

'If a doctor believes that his patient presents a danger to others, he should be allowed to warn those who might be at risk. But he is not, and should never be, duty-bound to do so.' Consider and discuss analytically the preceding statement. Your answer should make reference to case law. Your essay should be approximately 5,000 words in length.

CONFIDENTIALITY

1. Introduction

American university student Cho Seung-Hui only last week calmly walked through his Virginia Tech campus shooting randomly at his loathed fellow students and professors pausing only to post his tirade on the World Wide Web. Clearly troubled and depressed as long ago as 2005 his "sullen and aggressive behavior culminated in an unsuccessful effort by the campus police to have him involuntarily committed to a mental institution."¹ A local judge then signed an order referring Cho to the local psychiatric hospital for assessment stating that at that time he clearly presented "an imminent danger to self or others"²

However the hospital psychiatrist determined that Cho, although clearly depressed, he was of sound insight and judgment, on this basis the judge did not commit Cho but referred him instead for outpatient appointments. Shortly later it is believed that the concerns of a literature professor combined with the reported harassment claims by two female students may have attracted the attention of the Virginia Tech Counseling centre, which employs eleven psychiatrists. The Director of the centre Dr Flynn refuses to discuss the details of the gunman's case. If Cho had indeed sought advice and if his psychiatrist had, divined as clearly as the judge that he had the potential to present a danger to others - in particular his fellow students, the rich kids he hated - he or she clearly did not feel duty bound to inform either the university or police authorities about his mental state. If a psychiatrist in the UK were to find himself in this position, should he be expected to have confidence enough to forego the ethical concept of patient confidentiality in order to report his findings to the authorities, or should he in fact be compelled to report his patient by virtue of statute? This essay will explore the concept of confidentiality within the patient physician relationship; ascertain when the patient is right to expect that his confidences will be met and the circumstances of any exceptions to the general rules. Using case law I will examine the ethical moral and legal position presented by the physician who finds himself in possession of patient information that may indicate a possible harm or danger to the health and or safety of third party(ies), how the current common law duty of confidentiality facilitates the reporting of such information and evaluate the merits of developing the law to facilitate the future imposing of a statutory duty on the doctor.

¹ New York Times April 19th 2007 www.nytimes.com/2007/04/19/us/19gunman.html

² *ibid*

2. Sworn to Secrecy?

“All that may come to my knowledge....which ought not to be spread abroad, I will keep secret” It would be fallacious to assign the medical profession an automatic moral underpinning deriving from their much fabled swearing of the Hippocratic oath. Lacking legal authority this declaration was originally a mere commercial tool employed by the Ancients to instill confidence in the first Roman, Greek and Medieval European medical practitioners, providing same with a higher earning capacity than their sorcerer competition, whose services were often proffered free of charge³. This was one of the earliest recorded examples of the modern marketing strategy of “added value” - increasing the income of the medical practitioners and thereby aiding in the ongoing recruitment drive.

Physicians neither swore the oath, abided by its terms, nor claimed any allegiance to its ethos and so it is today. Conversely any declarations made by these early doctors were pragmatic in nature formalizing allegiances to either colleges, countries, royalty or specific councils, effectively securing their own medical domain or medical practice. The modern reciting of what is perceived to be a contemporary rewriting⁴ of an historical pledge can be attributed more to the establishing of professional bonding which in itself has negative connotations, than to a serious undertaking to act in a prescribed moral fashion at all times, serving only to further distance medics from their patients,⁵ arguably making empathy more difficult and endangering successful communication. However the romanticism of the fantasy of the Oath has survived through the centuries and these rather dubious lines underpin the notion that keeping a patients confidence is an ethical duty of the medical practitioner, reiterated by the GMC⁶. The ethicism in part at least is practical in nature, facilitating the accurate diagnosis of illness and the best course of treatment with the trusting patients full consent, with this trust being difficult or at least harder to gain without the tacit understanding that patient confidence is paramount in the physicians mind.⁷ Confidentiality “produces utility”.⁸ The primacy naturally attached to the autonomy held by the medical patient in western societies automatically associates the patients right to dispose of her body in accordance with her personal beliefs and wishes. The patients right to confidentiality spawns from this inalienable right to autonomy – the right to privacy and the derived right to decide who will have access to his/her information. The patient has a natural right to expect that the private nature of the information shared with the physician will be acknowledged by the confidentiality afforded it by his/her doctor⁹, even if the physician has disclosed information regarding the patient without the patients knowledge, where the principle of respect for patient autonomy underpins the duty of confidentiality, this constitutes a breach, regardless of whether the patient has

³ White coat ceremonies for new medical students. Raanan Gillon. J Med Ethics. 2000 Apr;26(2):83-4.

⁴ Most commonly declaration of Geneva, the Prayer of Maimonides, the Oath of Lasagna, and the Reinstatement of Hippocratic Oath.

⁵ White coat ceremonies: a second opinion. RM Veatch. J Med Ethics. 2002 Feb;28(1):5-9.

⁶ General Medical Council. Confidentiality: Protecting and Providing Information, September 2000, Section 1.1. www.gmc-uk.org/standards

⁷ Beauchamp and Childress Principles of Biomedical Ethics (Fifth Edition), Oxford University press, 2001, at p307.

⁸ Ngwenya and Chadwick ‘Genetic Diagnostic Information and the Duty of Confidentiality: Ethics and Law’ Medical Law International (1993); 1(1): 73-96 at p77

⁹ Emson, ‘Confidentiality: a modified value.’ Journal of Medical Ethics (1988); 14(2): p87

actual knowledge of the event of the breach. The virtue ethics approach encapsulates the opposite proposition, centering not on the patient but on the “virtuous” doctor”, what would he do, how would he act? It is often argued that the physician’s associated moral goodness would naturally mean that such a person would automatically respect his patient’s confidence. Consequentialism, implied promise and contract, utilitarianism, act utilitarianism, all offer routes by which to explore the issue of patient confidentiality. Reflecting these ethical tensions the law adopts a compromise position by appealing to the greater good (public interest), individual rights and interests (privacy and patient autonomy) and virtues. The result is a policy, which promotes a strong presumption in favour of confidentiality with utilitarian based exceptions in built.¹⁰

Medical professionals have an obvious common law duty to respect the privacy of their patients¹¹, with this duty¹² extending not only to medical and therapeutic information, but to all information received by a medical practitioner from his patient (unless already in the public domain). This ruling applies if either the information is expressly denoted in it’s communication as being of a confidential nature, or, as more often happens, where the reasonable person,¹³ and thereby the rational medical practitioner, would deem the information to be of a confidential nature¹⁴, or if there exists a notion of secrecy or privacy¹⁵ in the communication of the information i.e. within the context of a private (a limited number of people, not independent healthcare, although it would equally be the situation within the private sector) consultation then the patient has every right to expect the automatic application of this duty of protection to their data. The duty of confidence automatically arises when an individual in receipt of information knows, or should know that it is confidential by the manner, content and circumstances of its disclosure,¹⁶ the fact that medical consultations are not communal exercises, but individual meetings behind closed doors would in itself be demonstrable of the privacy of the occasion. It is not actually necessary that the patient suffered any great detriment as a result of the doctors breach of confidence (although it is almost always the case) since the fact that the breach exists has been proved to be detriment enough¹⁷ The HOL have decreed that information relating to the details of one’s medical situation is “obviously private”¹⁸ An action for breach of confidence can be brought by a patient independently of any associated claim in negligence or in contract¹⁹ (only private patients enter into a contract with their doctor²⁰) Given that the GMC recently reported that over half of the UK’s doctors reported for health difficulties likely to affect professional competence were suffering from alcohol abuse²¹ it is to be presumed that the medics themselves have a vested interest in maintaining the appropriate

¹⁰ Pattinson S Medical Law and Ethics, London Sweet and Maxwell, 2006 p175

¹¹ Hunter v Mann [1974] 1 QB 767, at p772

¹² Stephens v Avery [1988] 2 All ER 477 at 482 per Browne – Wilson V-C.

¹³ Coco v AN Clark (Engineers Ltd [1968] F.S.R. 415 ; [1969] R.P.C. Ch D

¹⁴ Attorney General v Guardian Newspaper Ltd (No.2) [1990] 1 AC

¹⁵ Franklin v Giddins [1978] Qd R 72

¹⁶ Attorney General v Guardian Newspaper Ltd (No.2) [1990] 1 AC, 109, 281

¹⁷ Corneliuss v De Taranto[2001] EMLR 12

¹⁸ Campbell V. MGN [2003] QB 633; [2004] EMLR 247 84, 85, 86

¹⁹ Attorney General v Guardian Newspaper Ltd (No.2) [1990] 1 AC

²⁰ Reynolds V The Health First Medical Group [2000]

²¹ Dale Harrison, Jonathan Chick (1994), Trends In Alcoholism Among Male Doctors In Scotland, Addiction 89 (12), 1613–1617

standard of protection of patient information²². The duty of confidentiality extends to information requests from third parties, in which instance doctors should assert their confidentiality and refuse to provide information so long as it does not contravene public interest policy²³.

3. Exceptions.

The most obvious exception to the doctor's duty of confidence occurs when the patient himself grants the physician his express permission to disclose the information or implies consent by his actions - providing that the patient is competent to consent and is fully aware of the nature of the proposed disclosure and of its intended audience. The incompetent patient is subject to a best interest test. It is established that the doctors obligation of confidence to his patient does not supersede his obligation to freely provide information regarding his patients information that he is compelled by law (either by statute or by a court order²⁴) to disclose. The extent of his obligation would in these circumstances be an obligation not to volunteer the information, but there the obligation ends.²⁵ The information which the doctor is expected to keep confidential must contain information which clearly identifies the patient before being the subject of an obligation of confidence²⁶, any anonymous form of patient information is free to be published and disclosed and often forms the basis of medical trial data bases, national mortality reports such as SMR1 and government performance indicators. The GMC recognize four instances where information disclosure without the patients consent would be justified: where the patient is incapable of granting consent because of a mental deficiency, where the disclosure is necessary to save the patients life, where the act of requesting the patients consent to disclose the information in itself would likely cause the patient harm or distress and lastly where the consent is unable to be granted as a result of the patients suffering neglect or abuse.

The last exception to the duty of confidentiality is when the disclosure of is regarded as being in the public interest²⁷. This has been defined as information being disclosed in order to prevent a danger or public risk or harm.^{28 29} Public interest does not apply to all and sundry who comprise the general public, but rather it is legally contained within a need to know basis, for legal purposes the "public" consists solely of those who would be directly affected by the information disclosed.³⁰

²² It should be noted that according to GMC guidelines it will not be construed as professional impropriety for a medic to disclose that a colleague is placing patients at risk as a result of incompetence, addiction or illness, however in reality this would prove to an extreme step for any healthcare professional to take and may well risk their future career progression.

²³ *A Health Authority v. X and Others* [2002] LLRM 139 CA at paras 7 and 25

²⁴ *Cardiff Crown Court, ex parte Kellam* (1993) 16 BMLR 76

²⁵ *Hunter v. Mann* [1974] QB 767, at 772.

²⁶ *X v Y* [1988] 2 All ER 648, 661

²⁷ *A-G v Guardian Newspapers (No. 2)* [1988] 3 All ER 545

²⁸ *British Steel Corp v Granada Television Ltd* [1981] AC 1096

²⁹ *Beloff v Pressdram Ltd* [1973] 1 All ER 241

³⁰ *Initial Services v Putterill* [1968] 1 QB 396

It is often thought that the patient's private expectation of practitioner confidence relating to his confidential medical information is continually competing with the possibility of countervailing public interests promoting possible disclosure. This is inaccurate. In the case highlighted below it was stressed that the law's actual concern with confidences and their protection are themselves intrinsic matters of public interest³¹. This is of great importance as the equality introduced into the equation promotes an automatic fairness that would be lacking if the relative weight of private interest and public interest were compared against each other.³² Although the courts have relied heavily on input from the GMC to decide the exactness of the circumstances, which would determine that a doctor's ethical duty of confidentiality be overridden, the question remains a matter for the judiciary to decide.³³

4. What is Public Interest?

The common law doctrine of "public policy" has evolved into what is recognised today as being "the public interest". Winfield described it "as a principle of judicial legislation or interpretation founded on the current needs of the community". The public interest role in the development and protection of the law of confidence emulates that played by public policy in the development of contract law. It facilitates an entry point for the intervention of the courts whilst simultaneously circumscribing the ambit of that intervention.³⁴

5. Public Danger and Private Disease.

There appears to be two main exceptions to the public's general acceptance of the limitations of patient confidence. The first is where the patient has an ethical or moral reason for refusing particular treatments which may be required by law i.e. vaccinations or immunizations. The second is in the instances where the information disclosure is likely to be to the serious social detriment of the patient, or even as in days of old³⁵ loss of liberty³⁶ resulting from enforced medical confinement and separation.³⁷ There are a group of diseases whose etiology determines that in order to best safeguard the health of the populous as a whole, regardless of the consequences to the individual, a doctor must notify the relevant official immediately he suspects that a patient is suffering in this manner.³⁸ This directive originated at the end of the nineteenth century and exemplifies

³¹ X v Y [1988] op cit, Rose J

³² Kennedy, Grubb, Medical Law third Edition, Butterworths, London 2000 p1092

³³ Kennedy And Grubb, Principles of Medical Law. Oxford, Oxford University Press, 1998 p502

³⁴ Gurry Breach of Confidence (1998 reprint) Clarendon Press. Oxford p5

³⁵ Soper: The curious career of Typhoid Mary, Bulletin of the New York Academy of Medicine 15: 698-713, 1939

³⁶ Anonymous British Medical Journal 1985; 291;1102

³⁷ Emson., 'Confidentiality: a modified value.' Journal of Medical Ethics (1988); 14(2): p88

³⁸ s.11(1) Public Health (Control of Disease) Act 1984.

the theory of the greater good³⁹. This relieves the physician of struggling with any ethical or moral objections, which might otherwise have prevented him reporting the patient's status. The importance of maintaining confidentiality in patients with AIDS is illustrated by the fact that it is not currently a notifiable disease. The majority of informed medical opinion support government policy that the anonymity of such patients is of paramount import, and that any physician deviating from the strictest anonymity in respect of patient identity and or information must be expected to be closely scrutinized⁴⁰. That a patient is infected with AIDS should only serve to reiterate to doctors the special importance of maintaining the integrity of his confidence and medical records whilst recognizing the paramount social duty of preventing the infection spreading

The concerns of any patient objecting to the disclosure of his health records are likely to be manifold when the information relates to a particular disease from which the patient is suffering. Traditionally and predictably the main group of diseases to which there was a general resistance to reporting were the bacterial based, sexually transmitted diseases and estimates suggest that only about 10 per cent of known cases were ever disclosed, reflecting the grave social consequences likely to be suffered by the publicized patient. The social consequences of being known to be sexually diseased intensified in the mid 1980's with the discovery of AIDS and HIV, the uncertainty of its profile at that time and the widespread social ignorance as to its infectiousness or otherwise compounding an age-old stigma and reinforcing backward thinking homophobic tendencies. Even now when it is known that transference of the virus is limited to either blood contamination or sexual intercourse, the AIDS sufferer could still be susceptible to social prejudice endangering both employment and relationships. Recognising this, such patient's privacy is protected by statute⁴¹ with physicians being able to communicate information about STD's for the purpose of treatment and prevention.⁴² Simply because of the acknowledged strong public interest in avoiding actively discouraging those citizens suffering from a sexual disease from seeking prompt medical advice or treatment, it is difficult for a physician in these circumstances to claim that a breach of confidentiality was justified on a public interest basis in all but the most extreme cases.

Boyd argues that despite this, the moral and ethical reasons for maintaining patient privacy should not change, with a system of mutual empowerment facilitating both aims. Acknowledging that a clear understanding of the premise of the ethics of confidentiality be laid bare at the initial consultation, a contract would then be signed with the patient, Boyd would hope to circumvent the actual requirement for the doctor to break the patient's confidence by empowering the patient and if necessary their partners with counseling courses, with the aim of educating them out of their shame and denial into an informed state of acceptance whereby the patient would be transformed into a responsible

³⁹ Appendix A – list of notifiable diseases.

⁴⁰ Gillon, "AIDS and medical confidentiality", *British Medical Journal* 294 1675

⁴¹ The Public Health (Control of Disease) Act 1984 The National Health Service (Venereal Diseases) Regulations 1974

⁴² NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000 NHS Code of Practice (2003) The Health and Social Care (Community Health and Standards) Act 2003 (Supplementary and Consequential Provision) (NHS Foundation Trusts) Order 2004/696

and informed individual happy to take the necessary steps to prevent further infection spreading.⁴³

The conflicting responsibilities of the doctor considering not only with his patients safety, but also that of the patients sexual partners and the other members of the healthcare provision team have resulted in the GMC allowing the doctor to in good conscience disclose details regarding the patients status to other member so the health team if they are in direct danger of contamination whilst they remain ignorant of the AIDS diagnosis and also the informing of the patients sexual partner, in instances where despite copious counseling and encouraging the patient absolutely refuses to undertake this task on their own⁴⁴.

The English courts have clearly established the expected level of confidentiality that should legally be routinely applied to Aids patients finding that despite the strong public interest in having a free press, of greater public interest was the assurance that such patients should be absolutely assured of their entitlement to have their identity concealed. When a newspaper threatened to publish the names of two doctor hospital inpatients receiving treatment for AIDS, their employed Health Authority sought to prevent them as the patient names had been originally been disclosed illegally. They won primarily on the basis that neither doctor was in direct contact with patients in a manner that could facilitate infection and that both were actively taking every authorized precaution to minimize the risk of same. They also reasoned that the negative effect of disclosing the information could deter existing and future sufferers from seeking help. The court decided as was outlined above that this was not a matter of pitting private against public interest, but public interest against public interest and cautioned the Health Authority themselves against the practice which led to the original unlawful disclosure of patient names. Whilst hailing this decision as being a victory not only for health care professionals, but for AIDS patients as a group, some commentators have rather predictably blamed the salacious nature of the press for instigating such public interest, denying a cover up by the courts they rather deferentially imply that a medical justification can be found for this decision, suggesting that the chances of a “well – counseled physician” inadvertently passing on their disease to a patient would be minimal⁴⁵. This could be construed as being naïve given that consideration has been given only to patients of the physician post diagnosis, pre diagnosed patients are not considered neither are partners and the actual value of minimal remains unexplored. Arguably one patient in two million would be minimal but mightn’t that be one patient too much? The moral premis of this case was that of the absolute and inalienable right of AIDS patients in the UK to anonymity when seeking medical treatment, regardless of their profession or social standing, not that the relative education of doctors makes them less of a public interest concern than a non- medical AIDS patient.

⁴³ Boyd, ‘HIV Infection and AIDS: The Ethics of Medical Confidentiality’ *Journal of Medical Ethics* (1992); 18(4): 173-9

⁴⁴ GMC, *Serious Communicable Diseases*, October 1997.

⁴⁵ Mason and Laurie Mason and McCall Smith's *Law and Medical Ethics*. Seventh Edition. Oxford UP 2006 p266

The next time the issue of HIV infected healthcare professionals arrived before the courts⁴⁶ the newspaper had gained the details of such a dentist and intended to publish not the individuals name, but the employing health authority and / or the practitioners specialty and date of infection. The Court of Appeal faced a first in that both parties evoked their human rights (the practitioner Article 8 and press Article 10) and that the practitioner had already challenged existing government policy questioning the governments right to view his patients retrospectively.⁴⁷ The court again reiterated the previous ruling placing the public interest HIV patients confidence in having his privacy preserved before any public interest in discovering the dentists identity, although it did allow partial publication of the story, disallowing any reference to the actual health authority, but allowing the patients specialty as a dentist to be disclosed. According to some this action facilitated greater public debate by appropriating more interest to freedom of expression that the previous ruling had⁴⁸ but what is not open for debate is the continuance of the traditionally high level of confidence which can rightly be anticipated by the STD patient seeking medical help, this is indeed a matter of public interest as this level of faith is essential to ensure as many sufferers as possible seek advice that has the potential to cure or treat or educate them as to best practice to ensure that the problem is contained.

The GMC have put in place sufficient guidelines as regard STD's allowing the ethical breaching of the principle in set circumstances Emson insists that even if the principle of confidentiality is slightly and necessarily eroded by various statutes and common law precedent the principle of patient confidentiality will always remain and concomitantly the doctor will often find himself in the difficult ethical terrain of apparent conflict of interests, the weighing up of benefits, when to breach confidences in order to protect either others or the patient himself⁴⁹. This is part of contemporary doctoring and as with the rest of medicine, should become the finely honed skill of the competent physician. There may of course arise the situation where the AIDS patient and their partner are both patients of the same doctor. In this instance the doctor owes the same duty of care to both, the partner is not simply a third party but the partner patient is of equal standing to the AIDS patient. Echoing a turn of the century case American case⁵⁰ it has been held in England that a doctor has been negligibly liable for failing to ward his patient of the obvious danger of contracting a highly contagious disease, blatantly breaching his duty of care⁵¹. While obviously not an STD, this case reiterates the underlying responsibility of a doctor to warn his patient of foreseeable harm, it was to be anticipated in this case that the puerperal fever would be easily contracted, on this basis an extensions of the same principle could easily be applied to the identifiable patient partner of an AIDS, or other STD patient.

⁴⁶ H v Associated Newspapers Ltd [2002] EMLR 425

⁴⁷ HSC(1988/226)

⁴⁸ Brazier, *Medicine, Patients and The Law*, Third Edition, Penguin, London 2003 p69

⁴⁹ Emson, H.E. 'Confidentiality: a modified value.' *Journal of Medical Ethics* (1988); 14(2): 87-90

⁵⁰ Skillings v. Allen, 173 N.W. 663 (Minn. 1919)

⁵¹ Lindsey CC v Marshall (1971) 34 MLR 241

This was the case in California where it was found that the doctor's patient sexual partner was owed a duty of care by the physician when after receiving a blood transfusion the partner contracted HIV ignorant to the fact of disease due to the information being concealed by the doctor. The doctor was liable to the partner of the patient, but not to third parties as a whole.

6. Public Danger and Purported Threats

Psychiatric patients can as also as a by-product of their disease or their medication present a threat to society. Given that the potential to harm is not constrained to sexual intercourse or mingling of blood and fluids, the danger is potentially wider spread. The British case of *Edgell*⁵² examined the scope of medical confidentiality and its limits of application. W's solicitors had engaged Edgell to write a report on their behalf to support their clients appeal for conditional discharge – he was at that time being compulsory detained after a fatal shooting which had killed five. Edgell managed to uncover W's continuing fascination with explosives and on this basis his counsel withdrew application for discharge, refusing to forward the report to the authorities. This Edgell did of his own accord and in addition pursued the Home Office to take note of his findings in relation to W's case review. His solicitors sought an injunction and damages against Edgell citing breach of confidence. The court of appeal immediately dispensed with the private interest of both W and Edgell concerning itself only with the matters of public interest and deciding that Edgell had acted properly in attempting to avoid a "real" risk of danger to the public ruled that he had been justified in his actions.

Although setting out a number of limitations to the justified breach, (below) as with the New Zealand High Court⁵³ the law Lords failed to answer the specify if the doctor will be justified in breaching confidentiality if he actually believes that this type of risk has arisen or whether he requires objective proof that such a risk of physical harm exists.⁵⁴ Interestingly it was never clarified if Edgell had discovered new information regarding his subject, in which case the breach was justified, or whether Edgell simply disagreed with the others finding and construed this outcome then arguably this is nothing more than a differing of expert opinion.⁵⁵ The psychiatrist as the patient's doctor faces unique challenges with regards to the maintenance of patient's confidentiality. If the patient communicates to his doctor a desire to harm any person(s) other than themselves the doctor then has to utilise his own medical judgement and acumen to decipher the realness of any risk. This obvious short falling is indicative of the ill defined limitations placed on the justification of breaking a confidence based on a threat of serious harm:

- I. It must be shown that there is a serious and real risk to the public. The risk must be of significant and quantifiable harm, normally of a physical nature to the victim.

⁵² *W v Edgell* [1990] 1 ALL ER 835

⁵³ *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513

⁵⁴ Kennedy And Grubb, *Principles of Medical Law*, Oxford, Oxford University Press, 1998 p 505

⁵⁵ Kennedy, Grubb, *Medical Law* third Edition, Butterworths, London 2000 p1101

- II. The risk must be current, a retrospective threat of harm is insufficient to justify the breach⁵⁶
- III. The disclosure must only have been to the appropriate authority or individuals i.e. hospital officials home office

The situation is very different in the US following the case concerning fatal obsession of a UCLA student⁵⁷ who, prior to murdering the object of his obsession (Tatiana Tarasoff) had expressed his homicidal intent to his campus psychologist. When the deceased's parents later prosecuted they claimed that being in receipt of this information created a duty which should have resulted in them being warned of this threat to their daughter. At first hearing the court agreed, the psychiatrist was indeed under a duty to warn, on second hearing (Tarasoff II) this principle was communicated as being a duty to protect. On being reassured that a patient is a violent danger another the psychiatrist is obliged to protect the intended victim by warning them, informing the police or by taking whatever steps maybe necessary.⁵⁸ The jurisprudence underpinning this ruling established the obligation as a result of the existence of a special relationship that of doctor patient, and on entering into this relationship the psychiatrist assumed responsibility not only for his patient, but anyone likely to be harmed by him.⁵⁹ Later clarified by the Californian Supreme Court the physician is not liable for harm inflicted on any third party associated with his patient, but only a readily identifiable victim.⁶⁰ Tarasoff has been adopted in one three ways by most other USA states, indicating a general nationwide acceptance of the physicians principle duty to warn. It has been adopted expressly, applying an exact and accurate interpretation of the ruling to cases of similar circumstances. In the second format is an extension of Tarasoff, the principle of liability has evolved to include a specific class of victims,⁶¹ and the inclusion of any foreseeable victims⁶² and accepting the Tarasoff principle but refusing to apply it in instances of liability of imposition of liability.^{63 64} Not all of the patients have even been potentially violent, in one instance the patient herself was unaware of her diseased state that resulted in her death and her litigious partner contracting AIDS.⁶⁵

Even so, it is unlikely and undesirable that we will ever adopt the same position in the UK, the only case even suggesting that this might be the position⁶⁶ was subsequently viewed as being of uncertain authority based as it was on the degree of licensed control that the hospital psychiatrist held over the patient that established a duty of care. This is a

⁵⁶ R v Harrison [2000] WL 1026999

⁵⁷ Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976)

⁵⁸ *ibid* p431

⁵⁹ *ibid* p344

⁶⁰ Thompson v. County of Alameda (1980) 27 C3d 741. [S.F. 24006. Cal Sup Ct. July, 14, 1980]

⁶¹ Rollins v. Petersen, 813 P.2d 1156, 1159-60 (Utah 1991)

⁶² Kerrville State Hosp. v. Clark, 923 S.W.2d 582, 584 (Tex. 1996)

⁶³ Perreira v. State, 768 P.2d 1198 (Colo. 1989)

⁶⁴ Holgate v. Lancashire Mental Hospital Board [1937] 4 All E.R. 19

Stenger, Christine E. 'Taking Tarasoff Where No One Has Gone Before: Looking at "Duty to Warn" Under the AIDS Crisis' Saint Louis University Public Law Review (1996); 15(2): 471-504

⁶⁵ Reiser v. Regents of Univ. of Cal., 31 Cal. App. 4th 1195 (Cal. 1995)

⁶⁶ Holgate v. Lancashire Mental Hospital Board [1937] 4 All E.R. 19

type of control that that is unknown to the general psychiatrist and so duty of care is established on proximity. This was reiterated when the courts examined the potential liability of a doctor for non-disclosure which arguably resulted in the torture and ultimate death of a young girl⁶⁷. The action in negligence was brought by the girl's mother against the psychiatrist of the mental patient perpetrator who had suggested that he would act in exactly this manner on release. The non-identifiability of the victim by the psychiatrist, the lack of proximity between the doctor and either the victim or her mother led the courts to deny that any duty of care existed.

7. Conclusion

“A doctor shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted to him”.⁶⁸

Confidence is the essence of the medical relationship between doctor and patient. It is highly valued in the UK and rightly so. The courts are reluctant to interfere, following where the GMC leads with both clearly providing for circumstances where patients suffer from a STD. Less clear are the situations which would justify the breaching of patient confidence in the name of public interest where the patient has threatened serious harm to others.

There is little merit I think in comparing the idea of imposing on doctors a statutory duty doctor to warn potential victims with the lack of a statutory duty to rescue at statute. It is a cardinal feature of all legal obligations and servitudes that they are retrospective in nature and not prospective, and so it would be with rescuing, if developed it would be a retrospective act, we can only rescue what is in peril, the damage has been done. In this way a duty to rescue would be right to be considered to be a legal obligation. A duty to warn would be a prospective action, an attempt to prevent harm occurring, in this respect if ever developed legally such an legal duty would not be considered to be an obligation as the courts have already ruled that it is not in any manner a retrospective act⁶⁹. Therefore the two matters are intrinsically different. However it is the case that both situations (would) involve a duty to third parties, complicated by the duty of care, which exists between doctor and patient and does not exist between doctor and third party. The law has traditionally been reluctant to introduce any type of responsibility or duty or obligation to third parties, weakening as it would the clearly defined boundaries of such obligations, blurring the definitions of harm.

⁶⁷ Palmer v. Tees Health Authority [2000] P.I.Q.R. 1

⁶⁸ The World Medical Association's International Code of Medical Ethics quoted in Beauchamp and Childress Principles of Biomedical Ethics (Fifth Edition), Oxford University press, 2001, p304

⁶⁹ R v Harrison [2000] WL 1026999

The public interest test as it stands adequately facilitates any breach of confidence that a doctor may feel is necessary to safeguard or warn others, and although liable for this breach, if the public interest test failed to fully justify his actions, any liability could easily be avoided by the doctor acting with reasonable care for which the traditional application of Bolam⁷⁰ would allow his peers considerable discretion in the consideration of what they and subsequently the judiciary would consider to be reasonable.

In some parts of Europe medical confidentiality is an absolute right, in both France and Belgium it is protected in the criminal code.⁷¹ It is an absolute, a given. In general the medical profession as a whole recognise the importance of confidence⁷² with Warwick being unusual in expressing her rather extreme opinion promoting the banishment of this component of the doctor patient relationship. She argues that since the promises made by doctors to preserve confidentiality are not binding, then there is no reason why patients should view this expected element of confidentiality as being constant, rather than a malleable, transmutable piece of rhetoric that develops alongside physician determined priorities. This GP reasons that society will benefit from the ensuing openness and that an easy manner of protecting ones personal “secrets” is simple not to communicate them, and in the context of the healthcare provider, by the patient refusing to impart certain confidences then they remain totally protected with no damage to the relationship. For her part she promises that if patients do renege their right of confidence, doctors will promise not to idly gossip about their patients or sell their information for remuneration of any kind (echoing Bingham LF in Edgell) and in this manner the medical profession will actually be increasing patient autonomy and ultimately aiding the development of a healthier and more open society as a whole⁷³. In general this proposal is contra to the ideals currently promoted by the GMC and from a public interest viewpoint, would be detrimental to society as a whole and I believe indicates an ignorance as to the importance of the law of confidence to both the law of medicine and the law of commerce. As the Court Of Appeal has reiterated recently⁷⁴, this element of our law is very much alive and the value of confidence in both its commercial and private sense is no less valued today than it has been in the past, it underpins many legal transactions of varying natures and is an essential component of our democracy.

One commentator has formulated a clear relationship between a more recent UK case⁷⁵ and the establishment of an accepted and routine duty of care to third parties by psychiatrists reasoning that the implication of ECHR makes such an event inevitable.⁷⁶ The police were alerted by a family who became aware of a teachers obsession with their young son whom the teacher eventually murdered. Reaching the European Court the family were ultimately unsuccessful in their attempt to prove negligence on behalf of the police for their failure to prevent the teacher murdering the findings of the majority have given Gavaghan. He argues that Article 2 of The Convention spawns the duty by

⁷⁰ Bolam -v- Friern Hospital Management Committee [1957] 1 WLR 582; [1957] 2 All ER 118

⁷¹ France – Penal Code, art 378; Belgium Penal Code, art458

⁷² Herring, Medical Law and Ethics, Oxford University Press, 2006 p145

⁷³ Warwick, ‘A vote for no confidence’ Journal of Medical Ethics (1989); 15(4): 183-185

⁷⁴ Douglas v Hello! Court of Appeal May 1st 2007

⁷⁵ Osman v UK (2000) 29 EHRR 245

⁷⁶ Gavaghan A Tarasoff for Europe? A European Human Rights perspective on the duty to protect. Int J Law Psychiatry. 2007

protecting the right to life; the European Court reiterated that the duty applies only to identifiable individuals as per the UK courts with duty being limited by competing legal obligations and practical considerations. In this manner he suggests that via the European courts the first approach to a duty of care to third parties analogous to the Tarasoff approach of the US has been introduced to the European courts with the further evolving of Osman being only a matter of time⁷⁷. For the moment though, no such duty exists.

APPENDIX A

- Acute encephalitis
- Acute poliomyelitis
- Anthrax
- Cholera
- Diphtheria
- Dysentery
- Food poisoning
- Leptospirosis
- Malaria
- Measles
- Meningitis □ meningococcal □ pneumococcal □ haemophilus influenzae □ viral □ other specified □ unspecified
- Meningococcal septicaemia (without meningitis)
- Mumps
- Ophthalmia neonatorum
- Paratyphoid fever
- Plague
- Rabies
- Relapsing fever
- Rubella
- Scarlet fever
- Smallpox
- Tetanus
- Tuberculosis
- Typhoid fever
- Typhus fever
- Viral haemorrhagic fever
- Viral hepatitis □ Hepatitis A □ Hepatitis B □ Hepatitis C □ other
- Whooping cough
- Yellow fever
- Leprosy is also notifiable, but directly to the HPA, Cfl, IM&T Dept

⁷⁷ ibid p37, p38, p4, p5, p17

BIBLIOGRAPHY

Books, Texts, Cases and Academic Research Papers Sourced and Studied.

- New York Times www.nytimes.com
- Raanan Gillon White Coat Ceremonies For New Medical Students.. J Med Ethics. 2000 Apr;26(2):83-4.
- Veatch White Coat Ceremonies: A Second Opinion.. J Med Ethics. 2002 Feb;28(1):5-9.
- General Medical Council. Confidentiality: Protecting and Providing Information , September 2000, Section 1.1. www.gmc-uk.org/standards
- Beauchamp and Childress Principles of Biomedical Ethics (Fifth Edition), Oxford University press, 2001
- Ngwenya and Chadwick 'Genetic Diagnostic Information and the Duty of Confidentiality: Ethics and Law' Medical Law International (1993); 1(1): 73-96
- Hunter v Mann 1974] 1 QB 767
- Stephens v Avery [1988] 2 All ER 477
- Coco v AN Clark (Engineers Ltd [1968] F.S.R. 415 ; [1969] R.P.C. Ch D
- Attorney General v Guardian Newspaper Ltd (No.2) [1990] 1 AC
- Franklin v Giddins [1978] Qd R 72
- Campbell V. MGN [2003] QB 633; [2004] EMLR 247
- X v Y [1988] 2 All ER 648
- Reisner v. Regents of Univ. of Cal., 31 Cal. App. 4th 1195 (Cal. 1995)
- Gurry Breach of Confidence (1998 reprint) Clarendon Press. Oxford
- Gillon, "AIDS and medical confidentiality", British Medical Journal 294 1675
- A Health Authority v. X and Others [2002] LLRM 139 CA
- Beloff v Pressdram Ltd [1973] 1 All ER 241
- Osman v UK (2000) 29 EHRR 245
- Kennedy And Grubb, Principles of Medical Law. Oxford, Oxford University Press, 1998

- Stenger, 'Taking Tarasoff Where No One Has Gone Before: Looking at "Duty to Warn" Under the AIDS Crisis' Saint Louis University Public Law Review (1996); 15(2): 471-504
- Gavaghan A Tarasoff for Europe? A European Human Rights perspective on the duty to protect. Int J Law Psychiatry. 2007
- Kleinman, 'Confidentiality and the duty to warn.' Canadian Medical Association Journal (1993); 149(12): 1783-1785A-G v Guardian Newspapers (No. 2) [1988] 3 All ER 545
- Soper: The curious career of Typhoid Mary, Bulletin of the New York Academy of Medicine 15: 698-713, 1939
- Reynolds V The Health First Medical Group [2000]
- Skillings v. Allen, 173 N.W. 663 (Minn. 1919)
- Holgate v. Lancashire Mental Hospital Board [1937] 4 All E.R. 19
- Cornelius v De Taranto[2001] EMLR 12
- Palmer v. Tees Health Authority [2000] P.I.Q.R. 1
- Pattinson Medical Law and Ethics, London Sweet and Maxwell, 2006
- Almason, 'Personal Liability Implications of the Duty to Warn are Hard Pills to Swallow: From Tarasoff to Hutchison v. Patel and Beyond' Journal of Contemporary Health Law and Policy (1997); 13: 471-496
- R v Harrison [2000] WL 1026999
- Sizemore, 'Alabama's Confidentiality Quagmire: Psychotherapists, AIDS, Mandatory Reporting, and Tarasoff.' Law & Psychology Review (1995); 19: 241-257
- Boyd, 'HIV Infection and AIDS: The Ethics of Medical Confidentiality' Journal of Medical Ethics (1992); 18(4): 173-9
- Emson, H.E. 'Confidentiality: a modified value.' Journal of Medical Ethics (1988); 14(2): 87-90
- Herring, Medical Law and Ethics, Oxford University Press, 2006
- NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000
- NHS Code of Practice (2003)
- The Health and Social Care (Community Health and Standards) Act 2003 (Supplementary and Consequential Provision) (NHS Foundation Trusts) Order 2004/696
- The Public Health (Control of Disease) Act 1984
- The National Health Service (Venereal Diseases) Regulations 1974
- GMC, Serious Communicable Diseases, October 1997
- Emson,. 'Confidentiality: a modified value.' Journal of Medical Ethics (1988); 14(2): p87
- Initial Services v Putterill [1968] 1 QB 396
- Cardiff Crown Court, ex parte Kellam (1993) 16 BMLR 76
- H v Associated Newspapers Ltd [2002] EMLR 425
- Brazier, Medicine, Patients and The Law, Third Edition, Penguin, London 2003
- W v Edgell [1990] 1 ALL ER 835
- Duncan v Medical Practitioners Disciplinary Committee[1986] 1NZLR 513
- Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976)
- The World Medical Association's International Code of Medical Ethics
- Emson,. 'Confidentiality: a modified value.' Journal of Medical Ethics (1988); 14(2): 87-90
- MacKay, 'Dangerous Patients. Third Party Safety and Psychiatrists' Duties - Walking the Tarasoff Tightrope' Medicine, Science and the Law (1990); 30(1): 52-56
- Harrison, Chick (1994), Trends In Alcoholism Among Male Doctors In Scotland, Addiction 89 (12), 1613-1617
- British Steel Corp v Granada Television Ltd [1981] AC 1096
- Perreira v. State, 768 P.2d 1198 (Colo. 1989)
- Warwick, 'A vote for no confidence' Journal of Medical Ethics (1989); 15(4): 183-185
- Kennedy, Grubb, Medical Law third Edition, Butterworths, London 2000
- Thompson v. County of Alameda (1980) 27 C3d 741. [S.F. 24006. Cal Sup Ct. July, 14, 1980]
- British Medical Journal
- Douglas v Hello! Court of Appeal May 1st 2007

- Kerrville State Hosp. v. Clark, 923 S.W.2d 582, 584 (Tex. 1996)
- Lindsey CC v Marshall (1971) 34 MLR 241
- Rollins v. Petersen, 813 P.2d 1156, 1159-60 (Utah 1991)
- Mason and Laurie Mason and McCall Smith's Law and Medical Ethics. Seventh Edition. Oxford UP 2006