Confidentiality and HIV: ethical issues in the care of patients with HIV

Confidentiality is a cornerstone requirement of a doctor's duty, but it appears to be an issue that consistently produces uncertainly in practitioners. The British Medical Association states that 'the volume of [confidentiality enquiries] outstrips other issues of ethical concern raised by British Medical Association members'. This article looks at confidentiality in respect of the human immunodeficiency virus (HIV)-positive patient.

The original Hippocratic Oath, an ethical code attributed to the ancient Greek physician Hippocrates, was adopted as a guide to conduct by the medical profession throughout the ages. It is still used in the graduation ceremonies of many medical schools, albeit in a modified version. Mason et al (2002) have noted that:

> **'The Hippocratic Oath makes several demands which can scarcely be regarded as binding on the modern doctor; [but] nonetheless its stipulations as to professional confidentiality are still firmly endorsed'.**

McLean and Mason (2003) have further explained that:

> **'...there are some relationships where the need for trust in confidence is so obvious that the parties to that relationship expect their confidence to be respected or, looked at another way, the expectation of trust establishes what is known as a fiduciary duty owed by the doctor to his or her patient'.**

English common law has long recognized the need for a doctor to respect confidentiality regarding his/her patient, and the courts have affirmed this (*AG* v *Guardian Newspapers Ltd (No2)* [1988]; *Stephens* v *Avery* [1988]).

Relevant UK statute requiring personal information to be safeguarded now exists with the Data Protection Act 1998 (see Boyd (2003) for further discussion). Further to this, Article 8 of the European Convention on Human Rights affords a legal remedy where an individual's right to privacy has been violated by a public body, of which the NHS is one. Beyond the law, the General Medical Council (GMC) imposes a strict duty on doctors to respect patient confidentiality, and may indeed remove a doctor's registration in serious cases where an unjustified breach has occurred.

Breaking a confidence

Where a competent patient consents to a disclosure then there is of course no conflict (*C* v *C* [1946]), although the British Medical Association (1999) advises that evidence of this ought to be kept on the patient's file. The difficulty for practitioners can arise in identifying at what point, in the absence of consent, the confidence may legitimately be broken.

It is clear that confidence cannot be regarded as absolute. There exist situations where it would be quite improper to expect a doctor to keep a confidence in the face of competing interests. Knowledge of an epileptic patient who refuses to stop driving and resists encouragement to report his/her condition to the Driver and Vehicle Licensing Agency is such an example (GMC, 2000).

Even more compelling might be the discovery by a doctor that his/her patient is an active criminal, although there is a significant distinction to be drawn between the patient whose criminal activities are confined to crimes against property and the one who commits offences against another person. The doctor who considers lacerations that he/she is treating on his/her patient's elbow to be consistent with having been put through the window of the previous night's burglarized shop may not wish to act on this suspicion. However, should the same doctor then discover that an undetected local rapist is in fact his/her patient, he/she may feel obliged by his/her conscience to disclose this. It is therefore vital that doctors need to have a thorough grasp of how the law impacts on medical practice.

At this point it ought to be noted that there no longer exists the old common-law offence of misprision of felony (failure to report), other than as regards treason (Criminal Law Act 1967 s.5(5)). Save for the following statutory offences, a person (including a doctor) is not obliged to notify the police of an offence that they are aware of. The exceptions are a failure to disclosure knowledge of:

1. Terrorist acts or funding (The Terrorism Act 2000, s.19)
2. Money laundering (Proceeds of Crime Act 2002, s.330). However, this offence is limited to the regulated financial sector and so will almost certainly never apply to a doctor.

Mr Damian Warburton *is Lecturer in Law, Faculty of Law, University of the West of England, Bristol BS16 1QY*

The patient with human immunodeficiency virus infection

Returning to a realistic clinical setting, far more sensitive, however, is the situation concerning confidentiality when the patient has a venereal disease (National Health Service (Venereal Diseases) Regulations 1974), in particular human immunodeficiency virus (HIV). This author has previously observed that an individual with HIV will experience an asymptomatic period, possibly lasting several years, during which time most transmissions will occur (Warburton, 2004). With the absence of any obvious indications to a prospective sexual partner, the asymptomatic HIV-positive individual poses a very real threat for communication of the virus.

There exists little empirical research aimed at establishing the public's views on this subject. However, a small group (30) of random GP patients were surveyed by a consultant forensic psychiatrist on various matters relating to doctor–patient confidentiality, circa 2002 (Jones, 2003).

When asked if they felt it acceptable for a doctor to inform a man's wife against his wishes of his carrying a sexually transmitted disease (STD), only 50% supported this action. It is notable that the survey did not specify any particular STD, and perhaps the result may have been different had the words HIV or AIDS (acquired immunodeficiency syndrome) appeared in the question.

As only 30 people were asked to complete this questionnaire this may not be representative of the general public's position, a point that Dr Jones has acknowledged. Nevertheless, of these individuals, fifteen preferred the risk of the wife being exposed to an STD than for the doctor to have broken a confidence.

Judicial authority has considered the wider issue of confidence and factors that may impact upon it. In *AG* v *Guardian Newspapers Ltd (No2)* [1988], Lord Goff stated that:

> **'...although the basis of the law's protection of confidence is that there is a public interest that confidence should be preserved and protected by the law…that public interest may be outweighed by some other countervailing public interest which favours disclosure'.**

This author's previous submission was that 'where an individual's behaviour is a serious threat to public health… [then] that individual could not rely on [the European Convention on Human Rights] Article 8 [right to respect for private and family life] to prevent medical information regarding their HIV status from being disclosed…' (Warburton, 2004). The focus of the examination in that instance was the HIV-positive individual who has embarked upon a path of malicious transmission, and who by definition is likely to be very rare.

Far more common to a medical practitioner will be the infected patient who has no desire to pass on the virus, but who just does not want anyone else to know, perhaps because of shame about how he/she came to acquire it, or the inevitable stigma that is experienced by known sufferers. For this situation, and in the absence of an identifiable at-risk third party, it is inconceivable that the words of Lord Goff could be applied to justify rigorous utilitarian measures, perhaps to make public the identities of HIV-positive individuals. While almost certainly reducing their opportunity to spread the virus, to do so would, other than being illegal, be both distasteful and in all probability counter-productive.

This author is not of the opinion that existing HIV sufferers would shun treatment (Warburton, 2004), but strongly suspects that the at-risk groups already living on the fringe of society would be highly likely to withdraw yet further and fear the consequences of testing. Eminent opinion has already mooted that a measure as simple as just 'relaxing the confidentiality rule' would lead to such a failure to seek assistance (Mason et al, 2002).

On a related issue, an HIV 'look back' programme has been documented that was extensively conducted in Cuba, seemingly without consideration to, or subsequent evidence of, driving subjects underground (Valluerca et al, 2001). Perhaps that Cuba only has the population of a single typical capital city, or more likely the political climate of the country, influenced the approach taken in this case. Nevertheless, various leading considered opinion in the UK remains that draconian measures are 'only likely to increase the difficulties in achieving effective control, and perhaps eradication, of the disease' (Campbell et al, 2005).

The law

The leading English case on breach of confidence in the interests of public safety was *W* v *Egdell* [1989], but there is a key difference between W and the hypothetical HIV-positive patient. W was already incarcerated for having committed a multiple murder in circumstances of extreme violence, and the consultant psychiatrist (Dr Egdell) who examined him was resolutely of the view that W posed an immediate and significant threat to anyone he might encounter if released. Furthermore, when Dr Egdell went ahead and disclosed his medical opinions regarding his patient, this was limited only to the proper authorities in charge of W – those who could be considered as having a need to know.

Professor Montgomery has observed that from Egdell came 'three general guidelines [on disclosure for public interest]:

1. It is probable that a real and serious danger to the public must be shown.
2. Disclosure must be to a person with a legitimate interest in receiving the information… [and]
3. Even where public interest requires disclosure [it must be] confined the extent strictly necessary' (Montgomery, 2003).

There can be no doubt that where a doctor is presented with an HIV-positive patient, and is aware of who that patient's current or intended sexual partner is (perhaps because of an impending marriage), then the doctor would face neither legal nor professional barriers to informing the third party of the patient's status. Campbell et al (2005) have noted that:

> **'...doctors cannot be ethically obliged to act as accomplices in immoral and dangerous actions'.**

The above is of course subject to the doctor first attempting to persuade the patient to inform the other person him-/herself (Almond, 1996; McLean and Mason, 2003).

It is absolutely essential for the doctor to make a reasonable attempt to coax the patient into making the necessary disclosure him-/herself (GMC, 1997). Where this is refused then the doctor may rely upon the justification of acting in the public interest if he/she wishes to go ahead and make that disclosure directly. The boundaries of what can rightly be said to be in the public interest may appear ambiguous, but can quite properly be invoked in the favour of only one individual; in simple terms, the sexual partner of the present patient is a member of the public and is therefore entitled to the protection discussed.

The limits of duty

What does not exist, however, is an obligation under the criminal law upon the doctor to inform the third party of his/her patient's HIV status. Unlike in France, there is no duty to rescue as recognized by English law, but this point will be expanded upon below, for as with many rules within law, there are exceptions. More than a century ago Lord Chief Justice Coleridge stated in *R* v *Instan* [1893] that 'it would not be correct to say that every moral obligation involves a legal duty', and while it may seem reprehensible for a doctor to leave an at-risk third party in the dark, he/she will not face criminal sanctions should he/she choose to do so.

That is not where the matter rests, however; and although within the bounds of English civil law there has yet to be a case dealing factually with a doctor's duty in circumstances involving HIV, the possibility of a valid claim is not without merit. We must look abroad to find cases to provide guidance on this point, such as in Australia, where in *BT* v *Oei* [1999] the New South Wales Supreme Court held that 'a duty of care could be owed to a third party; [although the court held that] the duty could be discharged through the provision of appropriate advice to the patient' (Bell and Bennett, 2001).

There is perhaps no more compelling an example of a duty being found in favour of a third party than the United States case of *Reisner* v *Regents of the University of California* [1995]. In what can only be described as an appalling state of affairs, the doctor of Jennifer Lawson, a 12-year-old girl, failed to inform, and therefore obviously counsel, her or her family that she had contracted HIV as a result of a blood transfusion that he had administered. Several years later, her then boyfriend Daniel Reisner contracted the virus via his sexual relationship with the girl and subsequently brought an action for damages against the doctor.

Reisner was successful because the court found that although Daniel was not this doctor's patient, not only had the doctor caused Jennifer Lawson to become infected, but he had then failed to arm her with the information that she needed to prevent any subsequent transmission. Although at the time of the doctor's error Daniel was not an identifiable third party, he was certainly part of a foreseeable class, as a future sexual partner of Jennifer.

With the exception of the decisions of the European Court of Human Rights in Strasbourg, cases decided under foreign law are never binding upon UK courts. Nevertheless, where the facts or legal principles of a given case are sufficiently similar to that being considered here, then the UK court is entitled to look at the ratio decidendi (reason for the decision) of the foreign judgment and employ a similar thought process if appropriate.

...where a doctor is presented with an HIV-positive patient, and is aware of who that patient's current or intended sexual partner is..., then the doctor would face neither legal nor professional barriers to informing the third party of the patient's status.

In Reisner, the California Appellate Court was particularly unimpressed that the doctor had, albeit unintentionally, created the dangerous situation, and then done nothing to minimize the risks to the third party from the actions of the blameless Jennifer Lawson. Professor Grubb (1997) has observed on this very issue that:

> **'[English] law is more inclined to hold responsible those who increase the risk of harm to others than those who merely allow an existing risk to continue'.**

The exceptions to the rule of no duty to rescue are those relationships where there is a voluntary or imposed assumption of responsibility, giving rise to a special relationship as recognized by law, and described by Lord Goff in *Smith* v *Littlewoods Organization Ltd* [1987]. The duty of care that a parent owes to his/her child is such an example, as is the duty attracted by the doctor–patient relationship.

Where English law is reluctant to find that a duty exists is toward a third party (C) whom the alleged tortfeaser (A) has not contracted with, or otherwise assumed a responsibility. As Professor Grubb describes, 'the law takes the view that it is no business of A to prevent injury to C, [for] if C wishes to claim damages from anyone for harm caused by B, it should be B directly' (Grubb, 1997).

The facts of Reisner would in all probability not present any difficulty within English law for they are not inconsistent with the above concept. The wrong committed by the doctor was that toward his patient, first by allowing her to become infected and, as regards Daniel's interest, by failing to notify Jennifer of her infection. *White* v *Jones* [1995] is the leading English example of duty being found in circumstances where the relationship and principles are alike, albeit White concerned a solicitor failing to draw up a will, with subsequent financial loss to the intended beneficiaries, and not a doctor failing to take proper care.

In the far more common scenario of a doctor being presented with an HIV-positive patient (B) who does not want his/her partner (C) informed of his/her status, then there only appear to be two ways in which the doctor could incur liability for failing to disclose, the first of which is in the face of a direct question from C. The 'assumed responsibility' principle that arose in *Hedley Byrne & Co. Ltd.* v *Heller & Partners Ltd* [1964] has been summarized that 'if A takes on the job of advising [C] on a particular matter and he indicates to [C] that [C] can safely rely on that advice, then A will owe [C] a duty to take care that he does not give [C] incorrect advice on that matter' (McBride and Bagshaw, 2005).

The remaining instance is where the partner C is also a patient of the doctor; in such a case the duty of care owed by the doctor to this patient is greater than the duty of confidentiality that he/she owes to the first patient B. How could it possibly be convincingly argued that covert exposure to HIV is a lesser wrong than being subject to a broken confidence?

KEY POINTS

- Confidentiality is essential for effective, ethical and legal medical practice, but cannot be regarded as absolute.
- It would exceptionally unusual for a doctor to ever encounter a situation where he/she would be legally required to breach confidentiality for the purposes of reporting crime.
- The doctor may choose to breach a confidence where he/she sees it as morally correct and professionally justifiable, providing he/she first notifies the patient and makes reasonable efforts to gain the patient's cooperation.
- The public interest in protection of health is a valid reason for breaching confidence where it is necessary to prevent a real and serious danger to a known or foreseeable individual.
- There is no duty to rescue, it is a decision for the individual, but where the person in danger is also a patient of the doctor, a monetary claim in damages is likely to succeed if the doctor neglects to act for that patient's welfare.

Conclusions

Until recently English law has shied away from HIV-related issues. The first criminal prosecution stemming from knowingly transmitting the virus took place in 2003 and 2005 has brought a second (*R* v *Konzani* [2005]), although the conviction of Dica has now been quashed pending retrial (*R* v *Dica* [2004]).

Criminal law is unlikely to impact upon this area of medical practice in anything other than the most grossly unsatisfactory of doctor performance. However, the continually increasing litigious nature of western society does mean that doctors and the wider health service must be alert to their choices and limitations within the context of HIV and confidentiality. **BJHM**

Conflict of interest: none.

AG v *Guardian Newspapers Ltd (No2)* [1988] 3 All ER 589

Almond B (1996) *AIDS, A Moral Issue.* 2nd edn. MacMillan Press, London

Bell D, Bennett B (2001) Genetic secrets and the family. *Medical Law Review* **9**(2): 130–61

Boyd P (2003) The requirements of the Data Protection Act 1998 for the processing of medical data. *J Med Ethics* **29:** 34–5

British Medical Association (1999) *Confidentiality and disclosure of health information.* British Medical Association, London http://www.bma.org.uk/ap.nsf/content/confidentialitydisclosure?opendocument&highlight=2,confidentiality

BT v *Oei* [1999] NSWSC 1082

C v *C* [1946] 1 All ER 562

Campbell A, Gillett G, Jones G (2005) *Medical Ethics.* 4th edn. Oxford University Press, Oxford

General Medical Council (1997) *Serious Communicable Diseases.* General Medical Council, London

General Medical Council (2000) *Confidentiality, Protecting and Providing Information.* General Medical Council, London

Grubb A (1997) *HIV Transmission - Doctor's Liability to Future Partner.* Medical Law Review. Oxford University Press, Oxford

Hedley Byrne & Co. Ltd. v *Heller & Partners Ltd* [1964] AC 465

Jones C (2003) The utilitarian argument for medical confidentiality: a pilot study of patient's views. *J Med Ethics* **29:** 348–52

Mason JK, McCall-Smith A, Laurie GT (2002) *Law and Medical Ethics.* 6th edn. Oxford University Press, Oxford

McBride N, Bagshaw R (2005) *Tort Law.* 2nd edn. Pearson Education, Harlow

McLean S, Mason JK (2003) *Legal & Ethical Aspects of Healthcare.* Cambridge University Press, Cambridge

Montgomery J (2003) *Health Care Law.* 2nd edn. Oxford University Press, Oxford

R v *Instan* [1893] 1 QB 450

R v *Dica* [2004] EWCA Crim 1103

R v *Konzani* [2005] EWCA Crim 706

Reisner v *Regents of the University of California* [1995] 529 P 2d 55, Cal.App.Dist.2 01/26/1995

Smith v *Littlewoods Organization Ltd.* [1987] 1 All ER 710 at 730

Stephens v *Avery* [1988] 2 All ER 477

Valluerca JP, Fiol JJ, Castillo RR (2001) Epidemiological follow-up of notified partners of HIV infected individuals. *Medicc Review* **111**(1&2) http://www.medicc.org/Medicc%20Review/III/hiv-aids/pages/epi.html

W v *Egdell* [1989] 1 All ER 1089

Warburton D (2004) A critical review of English law in respect of criminalising blameworthy behaviour by HIV+ individuals. *Journal of Criminal Law* **68.1:** 55–77

White v *Jones* [1995] 2 AC 207