Can you tell? Should you tell?

Dr Paul Nisselle, AM, MB BS, FRACGP

AT A RECENT MEDICAL BOARD HEARING, a finding of "gross carelessness and improper conduct" was made against an Australian Defence Force doctor who had, according to the Board, "improperly referred [a senior officer] to a psychiatrist in the absence of any symptoms" and "acted against [the officer's] trust and confidence" when he conveyed his concern about the officer's mental state to her Commanding Officer. There were a number of legs to the complaint — first, that he wrote inaccurate reports about the patient; second, that he referred the patient to a psychiatrist without her consent; and third, that he breached his duty of confidence by discussing the patient's condition with her CO. Predictably, this precipitated a wave of concern, as both ADF doctors and the COs of the units to which they are attached would expect doctors to breach patient confidentiality if they believed, on reasonable grounds, that there was a significant chance that others could be put at risk by a patient's illness.

There is no question that, even in the armed forces, doctors have a duty of confidentiality to their patients. People do not give up their right to medical privacy just because they have enlisted. But doctors sometimes must decide, when there is a conflict between their duty of confidentiality to the patient and their duty to prevent foreseeable harm to others, which duty should prevail. It is certainly wrong, but can breaching patient confidentiality be seen as the lesser of two evils?

In 1969, Lord Denning, the most famous English Law Lord of the 20th century, said:

> [T]here are some things which may be required to be disclosed in the public interest, in which event no confidence can be prayed in aid to keep them secret.[1]

In that same year, I came (in all modesty) to a similar conclusion, while temporarily serving as an Army doctor.

Paul Nisselle *was a general practitioner in suburban Melbourne for 18 years before entering the medical indemnity industry in 1989. He writes and lectures widely on medicolegal issues. He was for 30 years a Council Member of the AMA Victoria, during which time he served terms as President, Chairman and Federal Councillor. He is a past member of the Medical Practitioners' Board of Victoria, and is currently a member of Victoria's Health Services Review Council, a director of the AMA Health Fund, has appointments at Monash University's Faculty of Medicine and is the Convenor of Medical Panels in Victoria's WorkCover system (a ministerial appointment).*

Medical Defence Association of Victoria, Carlton, VIC.
Paul Nisselle, AM, MB BS, FRACGP, Senior Advisor, Risk Management.
Correspondence: Dr P Nisselle, Medical Defence Association of Victoria, PO Box 1059, Carlton, VIC 3053. paul.nisselle@mdav.org

In the 1960s, medical students conscripted as a result of the ballot system in place during the Vietnam War deferred entry into the Army until they had completed their course and their intern year. In 1969, none had yet entered service and there were not enough ADF doctors to fill all medical posts. Hence, as an intern at the Royal Melbourne Hospital, I found myself in a 5-week rotation in a Regimental Aid Post at Puckapunyal — in uniform, with a temporary commission as a Captain.

One day at Sick Parade, I saw a soldier sent to me straight from guard duty. He arrived in full uniform, carrying his rifle, with bayonet still attached. He had been heard to threaten that, when next sent on manoeuvres, he planned to roll a grenade into the sergeant's tent. Those around him at the time felt that he was mentally ill, so he was sent to the doctor, not the stockade. When I saw him, even as a very recent graduate I recognised the diagnostic stigmata of schizophrenia — paranoid delusions, inappropriate affect, and knight's-move thinking. He was a "volunteer" conscript. Although he had said in his application that he wished to serve his country, he told me that he had joined to learn the skills necessary to "deal" with people conspiring against him back home. I contacted his CO and the senior medical officer and arranged for the man to be escorted to Watsonia to undergo specialist psychiatric assessment. (The consultant agreed with my diagnosis and ordered the man's medical discharge from the Army — but arranged no referral to a civilian psychiatric service!)

This is the type of breach of confidentiality with which most doctors would be familiar. We all learned as students that, if a mentally ill patient is a risk to themselves or others, we can recommend them for certification. That recommendation is sufficient to allow the person to be taken and held, without their consent, in a psychiatric hospital, for a defined period. During this period, they must be formally assessed by the psychiatric superintendent (or deputy) of the hospital, who will then either formally "certify" the patient and continue the involuntary detention, or not accept the recommendation for certification.

Legal sanction for breaching patient confidentiality

The key to psychiatric certification is that the breach in patient confidentiality is sanctioned by law — when made to the appropriate authority. The patient's common law right to confidentiality is overridden by statute. Perhaps the ADF doctor in the recent case erred by notifying his CO and a

psychiatrist, as I did in 1969, and not making a formal recommendation for certification.

There was much publicity given to the judgment handed down in the Supreme Court of New South Wales in 2003, in *PD v Harvey*.[2] A woman and her fiancé consulted a general practitioner, requesting screening for sexually transmitted diseases, including HIV. The woman knew her prospective husband came from an area in Africa with a high incidence of HIV infection and wanted to ensure it was safe to commence a sexual relationship with him.

At that joint consultation, the GP did not seek the consent of the patients to have their test results conveyed to each other. The woman later rang to get her results, which were negative, and asked for her fiancé's results. She was told that she would have to ask him.

When the man rang, he was told he was HIV positive, and was told the doctor had made an appointment for him to attend an HIV clinic and would leave a letter of referral at the reception desk for him. The man did not attend the HIV clinic, and altered the test report to make it appear he was HIV negative. On the basis of that fraudulently negative report, the woman commenced a sexual relationship and was later found to be HIV positive. By that time, the relationship had ended and the man had left Australia.

The woman involved sued the doctors who had seen her, alleging *inter alia* that they had a duty to prevent her from foreseeable harm. The Court found for her — but for a different reason.

In NSW, a patient's common law right to confidentiality is confirmed by section 75 of the Public Health Regulation 1991. It was argued for the doctors that:

> . . . without a patient's consent, a medical practitioner disclosing information would have a defence to a prosecution under [section 75 of the Public Health Regulation 1991] because of what was recognised by a responsible body of medical opinion to be the "higher duty" of the medical practitioner to the public in general and to their patient in particular.

However, the Judge said, "I do not accept this submission." He went on to find that the lack of proper pre-test counselling was a negligent omission, as it clearly did not meet the health department's guidelines. Another negligent omission was that the doctors did not contact the man to tell him that, unless he attended the HIV clinic and demonstrated to them that he had informed his fiancée of his HIV status, they were required by legislation to refer him to the Director-General of Health as a person known to be HIV positive who was not attending for review and was putting others at risk. Finally, they negligently failed to comply with that legislation by not reporting him to the health department.

So it was not necessary for the doctors to breach their common law duty of confidentiality to the man to prevent foreseeable harm to the woman, because they had a statutory power (and immunity from civil action for breach of confidentiality) to report the man to the health department. Section 7(2) of the Regulation permits disclosure to the Director-General of Health in NSW where a healthcare worker has reasonable grounds to believe that failure to disclose could place the health of the public at risk. If the doctors had done that, it would then have been the responsibility of the health department to perform the necessary contact tracing and notification. The woman would have been told the man's HIV status, and could have taken steps to reduce her risk. The doctors were found negligent for not acting in accordance with the applicable sections of the Public Health Regulation, not for a direct failure to tell the woman the man's HIV status.

Psychiatric certification and notification of specified infectious diseases are examples of situations where a doctor has a statutory duty to breach patient confidentiality. There are other circumstances in which a duty imposed by law is balanced by legislated immunity from civil action where a doctor breaches patient confidentiality. For example, doctors cannot be sued if they report to the relevant authority that a patient is no longer medically fit to hold a driver's licence. Mandatory reporting of child abuse is a more subtle example. Such laws are stated to require doctors to report a *suspicion* of child abuse. Alleging unfitness to hold a driver's licence is based on measurable or demonstrable facts (eg, poor vision). If a doctor waits for factual confirmation of child abuse before making a report, it may be too late. What is a *suspicion*? In fact, the point of the legislation is not so much to prescribe punishment to people who fail to make a report, but to protect, by statutory immunity, people who report a suspicion, in good faith, and without malice. But that protection only applies to reports made to the relevant authority. It would not apply, for example, if you told a mother that her husband (a patient) had admitted abusing their child.

In a New Zealand case,[3] a doctor was successfully sued by a woman for giving a report to her husband's solicitors about her mental condition, without her consent. The report was used to her detriment in divorce proceedings. If the doctor was sufficiently concerned about her mental health, he would have been immune from litigation if he had recommended her for certification. But giving a report to her husband without her consent was a clear breach of his duty to her.

Duty to the community

Is there any weight to the argument that a duty to the community at large (even a closed community like a defence force unit) can override the duty of confidentiality to a patient?

There is one Californian judgment that addresses this point.[4] Tatiana Tarasoff, a student at the University of California in the 1970s, was murdered by a mentally disturbed fellow student, Prosenjit Poddar. He had earlier discussed his intention to kill her with a University Health Service psychologist, who felt bound by his duty of confidentiality not

to report this threat to Ms Tarasoff directly. However, the psychologist did tell his supervising psychiatrist, who reported the matter to the campus police, who interviewed Mr Poddar, but let him go. After the murder, the girl's parents sued the psychologist (or, rather, his employer) for "failure to warn", in that no warning was conveyed to their daughter. The trial Court held that no such duty to warn existed, but, on appeal, the Californian Supreme Court disagreed and found for the parents of the dead girl.

The appeal judgment cited a 1920 precedent from New England.[5] A doctor had seen a young man who appeared to have syphilis. At that time, syphilis was not considered a venereal disease, but generally contagious with simple contact. Thus, the doctor advised the man to leave the boarding house. He did not. The doctor warned the landlady of the boarding house about the patient's syphilis. She ejected him from the boarding house, whereupon he sued the doctor in the Supreme Court of New England, alleging breach of the doctor's common law duty of confidentiality to him. The Court found for the doctor, saying he had a professional obligation to protect the public. The Court said, succinctly, "[T]he private privilege ends where the public peril begins."

This is a very similar sentiment to that expressed by Lord Denning in 1969, on the other side of the Atlantic (see earlier).

Conclusion

So where does all this leave you?

I believe that sometimes a doctor is justified in breaching confidentiality to prevent a greater harm. The key is the proper form for the "breach". Doctors should be aware of law that allows them to protect the public by providing information, in accordance with the law, to relevant authorities. If a doctor is seen to act thoughtfully, on reasonable grounds, without malice, he or she is unlikely to face a significant judgment if there has been a breach of confidentiality — provided the doctor has used such legal avenues as are prescribed and available, and only directly breached confidentiality when there were no statutory avenues available. In this circumstance, the doctor must be prepared to demonstrate that he acted on sound clinical grounds, in good faith, and without malice.

Competing interests

None identified.

References

1. *Fraser v Evans* [1969] 1 All ER 8,11.
2. *PD v Dr Nicholas Harvey* [2003] NSWSC 487.
3. *Furniss v Fitchett* [1958] NZLR 396.
4. *Tarasoff v Regents of the University of California* 529 P 2d 253 (1974).
5. *Simonsen v Swenson* (1920) [NE 104 Neb 224, 177 NW 831 NE Supreme Court].

Malaria update

Malaria in the ADF

Seven cases of malaria in ADF personnel were reported to the Central Malaria Register in the period 1 July – 31 December 2004.

One case was diagnosed on return to Australia from East Timor.

Three cases were diagnosed on return to Australia from the Solomon Islands. One of these was a relapse of a previously acquired infection.

Three cases were acquired in mainland Papua New Guinea.

Total malaria infections in ADF personnel in various deployments

East Timor, September 1999 – December 2004	
Diagnosed in East Timor	82
Diagnosed on return to Australia	388
Total	**470**
Solomon Islands, July 2003 – December 2004	
Diagnosed in Solomon Islands	0
Diagnosed on return to Australia	12
Total	**12**
Iraq, February 2003 – December 2004	
Diagnosed in Iraq*	1
Diagnosed on return to Australia	0
Total	**1**

*This case appeared to be an infection acquired in Papua New Guinea before deployment to Iraq.

Major Nathan Elmes
Research Medical Officer, Army Malaria Institute

Malaria reporting

All Health Service personnel are encouraged to notify the Central Malaria Registry promptly when a malaria casualty is detected. Informal notifications preceding a PM40 can be made by telephone (07) 3332 4836 or by email Nathan.Elmes@defence.gov.au