PROFESSIONAL PRIVILEGE, or CAN'T YOU KEEP A SECRET

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THIS subject has already been given a sub-title by Mr. Douglas Menzies but I think I ought to choose one for myself. I think the proper sub-title for my talk to you should be "Mum's the word".

There are, of course, all kinds of people in our community claiming privileges. The lawyer, the doctor, the clergy, the newspapers, jurors, officers of State and others. Tonight I consider the subject only in relation to the doctor and the lawyer and I urge a new approach to the matter of the privilege of medical men. By the law of Victoria they have a privilege of a kind. It is embodied in Section 28 of the Evidence Act 1928. In speaking about this matter it is necessary to keep two things quite separate. First of all, there is the question whether there is any right or duty in a doctor to disclose or not to disclose, out of Court, facts concerning his patients which have come to his knowledge by reason of the doctor-patient relationship. The second question, is whether the doctor should have any legal right or duty to refrain from giving evidence of such facts in Court if he should be called as a witness. This paper supports the view that it is usually the doctor's moral and legal duty to refrain from disclosing such facts out of Court. It also argues that through the voluntary performance of this duty, the profession will best contribute to create a suitable atmosphere in which to perform its work and achieve its highest objectives. Finally it is submitted that the Victorian statutory provision prohibiting physicians and surgeons from disclosing, in civil cases, certain information gained in treating patients, ought to be abolished.

Now, at common law, there is no restraint or privilege which operates against or in favour of the doctor in relation to disclosure of such information. Since the fifth century, at least, the doctor has rendered allegiance to Hippocrates but no very sure lead

was given by Hippocrates. He merely said, "Whatsoever in the course of practice I see or hear (or outside my practice in social intercourse) that ought not to be published abroad, I will not divulge, but will consider such things as to be holy secrets".

Now, the spirit of that oath was for silence, but it obviously left plenty of room for individual decision in each particular case.

In modern days, medical men do not bind themselves by this oath, but it has served as the foundation for the development of modern medical ethics.

So far as I can ascertain, no enquiry has ever been held by the British General Medical Council into a charge of infamous conduct on the ground of breach of professional secrecy. Nevertheless, the subject of professional secrecy is one on which the British Medical Association has a clear and rigid policy. That policy is for complete secrecy under all circumstances with the possible exception that the doctor may warn persons against possible infection by venereal disease in an affected patient.

Just how strong is the official disposition towards secrecy can be judged by the proceedings of the British Medical Association's Annual Representative Meeting in Dublin in 1952. At that meeting, the Ethics Committee of the Association through the person of one Dr. Forbes, with whom one can't help feeling a good deal of sympathy, submitted a resolution in the following terms, "That in general, it is the practitioner's obligation to observe strictly the rule of professional secrecy by refraining from disclosing voluntarily, without the consent of the patient (except with statutory sanction) to any third party, information which he has learned in his professional relationship with the patient, but that there will doubtless occur certain special occasions when it may become the doctor's social or moral duty for the protection of innocent persons, to make a disclosure to an interested party, if the patient, after being properly and clearly advised as to the appropriate action he should take, refuses or fails to do so on his own responsibility". It was urged that doctors often wanted advice on what they should do in various situations when, if they did not disclose what they had discovered about a patient, damage might result to the community, to the patient and to the doctor. For instance, a doctor might discover that a driver of a lorry, bus or train, suffered from a serious condition which subjected him, from time to time, to the possibility of blackouts. Again, a doctor might discover that one of his patients who worked amongst machinery, suffered from epilepsy, and might

injure himself if he had a fit while at work; also, innumerable instances had occurred where doctors had become aware of criminal acts or threatened criminal acts and had been concerned to know whether concealment of such knowledge would result in peril to themselves. The committee urged, through Dr. Forbes, that it rested with each practitioner to decide for himself, when such a situation arose, what steps he should take—that he should warn the patient of the steps he intended to take, and tell the patient that if he did not take proper steps he himself would do what was necessary to put the matter right.

However, this proposed resolution found no sympathy in this meeting. No sooner had Dr. Forbes finished, than Dr. Smith of Greenwich moved an amendment that the words "in general" should come out of the resolution and that the second part of the motion—from the words, "but there will doubtless occur", should also be deleted. It was urged by this doctor that the proposed resolution would make it possible for "the onus to be placed quite definitely on the doctor" who could interpret his responsibility in a variety of ways, and that if widespread publicity were given to this proposed alteration of policy the confidence of patients in their doctors would be undermined.

Dr. Pemberton said that the bond between patient and doctor was a sacred one and that already patients' confidence had been weakened by doctors having to keep records of their illnesses. He urged that it was important to avoid any step which might tend to prevent persons suffering from certain illnesses from seeking medical advice.

Dr. McArthur stated that he had recently obtained an opinion from Counsel which was as follows:

> "Although originally an ethical matter it has long been established at Common Law that secrecy is an essential condition of the contract between a medical practitioner and his patient and that any breach of secrecy affords a ground for action for damages. In Kitson v. Playfair in 1896 a doctor had communicated certain information concerning his patient and her relatives and was held guilty of a breach of an implied covenant of secrecy, and damages were assessed at £12,000."

As a matter of fact the case of Kitson v. Playfair was not a case of breach of contract but was a case of libel. It does not matter very much; the results were the same. The doctor had said that

a lady was not chaste; he had relied upon the evidence of his own eyes, but he had mistaken certain uterine mucous membrane of a virgin for decidua, an error which it seems could easily be made.

Dr. McArthur then urged that as there was a risk of the doctor being sued for damages, not only for libel but for breach of contract, it was essential that the meeting should not refer this proposed resolution back to the sub-committee, but should put on record in no uncertain fashion that doctors would keep absolute secrecy.

In the end, with almost but not quite 100 per cent of those present and who are reported as having spoken, being against any relaxation of the rule of secrecy, the proposal of the sub-committee was lost. Further, a substantive motion was carried in the terms of the motion after deletion of the words "in general" and of all the other words which would have given any discretion whatsoever to the doctor.

And so the policy of the Association was quite clear, that the practitioner should not disclose voluntarily and without the consent of the patient information which he had obtained in the course of professional relationship with the patient. And this included, of course, information concerning criminal abortion, attempted suicide, birth concealment, venereal diseases and the rest. The State was regarded as having no right to require information except where, according to the provisions of statute, disclosure was enjoined.

It did seem, apparently, to one medical man (Dr. Dawson of Derby) that there was a touch of unreality about all this, and so he sent out a questionnaire to representative medical men and to representative laymen. The medical men were divided into four classes, namely, general practitioners of 50 years and over, general practitioners 40 years and under, consultants attached to hospitals, and municipal officers of health. The laymen were chosen from solicitors, Justices of the Peace and Church of England clergy. The names were taken in alphabetical order from statutory lists and the first question was:

> A doctor diagnoses epilepsy in the case of an engine-driver who controls the engine of a main line passenger train. The patient refuses permission to the doctor to disclose his disability to the railway authorities, and makes clear to the doctor his intention of continuing to earn his living as the

> driver of passenger trains. Has the doctor an overriding duty to ignore his patient's wishes and to report his state of epilepsy to the railway authorities?

The answers to the questionaire by the medical men were as follows:

Of general practitioners over fifty 76 per cent voted "Yes"; of those under fifty 82 per cent voted "Yes"; of consultants 88 per cent voted "Yes" and of the municipal officers 91 per cent voted "Yes".

Among those who answered "Yes" several comments indicated an opinion that the doctor would himself be breaking the law if he refrained from disclosing the facts of the case; this is wrong. The most satisfactory reason for voting "Yes" advanced by the great majority was that grave danger to loss of life, the safety of the community, social responsibility, or the interests of public welfare override all obligations of professional secrecy.

Amongst the replies of those who voted "No" were the following comments: "The railway doctor should have or has the responsibility of making the diagnosis of epilepsy himself, either on clinical grounds or with the help of doctors' certificates." "The responsibility of the doctor ends with the treatment of the patient." "An accident may never occur, as the driver is always accompanied by a stoker;" or "Pass the patient over to a specialist".

All these reasons for a "No" vote were regarded by Dr. Dawson as unsound. He said that there could only be two sound reasons. One was that the preservation of professional secrecy overrides all other obligations in accordance with the B.M.A. policy, and, secondly, that violation of professional secrecy, even under the most exceptional circumstances, will impair the doctor and patient relationship. The curious thing was that none of the people who voted, gave either of those two reasons for their opinion. The laymen voted 82 per cent for the affirmative and 15 per cent for the negative.

The second question was:

> A doctor attending a woman for an abortion finds that it was criminally induced by a professional abortionist. He learns the abortionist's name and address. The patient forbids him to report the matter to the police or even to disclose the abortionist's identity. What should the doctor do?

Of course, procuring an abortion is a felony, carries a very serious penalty, and the question of a possible charge against the doctor for concealment of a felony arises. The answers given showed a swing to "No", but the "Yes" vote was very strong—of G.P.'s over 50, 44 per cent favoured disclosure; of G.P.'s under 50, 50 per cent favoured disclosure; of consultants 64 per cent favoured disclosure; but, and curiously, of municipal officers of health—only 45 per cent favoured disclosure.

Looking at the various comments of the doctors, the basic conflict between the desire for preservation of secrecy and the desire for public welfare appears again. Among those who voted "Yes" many made a stipulation that the patient's name should not be disclosed. This condition would be very difficult to guarantee, in view of the possibility of the abortionist later disclosing the names of his victims in confessions to the police. Two comments deserve notice. One from a pathologist—"Have you ever seen a fatally procured abortion and the shocking mess it produced?" The other was, "Will do himself and the profession harm by withholding information that endangers public safety." One commented that the doctor should himself personally warn the abortionist. Another—"Abortion should be legalized." Another—"The doctor should send the case to hospital." Again—"The doctor should concentrate only on the patient's welfare." All these were regarded by Dr. Dawson as unsound.

The third question was:

> A doctor treats a man who is suffering from a rupture. Later the patient is involved in a minor accident at work and successfully, and fraudulently, claims industrial injury benefit and a pension in respect of the rupture, which he asserts resulted from the accident. The Ministry accepts his claim. His doctor knows that the rupture was neither caused nor aggravated by the accident. Has the doctor a duty to report his knowledge to the Ministry?

In the answers to this question we find a further tilt to "No", but on the whole there is a very substantial body which says "Yes". Twenty-four per cent of general practitioners over 50 would report the fraud. So would 36 per cent of those under 50; 20 per cent of consultants; and 54 per cent of the municipal officers of health.

It is interesting to note that the younger the group the more willing it is to make a report to the authorities, a development

which does not bring any comfort to me personally. It may show a trend of community feeling reflecting the impact of the welfare state.

The next question was:

> A doctor attending a patient in a patient's home notices, by chance, jewellery in the bedroom which clearly corresponds with a newspaper description of property recently stolen in a housebreaking raid. Is it the doctor's duty to report his discovery to the police?

To this question the medical replies showed a good majority for "No", but solicitors, justices of the peace and clergy were fairly evenly divided between "Yes" and "No".

Dr. Dickson has asked that the lawyers should say at what stage public duty overrides the duty of non-disclosure? The basis of the obligation not to disclose is that it is the high and sacred duty of the medical profession to heal the sick, and to accomplish that task the profession must establish and maintain a state of affairs in which the patient has confidence in the discretion of the doctor. The patient must feel free and safe so that he will speak frankly or not at all to his medical adviser.

The law assists the doctor by telling him that it would ordinarily be a breach of contract for him to disclose his patient's secret. It warns him also that if he speaks erroneously of his patient's condition he may be sued for libel. But at the same time the doctor is troubled by the notion that he should act as a good citizen and feels that public and private interests may sometimes require disclosure.

The answers to the questionnaires mentioned above show that the profession is tending to regard disclosure as a duty of increasing importance. The demands of the welfare state for all sorts of information and the general socialistic trend may be tending to displace the rights of the individual in favour of the interests of the mass. But I think that compassion for the sick, the overriding good of relieving the suffering of the patient, even of the patient who has wickedly induced his own ills, the interest of the state itself in healing and curing and in discouraging the concealment and consequent non-treatment of wounds and disease, provide a firm foundation for the medical profession to lay down strict rules against disclosures.

The extent to which the duty to heal the sick is to be treated as paramount and what are the steps necessary to create the

conditions under which this duty can be carried out would seem to be matters which the medical profession can and should best decide for itself, and the public should in general accept the judgment of the profession. However, for the individual doctor there will always remain the conflict of public duty and private duty. So far as lawyers speak the issue is not clearly resolved.

Mr. Justice Hawkins (Lord Brampton) is reported to have said in addressing a jury: "It was also said by the medical witnesses that if in the course of professional practice they came across a case which indicated either that a crime had been committed, or was about to be committed, that under those circumstances they were bound to divulge it. To whom? To the public prosecutor? If a poor wretched woman committed an offence for the purpose of getting rid of that with which she was pregnant and of saving her character, her reputation, and it might be, her very means of livelihood; and if a doctor was called in to assist her—not in procuring abortion, for that in itself was a crime—but called in for the purpose of attending her and giving her medical advice —how she might be cured so as to go forth about her business— he (the learned Judge) doubted very much whether he would be justified in going forth and saying to the public prosecutor—'I have been attending a poor young woman who has been trying to procure abortion with the assistance of her sister. She is now pretty well, and is getting better, and in the course of a few days she will be out again, but I think I ought to put you on to the woman.' To his (the learned Judge's) mind, a thing like that would be monstrous cruelty. He did not know what the jury's views would be; he spoke only of his own. Therefore, when it was said there was a general rule existing in the medical profession that, whensoever they saw in the course of their medical attendance that a crime had been committed or was about to be committed, they were in all cases to go off to the public prosecutor, he (the learned Judge) was bound to say that it was not a rule which met with his approbation, and he hoped it would not meet with the approbation of anybody else. There might be cases when it was the obvious duty of a medical man to speak out. In a case of murder, for instance, a man might come with a wound which it might be supposed had been inflicted on him in the course of a deadly struggle. It would be a monstrous thing if the medical man might screen him and try to hide the wound which might be the means of connecting the man with a serious crime. That was a different thing altogether. His Lordship only protested

against the rule being supposed to be applicable to all cases where a doctor had reason to suspect a crime. If the rule existed, he did not think the public prosecutor would pay very much attention to it."

This opinion may be compared with that given to the Royal College of Physicians in 1896 by Sir Edward Clarke and Mr. Horace Avory, which was to the effect that a medical man should not reveal facts which had come to his knowledge in the course of his professional duties, even in so extreme a case as where there were grounds to suspect that a criminal offence had been committed.

But then in 1916 Mr. Justice Avory went out of his way to contradict this view in a case in which he referred to his earlier opinion and said he desired to correct some wrong impressions concerning it.

He said, concerning a charge of murder arising out of the death of a woman by reason of an illegal operation: "This woman has been committed on the coroner's inquisition on a charge of murder. The deceased woman clearly died as the result of an illegal operation. Three medical men in succession attended her and to one at least she confided the name of the person who performed the act. No information was given to the police or the authorities and the woman died without a deposition being taken or without any statement being made by her on her death bed which could be used in a court of law.

The statement made by the deceased to a medical man is not evidence in a court of law. The law provides that in the case of any person who is seriously ill and who in the opinion of the medical man is not likely to recover, the evidence of such a person may be taken by a J.P. I cannot doubt it is the duty of the medical man to communicate with the police or with the authorities, in order that one or other of these steps may be taken for the purpose of assisting in the administration of justice. No one would wish to see disturbed the confidential relation which exists and which must exist between the medical man and his patient, but there are cases of which it appears to me this is one where the desire to preserve that confidence must be subordinated to the duty which is cast upon every good citizen to assist in investigation of a serious crime such as is here imputed to this woman.

It may be the moral duty of the medical man, even in cases where the patient is not dying or not unlikely to recover, to

communicate with the authorities when he sees good reason to believe that a serious crime has been committed. However that may be, I cannot doubt that in such a case as the present where the woman was in the opinion of the medical man likely to be lost it was his duty and that some of these gentlemen ought to have done it in this case."

Stung by this the Royal College of Physicians went into conclave, took counsel's advice and thereafter resolved—"That in the opinion of the College:

1. A moral obligation rests upon every medical practitioner to respect the confidence of his patient and that without her consent he is not justified in disclosing information obtained in the course of his profesional attendance on her.
2. Every medical practitioner who is convinced that criminal abortion has been practised on his patient should urge her, especially if she is likely to die, to make a statement which may be taken as evidence against the person who has performed the operation, provided that her chances of recovery are not thereby prejudiced.
3. In the event of her refusal to make such a statement he is under no legal obligation (so the College is advised) to take further action but he should continue to attend the patient to the best of his ability.
4. Before taking action which may lead to legal proceedings the medical practitioner will be wise to obtain the best medical and legal advice available both to ensure that the patient's statement may have value as legal evidence and to safeguard his own interest, since in the present state of the law there is no certainty that he will be protected against subsequent litigation."

The views of the College appeal to me.

To those doctors who feel that failure to disclose such matters may involve them in a crime it is thought that they may quiet their fears.

A recently published note by Dr. Norval Morris of this society concerning a recent case before Judge Stephen of New South Wales is in point and I quote:

"At the Court of Quarter Sessions held in Sydney, N.S.W., on the 21st July, 1954, one Hosking was charged before Judge Stephen with misprision of felony. The issue was simply phrased:

'Does the misdemeanour of misprision of felony still exist and, if so, what are its constituent elements?'

Stephen, in his History of the Criminal Law, dodged the task of tracing the growth of misprision and precisely defining its functions, merely referring curtly to his *Digest*. In 1887, in the last edition of the *Digest* which he edited, he wrote (Art 157) 'Everyone who knows that any other person has committed felony and conceals or procures the concealment thereof, is guilty of misprision of felony.' In a note he added (page 372)—'The definition of misprision of felony is extremely vague'.

An authoritative definition was still unavailable to Judge Stephen. The last reported English judicial consideration of this offence was by the Court of Criminal Appeal in Aberg's case (1948) 2 K.B. 173) where Lord Goddard said: 'The third count was a count for misprision of felony . . . Misprision of felony is an offence which is still described in the textbooks, but is generally regarded nowadays as having become obsolete or as having fallen into desuetude, although there have been recent cases in which counts for misprision of felony have been included in indictments. If in any future case it is thought necessary or desirable to include in an indictment a count of misprision of felony, great care should be taken to see what—at any rate, according to more modern authorities—are the constituents of the offence.'

Some points are clear—misprision of felony approximates to but is clearly distinguishable from compounding a felony (which requires an agreement not to prosecute; misprision does not), from accessory before the fact (which requires privity to the commission of the felony; misprision does not), and from accessory after the fact (which acquires assistance to the felony; misprision does not). But if the above definition and these propositions completely define misprision of felony, then, as Professor Glanville Williams has pointed out (*Criminal Law—the General Part, 69*), 'it would make it an offence for a mother to fail to inform the police that her eight-year-old son had taken a cake from the pantry, knowing that it is wrong to do so'.

Before Judge Stephen the defence argued that the offence originated when there were elements of communal responsibility for crime and no organized police force and when a duty, subject to a sanction, was necessarily cast on every citizen to assist directly in capturing the felon—the 'murdrum', or fine on the members of

the Hundred for a Norman killed within the Hundred if the culprit were not produced, is a well-known illustration. The defence advanced the consequent proposition that the offence is completely archaic and inapplicable to modern conditions. Judge Stephen rejected this line of argument, holding that misprision of felony, not having been abolished by Statute and being well known to the developing common law, remained a crime.

The defence argued further that if misprision of felony existed it required either that the accused was an actual eyewitness of the commission of the felony, or if not, and his knowledge of it was indirect, that he must have made some profit or gained some material benefit or emolument by concealing his knowledge. The 'eyewitness' distinction has only the most mediaeval support. Judge Stephen ignored it and held simply that for a conviction of misprision of felony it must be established that the accused took some material gain, benefit or emolument from his concealment of the felony. Proof of this element being lacking in the instant case, he directed an acquittal."

To heal the sick even for a fee, cannot, it is thought, be regarded as taking a benefit from the concealment of the crime.

However, outside this matter of misprision of felony, demands on the conscience of the doctor may arise. Thus, what does the doctor do who has knowledge gained in his professional capacity that a crime is being or is about to be committed?

Similarly where a crime has been committed and the doctor has knowledge gained in his professional capacity which would assist in convicting the criminal or clearing an innocent man?

Is that problem affected by the fact that the person on trial is not his patient and the relevant information relates to some other person who is the doctor's patient?

Again in matrimonial matters, where there is an allegation of adultery based on an alleged condition of venereal disease, suppose the doctor by reason of his knowledge of the pathological condition of the accusing party knows facts material to establish the innocence of the party against whom the charge is made.

Again, what is the situation where an action is brought by a patient against a medical man in a case in which the relation of doctor and patient exists between the plaintiff and several medical men simultaneously.

In the action against one of them, are the others bound to silence?

All these cases indicate wisdom on the part of Dr. Forbes who wished to reduce the strictness of the doctors' obligation of silence.

Thus it appears that notwithstanding the general desire of the profession to maintain the secrets of its patients there are innumerable cases and infinite sets of circumstances which will require the doctor to decide nice and delicate questions in which public duty or duty to some one member of the community will be calling for action inconsistent with his desire to remain silent.

The doctor asks for guidance and wants to know why he should be put in such a difficult position. The answer is that he cannot have guidance and he always must remain in this difficult position. Nothing can be done for him except to comfort him with the words of Lord Birkenhead that "the ultimate decision taken is to be in accordance with the high ethical sense of a learned and honourable profession whose aim is to raise or at least to maintain the standard of physical health in the community".

In the end the decision as to the extent to which the confidence of a patient is to be preserved is really where it ought to be, namely, in the hands of the doctors themselves. Although the making of decisions on these matters will cause doctors considerable pain and anxiety they must remember that the problem is in essence no different from the problem which is likely to come up for decision in the life of any one of us. Any member of the community may see a motor accident and have to decide whether he should speak or not. Any one of us may get information that the man about to marry our best friend's daughter is a confidence man, a convicted man or comes from a family suffering from hereditary insanity. Any one of us may become the repository of information that X or Y has committed a crime of more or less importance. The decision whether a man should speak in such cases depends upon a tremendous number of circumstances. First the degree of certainty that one feels as to the accuracy of the information. Secondly, whether the interests of innocent persons may be unduly affected; and, thirdly, whether one's own interests are likely to be affected. All these decisions will be made according to the degree of moral courage, clarity of moral vision, and public spirit of the person concerned. If the decision has to be made, however, in the light of the experience of an ancient profession with a background of sincerity and a desire to reconcile

the competing interests of public right and private wrong, then the chances of right decisions being made are fairly high.

When I say that the matter is really in the hands of the medical profession I do not overlook the fact that the doctor may be called as a witness in many cases and it may be said therefore that lots of these decisions do not rest with him. To a slight degree this may be true but in general a doctor is not likely to find himself in the witness box unless he had made some communication to somebody other than the patient concerning his medical knowledge of the patient's condition. It is seldom that a lawyer will call a witness concerning whose evidence he is in the dark. If therefore a doctor maintains silence he may expect to be untroubled by being called although a lawyer may well try to force him by giving him a subpeona.

I come now to the Victorian statutory provision which prohibits a physician or surgeon from divulging in any civil suit action or proceeding unless the sanity of the patient or his testamentary capacity is the matter in dispute, any information which such physician or surgeon has acquired in attending the patient and which was necessary to enable him to prescribe and act for the patient. (See Section 28 of the Evidence Act 1928.) It is my submission that this section is ill-conceived, unnecessary and in fact contrary to the public interest. Like all privileges from prohibitions against discovery of fact it tends to suppress truth and therefore tends to prevent the attainment of justice and to increase the possibility of miscarriages of justice.

Good reasons must therefore be sought if the section is to be supported. It is said that such a statutory provision is necessary in order to preserve this thing about which we have been talking, namely, the confidence which ought to exist between patient and doctor. It is said that if this section did not exist, persons requiring treatment would fail to seek treatment and that those who did seek treatment might tend to conceal things which they ought to tell the doctor. If there were any substance in this suggestion one would think that doctors practising their profession in a State where there is such legislation would enjoy a very happy position as compared with their brothers in States in which there is no legal privilege of this kind. Yet this does not seem to be so. Victoria and Tasmania are the only Australian States in which there is any legislation in the terms of Section 28 of the Victorian Evidence Act. Yet I do not hear that people cross the border in order to consult Melbourne psychiatrists or Melbourne physicians

in whom they have confidence rather than consult their own doctors in Sydney, Adelaide and Brisbane. There is no evidence that a person going to a doctor in Sydney fears garrulous propensities of his doctor any more than a similar person going to a doctor in Melbourne.

To find a person to whom this legislation gives comfort we have to search a very long way and find a very peculiar kind of being. He has to be a person who has no confidence whatever in the doctrine of secrecy which has grown up under the influence of the Hippocratic oath. He must have no confidence in the fact that if the doctor talks it would be a breach of contract, and he has no confidence in the general moral discretion which he may ordinarily expect his doctor to exercise.

Yet ex hypothesis he is a person who has some secret which he will not disclose to a doctor unless he knows that Section 28 of the Evidence Act exists. Curiously enough however, he knows that this secret will be no secret in the criminal court because Section 28 does not grant his doctor any protection in that court. But somewhere tucked away in the mind of this curious person is the notion—"Well, if I did not know that my doctor will not be able to disclose my condition in some civil action at law in which I or my personal representations may be involved I would not go to Dr. X for treatment. I would sooner die, or suffer the agony of this unhappy complaint."

What sort of a person is this? He wants to conceal the truth and apparently he wants to cheat. On the face of it this statutory privilege exists to protect somebody whose merits are not outstanding. What sort of secrets does he want to keep? Does he want to prevent somebody proving in a civil action that he has venereal disease although as between him and the other citizen concerned the existence of such disease vitally affects their rights? Is the person who contracts venereal disease the sort of person who should be assisted to cheat his fellow man in a civil action? Is the person concerned a pervert of some kind in respect of whom disclosure of that fact would weaken his case against some decent citizen? These are the kind of people for whom this section exists.

It may be said, "Oh what about the young woman in the family way who needs treatment? If she thinks that the doctor may betray her secret she may refrain from seeing the doctor". Can anybody really think that that young woman knows anything about Section 28 of the Evidence Act. Can one imagine her saying to herself—"I'll go and get treatment so long as I know that the

doctor won't be able to tell anybody I'm pregnant if I get caught up in some civil action of law. Of course I don't mind him disclosing it in criminal cases or telling father, but if it's going to come out in a civil case I'd rather go without treatment."

Having had a look now at the sort of person who is protected (?) by this section let us look at the sort of person who is hurt by it.

First let us consider the insurance company. The insured has entered into a contract and has warranted that he has never had certain diseases. The insurance company being called upon to pay at the maturity of the policy, discovers information which leads it to believe that the insured had had one of these diseases. In order to prove the matter it is necessary to call the evidence of the man's doctor. The plaintiff or his executor suing the insurance company takes advantage of Section 28 of the Evidence Act. The insurance company loses the case; injustice is perpetrated; breach of contract has been committed without penalty. The position would be the same if it were a case of fraudulent concealment. In such a case it can be said that Section 28 has assisted in the perpetration of successful fraud; all this in the name of preserving the relationship of doctor and patient.

Let us turn it round the other way—this time the insurance company has discovered enough evidence to raise a prima facie case that the insured has suffered from the disease in question. The insured is dead; he did not give his consent to disclosure by his doctor of the facts in possession of his doctor. His widow, having consulted the family doctor, has been assured by him that if he gave evidence he would be able to show conclusively from information obtained from treating her husband that he never had such a disease. He is, however, a conscientious doctor and very law abiding and he knows about Section 28. He consults his lawyer as to what he should do and his lawyer says to him: "Well, Section 28 creates a prohibition against your giving evidence. No penalty is set out in Section 28 but it will undoubtedly be a crime for you to give this evidence—it will be a misdemeanour and you will render yourself liable to a penalty." The doctor may well say that in such circumstances it would be wrong for him to act contrary to the policy of the law and unwise for him to place himself in jeopardy. He may therefore reluctantly say that he is unable to help this unfortunate widow either to restore her husband's reputation or to get the insurance moneys.

Again Section 28 has been a material feature in achieving an unjust result.

If we think of cases under the Wrongs Act, it has to be remembered that the plaintiff may or may not be the personal representative of the deceased man. In such cases it is always necessary to prove that the act of negligence or breach of contract which it is alleged caused the death was in fact the cause of death and to prove that the deceased was a healthy man. In such cases it is clear that it may frequently be necessary to rely upon the doctor who attended to the deceased in his illness or his death. If the doctor gives evidence in such a case he must do it in the teeth of Section 28. He will contravene the policy of the law and he will render himself liable to a penalty. This situation is quite capable of rendering a widow unable to prove her claim although she is able to prove every other element of the case.

The next thing that we notice about this section is the narrow limit within which it gives protection even in civil cases. In the first place the information must have been acquired "in attending the patient". No doubt the area of "attention" will be regarded very widely, but then the information must be information which was necessary to enable the doctor to prescribe or act for the patient. In the course of consultation a medical man no doubt asks many questions and gets many answers on matters which are material only at the stage when he is exploring the plaintiff's condition. When he has explored the patient's condition he will no doubt decide what is wrong with the patient and will decide upon his course of action. Much of the material which has been disclosed to him will, in the state of his then knowledge, be entirely immaterial and irrelevant with respect to any prescription or other action which he may desire to take for the patient. It may well be that this information which is now immaterial is information which was not necessary (looked at purely as a question of fact) to enable him to prescribe and act for the patient. The next thing is that in the course of acting for the patient in relation to malady A, the doctor may observe that the patient has suffered in the past or is suffering now from malady B. Such information is not information which he has obtained as "necessary to enable him to act for the patient". Accordingly our peculiar person who has the deadly secret which would prevent him from taking medical advice but for Section 28 can never get the protection under Section 28 unless this secret is a matter necessary for the doctor to know for the purposes of the illness

for which the patient desires to consult the doctor. Thus, one might imagine a case of a woman who had had a previous operation which rendered her incapable of child bearing. This may be her secret and having no confidence in the doctor's discretion she looks hopefully to Section 28 to protect her in relation to this secret. She may be involved in litigation in which her capacity to bear children in the future may be in issue. Her present malady may be such that in the course of, say, operating, or carrying out some examination, the doctor cannot help but see the facts which prevent childbirth but which are quite irrelevant for the purpose of treating the present malady. Such information is not protected because although acquired in treating the patient and in attending the patient it was not necessary for any prescription or act of the physician or the surgeon to enable him to act for the patient.

Further, the doctor may in the course of treatment remove some portion of the patient's body. It may be put on a slide or preserved in some way for the purposes of research and study after the patient has either died or become quite well. These slides or preserved portions of the body may on study reveal the existence of certain bodily conditions hitherto unidentified. Such information is not protected: it was not gained for the purpose of treating the patient.

Similarly, a nurse who attends the doctor's consultation or attends in the operating theatre can give evidence of all that she hears and sees.

The result is that the protection afforded by Section 28 is somewhat capricious; it may do irreparable harm to the interests of the patient or his widow and it may cause injustice to persons having dealings with the patient.

In the light of these considerations the case for examining the policy of the section becomes fairly strong.

Is it any wonder then that we read such comments as the following?

"The injury to justice by the repression of the facts of corporal injury and disease is a hundredfold greater than any injury which may be done by disclosure and further more the few topics such as venereal disease and abortion upon which secrecy might be seriously desired by the patient come into litigation ordinarily in issues in which common sense and common justice demand that that desire for secrecy shall not be listened to." (Wigmore p. 810.)

In England there is no section comparable to Section 28 and indeed there is no demand for it. Even Lord Dawson of Penn speaking in 1922 in favour of the creation of some legal privilege in England himself excluded criminal cases and curiously enough also cases of malpractice against medical men. Indeed this particular class of case well illustrates the dangers of the legislation. If you have a man who has been to three or four doctors for the same complaint and then fails or pretends that he has failed to get relief and sues one of them for negligence, the other three may have knowledge of facts most useful to the defendant. If however, their knowledge was obtained in the course of and for treatment of the plaintiff their mouths will be closed—a most disturbing prospect.

We have yet to learn that the medical profession of England finds that its relations with its patients are unsatisfactory. Similarly in America where 24 of the 48 States have no Section 28 or anything like it, there is no evidence that the sick are untreated.

These observations suggest that the preservation of the patient's confidence in the doctor is not to be achieved by law but by the individual and collective wisdom of the members of the medical profession.

The speaker's remarks concerning legal privilege were curtailed and conventional and have been omitted to permit fuller publication of his remarks concerning disclosure by doctors.

Discussion

DR. LEONARD BALL said that fortunately cases like the hypothetical cases mentioned by Mr. Smithers did not arise in practice. His view was that the matter must be left to the practitioner's discretion to decide what is right. He thought that it was a matter incapable of solution by the laying down of rules.

DR. C. H. FITTS said that the concept of keeping inviolate the patient's confidence had gradually been broken down by a number of factors. One was the requirements of the laws relating to the reporting of certain diseases, the outstanding disease in this category being tuberculosis. Again patients frequently signed an authority to a doctor to divulge information, though the patient had very little knowledge of what use was going to be made of the information so divulged. Further, there were in his view many breaches of professional confidence committed in ordinary day-

to-day social contacts by the answering of the question—"How is old So-and-so?"

DR. MICHAEL KELLY said that Mr. Smithers had approached the question of medical privilege from the wrong aspect. The doctor's task was to treat patients and to cure disease. The rule of professional secrecy should not be whittled away in any degree.

MR. G. H. LUSH said that the Council of the Victorian Branch of the British Medical Association had entered into an agreement with authorized workers' compensation insurers by which fees were prescribed for a large number of treatments and by the terms of which the practitioner treating the patient was obliged to give to the insurer any reports and certificates for which the insurer asked. There was also an undertaking by the insurer to pay fees for reports or certificates even if it turned out in the end that the patient was not entitled to workers' compensation. He said that the contents of this document were quite inconsistent with the rules of secrecy which had been championed during the course of the evening.

MR. P. MURPHY said that the agreement referred to by Mr. Lush was in fact carried out in practice. In giving a certificate or a report to an insurer, the doctor might not in many cases act through lack of appreciation of his duty to his patient and in most cases would feel that he was acting in the interests of his patient. The vice which he saw in the agreement became apparent when it was remembered that the insurer in compensation cases was bound to pay the medical expenses whether it obtained the reports referred to in the agreement or not. To this legal obligation the agreement added an obligation on the doctor to make reports, and an obligation on the insurer to pay for them in those cases which turned out not to be covered by the workers' compensation acts.

DR. J. NEWMAN MORRIS said that it should be appreciated that the reports and certificates to which reference had been made were usually given for the benefit of patients, who would encounter difficulties in obtaining their rights if they were not armed with the reports and certificates. Many members of the profession gave the report or the certificate to the patient himself, leaving it to him to decide what use he would make of it. Moreover, it was to be borne in mind that the insurer was entitled

to have the worker medically examined in any event. Turning to another subject, he drew attention to the fact that the common practice, when a patient was referred for examination on behalf of an insurance company, was to ask for and obtain the results of X-rays or pathological tests which had previously been carried out on the patient. The X-ray or test reports were usually obtained merely by direct request from doctor to doctor without any authority from the patient.