

Medical Confidentiality: The Right Of A Commanding Officer To Know

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ABSTRACT

Recent changes in the law and in patients' expectations have necessitated alterations to the way doctors maintain the medical confidentiality of their patients. This paper investigates the ethical and legal aspects of medical confidentiality in general, examines their relation to the military context and analyses the guidance offered. Military personnel give up some individual rights on enlistment. The requirement for the medical officer to share patients' medical information, without consent if necessary, with the Commanding Officer is ethically and legally acceptable provided recruits are adequately warned of this restriction to human rights before joining. Although the paper concentrates on the guidance given in the RAF, the principles are common to the 3 Armed Forces' medical services.

Introduction

This paper will detail the advice offered to Royal Air Force (RAF) personnel and will examine how that is supported by the ethical and legal arguments relating to medical confidentiality. Although this paper refers throughout to the RAF, the Royal Navy and Army face similar challenges with medical confidentiality and have comparable regulations.

Whilst there is no formal legal definition of confidentiality, the basis that there was jurisdiction in equity to protect confidence was first clearly enunciated in 1948 (1) and restated 40 years later (2). The general understanding of medical confidentiality is that it is the right of a patient to control access to, and disclosure of, medical information entrusted to a doctor.

Civilian occupational physicians generally are faced with conflicting duties - to their employer, to the individual patient, to the workforce and to society. This is also true for Armed Forces medical officers but it could be argued that the balance between these duties differs. The RAF Medical Branch is an advisory branch without executive authority. This means that the advice medical personnel proffer may be over-ruled by the Commanding Officer, who is a member of the General Duties Branch, an executive branch of the RAF. The relationship between

a Commanding Officer and his Medical Officer is more than that between a company managing director and his medical adviser. The Service medical officer in primary care, as a general practitioner as well as an occupational physician, has more detailed knowledge of his patient than a civilian occupational physician. Service Medical Officers are expected to share a selected amount of individuals' medical information with their Commanding Officers. This is required in order to maintain the military effectiveness of the unit and for disciplinary and security reasons. In some circumstances, medical information must be disclosed in order to protect the patient or others if the patient's condition may involve danger to others. An example may be a pilot whose condition may give rise to subtle psychological performance degradation or to a risk of in-flight incapacitation.

For the Service Medical Officer, the balance between disclosing and withholding, and in what circumstances, has traditionally been a matter for the exercise of some discretion, albeit with guidance from higher military medical authorities. The guidance used to be provided in confidential letters held by both Commanding Officers and medical officers. These have not existed for some years and the actual guidance has been transferred to official medical publications, but not to corresponding publications for the Commanding Officers (3). The subject is addressed by medical officers in lectures to Commanding Officers designate as part of their induction courses but comes at a time of information overload. As a result, there is often an unrealistic expectation by Commanding Officers of how much they can be told by medical officers about the personnel under their command. Thorpe LJ has remarked that in very senior commanders "there may be a natural instinct to contend for the needs of the service as they perceive them in disregard of human rights protection" (4).

At the same time, the passing of the Data Protection and Human Rights Acts has created uncertainty for medical officers in the Armed Forces. Although the occasions are rare when confidentiality is required to be breached to a commanding officer, individual cases are usually problematic. No-one in the RAF has yet complained, although this is probably only a matter of time (5).

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Current RAF Guidance

Within the RAF there exists a hierarchy of guidance which provides the template on how to conduct business. The Queen's Regulations (QR) for the RAF derive their authority from the Royal Air Force Acts. Below the level of QR exist a variety of Air Publications (AP) which provide detailed instructions; that for medical administration is AP 1269. Until such time as the AP can be periodically updated and reissued, direction is given in Policy Letters issued by the Director General of RAF Medical Services or by the tri-Service Surgeon General. These Policy Letters extract guidance from Department of Health guidelines and codes of practice that are relevant to the Armed Forces. In addition, Joint Service Publications (JSP) promulgate tri-Service procedures. JSP 400 deals with the disclosure of information and Chapter 4 with the disclosure of medical information.

The current advice in the AP 1269 acknowledges that "confidentiality is the cornerstone of good medical practice" (6) and makes reference to the publications of the General Medical Council (GMC) (7). It states that

"In rare circumstances the Medical Officer may have to disclose information to the Commanding Officer...without consent or contrary to the wishes of the patient" (8). These rare occasions "arise when the security, health, safety or welfare of the unit or the individual are at serious risk" (9).

Examples given are drug abuse or alcoholism. In addition, QR for the RAF require the medical officer to

"bring to the attention of the Commanding Officer any officer or airman engaged on flying duties whose physical or mental efficiency is deteriorating through fatigue or other causes" (10).

Cases of doubt should be discussed with the single Service Medico-Legal staff or C&L (F&S) L1.

The AP also advises that the Medical Officer should try to obtain consent from the patient before disclosing information to the Commanding Officer. The patient should be told what information is to be disclosed and to whom, the reasons for disclosure and the possible consequences. If consent is not given, the patient must be told that confidentiality will be breached. In any case, the amount to be disclosed is a matter for the Medical Officer's judgement but should be the minimum necessary for the purpose. The information should be disclosed to the Commanding Officer verbally, in private and in confidence (11). The AP emphasises that the Medical Officer may be required to justify disclosure to the GMC but does not draw attention to the possibility of court action. The direction given in the AP is also in general accord with that provided by the British Medical

Association (12).

Ethical Issues

The concept of medical confidentiality was first expounded in the Hippocratic Oath which states quite clearly,

"All that may come to my knowledge in the exercise of my profession...which ought not to be spread abroad, I will keep secret and never reveal" (13).

However, this implies that there may be some things which ought to be spread abroad. John Stuart Mill wrote

"...the only purpose for which power can rightfully be exercised over any member of a civilised community, against his will, is to prevent harm to others" (14).

Beauchamp and Childress contend that there are three types of argument to support the requirement for confidentiality (15). The first is consequentialist. Without confidentiality, patients would not trust their doctors and would be less likely to yield enough information in a consultation to allow an accurate diagnosis. Second, there is the argument based on autonomy and rights to privacy. Third, there is the requirement for fairness in the doctor-patient relationship, with the patient having the right to expect discretion and the doctor the right to hear the truth.

But should the code of behaviour be absolute? On the one hand, Kottow claims that it is perverse to

"offer confidentiality as an enticement to sincerity, only subsequently to breach it" (16),

and that breaches of confidentiality automatically introduce unfairness into the doctor-patient relationship. He also argues that if doctors are committed to confidential consultations, they have no right to

"infringe this agreement for the benefit of other interests" (17).

Conversely, if they owe loyalty to their employers, they have no right to abuse their employer's confidence to

"honour a personal desire for confidentiality" (18).

However, Beauchamp and Childress reason on the other hand that these arguments do not impose an absolute requirement for confidentiality. They explain that the breaking of confidentiality may be permissible or obligatory. In some cases, the doctor may have an option of whether or not to break confidentiality. In other cases, for example where there is a serious risk to a third party, it could be argued that there is an obligation to breach confidentiality.

Jacobs makes two main arguments against doctors breaching medical confidentiality to employers (19). First, information provided for one purpose should not be used for another. Second, he maintains that a court would hold that a doctor should comply with the rules of his profession as an implied term of his employment contract if he was

required to be medically qualified for that employment. Nowadays in the UK, the rules of the profession are laid down by the GMC (20) which reflects the tenor of the Hippocratic Oath, and further developed for occupational physicians by the Faculty of Occupational Medicine (21). These rules confirm that consent must be given before disclosing information to employers. The GMC publication states quite clearly that if confidentiality is breached the doctor must be prepared to justify the decision. Information can be disclosed without the patient's consent in exceptional circumstances and with specific safeguards. Of the stated circumstances, the most relevant to the present discussion is disclosure in the interests of others. This includes the situations when a patient may put others at risk (for example, when continuing to drive against medical advice) or to aid the prevention or detection of a serious crime (involving risk to life or of serious injury). The guidance given to Canadian doctors is that the duty to warn may override the duty to respect confidentiality when

"the anticipated harm is serious (and irreversible), unavoidable except by unauthorized disclosure, and proportionate to the harm likely to result from disclosure" (22).

From the point of view of the military, it is now well understood that military personnel give up some of their rights as normal citizens when volunteering to join the Armed Forces. For example, they agree to abide by the provisions of the single Service disciplinary Acts which do not apply to the populace at large. Beauchamp and Childress confirm that military physicians have a dual responsibility to their patients and to the military. They emphasise that military doctors have a moral responsibility to ensure that

"soldier-patients understand at the outset that traditional rules of confidentiality do not apply" (23).

Given that most non-commissioned Service personnel enlist as late teenagers, it would be expected that they should be competent to consent to such restrictions. That consent would only be found to be valid in a court of law if appropriate information or briefing had been given.

Statute Law

Two major pieces of legislation are designed to protect the right of the patient to medical confidentiality – the Human Rights Act 1998 which enjoys a high profile but which has, arguably, not yet contributed significantly to medical confidentiality cases and the Data Protection Act 1998 which may, in the final analysis, be more powerful. The Human Rights Act incorporates the European Convention on Human Rights which requires states to take positive steps to protect certain rights of individuals against

violation. The Act makes it unlawful for a public authority to act in a way which is incompatible with Convention rights (24). There is a hierarchy of rights, of which some are absolute, some limited and some qualified. Of these rights, the most pertinent to medical confidentiality is Article 8(1) which allows everyone the right to respect for his private and family life. This Article is a qualified right and therefore Article 8(2) gives a public authority the ability to interfere with this right to the extent necessary in a democratic society in

"the interests of national security, public safety...for the protection of health or morals"

with the proviso that such interference should be in accordance with the national law. The Home Office construes the phrase *"necessary in a democratic society"* as *"fulfilling a pressing social need, pursuing a legitimate aim and being proportionate to the aims being pursued"* (25).

The Data Protection Act 1998 incorporates the common law concept of confidentiality and repealed most of the Access to Health Records Act 1990. In particular, s2 of the Data Protection Act defines information on the physical or mental health or condition of a patient as sensitive personal data and s68 classifies such medical information as a health record. Section 55 states that a person must not knowingly disclose information without consent unless he believed that in the particular circumstances the disclosure was justified as being in the public interest. Moreover, under the provisions of s30, the Secretary of State may exempt from the provisions of the Act personal data concerning physical or mental health of an individual (26). In addition, Schedule 3 of the Act sets conditions for the fair and lawful processing of sensitive personal information. It permits a defence that processing is necessary (27). It also permits processing for medical purposes when undertaken by a health professional or

"a person who in the circumstances owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional" (28).

The Health and Social Care Act 2001, on the other hand, gives the Secretary of State powers to make regulations to permit disclosure of patient information without patient consent if necessary. Initial applications for regulations concerned disclosure to cancer registries but other circumstances are possible. However, s60 of the Act does require that disclosure is consistent with the requirements of the Data Protection Act 1998. In effect, the Section allows the use of medical information in the public interest. This would support the use of medical data to facilitate force protection.

However, there are other statutory provisions for the breaching of medical

confidentiality. Kennedy & Grubb list six such instances, examples of which are the Abortion Regulations and the Prevention of Terrorism Act (29). Perhaps the most relevant to the present discussion is that of the Health Act 1999 which lays down the framework for the activities for the Commission for Health Improvement (CHI). Here, s26 allows disclosure to a person to whom CHI considers that the information should be disclosed in the interests of health and safety of individuals (30). In addition, medical “whistleblowers”, who may draw attention to the potential for danger to patients of underperforming doctors may be protected by the Public Interest Disclosure Act 1998.

Case Law

The law on medical confidentiality rests on equitable rather than tortious principles. Wrongful conduct may lead to a claim in damages but equity will enforce an obligation to respect patients’ confidences once a fiduciary relationship has arisen. Usually, this will concern a breach of confidence, for example *W v Egdell* (31). However, in the common law, it is likely that action for breach of medical confidentiality could be found in the tort of negligence, since confidentiality is an expected and fundamental part of medical care. Montgomery argues that it is also likely that the courts would expect that the following conditions would be satisfied in any such case: the information would have to be of a confidential nature; it would have to be given in situations where there is an obligation of confidence; and the patient would have to suffer from the disclosure of the information (32).

There is little case precedent directly relevant to the military context. However, there are some cases whose findings may be extrapolated to other circumstances. In an early non-medical case, Page Wood V-C stated,

“There are some things which may be required to be disclosed in the public interest, in which event no confidence can be prayed in aid to keep them secret” (33).

More recently, Shaw LJ noted:

“If the subject matter is something which is inimical to the public interest or threatens individual safety, a person in possession of knowledge of that subject matter cannot be obliged to conceal it although he acquired that knowledge in confidence. In some situations it may be his duty to reveal what he knows..” (34).

Similar views were expressed in the “Spycatcher” case:

“...although the basis of the law’s protection of confidences is that there is a public interest that confidences should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public

interest which favours disclosure....It is this limiting principle which may require a court to carry out a balancing operation, weighing the public interest in maintaining confidence against a countervailing public interest favouring disclosure (35).

The concept of a duty of medical confidentiality was set out in *Hunter v Mann* (36). Here Boreham J held that:

“...the doctor is under a duty not to disclose, without the consent of his patient, information which he, the doctor, has gained in his professional capacity, save...in very exceptional circumstances” (37).

However, the public interest has been claimed successfully as a defence against an action for breach of confidence (38) although Lord Wilberforce has explained that *“there is a wide difference between what is interesting to the public and what it is in the public interest to make known”* (39).

In a recent case seeking judicial review, the court found that the GMC was justified in not disciplining a doctor for releasing confidential patient information without consent to preserve his reputation which was being undermined by aggressive press interest and unsubstantiated allegations (40). The GMC had argued that the impugning of a doctor’s reputation would undermine patient trust and thus damage standards of medical care. Afterwards, both the British Medical Association and the Medical Protection Society advised that a doctor in similar circumstances should seek guidance before making a similar disclosure (41).

Article 8(2) of the European Convention on Human Rights has been invoked in two cases heard before the European Court. Both cases involved the alleged breach of medical confidentiality in releasing information to state authorities – in one to the police and in the other to a social security agency (42). In the first case, the court found that there was no contravention of the Article in the seizing of the medical records and their incorporation in the investigation file, but that there had been a violation in publishing the claimant’s details in the Finland Court of Appeal’s judgment. In the second case, the court found that there was no infringement of the Article in transferring the medical records for the legitimate aim of assessing benefit. In each case the court analysed with respect to Article 8(2) whether or not the disclosure without consent was in accordance with the law, whether or not it was for a legitimate aim and whether or not it was necessary in a democratic society. Kennedy & Grubb conclude that this is how English law

“will need to take account of the basis for, and scope of, disclosure in formulating the common law justifications” (43)

in human rights cases.

In a case relating to the discharge of personnel from the Armed Forces because of their homosexuality, Sir Thomas Bingham MR observed that

“...membership of a disciplined fighting force involves a curtailment of freedoms enjoyed by others in civilian employments” (44).

He approved of the argument put forward by counsel that

“The more substantial the interference with human rights, the more the court will require by way of justification before it is satisfied that the decision is reasonable...” (45).

Although the judgement attracted wide criticism at the time, this was aimed more at the judicial support for the Armed Forces’ attitude to sexuality rather than to potential tests for justification for violation of human rights. In a further case, Lord Bridge stated,

“Most of the rights spelled out in terms in the [European] convention [on Human Rights]... are less than absolute and must in some cases yield to the claims of competing public interests” (46).

Before the enactment of the Human Rights Act, *W v Egdel* (47) considered the case for disclosure to the Home Office of a medical report on a dangerous patient who was being evaluated for discharge. In this case, the courts balanced the interest to be served by disclosure against that served by non-disclosure and preferred the public interest in disclosure to the individual right to privacy. However, the court did propose that disclosure should be limited to

“the responsible authorities” (48).

This is in line with another medical case in the UK, *X v Y* (49), where the demands for confidentiality relating to a medical practitioner’s HIV status, were held to outweigh the public interest argument for disclosure. These two cases demonstrate the willingness of the English courts to balance public and private interests, basing their decisions on a pragmatic analysis of the proportionality of risks.

In other jurisdictions, similar outcomes have been achieved. In New Zealand, the courts found against a doctor who reported a bus driver’s coronary by-pass operation to his employers (50). Jeffries J held that if the disclosure itself were justified, it must be made to the appropriate authorities. Arguably the most celebrated case is *Tarasoff v Regents of University of California* (51). In this case, the court determined that when a patient posed a serious danger to another, the therapist incurred

“a duty to use reasonable care to protect the intended victim against such danger” (52).

The court determined that the

“protective privilege ended where the public peril began” (53).

However, as Perlin points out (54), a variety of cases have distinguished *Tarasoff*, particularly where the potential victim is not individually identifiable (55).

Discussion and Conclusions

The military working environment is different from most civilian employment. Accordingly, different regulations and practices are needed to allow the smooth delivery of military outputs. Some medical information is handled by non-military personnel. An example would be PULHHEEMS profiles and medical fitness for deployment. This is comparable to the handling of medical information by non-medical staff in the civilian sector. It is acceptable provided the same standards of protection of the individual are maintained. In addition, medical information, but not copies of records, may be provided by the appropriate medical authority for the purpose of security vetting. Only conditions that could have an impact on security clearance should be disclosed. The disclosure of other medical information, for the purpose of population surveillance or research, is acceptable provided that the information is anonymised (56). On the other hand, the disclosure of medical details in casualty signals is never justified. Medical staff should be punctilious in protecting their patients from unauthorised, albeit well-meaning, disclosure. This is why aeromedical evacuation signals are generated in a 2 signal format. The medical details are restricted to the second signal with the appropriate signal indicator codes to ensure that it is distributed only to medical staff. A commanding officer who is also a medical officer is not a member of the therapeutic team. He or she should only have access to the same medical information about a member of the unit as a non-medical commanding officer.

An examination of the ethical arguments suggests that there are exceptional occasions when it may be ethically possible to breach confidentiality without a patient’s consent. This is reflected in the guidance given to all doctors by the GMC. Legislation in the UK and other countries similarly allows the deliberate breaching of medical confidentiality without consent in certain specific circumstances. Both the Human Rights and the Data Protection Acts make provision for the selective non-consensual disclosure of medical information and therefore, in some circumstances, disclosure may be in accordance with the law. Case law suggests that there are occasions when the breach of medical confidentiality may be for a legitimate aim and also necessary in a democratic society. Thus the criteria set by the European Court of Human Rights are likely to be met in appropriate circumstances. However, the legislation also allows for action to be brought if the circumstances are not justifiable. It is likely that this action would be brought in the tort of negligence.

Case law in the UK suggests that three principles would be applied to the defence: that disclosure is justified only in the

presence of a threat to safety; that it must be made to a person

“with a legitimate interest in receiving the information” (57);

and that it should be restricted to the minimum necessary. However, enlistment in the Armed Forces entails the voluntary forfeiture of some human rights. Would enlistment therefore give grounds for the defence of implied consent were information to be released without specific consent? It is arguable that this defence would not be acceptable unless the individual was aware of the impact of enlistment on human rights. With appropriate briefing, it is likely that all recruits would be considered competent to decide whether or not to join and thus to waive this aspect of their rights.

It is evident that were there to be a complaint, the court would require proportionally greater justification the more the perceived interference with human rights. Thus the way appears to be open for some flexibility in the interpretation of human rights legislation in the military context. However, disclosure of confidential medical information in the Armed Forces would have to be to the appropriate authority, be the minimum necessary and be justifiable in the courts. In each case, the doctor would have to balance the pros and cons of disclosure against those of non-disclosure. In the event, this may have to come to the GMC or to trial for adjudication. As Bingham MR stated:

“It is not the constitutional role of the court to regulate the conditions of service in the armed forces of the Crown, nor has it the expertise to do so. But it has the constitutional role and duty of ensuring that the rights of citizens are not abused by the unlawful exercise of executive power (58).

What would concern many is the lawful use of executive power. It would be likely that any medical rules on non-consensual disclosure laid down by the military would be subject to judicial scrutiny using the test of reasonableness laid out in *Bolam v Friern Hospital Management Committee* (59), qualified by *Bolitho v Hackney Health Authority* (60) as to whether or not it was justifiable. To this would be added a test of proportionality to balance risks and benefits to the individual and to society. In addition, the doctor would have to decide whether or not the risks were so

“imminent, serious and foreseeable” (61)

that delay in disclosure would be not be advisable.

For the Royal Air Force, and indeed for the other two Services, any claim would be handled by the Ministry of Defence Claims Department. To date, no such case has arisen. The Claims Department will always fight a case on a point of principle but Medical Officers are advised to maintain membership of a medical defence organisation in case of any complaint to the

GMC. It is essential to keep full, contemporaneous records, preferably separate from the clinical record, detailing the justification for the actions taken.

The advice given to RAF medical officers appears to be pragmatic, appropriate and reflecting both professional guidelines and available case law. However, it could usefully be expanded to draw attention to the remote possibility of court action. It should also include the positive advice to seek guidance from higher authority in case of doubt. Advice may also be sought from professional and indemnifying bodies, but their knowledge of the specific requirements of the military may limit its ultimate usefulness. On the other hand, there is little written guidance available to commanders. This could be achieved by amendment to QRs. In addition, the average airman or airwoman is not aware of the reduction in human rights inherent in enlisting in the RAF. This departure from normal expectations should be briefed to all personnel – who are *de facto* RAF patients – during initial training.

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