CLINICAL ETHICS

Community versus individual benefit

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A 28-YEAR-OLD self-employed glazier ("Ian") comes to see you, accompanied by his wife, after having had a "funny turn" at work. He says that this has happened before but that he had not paid much attention to it. Your initial investigations lead you to think that Ian has suffered a seizure. You refer him to a neurologist for confirmation of your diagnosis and for treatment and, at the same time, advise him of his obligation to report himself to the local driver-licensing authority. Some time later, Ian's wife returns to tell you that she is still worried about him, that he had a "little prang" in the car the other day, that she thinks that he may be drinking more than he usually does, and that he has neither seen the neurologist nor informed the driver-licensing authority of his condition.

ABSTRACT

- Australian law embodies a "communitarian" conception of the doctor's responsibility to respect the confidentiality of the doctor–patient relationship.
- This implies that respect for confidentiality sits alongside two other responsibilities: proper care for the patient's general wellbeing and proper attention to the safety of the community.
- Most jurisdictions now require drivers to advise their local driver-licensing authority of any permanent or long-term injury or illness that affects their ability to drive safely.
- Some jurisdictions require doctors to inform the driver-licensing authority about patients whose medical condition may impair their driving to the extent that they are likely to endanger the public.
- If you can not persuade a patient to inform the driver-licensing authority of the need for an assessment of his or her ability to drive safely, then you should inform the relevant authorities yourself.

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THIS CASE RAISES a difficult issue for you, his general practitioner. How are you to respond to Ian's medical needs in a way that fulfils both your responsibility to treat as confidential what he revealed to you in consultation and your responsibility to the community as a custodian of the public interest? One source of your difficulties lies in the ethical debates about the meaning and limits of the duty of medical confidentiality, on the one hand, and the meaning and limits of the social responsibility to act for the sake of the common good, on the other. Let us start by clarifying what is at issue in these debates.

There are at least four ways in which the duty to maintain medical confidentiality may be characterised:[1]

1. The Hippocratic conception of medical confidentiality. In today's world there are multiple pressures on doctors to treat what patients tell them as little more than public property. It is worth recalling the seriousness — the "absoluteness" — of the Hippocratic conception of medical confidentiality as a religious duty: a doctor must treat as "unutterable" the things that he "may see or hear in the course of treatment or even outside of treatment regarding the life of human beings…". However, that conception of confidentiality was framed in circumstances in which doctors visited patients in the intimacy of their own homes, could offer little of therapeutic benefit to patients and were relatively powerless to prevent a patient's medical condition from causing harm to others.

2. Medical confidentiality as a matter of contemporary professional standards. On this view, confidentiality is a part of the service delivered by a doctor *as that service is understood by colleagues and professional bodies*. The scope and limits of that service are a matter for the profession itself to decide.

Although the profession may see confidentiality as a standard that goes to the heart of professional practice, this view implies that the proper thing to do in cases like this is to be resolved by reference to contemporary professional standards, *whatever they happen to be*. If *Rogers v Whitaker*[2] taught us anything, it was that, in some crucial respects, proper conduct on the part of doctors is *not* determined by reference to contemporary professional standards. In that judgment, a distinction was made between the standards for surgical practice and the standards for information- and advice-giving. The former were said to be a matter for the profession, the latter not. The reason for this is not difficult to understand: just as an individual doctor could be mistaken about what information and/or advice should be given to the patient, so too could the whole profession; similarly, just as an individual doctor could make a mistake about (say) the scope and limits of the duty of confidentiality, so could the profession itself.

3. Medical confidentiality as a contract between two people. Another way of thinking about medical confidentiality sees the doctor–patient relationship as a species of contract between two people, each of whom enters into the contract as

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the bearer of rights that must be respected by the other. On this view, patients reveal personal information to doctors on the understanding that the doctor will not reveal that information to others unless the patient has consented to the disclosure. Consent then becomes the key issue, and various forms of "consent" (eg, presumed consent, proxy consent, consent given in advance) are crafted to deal with difficult cases. However, this conception of confidentiality lends itself to a rights-based impasse that engenders an adversarial relationship between doctor and patient, and between doctor and public authorities, while offering no principled way of working out a reasonable solution to a particular case. Furthermore, it inappropriately privatises information. Information about Ian's seizures is personal in one sense (it is information about him as an individual), but it has serious implications for others (for example, those who use the same roads as he does).

4. Medical confidentiality as a collaboration in a common purpose. This way of thinking about medical confidentiality offers a better starting point than do any of the first three. This view sees the doctor–patient relationship as a collaboration in a common purpose, that purpose being the restoration of the patient's health *in a manner that preserves and promotes the common good*. Such a relationship requires the development of trust — a trust that allows and encourages patients to reveal themselves more fully than they would to most other people. There is a presumption, but not an invariant rule, in favour of keeping confidences. Patients ought to be able to trust that their doctors will not, for example, gossip about them, will not question them within earshot of others who have no need to know what is being said, will not leave their records open for others to see, and so on. However, patients should be encouraged to see that the very social institution (the doctor–patient relationship) that enables them to be treated therapeutically itself allows the divulging of information gained in the course of that relationship *in certain circumstances*. On this view, respect for the confidentiality of what the patient discloses to you has to sit alongside two other responsibilities: proper care for the wellbeing of the patient (doing what you reasonably can to ensure that he does not put his own life at risk when driving) and proper attention to the wellbeing of the community (doing what you reasonably can to ensure that his driving does not put others at unacceptably increased risk).

Though differing somewhat from State to State, Australian law generally reflects this fourth, "communitarian", conception of medical confidentiality.[3] Most States and Territories have legislation requiring *drivers* to advise their local driver-licensing authority of any permanent or long-term injury or illness that affects their safe driving ability.[4] Some jurisdictions have legislation requiring *doctors* to inform the local driver-licensing authority about patients whose medical conditions may impair their driving to the extent that they are likely to endanger the public.[4] And most States and Territories have legislation that protects doctors (and others) from civil or criminal liability if, in good faith, they report a driver to a driver-licensing authority.[4] (Similarly, the Code of Ethics of the Australian Medical Association acknowledges that it is ethically permissible for a doctor to "breach" confidentiality when there may be a risk to the safety of others.)

Let us return to the case of Ian. Your initial investigations led you to think that Ian's "funny turns" had a neurological cause and so you referred him to a neurologist for further assessment. Let us imagine that you also made it clear to Ian at the time that *your* duty to him as his doctor included not only looking after his medical needs but also doing what you reasonably could to ensure that he did not continue to put his own life (and the lives of others) at risk by driving. It would have been desirable if you had also made an effort to help him to appreciate *his* responsibility not to put the lives of others at an unacceptably increased risk.

At this point, you should help Ian's wife find a way to encourage him to return of his own accord to see you again. She is probably best placed to know which consideration is more likely to motivate him to do so: his own need for further investigation and treatment, or the fact that he will be breaking the law and voiding his vehicle insurance if he continues to drive while medically unfit.

For the moment, let us imagine that she is successful, and that together they return to see you. Let us also imagine, however, that he minimises the significance of the "little prang", is defensive when you try to broach the subject of his drinking habits, and that he claims that because he'd been "feeling fine" he had no need to see the neurologist.

You will now have to do everything you reasonably can to convince Ian that it *is* in his own interests to see the neurologist and to undergo whatever investigations the neurologist might recommend: his condition may be controllable, and his capacity to drive a car safely may be unimpaired, if he undergoes appropriate therapy. Having the neurologist endorse your recommendation that he cease driving may also lessen any blame he may place on you, thereby reducing the damage to your relationship with him. And, if you can't convince him of what he stands to gain by doing as you recommend, then you must emphasise to him his ethical and legal obligation to inform the relevant authorities of his condition.

Finally, you will need to ensure that he understands that unless you hear from him (within, say, a week) that he has voluntarily done what he should do, your responsibility *to him*, together with your responsibility *to the community*, will jointly motivate you to inform the relevant authorities yourself that his fitness to drive needs to be assessed by them.

But if, after some time, it seems clear to you that Ian's wife has not managed to persuade him to come to see you again of his own accord, you should go ahead and inform the relevant authorities yourself.[4]

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References

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