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SECRETS REVEALED: THE LIMITS OF MEDICAL CONFIDENCE

Professor Louis Waller, AO*

I.

On Monday 8th December 1987, within less than one quarter of an hour in that dull, somewhat humid afternoon, nine people—5 women and 4 men—died awful, violent deaths, in the very heart of the Central Business District in the city of Melbourne, Australia's second largest metropolis. Eight of them were shot at point-blank range by the ninth victim, a 23-year-old man named Frank Vitkovic. Breaking free from the restraining hands of several heroic colleagues of his dead victims, Vitkovic plunged to his own death through a window already shattered by one of the many shots he had fired.

The State Coroner conducted an investigation and held an inquest into those nine deaths, which quickly became known as the Queen Street massacre.1 Vitkovic, he found, was a keen sportsman2 who had done so well in his secondary schooling that he was admitted to the Faculty of Law in the University of Melbourne, where in 1984 he completed the first year courses. That year a knee injury had affected his tennis; this worsened and in 1985, he also became quite depressed.3 In 1986, he re-commenced his interrupted studies in law and successfully underwent knee surgery. To a friend, he showed continuing signs of depression; he talked of suicide. In his law of contract examination paper, written in November 1986, Vitkovic wrote, in the words of the Coroner, “a bizarre and inappropriate essay about crime, death, capital punishment and a violent and chaotic society”.4 After that answer had been read, Vitkovic was advised by teachers and administrators

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1. See generally Victoria. State Coroner's Office. Record of Investigation and Inquisition into the Deaths of Frank Vitkovic and Others. (Coroner's Office, October 7, 1988) (discussing the deaths of Frank Vitkovic and his eight victims) [hereinafter State Coroner's Report].
2. Id. at 1.
3. Id. at 11.
4. See generally id. at 12 (discussing the "bizarre essay").
in the Melbourne Law School to seek help. He consulted a qualified psychologist employed in the University Counselling Service. The psychologist considered his client to be "severely disturbed"; suffering deep psychological and prepsychotic problems; indicating violence to his friends and himself (though this, the psychologist considered was fantasy and not a real intent); speaking of suicide; and "in need of psychiatric assessment" and "most likely requiring medication and hospitalization". Vitkovic completely rejected the psychologist's suggestion that he should see a psychiatrist; he did not keep his next counselling appointment. Many questions spring from or are stimulated by the statements in a report that eventually goes on to describe in precise details what occurred just a year after Vitkovic visited the counseling session. Vitkovic, according to ex post facto psychiatric assessments provided for the State Coroner, was a paranoid psychotic, probably schizophrenic, totally out of touch with reality and insane. Should the psychologist have spoken about his assessment? To whom? Was he under an obligation to utter a warning?

There are other, less awful but still disturbing situations that give rise to the same sorts of questions. What should the endocrinologist, whose severely diabetic patient bluntly refuses to relinquish his job as a dogman-rigger, riding huge steel girders as they swing in the air above busy city thoroughfares, say or write to his employer, or to the police? Is the right answer "Nothing at all"? Thirty years ago the present Vice-Chancellor of the University of Melbourne, a distinguished haematologist, told the Medico-Legal Society of Victoria, in opening the discussion on a paper on professional secrecy, that "the late W.R. Boyd [a well-known Melbourne doctor] had told him that he would never fail to communicate to one spouse that the other was suffering from venereal disease." Today, doctors in private and public practice, here and everywhere, must wonder, and often be wracked by uncertainty, when they have before them reports that their patients have been diagnosed as infected with the human immunodeficiency virus (HIV), which will lead to that now so well-known but dreaded acronym, AIDS. Should the patient's spouse, or longtime or short-term partner, be told that, by the doctor? Or is it the patient's secret, to be revealed, or not, by her or by him only? A few years ago, an Australian doctor participating in a TV "hypothetical" on AIDS screened by the Australian Broadcasting Corporation said—hypothetically—that he would not tell a spouse

5. Id.
6. Id. at 2.
7. Discussion with Dr. J. Pennington following paper given by K.A. Aickin, Professional Secrecy as an Enforceable Obligation, IX THE PROCEEDINGS OF THE MEDICO-LEGAL SOCIETY OF VICTORIA 1, 17 (1960-63) [hereinafter Pennington].
that her or his partner was suffering from AIDS—but would tell a fellow
doctor who was treating the person.

I shall consider two separate but related questions arising out of these
instances. My perspective is a lawyer's, but, as ever, there is both interplay
and close-knit interaction between ethics and legal principles, standards and
rules. Although my central concern is with the relationship of doctor and
patient, it is patent that relationships arising in the practice of many allied
health professions, such as that of clinical psychology in the Vitkovic epi-
sode, or in the realms of the speech or the occupational or the physical ther-
pies, or in the profession of nursing, may come with the same questions, as
urgent and as difficult as in the practice of medicine.

My first enquiry is this. If the doctor-patient relationship is one of confi-
dence, when, if ever, may the doctor or health professional tell her or his
patient's secrets? Could the psychologist, ethically and lawfully, have told
the University authorities, or the police, of his assessment of Vitkovic? My
second enquiry is, when, if ever, must the doctor or health professional re-
veal a patient's confidences? Can the dependents of the victims obtain legal
redress because the psychologist was silent? Secrets and confidences, in this
context, include not only what is conveyed by the patient but also what is
discovered or learned by the doctor, however, that occurs. The fourth of
King Charles I's "twelve good rules" is plain: "Reveal no secrets." But it is
the Hippocratic oath attributed to the Greek priest-physician who lived 2400
years ago that serves still to enunciate a fundamental medical ethic. "Whath-
ever in the course of practice I see or hear (or outside my practice in social
intercourse) that ought not to be published abroad, I will not divulge but will
consider such things as to be holy secrets.""8

II

The physician's ethical duty had been incorporated in current statements
and guidelines adopted and published by medical and other professional as-
sociations. It is, for instance, in the "Advice on Standards of Professional
Conduct and on Medical Ethics" published by the General Medical Coun-
cil. A breach may result not just in professional censure, but in exclusion
from practice, for a time or indefinitely, in the context of that disciplinary
framework that the law has fashioned for medicine, and as they have
achieved recognition as professions, for the allied health therapies as well.

8. See Oliver Goldsmith, The Deserted Village in Poems, Plays and Essays
86 (1960); see also Pennington, supra note 7, at 2 (quoting the Hippocratic Oath).
10. General Medical Council, Advice on Standards of Professional Con-
duct and on Medical Ethics.
The real force of the medical ethic was recently made apparent in a New Zealand case. Dr. Ian Duncan practiced in a small town in the North Island. One of his patients was the owner-driver of a bus, who had operated it for 30 years. In 1982, the driver had several heart attacks, culminating in a cardiac arrest. Dr. Duncan attended the driver as his general practitioner; he was admitted to hospital where a specialist surgeon performed a triple coronary artery by-pass operation. The surgeon subsequently examined his patient and, at his request, gave him a certificate that enabled him again to obtain a bus-driver’s licence.

When Dr. Duncan learned that his patient intended to drive his bus on a charter trip to Auckland, he told him he had no licence, or medical clearance, and could not drive. The driver corrected him. Dr. Duncan then asked the local police constable to revoke the driver’s licence; the local policy told Dr. Duncan that was impossible. Before speaking to his patient, Dr. Duncan had spoken to one of the charter passengers: He told her that the driver was not fit to drive and could have a heart attack at any time. After the trip had been uneventfully completed, the patient discovered that a friend of his had been asked by Dr. Duncan to help organise a petition to have him barred from driving buses. Unsurprisingly, he complained to the Medical Practitioners Disciplinary Committee, which found Dr. Duncan “guilty of professional misconduct in that he breached professional confidence in informing lay people of his patient’s personal medical history.”

Dr. Duncan then heaped Pelion upon Ossa. He wrote to metropolitan newspapers and gave television interviews “ventilating his opinion about the complainant’s [his patient’s] health and acceptability as a public driver and complaining that the Disciplinary Committee had not given a fair hearing.” This resulted in a further complaint by the patient, whose medical history was now embodied in what he described as “an outburst to the whole nation.” Ultimately, the Medical Council of New Zealand found Dr. Duncan “guilty of professional misconduct by disclosing confidential information to the national news media in breach of his professional responsibilities in respect of [the patient’s] medical history.” Dr. Duncan’s media foray had unleashed other, unrelated complaints of professional misconduct, also found proven. The Medical Council ordered that his name be removed from the medical register, and that he might not apply for registration for 12

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12. Id. at 518.
13. Id. at 540.
14. Id. at 550.
months. I shall return to Dr. Duncan, who sought judicial review of these disciplinary decisions in the High Court of New Zealand.

There is no doubt today that the long-recognized ethical duty has its legal counterpart. A doctor may be restrained at the suit of a patient from revealing information discovered in the professional relationship. A doctor may be mulcted in damages because confidential information has been revealed. This is how Justice Bingham put it in the now much-publicized English case of *W. v. Egdel* in 1989:

> He could not lawfully sell the contents of his report to a newspaper . . . . Nor could he, without breach of the law as well as professional etiquette, discuss the case in a learned article or in his memoirs or in gossiping with friends, unless he took appropriate steps to conceal the identity of W.\(^{15}\)

Nearly 150 years ago, Lord Ivory, sitting as one of the judges in the First Division of the Court of Session, had stated this, robustly and simply, in his judgement in a case where pursuer and defender — a doctor — were both accorded alphabetical alibis:

> It would be a most serious thing to admit the argument of the defender, that there is no confidentiality between a medical man and his employer . . . . If it could ever have been doubted that such a confidential relationship subsists between a medical man and his employer, I think it is high time that such a doubt should now be set at rest for ever.\(^{16}\)

Today the assumption of a contract of service with an implied term of confidentiality upon which Lord Ivory’s statement depends need not be made. In modern judgments, in many common law jurisdictions, it is the existence of a doctor-patient relationship that is the foundation of the duty to keep a patient’s secrets. “It is beyond doubt,” said Justice Kelly in the Supreme Court of the Australian Capital Territory in November 1986, “that a duty of confidentiality lies between a doctor and his patient.”\(^{17}\) The doctor in question was an employee of the ACT Health Authority, whose duties were to see anyone who came to a city clinic. The fiduciary quality of the doctor-patient relation is the foundation of the duty, said Justice Jeffries in *Duncan*.

More attention is paid today to the reason why there is a legal duty to guard those secrets. In Victoria, where that legal duty is further armored in that a doctor must claim privilege\(^{18}\) against answering questions, in pretrial

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18. *VICT. EVIDENCE ACT § 28(2) (1958).*
interrogatories or in court, about a patient's communications, in the course of most civil proceedings, Justice Sholl said:

... I think the great preponderance of judicial opinion is to the effect that the policy of the legislation [i.e. the privilege provision in the Victorian Evidence Act 1958] is to protect the patient from the fear of disclosure. The fear seems to have been that persons suffering from illness or disease might be restrained by fear of the ultimate disclosure of their confidences from seeking medical attention in due time, or at all. True it is, that there has been, as a matter of historical fact, pressure upon public opinion by the medical profession in favor of some statutory protection of communications made to its members, but, in my view, the general purpose of the legislation is the protection of the patient's interests, and not the protection of the medical man's interests as such.19

At much the same time a United States judge said:

Since the layman is unfamiliar with the road to recovery, he cannot sift the circumstances of his life and habits to determine what is information pertinent to his health. As a consequence, he must disclose all information in his consultations with his doctor — even that which is embarrassing, disgraceful or incriminating. To promote full disclosure, the medical profession extends the promise of secrecy.20

To those specific reasons or explanations there may now be added that clearly recognized interest in the protection of personal privacy, including particularly, every kind of information about an individual's health and habits of life. In Australia, the never quiescent debate engendered among common lawyers by Warren and Brandeis's seminal article of 1890 on privacy21 and its legal protection has been overtaken by, first, the publication in 1983 of the Australian Law Reform Commission's Reports on Privacy,22 which were to some degree heralded by the pioneering work and reports of the New South Wales Privacy Committee, and then by the enactment by the Commonwealth Parliament of the Privacy Act of 1988. That legislation states in its preamble its connection to international conventions enunciating and seeking to protect the right of personal privacy. The Act specifically extends the common law, by building on the established action for breach of confidence, in which a federal agency or officer, or any person within the Australian Capital Territory, is subject to an obligation of confidence.23 The

22. AUSTRALIAN LAW REFORM COMMISSION PRIVACY § 164.9 (Vols. 1 & 2 1983).
23. AUSTL. PRIVACY ACT § 89 (1988).
general language of the legislation clearly encompasses personal information and communications\textsuperscript{24} passed in or arising out of any kind of medical research,\textsuperscript{25} in federal contexts.

The Privacy Act of 1988 also deals specifically with personal information and medical research. It empowers the National Health and Medical Research Council to issue guidelines "for the protection of privacy in the conduct of medical research."\textsuperscript{26} The guidelines may only be promulgated if they are approved by the Privacy Commissioner,\textsuperscript{27} appointed under the Act to oversee the implementation of the provisions. The Commissioner may only approve them if "satisfied that the public interest in the promotion of research of the kind to which the guidelines relate outweighs to a substantial degree the public interest in maintaining adherence to the Information Privacy Principles"\textsuperscript{28} set out in the Act. Chief among these are that personal information may only be collected from people clearly informed about the reasons why collection is undertaken; in a manner not too intrusive; with protections against its misuse and unauthorized disclosure; and with its use restricted to the collecting agency, unless the person concerned permits wider disclosure.

The NH & MRC has published interim guidelines for the Protection of Privacy in Medical Research, originally in force until December 31, 1990 which has since been extended. The central element in them is that Institutional Ethics Committees in universities, research institutes, and hospitals, which determine whether any research project involving human subjects or human tissue may be undertaken, must now determine whether each project is concerned with research where the public interest in it outweighs to a substantial degree the public interest in privacy. The chief impact of the guidelines will be in relation to epidemiological research, where it may be regarded as necessary to collect very large amounts of information about very substantial groups or constituencies in the population. In its statement\textsuperscript{29} accompanying the guidelines, the NH & MRC has emphasized the value of large scale epidemiological research, in the improvement of Australian public health. Its chief examples are on cigarette smoking in the 1950s, oral contraceptive pills, long-term effects of ionizing radiation, and chemical

\begin{itemize}
  \item \textsuperscript{24} \textit{Id.} §§ 14, 96.
  \item \textsuperscript{25} \textit{Id.} § 95.
  \item \textsuperscript{26} \textit{Id.} § 95(1).
  \item \textsuperscript{27} \textit{Id.}
  \item \textsuperscript{28} \textit{Id.} § 95(2).
  \item \textsuperscript{29} \textit{See} \textit{NATIONAL HEALTH & MEDICAL RESEARCH COUNCIL NEWS RELEASE}, February 26, 1990 (incorporating "The Public Interest in Medical Research" and parts of the National Health & Medical Research Council Report on Ethics in Epidemiological Research 1980).
\end{itemize}
exposures and war service. *Ex post facto*, the NH & MRC believes that the public interest in properly conducted medical research in those instances, which "advances the Community’s understanding of disease and improves its capacity to prevent or heal disease,"\(^{30}\) satisfied the criterion in the guidelines. What is significant is that personal privacy is paramount. As Justice Jeffries said in Dr. Duncan’s case, in the High Court of New Zealand,

> Overall, confidentiality has recently become more prominent as an issue. Society’s response has been articulate in that it seeks to break down unnecessary official secrecy but to strengthen protection of personal confidences and secrets.\(^{31}\)

The juxtaposition of the Australian Privacy Act of 1988 and the consequences it has had, and the overall thrust and tone of the few recent cases mentioned, with the statements on public interest immunity, or Crown privilege as it was once called, in recent major judgments\(^{32}\) of the High Court of Australia, and the whole saga of the Spycatcher\(^{33}\) litigation, especially in the courts of New South Wales, justifies that statement by Justice Jeffries. Although flood-lights may now shine legitimately upon the *arcana imperil* and even the records of the Australian Security Intelligence Organisation may be scrutinized by the High Court to see whether they may be discovered in litigation, private secrets—especially medical secrets—must be sedulously preserved from any revelation. Are there any exceptions? When may medical secrets be revealed?

### III

One of the issues argued in the New Zealand case of *Duncan v. Medical Practitioners Disciplinary Committee*, was that the Committee’s “view of medical confidence was generally too narrow and inflexible.”\(^{34}\) Dr Duncan, it will be recalled, believed that his patient’s cardiac condition made it dangerous for him to drive a charter bus. According to Justice Jeffries,

> There may be occasions, they are fortunately rare, when a doctor receives information involving a patient that another’s life is imme-

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30. Id.
34. Duncan v Medical Practitioners Disciplinary Committee, 1 N.Z.L.R. 513, 520 (1986) (Austl.).
diately endangered and urgent action is required. The doctor must then exercise his professional judgment based upon the circumstances, and if he fairly and reasonably believes such a danger exists then he must act unhesitatingly to prevent injury or loss of life even if there is to be a breach of confidentiality.\textsuperscript{35}

For Justice Jeffries there is a "clear and present danger to life or limb" exception—"fortunately rare." That kind of exception or limitation on medical confidence has been explored very recently in two cases in the English Court of Appeal.

In 1974, W shot and killed five people and wounded two others, in an episode during which he also hurled a number of hand-made bombs from his car. He was diagnosed as suffering from paranoid schizophrenia, involving delusions of persecution by neighbours. The Crown accepted W's plea of guilty of manslaughter on the grounds of diminished responsibility; after conviction he was detained in a number of special hospitals on the authority of orders made under the United Kingdom Mental Health Act 1959.\textsuperscript{36} In the course of the review process conducted by a mental health review tribunal, which began in 1984, W's solicitors instructed Dr. Henry Egdell, "a distinguished consultant psychiatrist," and himself a member of a mental health review tribunal, to prepare a report on W, for use in the review process, with a view to securing W's transfer to a regional secure unit, and ultimately his release. Dr. Egdell formed the view that W was still dangerous, and should not be transferred to less secure conditions, much less discharged. His opinion was in striking contrast to those formed by W's responsible medical officer, and by a consultant psychiatrist in the regional secure unit. Upon receipt of Dr. Egdell's report, W's solicitors withdrew his application for transfer.

Dr. Egdell wanted his report to be considered by both the tribunal conducting a routine review of W's case, and by the Home Office, the department ultimately responsible for W's disposition. W refused to agree to the disclosure of Dr. Egdell's report to the medical officer at the hospital in which he was detained. After he made further unsuccessful requests Dr. Egdell sent a copy to that officer, and copies subsequently reached the Home Office. W's solicitors took proceedings to restrain Dr. Egdell from revealing the report and requiring the delivery up of all copies of it. W was, they contended, Dr. Egdell's patient; his statements to the psychiatrist and Dr. Egdell's evaluations and conclusions were secrets not to be revealed without W's express or at least tacit consent. The trial judge, Justice Scott, dismissed

\textsuperscript{35} Id. at 521.

\textsuperscript{36} Mental Health Act §§ 60, 65 (1958) \textit{repealed by} Mental Health Act § 148(3) (1983).
W’s action. He held that though there was a duty of confidence owed by Dr. Egdell to W, it was overridden or outweighed by the public interest in the protection of members of the community secured by the communication of the report. In his judgment, Justice Scott contrasted what he labelled as W’s “private interest” in preserving the confidentiality of the report with “the weight of the public interest”. He also characterized W as a special kind of patient;

W was not an ordinary member of the public . . . . W’s own interests would not be the only nor the main criterion in the taking of those decisions [decisions about transfer or discharge]. The safety of the public would be the main criterion. In my view, a doctor called upon, as Dr. Egdell was, to examine a patient such as W owes a duty not only to his patient but also a duty to the public.\(^3\)

In parenthesis, it is easy to imagine Dr. Duncan saying, “What about me?”

There are some disquieting elements in the judgment of Justice Scott. His characterization of W as a special kind of patient, because he was held in highly secure custody, suggests that for that judge there is a different kind of duty of confidentiality than that owed to a patient then and there considered by her or his psychiatrist to be highly dangerous, like, perhaps, Frank Vitkovic in December 1986.

The Court of Appeal dismissed W’s appeal. But neither the presiding judge, Sir Stephen Brown, President of the Family Division, nor Justice Bingham (with whose judgments the third judge, Sir John May, simply agreed) adopted Justice Scott’s approach. Both emphasized that there is an important public interest, which is expressed in a legal duty, in the preservation of medical confidences. Justice Bingham explicitly rejected any restrictions on the duty of confidence flowing from W’s situation as a security patient seeking a review of his position. Those circumstances did not, he concluded,

“deprive W of his ordinary right to confidence underpinned, as such rights are, by the public interest. A restricted patient who believes himself unnecessarily confined has, of all members of society, perhaps the greatest need for a professional adviser who is truly independent and reliably discreet . . . . [R]estricted patients should not enjoy rights of confidence less valuable than those enjoyed by other patients . . . .\(^3\)

This is a principled, attractive conclusion in this context.

Both judges, however, recognized that there is another public interest that was to be weighed in a balance the other pan of which held the public inter-

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38. Id. at 420, 423.
est in the preservation of medical secrets. Its expression is in the language of the public's safety and security, and the personal safety and security of every other member of the community. It is, perhaps, as general as Cicero's declaration *Salus populi suprema est lex*. Other duties of confidence in other significant relationships might also be limited, or overborne, by the public interest in public safety. The language used in the General Medical Council's "Blue Book," to guide doctors in practice, was mentioned with approval. In the instant case, the Court understandably looked at the "index offence." W had killed a number of people in frightening circumstances. "The authorities responsible for W's treatment and management must be entitled to the fullest relevant information concerning his condition. It is clear that Dr. Egdell did have highly relevant information about W's condition which reflected upon his dangerousness," said the President. Justice Bingham concluded that

Where a man has committed multiple killings under the disability of serious mental illness, decisions which may lead directly or indirectly to his release from hospital should not be made unless a responsible authority is properly able to make an informed judgment that the risk of repetition is so small as to be acceptable. A consultant psychiatrist who becomes aware, even in the course of a confidential relationship, of information which leads him, in the exercise of what the court considers a sound professional judgment, to fear that such decisions may be made on the basis of inadequate information and with a real risk of consequent danger to the public is entitled to take such steps as are reasonable in all the circumstances to communicate the grounds of his concern to the responsible authorities.

One public interest outweighed another, and the secret was lawfully disclosed. Earlier this year, the Court of Appeal (Criminal Division) adopted the same approach in the case of *Regina v Crozier*.

The defendant had pleaded guilty to the attempted murder of his sister, whom he had attacked with an axe. The background was a family trust dispute. A psychiatrist, Dr. Wright, who examined the defendant in prison formed the view that he was sane. The trial judge postponed sentencing until a medical report was provided. A second psychiatrist, Dr. McDonald, instructed by Mr. Crozier then examined him; he prepared a report that the defendant was suffering from a mental illness of a psychopathic nature, was a danger to his family, and ought to be detained in a maximum security

39. *Id.* at 416.
40. *Id.* at 424.
facility for an indefinite period. This report was not given to Mr. Crazier's counsel; he told the trial judge there was no medical evidence to be led on sentence. The judge proceeded to sentence the appellant to nine years imprisonment. As sentence was being pronounced the psychiatrist entered the court-room, expecting to testify. He then showed his report to counsel for the Crown. The Crown's application for a variation of sentence resulted subsequently in the quashing of the sentence of imprisonment and the substitution of a hospital order coupled with a restriction order. The defendant appealed on the grounds that his psychiatrist had given the Crown the report in breach of his duty of confidentiality, and thus denied him the choice of deciding whether medical evidence would be provided to the Court. His appeal against sentence was dismissed.

Justice Watkins stated that:

[A]t first blush it seemed entirely wrong that Dr. McDonald [the psychiatrist] should take the action he did. . . . [H]e felt impelled to ensure that the court became aware of it [the opinion]. . . . [T]his too is a case where there was strong public interest in disclosure of [the psychiatrist's] views than in the confidence he owed to the appellant.42

The psychiatrist showed his report to the Crown before the appellant knew its contents.43 The Court considered that even if, as in the Egdell case, Mr. Crazier had instructed the psychiatrist and his own advocate to conceal it, "Dr McDonald [the psychiatrist] would have seen it as his duty to take the action which he did."44 Again, the safety of others, apparently identified others, was held to outweigh the public interest in preserving a patient's confidences, and what was learned in that relationship.

Croziers45 is even more emphatic an expression of the limits of medical confidence than is W. v. Egdell.46 Here the appellant's doctor revealed his report to the Crown, the overt adversary in the forensic contest which the common law still contends is conducted between protagonists on even terms. Unlike Dr. Egdell, Dr. McDonald did not ask his patient to allow him to reveal the report. Since the sentence of imprisonment was already pronounced, special procedures to set it aside had to be invoked. Time for discussion was available. But none of this seems to have affected the Court of Appeal.

These cases make it clear that, in England today, there is both a duty to

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42. Id. at 211-213.
43. Id. at 213.
44. Id.
45. 12 Cr. App. R. 206 (Crim. App. 1990)
46. 1 Ch. 359 (1990).
preserve medical secrets, and limitations upon or exceptions to that duty brought under a general rubric of "countervailing public interest." It is a piece of judicial law making much in line with what has been done by courts, including the High Court of Australia, the final court of appeal in the country, in relation to that most favoured of confidential relationships, that of lawyer and client. There the client's secrets must not only be preserved by the lawyer; the common law will not allow them to be discovered in or out of court in legal proceedings, unless the client consents. Recently, the High Court of Australia\(^4\) has held that lawyer-client privilege protects confidences outside the courtroom, so that a lawyer could lawfully refuse to allow police officers or taxation investigators, though armed with warrants, to read the papers or run the tapes. Lawyer-client privilege has long been subject to an exception where the client is using, or seeking to use, the services of the lawyer to perpetrate crime or fraud. In 1980, the High Court decided that a solicitor acting for a client who had expressly requested that her address be kept secret was bound to reveal it in the course of Family Court proceedings focussing on the custody of the client's child, with whom she had absconded. Justice Gibbs, later Chief Justice of Australia, said that

> [T]he public interest in securing the welfare of the child, and in ensuring that an order made for securing that welfare is not deliberately flouted, prevails over the competing public interest that confidential communications between solicitor and client should be protected from disclosure in order that members of the public may be free to seek that legal advice without which justice cannot properly be administered.\(^4\)

In the notorious Spycatcher case, in the final English episode in that almost universal litigious whirligig, Lord Goff of Chieveley stated, in terms of broad generality, that:

> [A]lthough the basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure.\(^4\)

IV

The balancing process does not always result in justified revelation. Not long before Dr. Egdell's case was tried, Justice Rose heard an application by an English area health authority seeking an injunction to restrain a national

\(^{48}\) R. v. Bell, 146 C.L.R. 141, 146-7 (1980) (Austl.).
newspaper from publishing a detailed report that two doctors were being treated for AIDS in one of its hospitals. The newspaper contended that publication was justified, despite a clear breach of medical confidence, because it was in the public interest. Alphabetical anonymity once again conceals all participants; the case is X. v. Y.50 The judge recognized “the very important public interest in freedom of the press.”51 He recognized “some public interest in knowing that which the defendants seek to publish . . . .”52 But he concluded that “those public interests are substantially outweighed when measured against the public interests in relation to loyalty and confidentiality both generally and with particular reference to AIDS patients’ hospital records.”53 The public, said the judge, will suffer no real deprivation of knowledge here.

[Although the evidence before me shows that a wide-ranging public debate about AIDS generally and about its effect on doctors is taking place among doctors of widely differing views, within and without the BMA, in medical journals and in many newspapers . . . .]54

In his judgment, Justice Rose was clearly influenced by the 1974 Health Service (Venereal Diseases) Regulations, made under the provisions of the National Health Service Act of 1946. Those regulations mandate health authorities “to take all necessary steps to secure that any information capable of identifying patients . . . examined or treated for any AIDS shall not be disclosed . . . except for the purpose of treatment or prevention,”55 and primarily only to a doctor engaged in such professional activities. The judge said that the Regulations obliged health authorities to preserve patient confidentiality by “taking all necessary steps.”

Lord Morison came to a similar conclusion as to the proper balance in his decision in AB v. Glasgow.56 AB sought the identity of a donor whose blood he contended was HIV-infected; he had been given that blood by transfusion in 1986. The applicant wanted to sue the donor for damages in negligence. The Court held that disclosure would be against the public interest in that “any infringement of donor anonymity would put [the supply of donor

51. Id. at 661.
52. Id.
53. Id. The reference to loyalty points to how the newspaper got the information; a hospital employee gave it copies of the medical records.
54. Id.
55. Id. at 656.
56. See generally Unreported Scottish Court of Sessions decision, December 21, 1989.
blood] at risk." That interest outweighed the public interest that in the pursuit of justice according to law all relevant information must be disclosed.

The announcement by the legislature, or by an entity to which the legislature delegates its power to make law, of a policy for the strict, even absolute preservation of medical secrets is a clear signal to courts in the business of balancing competing public interests. In the midst of the sometimes vociferous and occasionally hysterical pronouncements and counterpronouncements about AIDS and its impact, a number of Australian health statutes or regulations providing for testing, record-keeping and treatment of HIV-infected persons emphatically and in fact sternly emphasise the nearly absolute preservation of patient confidentiality. In Victoria, for example, the Health Services Act of 1988\(^5\) states that a health employee must not reveal, without express statutory authority, any information identifying a patient, except to the extent necessary for her or his treatment. The Health (General Amendment) Act 1988 deals specifically with AIDS; it imposes a duty on those persons who, in the course of providing a health service, become aware that a person is or has been tested for HIV, or is infected with HIV, to take all reasonable steps to develop and implement systems to protect the privacy of that person.\(^6\) In \textit{X. v. Y,} Justice Rose justified the enactment of this kind of legislation.

Confidentiality is of paramount importance to such patients, including doctors . . . . If it is breached or if the patients have grounds for believing that it may be or has been breached they will be reluctant to come forward for and to continue with treatment and, in particular, counselling. If the actual or apprehended breach is to the press that reluctance is likely to be very great. If treatment is not provided or continued the individual will be deprived of its benefit and the public are likely to suffer from an increase in the rate of spread of the disease. The preservation of confidentiality is therefore in the public interest.\(^7\)

These very recent cases give, or appear to give, some guidance on when a doctor may reveal a patient's secrets. When, if ever, must the doctor reveal them?

\section*{V}

One answer to that question is when the law clearly orders the doctor to

\begin{itemize}
\item \textit{1} CENTRE OF MED. L. & ETHICS DISPATCH 5 (Autumn 1990).
\item VICT. HEALTH SERVICES ACT \S 141 (1988).
\item \textit{Id.} 131.
\end{itemize}
disclose. The common law knows no patient privilege; it is the creature of statute in some common law jurisdictions, including three in Australia: Victoria, Tasmania and Northern Australia. There it only avails in most civil litigation. Otherwise in the witness box the doctor must answer, if the question is relevant and otherwise admissible. A particular statutory provision, prescribing, say, the notification to an authority of certain conditions, such as infectious diseases other than those linked to sexual behavior, or certain injuries, such as gunshot wounds, may impose a clear obligation to inform. In that kind of case, the recipient of the revealed secret will be very specific — a health department or, perhaps, the police. The legislature has, presumably, there done the business of balancing competing interests; medical confidentiality has been outweighed by the public interest in the administration of justice, or the community's general health, or the prevention of serious crime. But are there other circumstances where the law imposes a duty to reveal a patient's secret?

Courts in the United States, in the federal and in several state jurisdictions, have held there are. The leading case Tarasoff v. Regents of University of California, a decision of the Supreme Court of California in 1976, has some very slight resemblances to some of the facts which the State Coroner of Victoria discovered in the Vitkovic inquest.

On 27th October 1969, a 26-year-old graduate student at the University of California at Berkeley stabbed a young woman to death, on the porch of her parents' home. Two months earlier, the student had told his therapist, a University health service psychologist, that he intended to kill a girl. Enough was said to identify the victim. The psychologist was so concerned by these threats that he initiated procedures to have the student committed for psychiatric evaluation. Those procedures were halted by the chief of the department of psychiatry, and the student was released from campus police custody. He terminated his therapy. Neither the psychologist nor the campus police told, or tried to warn, the victim or her family of those threats. After her death, her parents instituted a wrongful death action against the psychologist and his employer, the University.

A majority of the Supreme Court of California held that both were liable.

61. VICT. EVIDENCE ACT § 28(2) (1958).
62. TAS. EVIDENCE ACT § 96(2) (1910). A new exception was added to medical privilege in 1988 in relation to where the sanity of patient was in question — see TAS. EVIDENCE AMENDMENT ACT § 4 (1988).
63. N.T. EVIDENCE ACT § 12(2).
Justice Tobriner, speaking for the court, declared that when a psychotherapist actually determines, or even when such a determination should be made as a matter of professional judgment, that a patient presents a serious danger of violence to others, the therapist is under a duty to use reasonable care to protect the foreseeable victim from such danger. The source of that duty was the special relationship between the therapist and the patient. The duty could be discharged by a clear warning to the intended victim, or by notifying the police, or by confining or controlling the patient, as the case might be.

In extended argument before the Supreme Court, which responded to strong criticism of its original decision by granting a re-hearing in which the American Psychiatric Association filed an amicus curiae brief, it heard contentions based on the public interest in the protection of the confidences of patient to doctor or patient to therapist, and especially to psychiatrist or to psychologist. Threats, the APA argued, were not uncommonly voiced in therapeutic sessions; complete candor was at the heart of the therapeutic relationship. Predictions of dangerous behavior, even if foreshadowed as threats, could not be made on a sure and regular basis. All these arguments were rejected. Justice Tobriner stated:

Our current crowded and computerized society compels the interdependence of its members. In this risk-infected society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal. If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify concealment. The containment of such risks lies in the public interest.

That decision, has been followed by, and followed in, a number of similar cases. The Supreme Court of California limited the duty to warn to a known or readily identifiable victim, like Tatiana Tarasoff. In a 1980 case, a juvenile offender, with a record of sexual assaults on and an identified propensity to attack children, was released into his mother's custody. He murdered a neighbor's child. There was no duty to warn, said the Californian Court, where the victim "was a member of a large amorphous group of potential targets." Other American courts, however, have expanded the boundaries

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67. Id. at 344.
68. Id. at 347-8.
69. Id. at 345.
70. Thompson v. County of Almeda, 614 P 2d 728, 734 (Cal 1980).
of the duty.

The United States District Court for Nebraska held that a psychotherapist had a duty to warn and protect unknown victims, as well as those identified or identifiable — presumably through confining the patient.\footnote{Lipari v. Sears Roebuck & Co., 497 F. Supp 185 (D. Neb. 1980).} A psychiatrist discharged a drug patient, with a dreadful history of substance abuse, who then injured the plaintiff in a car accident whilst under the influence of narcotics. The Supreme Court of Washington held the driver's psychiatrist, and the State hospital that employed him, liable for failing to continue to confine their patient.\footnote{Petersen v. Washington, 671 P2d 230 (Wash. 1983).} The United States Court of Appeals for the Ninth Circuit has held that a psychotherapist owes a duty to warn, and protect, a victim of a patient diagnosed as "potentially dangerous," though no threats to that victim had been uttered.\footnote{Jablonski v. US., 712 F 2d 391 (9th Cir. 1983).} The Supreme Court of Vermont recently held that a mental health professional has a duty to protect a third person from the infliction of physical harm threatened by a patient—and that included damage to property as well as to the person.\footnote{Peck v. Counselling Serv., 499 A 2d 422, 427-28 (Vt. 1985).} The parents of a man who burnt down the barn on the family farm, as he threatened to do in an interview with his psychotherapist, recovered damages.

These pieces of judicial law-making have, not surprisingly, been deployed in discussions in the United States, and in other common law countries, about duties to warn spouses and, at least, known partners and associates of AIDS victims, or even those people testing positively for HIV infection. Rock Hudson's former sexual partner sued two physicians who had treated Hudson, alleging that they conspired to prevent him from learning of Hudson's disease and his condition. In February 1989, a Los Angeles jury awarded Marc Christian $21 million dollars for the "emotional distress" he had suffered as a result of the non-disclosure.\footnote{Rock Hudson's Lover Wins Suite, N.Y. Times, Feb. 16,1989, at 22; Hudson's Lover Wins $7 million More, N.Y. Times Feb. 18, 1989, at 7; AIDS Award May Be Trimmed, N.Y. Times Apr. 8, 1989, at 9.} The trial judge, concluding that the jury had allowed their "passion" against Hudson to color their thinking, reduced the amount of damages to $5.5 million dollars.\footnote{AIDS Award May be Trimmed, N.Y. Times Apr. 8, 1989, at 9.}

That is but one much-publicized case. The Tarasoff decision, and the later cases, build on much earlier American decisions that held that a doctor was under a legal duty to warn a patient's family of an infectious or contagious disease. Waiting in the forensic wings are cases which say, an AIDS patient has, after counselling by the doctor, agreed to tell her or his spouse or part-
ner of the condition—but has not done so. What is the doctor’s legal situation then?

There have been no cases such as these litigated in Australian, or in English, or Scottish courts—yet. There are no barriers to the institution of such sorts of litigation. More than 30 years ago, Sir Harold Barrowclough, Chief Justice of New Zealand, decided that a doctor owed a duty of care to his patient to avoid causing her physical harm through his negligence. What is the novelty, indeed the relevance, of that? It is that the case turned on a patient’s secrets and their disclosure by her doctor, who treated both her and her husband. She thought her husband was becoming insane and intended to poison her. He was not, but her statements that she believed he wanted her dead disrupted the marriage. The husband implored their doctor to give him a certificate about his wife’s mental state, which could be given to his solicitors. Finally the doctor did: It ended with his opinion that “she exhibited symptoms of paranoia and should be given treatment for same if possible.” This certificate was subsequent produced by counsel for the husband when he cross-examined the wife in separation proceedings. The wife suffered nervous shock, and sued her doctor. The Chief Justice held that the doctor owed the wife a duty not to disclose confidential information about her in any circumstances, when he could have foreseen it would cause her physical, including mental, harm or damage.

The possibilities for developing this legal conclusion particularly by arguments based on analogy, are considerable. Its authority is slight, but it has not been challenged since the case was decided in 1958, and it is constantly cited in modern cases and scholarly writing on the subject of medical confidences.

The common law in England and Australia recognizes already that in some situations a person may be bound to control the actions of other human beings, to avoid harm to others at their hands, or to warn those reasonably foreseeable as at risk. In 1970, for instance, the House of Lords held the Home Office was liable to the Dorset Yacht Company for the failure of prison officers to prevent the escape of seven Borstal boys, who in fleeing boarded an expensive vessel in Poole Harbour and badly damaged it. Courts in Scotland have imposed liability on owners of buildings for destruction caused by vandals whom they, in breach of their duty, failed to keep out. Courts in England, and in Australia, have imposed liability on par-

78. Id. at 397.
ents. and on schools and education authorities, when children or students have harmed others, even strangers, in various circumstances. True, in all those cases there were established powers of control invested in the luckless parents, teachers or gaolers. But there are clearly forensic opportunities. Developments in the rich litigious pastures of the United States stimulate and sometimes strongly encourage the institution of proceedings in other jurisdictions. The much publicized Agent Orange defoliant suits are one instance.

There is an older and more famous basis for these comments. In his celebrated speech in Donoghue v. Stevenson, doubtless the best known civil case decided in our century, and one which gave unique impetus to the development of tortious liability for causing negligent injury, Lord Atkin ended with this:

> It is always a satisfaction to an English lawyer to be able to test his application of fundamental principles of the common law by the development of the same doctrines by the lawyers of the Courts of the United States. In that country I find that the law appears to be well established in the sense in which I have indicated. The mouse had emerged from the ginger-beer bottle in the United States before it appeared in Scotland, but there it brought a liability upon the manufacturers.

The imposition of a duty to warn of known or clearly foreseeable dangers from a patient may be developed, in modest stages or even in broad terms, if the accidents or incidents of litigation in Australia, or in England, or in Scotland, present courts with that issue.

VI

In the relationship of doctor and patient, it is today the general rule that secrets will be kept inviolate. Courts today recognize and apply that rule. Legislatures and subordinate law making agencies embrace and embroider

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81. Evans, SLT at 17.
82. Ramsay v. Larsen, 111 C.L.R. 16 (1964) (Austl.).
84. Australian and New Zealand veterans from the Vietnam War [1961-72] joined, using the mechanism of a class action, with United States veterans in a suit which the latter had already begun against the Dow Chemical Coy. and others. There was an enormous amount of litigation, see re Agent Orange Product Liability, 597 F. Supp 740, 876-78 (E.D.N.Y. 1984), for a list of the large number and variety of actions involved in this matter up to approximately 1984. Australian and New Zealand veterans eventually were awarded a proportional share of the total settlement figure, In re Agent Orange Product Liability, 611 F. Supp 1396, 1444 (E.D.N.Y. 1985), aff'd, 818 F. 2d 179 (2d Cir. 1987), cert. denied, 487 U.S. 1234 (1988).
it, especially in some of the particular enactments produced in response to the threats seen as presented by AIDS and AIDS-related conditions. In Australia, the enactment of general privacy legislation by the federal Parliament, which it is likely at least some of the state legislatures will copy, strongly buttresses that rule. Yet we see that it is not absolute. Are its limits now clearly defined? Have doctors, and their patients, received precise instructions that set out the situations where confidences may, or must, be breached? I think not. This is an unsatisfactory, and unsafe, situation. The safety of the community from an apprehended attack, such as occurred in Queen Street, Melbourne, or the preservation of any single person’s life or bodily welfare, clearly justify the revelation of a medical secret. But circumstances are all important. Judgments of “when” and “how” and “to whom” are critical. The values of life, and of bodily integrity, have been given great weight in judicial balancing processes—after the event. Doctors need to know in advance, when they may, or must, reveal a patient’s secret.

One reaction to what may be seen as the absence of any complete guidance on the limits of medical confidentiality is to propose specific legislation to meet an identified need. In his report on the Queen Street massacre, the State Coroner of Victoria said that he was concerned that in December 1986, Vitkovic was considered by a psychologist to be in need of psychiatric assistance, but, by reason of the psychologist’s professional and ethical considerations, did not receive help. He recommended that consideration be given to the framing of regulations under the terms of the then recently revised and reenacted Psychologists Registration Act of 1987. These would require, the Coroner proposed, any psychologist administering or interpreting certain psychological tests to which the statute adverts, who formed the opinion that a patient or client “is likely to be a danger to himself or herself or others” to take all reasonable measures to make that person attend for or submit to psychiatric examination and treatment. The bulk of the Act remains unproclaimed, and no Regulations have been yet prepared. By contrast, there was a swift, almost immediate, response, even before the State Coroner’s enquiry was ended, to an identified lacuna in Victoria’s firearms legislation and its administration that allowed Vitkovic in late 1987 to buy a semi-automatic rifle. Before 1987 ended the Firearms Regulations were amended. Were the Coroner’s recommendations to be adopted there

87. See State Coroner’s Report, supra note 1, at 2.
88. Id. at 24.
89. Id.
90. Id. at 26.
would be no precise guidance to any health professionals except registered psychologists. Neither doctors in general practice nor psychiatrists would be affected.

There are directions to doctors and health professionals in some of the specific enactments which various legislatures, in Australia92 and in the United States,93 have passed to respond to the now universal spread of AIDS and AIDS-related conditions. These range from unequivocal prohibitions on the disclosure of any identifying information,94 even in the course of complying with mandatory provisions for the notification of AIDS and AIDS-related conditions, which I have already mentioned, to several American measures95 permitting disclosure of the condition by a doctor to a patient's spouse if the doctor reasonably believes that the patient will not voluntarily reveal it. There is, as might be expected, a cornucopia of models provided by some of the fifty-one legislatures in the United States. In the AIDS context, there are continuing, ever sharper tensions where disclosure to other health professionals providing care may be justified under current legislative provisions, but not to a spouse—even a wife anticipating a pregnancy. Notwithstanding these instances, the very precision and clarity of some of such particular statutes serve to accentuate what is lacking in those cases where AIDS or HIV infection does not figure in the doctor-patient relationship.

The very recent cases96 postulate that a balancing process must be undertaken to determine whether a medical secret may be revealed. In the nature of the making of law by judges, confined as Mr. Justice Oliver Wendell Holmes Jr. said, "from molar to molecular motions," they do offer guidance in England, until the House of Lords speaks, in those cases where it is highly likely, or probable, that the patient may kill or cause serious physical injury to others because there is evidence that she or he has already done that. They are persuasive in other parts of the common law world, to that same degree. Doctors and other health professionals are entitled to claim more direction, especially since decisions may need to be made very quickly, and

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95. CAL. HEALTH & SAFETY CODE § 199.25 (West 1990).
96. Tarasoff v. Regents of Univ. of California, 551 P 2d 334, 345 (Cal. 1976) (psychotherapist's duty to reveal medical secret limited to a known or readily identifiable victim); cf. Lipari v. Sears Roebuck & Co., 497 F. Supp 185, 193 9D. Neb. 1980 (physician's duty broadened to cover anyone whom the doctor could reasonably foresee as at risk from the patient).
without even that comforting consultation with senior colleagues, or reference to a medical defence society or professional association, as suggested in the rules of the GMC, which received such favorable scrutiny in *W. v Egdell.* Once the decision is made to reveal the secret, the situation changes forever. It can never be recovered, as may be possible in other breach of confidence situations involving commercial or trade secrets, or even government secrets, where proliferation and publication to a wide audience are the real concerns. The job may be lost, the marriage sundered, the body broken, the years added to a prison sentence. Or a less formal but nonetheless precious relationship may be irreparably affected. “Until you speak, the words are your prisoners,” runs a Yiddish proverb. “Once you speak,” it goes on, “you are theirs.”

The judges and the courts whose decisions I have considered, have understandably accorded weight and paid close attention to the statements made by professional bodies in the field of medicine. Given the disciplinary role and powers of the General Medical Council, its advice to the British medical profession is of great force and effect, as was emphasized in Dr. Egdell’s case. Its Rules state that

Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by the police of a grave or very serious crime, would override the doctor’s duty to maintain his patient’s confidence.

That sole example points those who read the text to past conduct and its consequences. The 1984 version of the Code of Ethics of the Australian Medical Association states:

It is the practitioner’s obligation to observe strictly the rule of professional secrecy by refraining from disclosing voluntarily without the consent of the patient (save by statutory sanction) to any third party information which he has learnt in his professional relationship with the patient.

The complications of modern life sometimes create difficulties for the doctor in the application of the principle, and on certain occasions it may be necessary to acquiesce in some modification. Always, however, the overriding consideration must be the adoption of a line of conduct that will benefit the patient or protect his interests.

The principle of professional secrecy still applies as between husband and wife but there are times when consent if not actually
given by a spouse could be reasonably inferred. The decision whether to divulge the information to the other spouse, when consent has not been obtained, would be a matter for the discretion of the attending practitioner which he must exercise with the greatest care and for which he must accept full responsibility at all times. He must adopt a line of conduct that will benefit the patient and protect the patient's interest. Moreover, if he does anything which damages the patient's interest he renders himself liable to an action at law.99

This language, which does not have the status of the Rules in the Blue Book but to which many Australian doctors will refer, could attract the acerbic comment which Australia's great Chief Justice, Sir Owen Dixon, enjoyed uttering in other contexts:

It was an American girl who said of the Ten Commandments that they confuse your mind and do not tell you what you ought to do.100

In June 1990, the Scottish Home and Health Department published a Code of Practice on Confidentiality of Personal Health Information. Its status is that it is part of the duty statement affecting all employees of the Scottish Health service, and it is incorporated into agreements with independent contractors. The Code states that it also applies to "students and trainees ... to local authority social workers who operate within the Health Service, and to voluntary workers and to any person who is granted access to personal health information."101 "Personal health information" is defined, or described, in very broad terms; it includes information supplied to the SHS "by local authority education and social work departments and other statutory and voluntary organizations."102 It applies "to information on personal, family or social circumstances which is relevant to an individual's health or treatment and becomes part of the personal health information."103

The central element in the Code is that personal health information is confidential. It should only be disclosed in connection with "health care and social welfare" to those SHS personnel who "need to know" so that "effective treatment and care" may be provided. It may not be disclosed without

101. Scottish Home and Health Department. Confidentiality of Personal Health Information Code of Practice cl. 4 (June 1990) [hereinafter Scottish Home & Health].
102. Id. cl. 5.
103. Id.
the patient's consent, which may be implied in a variety of circumstances, unless "disclosure is required by statute or is ordered by a court of law or by a body or person empowered by statute to require such a disclosure." The Code announces that patients should be informed of these matters, including the purposes of proper disclosures, the recipients of any disclosed information, and the safeguards to be applied, through information leaflets or the inclusion of a suitable section in a hospital patients' handbook.

The publication of the Code attracted what the Nursing Times called "a howl of protest from Scottish GPs." The focus of that was the section of "Disclosure by Implied Consent", which the BMA's Scottish General Services Committee thought was so widely cast that it would lead patients to a reluctance to give their doctors sensitive information, for fear it would be disseminated widely inside and outside the health system. Official efforts to allay those fears have been made. The AMA has asked for the Code to be withdrawn.

The SHS Code contains one section entitled "Disclosures Without Consent." It has not been the focus of the BMA's or Royal College of Nursing's Scottish Board's criticisms. These disclosures, the Code states, are "a last resort." "Every reasonable effort should be made to obtain the patient's consent." But there are three areas where, when that consent cannot be obtained or is adamantly refused, there is a discretion—the Code's term—to disclose personal health information. These are:

Where disclosure is in the wider public interest Such circumstances require the wider public interest to outweigh the rights of a patient to confidentiality. This might include cases where disclosure would prevent a serious risk to public health, or assist in the prevention, detection or prosecution of serious crime. In some cases the duty to disclose details may lie with the patient.

Where disclosure is necessary to prevent serious injury or damage to the health of a third party

In such instances, it will be necessary to assess the risk and the seriousness of the potential injury or damage to the third party against the rights of the patient to confidentiality.

Where disclosure is in the best interest of the patient

104. Id. cl. 6, 3.
106. SCOTTISH HOME & HEALTH, supra note 101, at cl. 8-10.
107. Id. cl. 8.
108. Id.
109. Id., cl. 9.1.
110. Id. cl. 9.2.
111. Id. cl. 9.3.
In exceptional circumstances the interests of the patient may outweigh the need for confidentiality even where there has been explicit refusal to give consent, but this should only be done after the most careful consideration.

The enunciation of these conditions is in more extensive terms, and at least apparently more precise, than what appears in the GMC's Rules or the AMA's ethical statement. The last of the three areas is laden with ambiguities and offers the possibilities of paternalistic interventions and revelations, particularly as affecting information to a patient's spouse or another family member. Information, it will be recalled, may be disclosed for the purposes of both health care provision and social welfare. The first two areas, however, spell out more clearly the limits of medical confidentiality for Scotland—at least as far as the widespread operations of the Scottish Health Service are concerned. The GMC's Rule 81(g), and the import of *W. v. Egdel* 112 and *R. v. Crozier*, 113 which focus on dangerous propensities evinced by past acts, may be contrasted with the Code's language. The second area encompasses situations such as those in the tragic *Tarasoff* case, 114 but not, perhaps, those threat situations where no specific third party is identified as the target. The Code concludes that section with a sober warning:

Disclosure without consent always raises extremely difficult questions involving moral, ethical and medical issues and such cases must be considered with great care.115

This section of the Code deserves more praise than criticism. Its overall emphasis is right. It does seek not only to signal to doctors and health professionals that there are instances where secrets may be revealed but also to advise them of the serious matters that must be examined and considered and the competing considerations that may need to be weighed. The Code's instructions on the importance of providing comprehensive patient information on these matters are particularly commendable.

There is a model which may, with appropriate diffidence, be offered as worth consideration in terms of improving further the Code of Practice. Earlier I mentioned the guidelines for the Protection of Privacy in Medical Research made by the NH & MRC of Australia, under the terms of the novel Privacy Act of 1988. In its Report on Informed Decisions about Medical Procedures, published in 1989, the Law Reform Commission of Victoria, in conjunction with the Australian and New South Wales Law Reform

112. 1 Ch. 359 (C.A. 1990).
115. SCOTTISH HOME & HEALTH DEPARTMENT, supra note 101, at cl. 10.
Commissions, recommended\textsuperscript{116} that detailed guidelines on the provision by doctors to patients of information concerning medical treatment and procedures be prepared. The nature and contents of the guidelines will encompass both general requirements and extensive illustrations “by reference to specific procedures.” Checklists of matters on which information should be given, covering choices and risks, may be included. Detailed examples setting out appropriate information may be produced. In relation to medical confidentiality and its limits, the adoption of this approach could result in the expansion of the SHS Code’s section on “Disclosure Without Consent”, say, to encompass accounts of actual and hypothetical situations which have presented themselves, or which may arise, with decisions clearly set out on whether the doctor should speak, or keep quiet. Even specific scripts for use in attempting to obtain the patient’s consent, as a necessary preliminary to disclosure in some instances, or to explain to a patient why a secret would be revealed, in others, could be incorporated in such guidelines.

The Australian Report on Informed Decision Making recommends that the guidelines receive recognition in appropriate legal contexts, either in actions where a patient seeks damages from a doctor,\textsuperscript{117} or in disciplinary proceedings for professional misconduct.\textsuperscript{118} Similar steps could be taken in relation to guidelines, or to an expanded Code of Practice, on medical confidentiality. The Report goes on to recommend that the guidelines be prepared under the auspices of the NH & MRC, so that they will be Australia-wide in operation, and will draw both on medical expertise and medical consumer contributions (in line with the normal practice of the Health Care Committee of the NH & MRC to include wide representation from the community on all its preparation subcommittees.) The Report recommends\textsuperscript{119} that the guidelines be disseminated widely, especially in undergraduate and post-graduate education programmes for doctors and health caregivers; by major teaching hospitals and private hospitals developing protocols for giving information to patients; by health complaints and medical disciplinary bodies reporting regularly on doctor/patient communication issues brought before on them; and by general patient education. All of these measures could be adopted in relation to an expanded Code of Practice or guidelines, on medical confidentiality.

\textsuperscript{117} Id. at 30.
\textsuperscript{118} Id. at 31.
\textsuperscript{119} Id. at 26.
VII

The preparation, the promulgation, and the wide dissemination of guidelines or of a comprehensive, expanded Code of Practice, with its proper setting in the texture of the law relating to the restraint of disclosures, or of compensation for breach of confidence, and professional discipline, will be of value for doctors, for health professionals, and for their patients and their clients. It should be made clear that as a matter of law a justified disclosure will carry protection from both disciplinary actions, and from suits for compensation for revealing medical secrets. That should also ensure that any litigation arising out of alleged failures to warn will not be instituted with any chance of success where the guidelines, or the Code, have been followed.

But it will not, because it cannot, remove always and everywhere a doctor’s need to decide, often alone, often swiftly what the Scottish Code of Practice describes as some “extremely difficult questions involving moral, ethical and medical issues . . . .”120 That task, however may be made less difficult than it is today. Doctors, and their patients, and that means us all, are entitled to expect that it should be.

120. SCOTTISH HOME & HEALTH DEPARTMENT, supra note 101, at cl. 10.