Leaders

Confidentiality, death and the doctor

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Overview
The means by which information regarding a patient is obtained by a pathologist from a postmortem examination is necessarily different from that by which a clinician obtains information from a living patient. The postmortem examination may be carried out in the absence of objection under the Human Tissue Act[1] or as part of a coroner's enquiry. Exactly what disclosure is permitted after death is not clear from guidance currently available from the British Medical Association (BMA),[2] the General Medical Council (GMC)[3] or the Department of Health.[4] This article discusses the legal and ethical aspects of confidentiality after death and explores, in particular, the position of a pathologist who discovers a potentially inheritable disorder of importance to relatives of the deceased. At present, it is uncertain whether it is permissible to disclose such information or whether a duty to disclose exists. If such disclosure is permissible, it is unclear who should disclose what to whom. This article argues that circumstances where disclosure of medical information to interested third parties is considered acceptable should be clarified and that an appropriate ethical code be formulated.

Introduction
The ability to diagnose, and the availability and efficacy of treatments for, some inherited disorders place doctors in possession of information of potential therapeutic importance to such patients' relatives. When the patient is alive consent to disclose can be obtained. If such consent is refused the doctor is faced with a dilemma—should he disclose on the grounds of preventing harm to a known and identifiable third party? Such situations are likely to arise frequently in medical genetics: Ngwena and Chadwick[5] have argued that the doctor should be allowed discretion to disclose in some circumstances and suggest that a code of ethics concerning such disclosure should be drafted. They do not, however, consider that there should be a duty to disclose; there is not adequate justification for such a radical departure from the general principle of confidentiality. The pathologist is peculiarly placed, given the different professional relationship with the dead "patient". The pathologist may act for coroner or clinician: if knowledge of inheritable diseases is gained from the postmortem examination, does the pathologist have a duty to maintain confidentiality or a duty to disclose that knowledge? To whom should disclosure be made?

Overview of confidentiality
The general acceptance of the duty of the doctor to keep the confidences of the patient is enshrined in the Declaration of Geneva: "I will respect the secrets which are confided in me, even after the patient has died".[6] In this statement there is a clear recognition that there are circumstances where disclosure may be justified. This contrasts with the International Code of Medical Ethics: "A physician shall preserve absolute confidentiality on all he knows about his patient even after the patient has died".[7] Here there is a denial of any circumstance in which disclosure might be justified. The contrasting views expressed in the two codes are surprising as both statements were published under the aegis of the World Medical Association. The apparent inconsistency may reflect contrasting views within the profession and differing national practices and seems to be derived from variation in the relative values placed upon patient autonomy, benefit to society from use of personal medical information and protection of the "innocent other". At one extreme, some argue cogently for absolute confidentiality[8]; an argument that may result, as in France, in a criminal offence if such confidentiality is breached.[9] At the other extreme, some argue for the complete rejection of the duty of confidentiality.[10] The current position in England and Wales is that confidentiality is not absolute. There are, according to the GMC,[3] a number of circumstances in which breach of confidentiality is not held to constitute a breach of ethical principle: when the patient gives consent; when it is in the patient's own interest; when the doctor has an overriding duty to society; when it is demanded by statute; when due legal process requires it; or for purposes of medical teaching, audit and research. These situations are subject to certain further conditions and are broadly similar to the five categories identified by the BMA.[2] Whilst this might appear to define tightly restricted dissemination of confidential information, the development of the "health care team" approach results in as many as 75 to 150 people having access to the medical record.[11,12] It is not sur-

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prising that it is commonly held in this country that there is erosion of the ethical principle of confidentiality.

The legal perception of confidentiality—of which that relating to medicine is but a single facet—is slightly different. Its definition arises out of the common law[13]; despite the recommendations of the Law Commission[14] there is no statutory tort of breach of confidence. Confidential information must "have the necessary quality of confidence about it"[15] and "have been imparted in circumstances importing an obligation of confidence". Damages may be awarded or an injunction granted following an action for breach should there have been "an unauthorised use of that information to the detriment of the party communicating it".[16 17] An injunction may even be awarded preventing disclosure even when no detriment is likely to result.[18] Such remedies are limited to the person entitled to the confidence,[19] but the action may fail if it is shown that the breach was justified. Most disclosures that would be regarded as exceptions to the ethical duty to maintain confidentiality, as above, would fail to meet the legal criteria for breach of confidence, but the disparity between the approaches to the subject made by medicine and the law places the medical practitioner in jeopardy when faced with a dilemma when deciding concerning whether or not to disclose. This has been examined in the case of disclosures made without consent on the basis of preventing harm to the general public. The key to permitted disclosure is adequate justification—the benefit to society or to a specific individual must outweigh the harm done through disclosure. Such harm may not only disadvantage the party whose confidence has been broken but also the principle of confidentiality itself—any disclosure is liable to diminish the public perception of privacy within medical consultation.

Confidentiality after death

ETHICAL PERSPECTIVE

The death of the patient does not absolve the doctor from the duty of confidentiality: breaches have resulted in censure from the GMC even when the details divulged were primarily of historical interest, such as in the case of Moran's *Churchill*,[20] or clarified information within the public domain that otherwise reflected badly upon the deceased, as in the case of Gladwin Buttle's obituary.[21] Nobody, including the next of kin, has any power to free the doctor from his obligation. The position of the clinician is, therefore, essentially straightforward. Exactly how this applies to the pathologist is less clear as, to start with, he/she is likely to have had no conventional doctor–patient relationship with the deceased. Furthermore, he/she may be acting for the coroner in an investigative role. The lack of detail in the wording of the GMC guidelines, however, implies that anything the pathologist might learn of the deceased, be it from the medical record, the attending clinician or the postmortem examination should be regarded as confidential.

LEGAL PERSPECTIVE

In law, whilst some rights pass to the estate, this is not so for confidentiality, an essentially personal concern. The person who sues for breach of confidence must be the confider and therefore the action dies with the patient. Thus, in 1820 Lord Eldon was quoted as saying, about King George III, "If one of the late King's physicians had kept a diary of what he heard and saw, this Court would not, in the King's lifetime, have permitted him to print and publish it".[22] The situation may be considered analogous to an action for defamation of the dead which will not lie in England and Wales unless the defamation was designed to break the peace,[23–25] thus constituting a separate offence. The position is less clear in Scotland and defamation of the dead may constitute a criminal offence in some countries.[26] It would seem, therefore, that if the doctor chose to breach confidentiality after the death of the patient legal redress would be unlikely. Consider then a pathologist who, having performed a postmortem examination, informs the son of the deceased of the finding of a potentially lethal inheritable condition which might not be the cause of death and, therefore, would not be recorded on the death certificate—for example, familial hypercholesterolaemia. The son, if he did not wish to be informed of this risk—perhaps because it might affect his ability to take out life insurance—could have no legal redress but might complain to the GMC that the confidentiality of the dead patient had been breached. How would the GMC respond? Such information may be relevant to other family members: if the doctor communicates the information, early diagnosis and treatment of a serious condition might be achieved saving pain, suffering, premature death, or the birth of an affected offspring. The pathologist may be the only person who has, or realises the relevance of, that information and, therefore, only he can impart it to the third party. One might argue easily that he is under a moral obligation to disclose but could there be a duty to disclose the information? Tarasoff *v* Regents of the University of California concerned a student who, in a consultation with a clinical psychologist, expressed an intent to kill a woman who had rejected his advances. The psychologist consulted with two psychiatrist colleagues following which the student was detained by the police but later released. The information about the third party at risk was not disclosed. The woman was killed by the patient two months later. The court held that a duty of exercising reasonable care for the protection of the third party existed.[27] It has been argued that an English court would be unlikely to follow this ruling[5 28] but further cases merit examination. In W *v* Egdell a psychiatric report prepared on behalf of a man detained in a secure hospital and whose case was under review by a Mental Health Review Tribunal was disclosed by the psychiatrist to the prison authorities without the consent of the prisoner. The court balanced the doctor's duty to put such information as the public interest required before the proper authority against the pro-

tection of the duty of confidence and ruled in favour of disclosure.[29] This was affirmed in a second, similar case.[30] In R *v* Instan the defendant lived with an elderly aunt who died as a result of want of food and medical assistance. The defendant was the only person with knowledge of the deceased's condition and the only person in a position to give assistance. It was held that the defendant had a duty to supply food and fetch medical assistance. Lord Coleridge said in his judgement, "It would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on a moral obligation. A legal common law duty is nothing else than the enforcing by law of that which is a moral obligation without legal enforcement ... it was only through the instrumentality of the prisoner that the deceased could get the food. There was, therefore, a common law legal duty upon the prisoner which she did not discharge. ... The prisoner was under a moral obligation to the deceased from which arose a legal duty towards her".[31] This does not seem far from the position of the pathologist, who, from the postmortem examination on the young victim of a road traffic accident detects unsuspected severe coronary artery atherosclerosis, but who fails to take steps to ensure that the family of the deceased are aware of their potential risk. The pathologist may be the only person who appreciates that such information may be of direct relevance to the next of kin, who may be identified from the hospital notes or through the coroner. Is there then a moral obligation, amounting to a common law duty, to take reasonable steps to inform those potentially affected? The fact that the patient is dead and therefore cannot be harmed by disclosure would seem to contrast with the similar situation concerning the live patient, where, as discussed by Ngwena and Chadwick,[5] the justification for disclosure is not so secure.

Disclosure of postmortem findings

"CONSENT" POSTMORTEM EXAMINATION

It has been implied that the status of a "consent" postmortem report is no different from that of any other part of the medical record[20 32]; it may be argued that such a postmortem report falls under the Access to Health Records Act 1990. Exactly who has access to the report is uncertain. The same Act states that "An application for access to a health record ... may be made to the holder of the record by any of the following, namely, ... (f) where the patient has died, the patient's personal representative and any person who may have a claim arising out of the patient's death".[33] The patient's "personal representative" is not defined in the Act—whether it means the next of kin, the executor of the estate, the person in lawful possession of the body, or any other person is unclear. Moreover, the nature of any "claim" that is sufficient to give access is not defined. This, admittedly, concerns those who may have access rather than to whom legitimate disclosure may be made but it would seem reasonable to suggest that if a person has valid access to the record, disclosure to that person of the postmortem report, being part of that record, would be permissible.

CORONER'S POSTMORTEM EXAMINATION

The issue of what may be disclosed by a coroner or his pathologist is clouded somewhat by uncertainty concerning what may be disclosed to such persons. However, when conducting a postmortem examination by the authority of a coroner, a medical practitioner would seem to have a duty of confidentiality to that coroner,[34] as well as to the deceased, so any disclosure would have to be made either by the coroner or with his/her approval. A coroner's postmortem report must be released by him/her to anyone who the coroner considers to be a "properly interested party"[35] but, although certain categories of person are defined as "properly interested parties",[36] close relatives, even siblings, may not so qualify.[37] It is not difficult to see how the disclosure of health information of potential diagnostic or therapeutic relevance to interested third parties, but of no relevance to the cause of death, might be regarded by a coroner as falling outside his/her jurisdiction; it is reasonable to assume that any disclosure would be most likely to come from the pathologist. The need for clarification of the legal and ethical issues regarding, and a practical framework for, disclosure of such information is apparent.

TO WHOM SHOULD DISCLOSURE BE MADE?

Should the person who might benefit from disclosure of postmortem findings also be a patient of the deceased's general practitioner, it would appear desirable that any disclosure by the pathologist should be to that practitioner. However, it is unlikely that the pathologist would be aware of such a situation and, in many cases, such a shared relationship might not exist. Under such circumstances, would the pathologist be deemed to have fulfilled any obligation to disclose information by informing such a practitioner? Clearly, neither has a professional relationship with the person who might benefit from disclosure of postmortem findings, so such a passage of information could be regarded as an evasion of responsibility. The most fundamental doctor–patient relationship is between patient and general practitioner and the latter is likely, therefore, to have easiest access to the deceased's family. Such a passage of information might be facilitated by alteration of the *Coroner's Rules* to require that a postmortem report be supplied to the general practitioner of the deceased. Under some circumstances, the hospital consultant under whose care the patient died might be considered the appropriate person to disclose information from a postmortem examination but, whilst seeming to have a right to view postmortem findings,[38] he/she has no right to a copy of the postmortem report and must apply to the coroner for a copy, on payment of a fee, as a "properly interested party". Although supply of postmortem reports to hospital consultants was recommended for other reasons by the

Allitt Inquiry,[39] and commended by the Home Office, there are no plans to amend the *Coroner's Rules* in order to enforce it.[40] Even if the consultant has attended the postmortem it is not clear whether he/she may communicate the findings to a third party. Moreover, it may be difficult for hospital consultants to contact the next of kin.

FORMULATION OF AN ETHICAL CODE

As the law relating to medical confidentiality is essentially judge made law based on the circumstances of past cases, it is not possible to say with any certainty what the legal outcome would be if any of the scenarios outlined above were to be tested in court. The pathologist, uncertain as to correct practice, might seek guidance from a defence association, the BMA or the GMC but it would be far more satisfactory if a clear statement as to the nature of information discovered at postmortem examination which may—or even, must—be disclosed, and to whom, were available to all pathologists—indeed to all doctors—so that uniform practice might be achieved.

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