
Limits of confidentiality

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This paper has two objectives: to review some aspects of the law of confidentiality in the health care field and to evaluate how the law of confidentiality impacts on the processes of child protection.

The law of confidentiality

The law of confidentiality can be regarded as having a “multi-faceted and undefined jurisdictional basis”. (Toulson & Phipps, 1996, p. 37). This absence of jurisdictional certainty will be significant in evaluating entitlement to pecuniary compensation for breach of confidentiality, particularly in the context of commercial litigation. For practical purposes the duty of confidentiality in the health care field is referred to, used, and acted on, despite the uncertainty of its legal origins. However, this uncertainty at the heart of the legal concept may be reflected in the lack of precision in its practical application.

General principles

“A duty of confidence arises when confidential information comes to the knowledge of a person (the confidant) in circumstances where he has notice, or is held to have agreed, that the information is confidential, with the effect that it would be just in all the circumstances that he should be precluded from disclosing the information to others” (A.-G. v. Guardian (No. 2), 1988).

It is legally well established that the relationship between doctor and patient constitutes such a circumstance. Therefore, in the event of breach of this legal duty legal action may follow including injunction and damages. The nature of the confidential relationship needs to be set out. The relationship between doctor and patient creates an obligation of confidence. However, the patient can,

by consenting to the disclosure of information, waive the obligation. Although information is described as being confidential, in reality the person to whom the duty of confidentiality is owed can, in general terms, do what he or she chooses with the information.

Striking a balance

There have been few cases in this area of law in the health care field that have come before the courts. When cases have been decided, the judges have had to strike a balance between the public interest in upholding confidentiality and the public interest in the disclosure of the information.

The case of *X. v. Y.* involved newspaper attempts to publish information from health records about two doctors who were continuing in general practise despite having contracted AIDS. The doctor’s employers obtained injunctions restraining the press from publishing the information. The judge referred to the various competing public interests that existed in the following terms:

“On the one hand, there are the public interests in having a free press and an informed public debate; on the other, it is in the public interest that actual or potential AIDS sufferers should be able to resort to hospitals without fear of this being revealed, that those owing duties of confidence in their employment should be loyal and should not disclose confidential matters and that, *prima facie*, no one should be allowed to use information extracted in breach of confidence from hospital records even if disclosure of the particular information may not give rise to immediately apparent harm” (*X. v. Y.*, 1988)

Taking into account these factors the judge decided that the information should remain confidential. However, in other circumstances the public interest in protecting confidentiality is outweighed by other, competing public interest considerations favouring disclosure. Justifications for disclosure on the ground of public interest may centre on public debate and

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press freedom or, in the case of *W. v. Egdell* (1990), the threat of serious harm to the public.

Limits of confidentiality

Confidentiality is not absolute. There are a number of exceptions to the obligations of confidence. Most obviously, where a patient consents to disclosure of confidential information and where a court requires confidential information to be provided. Other exceptions include statute, the public interest and 'need to know'.

Statute

Various statutory provisions affect and modify the obligation of confidence.

Disclosure is required

The Road Traffic Act 1988 requires that persons, including health professionals, must provide the police on request with any information that might identify a driver who is alleged to have committed a traffic offence.

The Public Health (Control of Diseases) Act 1984 requires a doctor to notify actual or suspected cases of patients suffering from various forms of infectious diseases to the local authority.

Various statutory instruments relate to the notification of industrial accidents and diseases, notification of births and deaths, and registration of addicts.

Disclosure may be compelled

Under the Supreme Court Act 1981 court orders may be made for disclosure of medical records in certain categories of litigation.

The Police and Criminal Evidence Act 1984 allows the police to gain access to medical records for the purpose of a criminal investigation on the order of a judge.

Confidentiality may be qualified

The Mental Health Act 1983 qualifies the obligation of confidence by requiring that a patient's nearest relative must be consulted before an application for admission under the Act is made.

Under the Mental Health (Patients in the Community) Act 1995 the responsible medical Officer (RMO) is required to consult a patient's

nearest relative before making a supervision application. The patient is entitled to object to this consultation proceeding. The RMO can consult regardless of the patient's expressed wish if the "patient has a propensity to violent or dangerous behaviour towards others".

Protection of confidentiality of third parties by statute

The Access to Medical Reports Act 1988 allows access to be refused in order to maintain the confidentiality of the doctor's informants. The Access to Health Records Act 1990 allows a health record to be withheld for similar, and other, reasons.

Public interest

"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, might override the doctor's duty to maintain his patient's confidence" (*W. v. Egdell*, 1990).

Guidance which is similar to this description is provided by the General Medical Council (1995). It is important to make clear that the judge of what constitutes the public interest in these circumstances is the individual health professional.

In *W. v. Egdell*, Dr Egdell was instructed by solicitors representing a patient detained in a special hospital in the context of the patient's application to a mental health review tribunal. Dr Egdell's appraisal of the patient was at variance with that of the patient's RMO. Dr Egdell decided that the patient represented a much greater risk to the public than was recognised by his RMO. Once Dr Egdell's views became known to the patient's lawyers they withdrew his application to the tribunal, with the effect that the report was not disclosed. Because Dr Egdell was concerned about the patient's potential dangerousness, he made the report available to the hospital authority responsible for the patient's detention, without the patient's consent. The patient's lawyers attempted to restrain the distribution of the report. They were unsuccessful. The judge decided that the public interest in disclosure overrode the patient's right to confidentiality.

The concept of public interest in justifying disclosure of confidential information is used in much the same way as practitioners of emergency medicine use the notion of the 'common law' to justify any action which feels right. However, the concept has been quite narrowly and precisely defined by the courts. The judge referred to the "very special circumstances" of the *Egdell* case in not preventing unauthorised disclosure.

Recent professional guidance widens the definition of public interest in identifying when information may be disclosed without patient/client consent.

“The public interest means the interests of an individual, or groups of individuals or of society as a whole, and would, for example, cover matters such as serious crime, child abuse, drug trafficking or other activities which place others at serious risk” (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1996, p. 27).

Need to know

A principle that was originally designed to ensure that a consenting patient received the best available medical care is being gradually extended.

A conventional analysis of medical practice assumes that there will be shared information within a medical team.

“In general, a patient who consults a doctor impliedly consents to the doctor disclosing such information about the patient to other appropriately skilled staff (whether by sending a sample for analysis or otherwise) as may be necessary to enable the doctor to decide how best to perform the three phases of diagnosis, advice and treatment” (Toulson & Phipps, 1996).

The notion of implied consent is one that reflects what a person believes will take place when he or she consults a doctor for most aspects of physical care. It is much less clear what psychiatric patients living in the community believe, or expect, about disclosure, and this notion of implied consent does not provide an answer

It is assumed that to allow the National Health Service to function effectively and efficiently, personal patient information will be seen and discussed with professional and administrative staff as well as “staff of other agencies contributing to a patient’s care” (Department of Health, 1996). In relation to the care of psychiatric patients in the community, the breadth of the concept of ‘need to know’ must be considered. Do staff working in housing associations and the police come within the community of professionals who are allowed, or expected, to know?

To justify disclosure on this particular ground we need to be clear about what information is relevant, to whom should it be disclosed, for what purpose the disclosure is required and how much information is required to be made available.

Consider the situation where an individual is being cared for in the community by various agencies. The service user does not wish personal information about their case to be disclosed. This decision should be respected unless there are

overriding considerations to the contrary, which could include ‘public interest’ justifying disclosure.

Children

The Children Act 1989 definition of a child as “anybody under the age of 18” is used throughout this section.

It is clear from what has already been discussed that a ‘pure’ notion of absolute confidence is, in practice, hedged around with qualifications. In relation to children a further qualification emerges alongside public interest and need to know, this is the justification for disclosure ‘in the best interests of the child’.

“In child protection cases the overriding principle is to secure the best interests of the child. Therefore, if a health professional (or other member of staff) has knowledge of abuse or neglect it will be necessary to share this with others on a strictly controlled basis so that decisions relating to the child’s welfare can be taken in the light of all relevant information” (Department of Health, 1996).

This guidance does not have any legal status, but certainly in cases involving children similar guidance has been referred to with approval (Re G. (a minor) (social worker: disclosure), 1996). It has been underlined (Home Office *et al*, 1991) that there is a positive duty on doctors to disclose information to a third party where child abuse is suspected, and this is the position adopted by the General Medical Council.

“Consideration for the safety and well-being of children should therefore be a fundamental part of any risk assessment ... It is important for those involved in the care of adult patients to remember that the best interests of the child should be a priority, and that confidentiality and loyalty to the adult may have to take second place ... Adult psychiatrists should be aware that the majority of their patients are parents, many of them caring for young children. They have a duty of care to consider the well-being of these children, and to act appropriately if they believe that they are being harmed.” (Oates, 1997)

What is advanced here is a proposition that not only is it lawful to breach confidence in the context of child protection, but in fact there is a positive obligation to do so. The Children Act does not create a statutory obligation to do so and although the courts in children’s cases may be moving towards that position there is not yet a statutory obligation to breach confidence. Although Part III of the Children Act deals generally with the question of cooperation between statutory authorities, it does not create such a legal obligation.

It appears that disclosure of confidential information in relation to children is justified in a much more general way than the confidentiality qualifications that we have considered in relation to adults. If we take as a general principle that the duty of confidentiality is not dependent on the capacity of the patient (British Medical Association, 1993), then how can we justify non-consensual disclosure for children on the grounds of best interests when that proviso is not being applied to the protection of vulnerable adults?

Although there is wide scope for disclosure in the case of children, the disclosure must be tempered by the expectation that the information to be disclosed is relevant (Department of Health, 1996). What is relevant in the context of risk assessment? The nature of the information and the purpose for which it is being sought needs to be categorised. Categories could include, for example, disclosure of medical information about the child, such as bruises or malnutrition; disclosure of medical information about the parents, such as depression; disclosure of other information about the parents, such as drug misuse, prostitution or alcohol dependency.

Disclosure within Children Act proceedings

Within Children Act proceedings there will be an expectation and requirement to disclose all relevant information if a professional is ordered or asked to do so. Public interest immunity may apply to cases involving children and may have application if a health or social service professional is requested to provide information within ongoing proceedings.

Conclusions

Professional guidance is given particular legal significance. In the case of *W. v. Egdell* the judge referred approvingly, and in detail, to General Medical Council guidance. Because of this it is important that the professional guidance in this field is clearly understood.

Every service needs access to clear and accessible confidentiality policy and guidance which goes further than merely referring the professional to legal or other specialist advice. Guidance needs to be developed in an inter-agency context in a manner such that individual professionals do not feel threatened by the involvement of colleagues from other agencies and cultures.

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Multiple choice questions

- In the *X. v. Y.* case the court decided that information should remain confidential on the following grounds:
 - hospital records should be confidential
 - the needs of AIDS sufferers
 - the welfare of society
 - needs of the health service.
- Confidentiality is not absolute. Disclosure of confidential information can be justified:
 - in the public interest
 - in the best interests of the patient
 - under court order
 - under some statutes.
- In the *Egdell* case the court decided that information could be disclosed without a patient's consent on the following grounds:
 - the needs of the health service
 - under professional guidance
 - for the social welfare
 - for the public interest.

MCQ answers

1	2	3
a T	a T	a F
b T	b F	b F
c F	c T	c F
d F	d T	d T