction preventing the ***disclosure*** of the report by Dr Egdell. The Court of Appeal refused to prevent ***disclosure*** of the report and held that ***public interest*** justified ***disclosure*** to the ***medical*** director and the Home Office. The report contained the dangerousness of W that is not known to many. To suppress it would have prevented material relevant to ***public*** safety from reaching the authorities responsible for protecting it. It was in the ***public interest*** to ensure that they took decisions on the need for such protection on the basis of the best available information. Bingham LJ remarked that balance should be struck between the ***public interest*** in maintaining professional confidences and the ***public interest*** in protecting the ***public against*** possible violence. He aptly said that:

> The breach of such a duty [of ***confidentiality***] is…dependent on circumstances … the law recognises an important ***public interest*** in maintaining professional duties of confidence but the law treats no such duties as absolute …. [it can] be overridden where there is held to be a stronger ***public interest*** in ***disclosure*** …. Dr Egdell did act in accordance with the law and his conduct was necessary in the ***interest*** of ***public*** safety and the prevention of crime.'[23]

The '***public interest*** defence in the prevention of crime' discussed was upheld by the Court of Appeal in *R v Crozier*.[24] In this case, a psychiatrist, instructed by the defendant in an attempted murder case, disclosed his report to the prosecution, when he realised that the defence has not produced it in court. As a result, the sentence of imprisonment of nine years was quashed. Instead, the judge made a hospital order.

The implication of these cases is that, in exceptional circumstances, the duty of ***confidentiality*** could be breached. However, for ***disclosure*** to be lawful, there must be an overwhelming ***public interest*** in ***disclosure***. A real and serious risk of danger to the ***public*** must be shown before the ***public interest*** exception is made out and the ***public interest*** exception can only justify ***disclosure*** so long as the threat persists.

Position in Malaysia

Given the lack of legal precedents in this area in Malaysia, the scope of the legal duty of psychiatrists with regards to ***disclosure*** of information is difficult to ascertain. Under the Malaysian law, the only privileged communication is as prescribe in the Evidence Act 1950.[25] For example, s 126 of the 1950 Act states that 'no advocate shall at any time be permitted, unless with his client's express consent, to disclose any information that he has obtained from his clients for the purpose of his professional employment.' However, the 1950 Act does not contain any section protecting the ***confidentiality*** of communication between the doctor and his patient. Despite this, the law does recognise the ethical duty of ***confidentiality*** between the doctor and his patient but compels ***disclosure*** if ***public interest*** demands it. For instance, W v Egdell has been applied in ***Public*** *Prosecutor v Dato' Seri Anwar bin Ibrahim & Anor*,[26] where the court held that there is no privilege under the law for a doctor to refrain from disclosing what transpired between him and his patient.[27] In this case, the court held that Dr Fadzil did not commit a breach of his duty of ***confidentiality*** when he disclosed what transpired between him and his patient, Sukma. He concluded that Sukma was suffering from a mental depression due to biological factors and family background. He further disclosed that Sukma told him that he had homosexual relationship with his adopted brother and his business partner although he did not disclose the identity of these two persons.

Conclusion

Striking a balance between the legitimate interests of the community and the rights of individuals is always problematic. No set of rules could completely address many complex issues facing the ***medical*** profession. The law must strike the difficult balance of protecting the rights and interests of the individual person while also maintaining the safety and interests of the ***public*** at large or any others who may be affected by the actions of individuals. The greater the potential harm to the ***public***, the greater the pressure to curb the actions of an individual. It is a matter of fine balancing, but at the end of the day, the law must ensure that any 'protective privilege should end where ***public*** peril begins.

[1] The *British* ***Medical*** *Association* defined '***confidentiality***' as 'the principle of keeping secure and secret from others, information given by or about an individual in the course of a professional relationship.'

[2] Gillon R, 1986. *Philosophical* ***Medical*** *Ethics*, Chichester: John Wiley at p 108.

[3] Paragraph 2.2.1 on *Abuse of Trust* of the Code states that 'Patients grant practitioners privileged access to their homes and confidences and some patients are liable to become emotionally dependant upon the practitioner. Good ***medical*** practice depends upon the maintenance of trust between practitioners and patients and their families, and the understanding by both that proper professional relationship will be strictly observed. In this situation practitioners must exercise great care and discretion in order not to damage this crucial relationship. Any action by a practitioner which breaches this trust may raise the question of infamous conduct in a professional respect.

[4] [1990] AC 109 at p. 281.

[5] *Ibid*.

[6] Id.

[7] Id.

[8] To be mentally competent, they must have reached the age of majority and of sound mind.

[9] The consent must be informed in nature.

[10] Section 10(2) requires ***medical*** practitioners to provide information of infectious diseases to the nearest ***Medical*** Officer of Health in the prescribed form.

[11] See ss 21(2), 23(2) and 24; Regulations 19 and 20 of the Poisons (Psychotropic Substances) Regulations 1989.

[12] See Stephen de Bate, 'A Mole's Charter?: A Review of Recent ***Public Interest*** Defence Cases' 1987 84:14 *Law Society's Gazette*, at p 1048.

[13] [1988] 2 All ER 648.

[14] Egs are *Tarasoff v Regents of University of California* (1976) 551 P 2d 334; *Lipari v Scars Roebuck and Co* (1980) 497 F Supp 185; *Jablonski v United States of America* (1983) 712 F 2d 391.

[15] *Ibid*.

[16] Id, at p 340.

[17] Mackay, RD, 'Dangerous Patients, Third Party Safety and Psychiatrists' Duties - Walking the Tarasoff Tightrope' (1990) 30 Medicine, Science and the Law 52, at p 53.

[18] [1988] 2 All ER 238.

[19] [1970] 2 All ER 294.

[20] *(1991) 7 BMLR 138*.

[21] *Ibid* at p 143.

[22] [1990] 1 All ER 835.

[23] *Ibid* at pp 851-852.

[24] (1990) The Independent, 11 May.

[25] Sections 121-127 and s 129.

[26] *[2001] 3 MLJ 193*.

[27] In *PP v Haji Kassim [1971] 2 MLJ 115*, the Federal Court held that the privilege excluding professional confidence in s 126 of the Evidence Ordinance 1950 does not protect professional ***disclosures*** made to clergymen or doctors.

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