

Law and Ethics in Medicine

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The Doctor's Duty of Confidentiality: Separating the Rule from the Expectations

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Introducing Law and Ethics in Medicine

Welcome to the *UTMJ's* new series, Law and Ethics in Medicine. This section is intended to serve as an introduction to legal and ethical issues in medicine. It will feature articles from experts in the field, as well as from medical students and trainees. One issue will be devoted to answering questions from readers. The goal of this series is to clarify important legal and ethical issues before they become concerns at the bedside. Please direct any comments, questions, or suggestions regarding this column to the Series Editor, Law and Ethics in Medicine at the following e-mail address: editors.utmj@utoronto.ca.

About the Author

We start this series with an article that deals with one of the most important legal issues in a physician's professional life: the issue of confidentiality. We are pleased to be able to open this series with an article by Professor Bernard Dickens, one of the world's leading experts in medical law.

Bernard M. Dickens, LL.B., LL.M., Ph.D. (Law-Criminology), LL.D. (Medical Jurisprudence) (London), Fellow, Royal Society of Canada, was called to the English Bar in 1963 and to the Ontario Bar in 1977. He is a Professor in the Faculty of Law, the Faculty of Medicine, and the Joint Centre for Bioethics. Professor Dickens specializes in Law and Medicine, and has taught at the College of Law in London and Columbia University, New York, in addition to the University of Toronto.

Professor Dickens is legal articles editor of the *Journal of Law, Medicine and Ethics*, as well as the co-editor of ethical and legal issues of the *International Journal of Gynecology and Obstetrics*. He also serves as a member of the editorial boards

of several journals including the *American Journal of Law and Medicine*. He has been involved in a wide variety of organizations in the field of medical jurisprudence. He was Project Director to the Ontario Law Reform Commission's Project on Human Artificial Reproduction and Related Matters. He has been a consultant on several projects of the World Health Organization including co-authorship of *Considerations for Formulating Reproductive Health Laws* (Geneva: World Health Organization, 1998), and he is currently working on issues in organ transplantation and tuberculosis control.

His writings include over three hundred publications including books, chapters in books, articles, and reports primarily in the field of medical and health law. In 1990-91, he was President of the American Society of Law, Medicine and Ethics. From 1994, he has been on the Board of Governors of the World Association for Medical Law, becoming a Vice President in 1996. He is a Fellow of the Royal Society of Medicine (London), Chairman of the Human Subjects Research Ethics Review Committee of the University of Toronto, and immediate past Chairperson of the Research Ethics Board of the National Research Council of Canada.

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Abstract

The legal duty to maintain patients' confidentiality is central to lawful and ethical medical practice. Exceptions to the rule of confidentiality are few, but tend to be given such emphasis that medical students may believe they are as significant as the rule itself. Courts excuse breach of confidentiality only when there is immediate danger to life or grave danger to continuing health. Privacy and confidentiality are distinguishable. Those who receive private information, whether volunteered by the patient or under mandatory reporting legislation, are bound by the legal duty of confidentiality.

The Duty of Confidentiality

The duty of the doctor strictly to guard private information about a patient is so fundamental in law and in medical ethics that in principle it requires little repetition. The Hippocratic duty to maintain patients' confidences and the foundational ethical duty of doctors to Do No Harm to their patients combine to prohibit a doctor from engaging in negligent and, even more, deliberate disclosure of a patient's confidential information to anyone outside the circle of those responsible for the patient's therapeutic care. Doctors have faced professional misconduct charges for publicizing information even about other doctors' patients, for discussing their identifiable patients with their own spouses, and for improperly discussing patients' conditions with the patients' family members.

The duty to maintain strict confidentiality is so clear in medical ethics and law that modern cases add little to its emphatic nature. Interest in modern cases arises from the exceptions or limits they present. Unfortunately, this exposes newcomers to medical professional ethics to the risk of distortion. Medical literature may so focus on the few exceptions to the rule of strict confidentiality that medical students fail to grasp the central significance of the rule to professional responsibility. They mistakenly believe that the rule is evenly balanced against exceptions, and that any use they feel entitled to make of patients' confidential information, perhaps in the public interest, is as likely to be covered by an exception as it is to be prohibited by the rule.

In 1992, the Supreme Court of Canada established that doctors and hospitals do not own their patients' information, even when they own the paper, computer system or other material or means that contain it. In *McInerney v. MacDonald*,¹ the Supreme Court demonstrated that though doctors may possess their patients' medical and other information, they do not own it. They serve as trustees who possess information only for their patients' benefit. They must use it properly to advance patients' care and best interests, such as in seeking necessary specialists' opinions, but are not free to disclose it otherwise unless they have patients' adequately informed and freely given prior consent.

Disclosure Among Health Care Professionals

The Supreme Court described the relationship between a doctor and a patient as being fiduciary in nature. That is, doctors are legally obliged to treat patients' medical and other information conscientiously in patients' best interests. They are not free to serve some public or social purpose they favour, however worthy it may be in itself, by releasing information they have acquired about patients. They are similarly not free to serve their own interests, for instance in earning fees from investigators, drug companies or other sponsors of studies, by disclosing identities of patients they know who meet study inclusion criteria. Universities, hospitals and professional licensing authorities consider receipt and payment of finders' fees to constitute serious misconduct, unless patients give informed and free consent in advance to this exploitation of their data.

Patients expect, and the law requires, that relevant information will be made available to all members of a patients' health care team. Patients' consent to this disclosure is an element of their consent to care. Courts recognize the role that the modern medical record serves in a patient's care, and observe how medical and related specialization feeds information into the medical file from a wide array of medical specialists and consultants, nurses, medical technologists, allied health personnel such as social workers, psychologists, perhaps hospital chaplains and health facility administrators. The patient's record provides the means by which health care professionals communicate about the patient with each other, and also with others the patient expects to have access to it in order to advance the patient's health and related interests.

Each of those who have access to the patient's record in order to discharge their legal and ethical duties to the patient is bound by duties of confidentiality. When a patient in a teaching hospital agrees to receive health care services from a medical student, the patient expects the student to be aware of the professional duty of confidentiality, and to observe it strictly as part of supervised training. While students may discuss cases with each other and instructors for advancement of students' knowledge and experience, they must be vigilant to guard identities of patients from whose care the students have acquired their information. In contrast, they may discuss personal details of an identified patient's best clinical care with others who share clinical responsibility for the patient's well-being, since this falls within the scope of the patient's implied consent.

Exceptions to Confidentiality

Because legal exceptions to the duty of confidentiality are very rare, the few instances in which a legal exception has been allowed gain wide publicity, in the medical profession, in the medicolegal literature and sometimes in popular newsmedia. This tends to make an exception well-known and commonplace, risking newcomers to medical confidentiality gaining the distorted impression that the exception is pervasive and widely available. In law, however, the exception rests on the very narrow excuse of necessity to save human life or to prevent serious, imminent harm. Even when allowed, necessity is not

a justification for breach of confidentiality. It does not justify a breach in the sense of making it just or right, but recognizes the breach as a wrong that may be excused and not punished. When a court of law finds that the wrong of breach of confidentiality may not warrant punishment, however, a medical professional licensing authority or association may nevertheless impose disciplinary sanctions for the misconduct.

The leading case in which breach of confidentiality was found excusable is the well-known 1976 *Tarasoff* case.² This concerned a patient who disclosed to his therapist an intention to kill a girl, and subsequently killed her. In a claim brought on behalf of her estate and family, the therapist and clinic sponsor, the University of California, were found liable for not providing necessary protection. The judgment of the California Supreme Court was that:

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 apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

The duty is not limited to psychotherapists, but applies to any practitioner who, according to “the standards of his profession,” believes a patient to pose “a serious danger of violence to another.” The duty is sometimes expressed as a duty to warn, but giving an identified victim due warning is only one option to discharge the duty “to use reasonable care to protect” foreseeable victims. When future victims are not individually identifiable, such as when a patient threatens violence against a class of persons, notice to the police will usually be appropriate.

The court in the *Tarasoff* case expressed the principle that “The protective privilege [of patients’ confidentiality] ends where the public peril begins,” showing that patients have no legally protected right to inflict violence or peril on others. It may be observed, furthermore, that protecting prospective victims against suffering violence also serves patients’ best interests in protecting them from legal consequences of causing it. The patient in *Tarasoff* was convicted of second degree murder, and later found not guilty by reason of mental disorder. However, where patients have legally protected rights to follow lawful pursuits that may be obstructed if others gain private medical or other information about them, no breach of confidentiality is permissible even in the best interests of others or of society in general.

Mandatory Reporting Laws

Enacted legislation may compel doctors to give particular information about their patients to others, without patients’ consent. Laws on public health, for instance, such as Ontario’s

Health Protection and Promotion Act, require patients with identified communicable diseases to be reported to the local Medical Officer of Health. Highway traffic legislation requires a doctor to report to traffic licensing authorities the name, address and clinical condition of anyone whose health makes it dangerous for him or her to drive, and child welfare legislation creates a duty for doctors and others to report suspected child abuse to a children’s aid society or other provincial child protection authority. Further, the provincial College of Physicians and Surgeons can require access to records for audit and disciplinary purposes.

This legislation limits privacy, but not necessarily confidentiality. “Privacy” and “confidentiality” are often considered synonymous, but they are distinguishable. Privacy involves the right to limit access to one’s health information, but confidentiality comes into effect only after that information has been obtained by another person or by an agency. People give up some of their privacy when they receive health care and other services, because the care they require cannot be properly planned or delivered unless those responsible for its provision have the information they need, for instance a person’s symptoms, history, characteristics, behaviour and lifestyle. However, those who receive this private information, including those to whom the patient voluntarily surrenders it and those who receive it under mandatory reporting laws, bear legal and ethical duties of confidentiality. Recipients of this private information may use it only for agreed purposes, whether by explicit or implied agreement of the patient or as agreed by the legislature that enacts reporting legislation.

Ordinarily, patients receiving or seeking therapy must be asked whether they agree that their identifiable information can be used for nontherapeutic purposes, such as research. If for any reason they cannot be asked in advance, a research ethics board may have to decide whether a particular research use of identifiable data falls within the scope of a patient’s implied consent. Recipients of information under mandatory reporting laws may use it for the purposes for which they receive it, and may release aggregated but not identifiable data, but other recipients may be more limited. For instance in May 1999, a judge in England upheld the Department of Health’s statement that it was a breach of patients’ confidentiality for doctors and pharmacists to give patients’ anonymous, aggregated data to a data collecting company that would sell data on doctors’ prescribing habits to drug companies. The breach of confidentiality consisted in using patients’ information for a purpose other than that for which it was given.

A Case Study

A March 1999 judgment of the Supreme Court of Canada illustrates the immense caution that must be exercised before a doctor may lawfully break medical confidentiality. Named by pseudonyms, the case indexed as *Smith v. Jones* arose when a lawyer acting for a man accused of aggravated sexual assault of a prostitute referred him to a psychiatrist for a forensic assessment. During assessment, the man described a detailed plan he

had begun to implement to kidnap, assault and murder a prostitute, as a "trial run" for a series of subsequent kidnappings and murders. The psychiatrist diagnosed a paraphiliac disorder manifested by sexual sadism, personality disorder, antisocial disposition and drug abuse, and concluded that the accused man was dangerous and likely to commit future serious offences unless he received sufficient treatment. The man pleaded guilty to the offence with which he was charged, so there was no evidence presented in court of his actions or personality, and the lawyer did not introduce the psychiatrist's report at the sentence hearing.

The psychiatrist was very concerned that, on release after completion of sentence, the accused man would be a danger to the public. However, rather than risk legal and professional liability for taking the information the accused had given him, and the conclusion he had reached, to the police, the psychiatrist wisely initiated his own legal proceedings for a judicial declaration that he was entitled to disclose his information to the police. In a hearing behind closed doors, the British Columbia trial judge granted the declaration, but sealed the Court file against any disclosure, pending an appeal. The provincial Court of Appeal also permitted, but did not require, disclosure to police authorities, but kept the court file sealed until final appeal to the Supreme Court of Canada, where proceedings were conducted in open court, subject to a publication ban.

The Supreme Court recognized that the issue did not concern a therapeutic doctor-patient relationship, since the conduct of the forensic assessment imposed no treatment responsibilities upon the psychiatrist, but it was closely comparable. The Court observed that the integrity of lawyer-client relationships is fundamental to the protection of the public interest in the due administration of justice. Accused persons must be able to speak freely with their lawyers, in the same way that patients must be able to speak to their doctors, secure in the knowledge that what they say will not be divulged without their consent. They must be equally secure that information they are advised to provide to specialists for purposes of their defence will not be disclosed without their approval. The Court found that any exception to the protection of this confidentiality applies to all confidential relationships, such as arise in a therapeutic doctor-patient relationship. Public interest or even protection against unspecified risk will neither justify nor excuse breach of fundamental confidentiality, such as secures clients in dealings with lawyers and patients in dealings with doctors.

The Court ruled, however, that danger of a particularly serious and imminent nature might excuse breach of confidential relationships. The three conditions for this exception are that:

1. There is clear risk to an identifiable person or group of persons;
2. The risk is of serious bodily harm, including serious psychological harm, or of death; and
3. The danger is imminent.

The Court agreed with the lower courts that all of these conditions were satisfied in this exceptional case. Nevertheless, disclosure should be limited as much as possible. Its scope should be restricted to essential information, and only those who need to be informed for purposes of protection should be informed. In this case this meant notifying the police, but in the *Tarasoff* case notification would be allowed only of the girl at risk or her immediate family.

The lessons of the case concern the conditions for breach of confidentiality, and, more particularly, the care the psychiatrist took in ensuring that the disclosure he wanted to make would be lawful. This presents a helpful model of the care with which doctors should treat any incentive they may have to violate medical confidentiality. Confidentiality remains fundamental not only to professional conduct, but also to patients' rights to appropriate medical care. Its compromise is excusable only in the most extreme of circumstances. It is never too early for medical students to learn this lesson.

Disclosure to Patients of Their Own Records

It is no breach of confidentiality that patients are legally entitled to know all of the contents of their own medical records. The Supreme Court of Canada affirmed in 1992 that doctors who possess the information are trustees, and so bound in principle to follow directions of the patients whose information they possess. This is so even when a doctor possesses information obtained or concluded by other doctors, such as those previously responsible for a patient's care.

Patients can accordingly direct that information in their medical records be made available to themselves or to others they identify, such as prospective employers. However, this right of patients does not compel doctors to hand patients their medical files. Doctors must always retain patients' records, in case access to them is required suddenly, such as for patients' emergency care. Copies of raw data in files need not be handed over either, since patients may not understand what is written or, worse, may harmfully misunderstand. Doctors may discharge their duty to afford patients access to the information in their records by answering patients' questions honestly, or by making copies available to others the patients elect who can tell them what the records show, and what the records mean. How patients are given their own information raises legal issues not of confidentiality, but of negligence.

References

1. *McInerney v. MacDonald*, (1992) 2 Supreme Court Reports 138 (Supreme Court of Canada).
2. *Tarasoff v. Regents of the University of California* (1976) 551 Pacific Reporter 2d 334 (Supreme Court of California).
3. *Ibid.* at 340.
4. *Ibid.* at 347.
5. *R. v. Department of Health ex p. Source Informatics Ltd.* (1999) Lloyd's Law Reports, Medical 264 (High Court, Queen's Bench Division).
6. *Smith v. Jones* (1999), 169 Dominion Law Reports (4th) 385 (Supreme Court of Canada).
7. *McInerney v. MacDonald*, note 1 above.