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Breach of confidentiality and the duty to warn in medical law: Examples from clinical psychiatry*

Summary

This article addresses various factors involved in the tension that may arise between breach of confidentiality on the one hand, and dereliction of the duty to warn, on the other, in the context of medical law. Per illustration, examples from clinical psychiatric practice, in which the sharing of personal information is especially relevant, are featured. In sum, a practitioner must be reasonable in negotiating the proverbial tightrope: if he or she reveals too much, liability can arise, and, if he or she reveals too little, liability can arise. In medical law, the standard of reasonableness is measured with reference to "the reasonable practitioner". Weighing up various factors (discussed herein), the reasonable practitioner takes confidentiality as the point of departure; only if there is a compelling reason to override confidentiality, will it afford legal justification to the practitioner.

Opsomming

Vertroulikheid en waarskuwingspligte in die geneeskundige reg: Voorbeelde uit kliniese psigiatrie

Hierdie artikel neem verskeie faktore wat 'n rol speel in die spanning wat kan ontstaan tussen die vertroulikheidplig aan die een kant, en die waarskuwingsplig aan die ander kant, onder die loep. Per illustrasie, word voorbeelde uit die kliniese psigiatriese praktyk, waar persoonlike informasie veral relevant is, vertoon. Ter opsomming moet 'n praktisyn redelik wees in die wyse waarop hy of sy oor die spreekwoordelike dwarslyn loop: as hy of sy te veel ontbloot, kan dit tot aanspreeklikheid lei, en, as hy of sy te min ontbloot, kan dit immers ook tot aanspreeklikheid lei. In die geneeskundige reg word die redelikheidstandaard gemeet aan die hand van "die redelike praktisyn". Die redelike praktisyn weeg verskeie faktore op (bespreek in hierdie artikel), met vertroulikheid as uitgangspunt; slegs as daar 'n grondige rede is om vertroulikheid in te kort, sal dit 'n geregtelike regverdigingsgrond aan die praktisyn verleen.

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1. Introduction

This article provides a brief comparative (considering particularly American law) overview of liability for breach of confidentiality on the one hand, and liability for dereliction of a duty to warn, on the other, in South African medical law. In this regard, a practitioner must negotiate somewhat of a tightrope: if he or she reveals too much, liability can arise from breach of confidentiality and/or an action for defamation, while, if he or she reveals too little, liability can arise from not disclosing information necessary to warn a person or group of persons of imminent danger.

The various factors involved in this potentially treacherous balancing act are here examined with special reference to examples in the context of clinical psychiatry, in which the sharing of personal information is especially relevant.

2. The importance of confidentiality

Confidentiality involves information shared by one person with another when there is a relationship of trust between them. The duty of professionals to maintain confidentiality is of ancient origin, and is recognised in numerous modern declarations.[1] As Clark[2] notes, considering American case law and judicial commentaries, it is clear that the extent to which a professional may be held liable in certain situations for disclosure or non-disclosure of confidential information, is a controversial issue. Nevertheless, there has emerged a clear duty, in various parts of the world, to warn persons of danger in certain situations,[3] and it is trite that a judicial officer can order a practitioner to disclose certain information in the South African courts.[4]

A concern raised in respect of this "relative" nature of confidentiality, especially in the psychotherapeutic context, is that unless patients are assured of confidentiality, they may be reluctant to communicate salient personal information and thoughts. According to Grabois,[5] this silence can then all but

1 Strauss 1996a: 185. See also, for instance, the International Code of Medical Ethics (as amended in Venice, 1983).

2 Clark 2000: 80.

3 As firmly established in the landmark American case *Tarasoff v Regents of the University of California*, which has been referred to in South Africa (see infra under 3), and also in other countries around the world; see, for instance, Tomkin & Hanafin 1995: 57.

4 See Harms *et al* 1999: 187, who state as follows: "[A] practitioner must, under protest, give information regarding a patient in a court of law if so instructed by the presiding judicial officer." Clark (2000: 80) reports that, in 1973 the American Medical Association's (AMA) Code of Ethics was revised to state as follows: "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community." Clark affirms that the most recent revision of the AMA Code of Ethics, adopted in 1981, still contains those statements regarding confidentiality.

5 Grabois 1997/1998: 50. See also Harms *et al* 1999: 187: "Ethically and legally psychiatrists and psychologists are required to keep their patients' confidences and it has been

totally defeat the purpose of psychotherapeutic treatment, and render it ineffectual. She contends that communications between a patient and psychotherapist are, by their very nature, confidential, with patients often revealing thoughts that they have revealed to no one else. She further maintains that patients who "express hidden thoughts and desires generally expect that such information will be kept confidential". The thought of having such deeply personal information revealed may well discourage patients from the free and open expression so essential to efficacious therapy.

3. Instances in which confidence may or must be overridden

3.1 Patient consent

The first and foremost situation in which confidence may be overridden[6] is with the consent of the person whose confidence is kept. Consent that is properly obtained will justify a practitioner's disclosure in so far as the disclosure occurs within the scope of such consent.

Although consent in writing is not theoretically necessary to be legally valid, it is always advisable, from a practical point of view, to have written consent on record.

3.2 Court of law

Although it is possible for a court to order disclosure (without consent) in a particular case, it can, as will be discussed, do so only under limited circumstances. The chances that the information that any given patient discloses during treatment will end up being revealed in a court of law, are actually rather remote. In both South Africa and the United States,[7] the practitioner is ethically required to urge upon the court his or her confidential relationship with his or her patient, and strenuously to object to his or her disclosing any information — only if the court rejects his or her objection, does he or she have to reveal the information.[8] The typification of this

said that secrecy is the *sine qua non* of the practice of psychiatry. A psychiatrist must have a patient's complete confidence, otherwise he cannot help the patient."

6 It is submitted that the use of the term breach should be avoided in the context of justification by consent; in other words, it should not be said that one breaches confidence with consent. If a patient consents to disclosure, it seems unsound to state that one "breaches" his or her confidence upon disclosure. Cf Harms *et al* 1999: 185.

7 Clark 2000: 80.

8 The consequence in both civil and criminal proceedings of then still refusing to reveal the information is that the practitioner will be guilty of contempt of court. In criminal matters he or she may be sentenced to continuous periods of imprisonment of two years or five years, depending on the nature of the crime allegedly perpetrated by the accused. See Harms *et al* 1999: 188.

form of ground of justification in terms of South African law would be "duty".[9] The court compels the practitioner to make the disclosure by placing a legal duty on him or her. Dereliction of this duty carries with it a criminal penalty.[10]

3.3 Statutory provisions

These can provide authority as justification in South African law.[11] These can also place a duty on someone to act; in this case the ground of justification is more specifically "duty", rather than just authority. Whereas in the case of authority the person is permitted to disclose, in the case of duty he or she is compelled to make the disclosure.[12] Section 13 of the *Mental Health Act*[13] (South Africa) places statutory duty to warn on practitioners who have reason to believe that a patient poses a danger to society.

3.4 Interests of specific third parties

The instances in which a practitioner would be legally justified in disclosing information to protect the interests of third parties (in the absence of some statutory or court authority or duty), are similarly limited. The typification of this form of justification in terms of South African law would be necessity,[14] or duty[15]. Due to the high premium placed on confidentiality, the instances in which confidence may be broken must be appropriately extreme in nature. The following cases illustrate some situations in which breach of confidentiality was justified and one in which it was not.

1) Case 1

Strauss[16] mentions a 1994 South African disciplinary case, whose facts are as follows: Dr X had been separately consulted by a divorcee, Mrs L, and her ex-husband Mr L. At one stage, she presented with a black eye after allegedly having been assaulted by her ex-husband. She handed Dr X a letter by her ex-husband to her, which featured allegations that she had been grossly promiscuous during their married life and after the divorce. Dr X gave her a brief note to the effect that her ex-husband appeared to be suffering from a paranoid disturbance and probably had to be certified. The note was apparently intended for use by the district surgeon with a view to an eventual application for a committal order. The disciplinary committee found that Dr X had made no attempt to make contact with Mr L before issuing the note, and recommended that

9 See Van Oosten 1999: 676-677.
10 See fn 9 above.
11 See Van Oosten 1999: 676-677.
12 Van Oosten 1999: 676-677.
13 18 of 1973.
14 This would be an instance where the interests of one party are infringed (the patient's right to privacy and/or good name) for the protection of those of another. See Van Oosten 1999: 676-677.
15 Van Oosten 1999: 676-677.
16 Strauss 1996a: 185.

Dr X be found guilty of disgraceful conduct in the form of breach of confidentiality. In her submission to the (then) South African Medical and Dental Council, Dr X's attorneys attacked the committee's finding on the ground that her conduct had been reasonable; although there had been a conflict of interests between her two patients (Mr and Mrs L), she had acted reasonably in an emergency situation by disclosing information in order to avert a danger to Mrs L. Dr X's attorneys referred to *Tarasoff v Regents of the University of California* in support of her case. The SAMDC, accordingly, set aside the committee's finding.

2) *Tarasoff v Regents of the University of California*[17]

"[P] had met weekly for a total of eight sessions with Dr Laurence Moore [M], a clinical psychologist at ... the University hospital. He revealed thoughts of harming even killing, a young woman, readily identifiable as Tatiana Tarasoff, who had rejected him. [M], with the concurrence of a colleague, concluded that [P] should be committed for observation ... and ... notified the campus police that [P] was dangerous and should be committed. The campus police questioned [P] and they also talked to other people familiar with him. They warned him to stay away from the girl. They concluded that commitment was not necessary. [P] never returned to the clinic, perhaps because he felt his trust with [M] had been betrayed. Two months later, when Tatiana returned from vacation he stabbed her to death."

Slovenko affirms that the effect of the *Tarasoff* ruling is that there is a duty on practitioners to protect potential third-party victims, provided that they are "readily identifiable".[18] It is not possible for the psychiatrist readily to predict dangerous behaviour in any given patient.[19] Only where there is a reasonably foreseeable risk to a readily identifiable third party (such as the one brought to light by the direct statement of intention as in the *Tarasoff* case), the practitioner must take reasonable steps to prevent that harm from eventuating. The *Tarasoff* court conceded that what is reasonably necessary to protect such third parties, can be determined only on a case-by-case basis.[20]

The similarity between the above formulation and the formulation of the general test for negligence in South African law is evident: not foreseeing what a reasonable person would have foreseen and/or not taking reasonable steps to prevent that foreseen.[21] Descriptions such as "reasonably foreseeable risk"

17 Here as summarised by Slovenko (1995: 211).

18 It is notable that the case as such was eventually actually settled out of court. Slovenko (1995:212) contends that, had it gone to trial, the court could have found that [M] had in fact discharged the duty by notifying the campus police.

19 See Mason & McCall-Smith 2002: 619: "[T]he prediction of dangerousness is an imprecise — and, perhaps, fruitless — exercise". Strauss (1996b: 286) also avers that the prediction of violence is extremely difficult. Be that as it may, Pergament (1998: 257) contends that "[g]enerally the courts conclude that the interests of society to be protected against the violent acts of patients outweigh the concerns of confidentiality, overcommitment, and difficulty of predicting violent acts".

20 Pergament 1998: 214.

21 As classically formulated by Holmes JA in *Kruger v Coetzee* 1962 (2) SA 428 (A). It is a two-prong question: would the reasonable person have foreseen the result, and which steps would he or she have taken to prevent the foreseen result?

and taking "reasonable steps to prevent that harm from eventuating" clearly demonstrate that the approach adopted in *Tarasoff* is reconcilable with the ordinary principles of negligence in South African law.

3) *MacDonald v Clinger*[22]

"[T]he plaintiff sued his psychiatrist, from whom he had received psychotherapeutic treatment, for disclosing personal information to the plaintiff's wife without his consent. The court held the parties had a relationship that gave rise to an implied covenant which, when breached, was actionable. The court found the breach of contract action of the plaintiff inadequate for a recovery for his mental distress, loss of employment and deterioration of his marriage ... [T]he court held that the patient who was the plaintiff should not be limited to a breach of contract action. Otherwise, the plaintiff would be limited to damages of an economic loss flowing directly from the breach, and could not recover for 'mental distress, loss of employment, and for the deterioration of his marriage'. The court believed that the relationship of a psychotherapist and his patient is not just a contractual one, but there is 'an additional duty springing from but extraneous to the contract and that the breach of such duty is actionable in tort'. It is an action in tort for a breach of a duty of confidentiality and trust."[23]

From the above cases, it is clear that in both South Africa and the United States, a practitioner may be caught between two fires, as it were: he or she must disclose information in certain situations or otherwise he or she may be held liable; on the other hand, if he or she is not justified in disclosing confidential information, he or she may be held liable.

4. The consequences of unjustified and culpable disclosure of information in terms of South African law

If information disclosure is not justified, the ordinary delictual principles governing infringement of *dignitas* based on disclosure apply to breach of confidentiality in the medical context. Contractual remedies are also available for breach of contract. Practically, it is advisable to institute claims providing for both options, *viz* a claim based on contract and/or a claim based on delict. In this way, one can accommodate the possibility of the failure of the delictual claim. Moreover, it is also possible to recover different losses with contractual and delictual remedies concurrently.[24] Where information concerning a patient is distributed in a manner which infringes his or her *fama* (reputation or good name),[25] such an infringement could also constitute delictually actionable defamation or, if

22 446 N Y S 2d 801 (Sup Ct 1982); as discussed by Grabois 1997/1998: 67.

23 Apart from illustrating an instance in which breach of confidentiality was not justified, this case reflects some similarities in the principles governing contractual damages in the United States and South Africa.

24 See Van Aswegen 1994: 150.

25 See Neethling *et al* 2001: 337.

the degree of severity is significant enough, even criminal defamation.[26] The ordinary defences to a claim based on defamation apply.[27]

5. Conclusion

This article has examined the area surrounding the proverbial two fires between which health professionals may find themselves: the danger of unjustified breach of confidentiality, on the one hand, and the danger of dereliction of a duty to warn, on the other. The practical question to be answered in concluding is: "how should the practitioner maintain the right balance in order to stay on the right side of the law?".

In medical law, the standard with which a practitioner must comply is that of "the reasonable practitioner". The law can establish and enforce that standard only with the assistance of the specialists in the various health professions themselves — they are the ones who are instrumental in informing the law in setting the standard. The reasonable practitioner is expected to be just that: reasonable.[28]

In the context of confidentiality and duty to warn, the practitioner should bear the following in mind: Confidentiality is the point of departure; it must be kept as far as reasonably possible. Only if there is an incontrovertibly compelling reason to override confidentiality should it be allowed to afford legal justification for doing so. It is of paramount importance in the therapeutic relationship (in the context of both medicine and psychology) that patients can rest assured that information about them will be kept confidential. Apart from sharing information amongst practitioners as a necessary part of collaboration in treatment (and/or clinical training),[29] there are four notable instances in which the law recognises that a practitioner may override a patient's confidence:

26 See Snyman 2002: 459-461. The elements of the crime are as follows: "a) the publication (b) of a defamatory allegation concerning another which is (c) serious and which is made (d) unlawfully and (e) intentionally" (ibid 459). Regarding private-law defamation, see Neethling *et al* 2001: 338-350.

27 Neethling *et al* 2001: 338-350.

28 Practically, it should be borne in mind that a patient bringing suit against a practitioner will generally bear the burden of proof. He or she would have to prove "on a balance of probabilities" that the practitioner acted unreasonably, leading expert testimony in that regard. Similarly, the state would, in criminal cases, have to prove "beyond reasonable doubt" the elements of the crime with which the practitioner is charged (one of which may be negligence). It should be noted that it is very important that careful records of treatment be kept at all times. When it comes to responding in defence, inadequate records can place a practitioner in a very vulnerable position indeed.

29 It must be emphasised that such sharing of information must indeed occur only in so far as reasonably necessary; casual disclosures may result in liability. See, for instance, *Jansen van Vuuren v Kruger* 1993 4 SA 842 (A).

- The patient consents to disclosure.
- A court of law orders the disclosure.[30]
- An Act of parliament requires the disclosure.
- There is some other legal obligation on the practitioner to make a disclosure.[31]

If a practitioner adopts the general approach of taking care not to disclose information unnecessarily, and carefully considers situations where disclosure might be necessary — as the reasonable practitioner would — he or she should not be singed by any of the two proverbial fires alluded to above. As a general rule, it is advisable to consult colleagues or other appropriate professionals in a discreet manner when faced with a difficult case, since that is invariably what the reasonable practitioner would do. The reasonable practitioner is always willing to eliminate the potential for costly errors by consulting and collaborating where there is time to do so. Indeed, in instances where medicine and law intermingle to serve patients' interests, mutual consultation and integrative collaboration between lawyers and clinicians, are similarly indicated.

In line with Holistic Multidisciplinary Management (HMM),[32] this should not be a situation of "law v medicine", where medicine and law work against each other to find balance in safeguarding patients' interests. Rather, law and medicine must collaborate so as best to promote the interests of patients and physicians alike. The potential minefields to which clashes between medicine and law can give rise can be avoided only if mutual understanding and integrated functioning are promoted and translated into sustainable practice.

30 In respect of the psychiatric context, in particular, Harms *et al* (1999: 187) expand as follows: "[W]here psychiatric evidence resulting in a breach of confidence is essential to the administration of justice, the court will require such evidence to be led; for instance: ... where the patient puts his mental condition in issue as part of a claim or defence; ... where it is necessary to establish the mental capacity of a testator; or ... in child custody suits."

31 This is where the *Tarasoff*-type situation would feature.

32 For a discussion of HMM, see Steyn 2002: 3-28.

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