Editorial/Van die Redaksie

Confidentiality in medicine

As medicine moves slowly and somewhat reluctantly, but perceptibly, away from its traditional exclusive advocacy for individuals (on which most practitioners have been nurtured) towards a growing recognition that the common good must also be given greater weight, many moral dilemmas in medicine are becoming more intense. The problem of how to serve both the individual and society without compromising either, thus remains a hotly debated and unresolved issue.[1,2]

Confidentiality in the doctor/patient relationship is recognised as one of the crucial factors in the development and maintenance of the trust and confidence required for good medical practice. In the modern era, the ability to maintain complete confidentiality has become very much more difficult than in the past — for many reasons. These include the greatly increased amount of information available about any patient, the expanding number of people involved in the health care team, the use of computerised records, the more serious nature of the issues at stake (e.g. AIDS), and the conflict between demands from individual patients for maintaining confidentiality and public health demands for revealing information that may be of value to society.[3]

In his article in this issue (p. 29), Taitz has outlined legal considerations in relation to confidentiality in the USA and in South Africa and has briefly alluded to medical codes. While his interpretation of legal considerations in relation to confidentiality may be correct, it is necessary, for the sake of completeness, to both illustrate the evolving content of medical codes and mention the philosophical basis for confidentiality in medicine.

But because the facts under consideration must first be as accurate as possible before other issues are debated, it is necessary to point out that Taitz has misinterpreted the South African Medical and Dental Council (SAMDC). Contrary to his statement that the SAMDC 'has recently passed a resolution requiring a medical practitioner to inform, *inter alia*, the spouse or other sex partner of a patient suffering from AIDS or who is HIV-positive', the factual situation is that the SAMDC has, in its guidelines for the management of AIDS patients, stated that if after discussing 'openly and honestly with patients the implications of the condition, the need to ensure the safety of others . . .', the patient refuses to inform his/her spouse or sexual partner, 'doctors are urged to consider it their duty to inform such partners in order to safeguard them from a possibly fatal infection'.[4] The SAMDC also stresses that its guidelines 'do not in any sense constitute a code, but are merely intended as advice. Doctors are urged to act with great compassion and responsibility in deciding the appropriate course of action in specific circumstances.'[4] It is necessary to stress this point, since Taitz claims that the SAMDC's 'resolution' would provide 'an absolute defence to the breach of medical confidentiality'. His insistence on calling the SAMDC guidelines 'a resolution' would appear to be an over-interpretation with regard to informing a spouse or sexual partner. The guidelines do seem more like a resolution in relation to informing other health care workers who may be at risk.

Regarding confidentiality in medical codes, it is of interest to note how the wording of codes has evolved over the years:[5] 'Whatever, *in connection with my professional practice, or not in connection with it*, I see or hear, in the life of men, which ought not to be spoken abroad, I shall not divulge, as reckoning that all such should be kept secret' (Hippocratic Oath).

'I shall hold in confidence *all that my patient confides in me*' (Declaration of Geneva, 1948).

'It is a practitioner's obligation to observe the rule of professional secrecy by refraining from disclosing voluntarily without the consent of the patient (save with statutory sanctions) to any third party information *which he has learnt in his professional relationship* with the patient. The complications of modern life sometimes create difficulties for the doctor in the application of this principle, and so on certain occasions it may be necessary to acquiesce in some modifications. Always, however, the overriding consideration must be adoption of a line of conduct that will benefit the patient, or protect his interests' (British Medical Association, 1959).

'A physician may not reveal the confidences entrusted to him in the course of medical attendance or the deficiencies he may observe in the character of his patients unless he is required to do so by the law or *unless it becomes necessary in order to protect the welfare of the individual or of the society*' (American Medical Association, *Principles of Medical Ethics,* 1971).

These codes reflect movement away from an absolute form of confidentiality, which even included information obtained outside the professional relationship, towards a less absolute confidentiality which gives greater weight to the common good.

Philosophically, there are three premises which support confidentiality *in general* and on non-utilitarian grounds:[6] (*i*) respect for individual autonomy over personal information; (*ii*) the legitimacy of having personal secrets and sharing these in intimate relationships, which serve as the basis for the loyalties that promote collective survival; and (*iii*) the obligation which arises from agreeing to maintain confidentiality.

An additional premise which supports professional secrecy *in particular* (on the basis of its utility value) is the usefulness of professional confidentiality to individuals, who, as a result, feel free to confide in their doctor; and to society whose professionals are thus encouraged to use their skills to defuse potentially dangerous events by counselling patients who have felt safe in communicating their most intimate thoughts to their medical practitioners. The importance of this for the preservation of trust in the doctor/patient relationship was emphasised by the judges who disagreed with the final majority decision in the *Tarasoff* case referred to by Taitz.

Like other moral rules in medical ethics, confidentiality is not absolute, but needs to be weighed against other moral principles such as beneficence and justice. The limits of confidentiality cannot be neatly circumscribed and there will always be a price to be paid if confidentiality is breached. It must be stressed that when medical practitioners are faced with such dilemmas it is not only their decision that is important, but also the process by which this decision is reached. Empathetic communication with the patient and consultation with colleagues, in particular those with an interest in medical ethics, and adherence to a justifiable process of action in the face of a moral dilemma will provide the careful and caring doctor with the support and justification for difficult decisions when these need to be made.[7]

Moral codes and codes of professional conduct play an important role in making widely known and indeed exhorting the standards by which professionals should practise. While necessary for fostering moral decision-making, they do not provide a sufficient basis for either justifying or ensuring the best course of action. Rational discourse on the moral basis for action is also required. Similarly, while it is of great importance to have insight into legal precedents and opinions in relation to medical decisions, it is appropriate (as Taitz has acknowledged) to recognise that meeting legal requirements does not necessarily satisfy all moral requirements (and vice versa).

Litigation and medicolegal problems are on the increase in South Africa. Medical practitioners should have an understanding of the law in relationship to medicine, but they should also recognise that there are moral arguments independent of the law that need to be considered in the process of trying to reach wise and good decisions, and these may form the basis for subsequent changes in law.

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1. Leaf A. The doctor's dilemma — and society's too. *N Engl J Med* 1984; **310:** 718-721.
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3. Beauchamp TL, Walters L. *Contemporary Issues in Bioethics*. 3rd ed. Belmont, Calif.: Wadsworth Publishing, 1989.
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The health crisis in Natal — a personal view

'Research is the art of the soluble'
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The deterioration in health services over the past few years is the culmination of the trials and tribulations endured by this sector for the past 25 years as a result of poor financial resources and lack of planning. Medicine is not only a science but a learned profession deeply rooted in a number of sciences and charged with the obligation to apply these for the benefit of mankind. It is a mutable body of knowledge, skills and traditions, applicable to the preservation of health, the cure of disease and the amelioration of suffering. Patients expect professional competence in medical science and technology, patients want to be reasonably informed, and patients do not want to be abandoned when facing death. When no more can be done it is time to care for the family. It is the caring role rather than the curing role of the physician that is so important.

We need to ask ourselves why the health situation in Natal has deteriorated. The Natal population has escalated. In 1985 it was 6 million, comprising 78% blacks, 11% Indians, 9,5% whites and 1,5% mixed race.[1] The majority of the population is underprivileged. Durban has a large peri-urban area with more than a million blacks, of whom 30% are unemployed. Poor sanitation and the impact of HIV have contributed to a host of infectious diseases, such as tuberculosis, bacterial pneumonia, typhoid fever and gastro-enteritis.

The health services in Natal are run by the Natal Provincial Administration (NPA), the KwaZulu Ministry of Health, the House of Delegates, the central Government, city municipalities and the House of Representatives. In South Africa there are 14 departments of health, each with its own costly infrastructure. This fragmentation of services has contributed to a lack of cohesion and planning of health services in Natal. The NPA is responsible for the bulk of tertiary health care, for example cardiothoracic surgery, oncology, renal dialysis and transplantation. This poses a tremendous financial burden, since the NPA has to provide a service for the whole of Natal and KwaZulu. Forward planning for hospitals and clinics in peri-urban Durban has been

lacking. Addington Hospital, which faces the seafront, serves mainly the white and 'mixed' racial groups in Durban. It is not easily accessible and was built for reasons other than accessibility or community needs. Grey's Hospital (essentially a white hospital) in Pietermaritzburg is modern and relatively newly built, and it is questionable to what extent it is needed by the community it serves. The lack of clinics puts a heavy load on King Edward VIII Hospital, the major regional and academic hospital in Natal. Owing to the recent violence and unrest in the black townships, peripheral clinics are poorly staffed by doctors. The clinics lack certain drugs for chronic diseases, and access to them is often difficult. The peripheral hospitals in the various towns of Natal are inadequately staffed by specialists, so that many patients are referred to King Edward VIII Hospital for medical attention. This could be rectified by the introduction of a health service with a good infractructure, like that provided by the National Health Service in Britain. Prince Mshiyeni Hospital, a hospital in Durban under the KwaZulu Ministry of Health, is grossly underutilised. One reason for this is the lack of adequate finance to run the hospital. Black doctors who work for the KwaZulu Ministry of Health have to take the 'Inkatha oath' before they are appointed. This dissuades doctors from accepting posts at Prince Mshiyeni Hospital.

King Edward VIII Hospital has about 2 000 beds and an occupancy rate of over 100%. About 1,2 million patients attend the outpatient departments every year. (This is in contrast to Addington Hospital, which has 65% occupancy and 5 closed wards.) King Edward VIII Hospital provides primary, secondary and tertiary care for the black population of Natal. It is hopelessly overcrowded. The recent violence in the black townships, which has resulted in a large number of gunshot and knife wounds, has added another burden to the surgical section of the hospital, and to date there has been no extra funding for this increased service load. Owing to different accounting procedures the comparison of costs between different hospitals in South Africa is problematical. However, it is reasonable to assume that the budget of King Edward VIII Hospital is about 40% of that of white hospitals such as Universitas Hospital in Bloemfontein or Johannesburg Hospital.[2] In South Africa there is an inequality in funding between the white academic hospitals and the black academic hospitals such as King Edward VIII, Baragwanath and Kalafong.[2] The overcrowding at King Edward VIII Hospital, inadequate numbers of doctors, nurses, social workers, dieticians, secretaries and messengers, no curtains to provide privacy when examining patients in most wards, inadequate equipment and the restriction of certain expensive drugs have led to poor working conditions. There are inadequate intern posts. Newly qualified doctors from the University of Natal are reluctant to do their internship at King Edward VIII Hospital and to accept the present working conditions, so fewer and fewer of our graduates of better calibre are attracted there to specialise and train. The poor attitude of administrators has aggravated the situation. Major decisions appear to be made through crisis management. The fall in the calibre of doctors has led to a drop in academic standards. The teaching of ethical aspects of patient care is compromised in such surroundings. Despite these conditions, however, the loyalty and devotion to duty shown by the nurses and doctors has been exemplary.

The Medical School of the University of Natal uses King Edward VIII Hospital as its main teaching hospital. Since its inception in 1951, the medical school has been treated unfavourably by the Nationalist Government. In 1957 the Government intended to remove the medical school from the University of Natal.[3] It was only international, national and local medical pressure that made the Government relent in its decision. In spite of these adversities the medical school has produced doctors of very good calibre.

The NPA has over many years been unsympathetic about providing adequate finance for staff, equipment and development of King Edward VIII Hospital; more has been spent on non-academic white hospitals. There may now be some change in the attitude of the NPA, and in spite of severe financial cutbacks one-third of the NPA health budget is spent, quite rightly, on King Edward VIII Hospital. However, because of severe restrictions on equipment and staff over many years, at present the hospital is unable to cope with the financial cutbacks and the escalating number of patients.

Academic medicine in South Africa is deteriorating because of resignations to private practice or emigration.[4] Natal is also affected. This involves mainly the 'middle core' group of specialists. At present most academic specialists fall into two groups: young specialists who wish to acquire more experience and expertise before entering private practice, and specialists in their 50s. Recruitment into research has declined because of an inadequate number of posts, lack of technology and poor funding for research.[5]

The encouragement of privatisation by the Government has vastly increased the number of private hospitals and clinics in Durban and Pietermaritzburg. They are equipped with sophisticated technology. The better working conditions, with greater remuneration, have encouraged doctors to flock into private practice. While there are patients who desire private medical care, it must be accepted that the majority of people in South Africa cannot afford it. Privatisation has distinct disadvantages, including lack of caring for elderly people with degenerative diseases and high cost compared with public hospitals. Some patients are subsequently transferred to public hospitals when their medical aid benefits have run out. Private hospitals do little research, and they do not train doctors.

Solutions to these problems are urgently required. There is a need to end fragmentation of health services in Natal and KwaZulu. The recent decision of the government to open hospitals to all races is a milestone in the history of medicine in South Africa. However, in order to implement this policy more funding and cooperation on the part of administrators will be required. An academic hospital is essential for the medical school in Natal and it should be run by an autonomous management board. More money to run the health service in Natal and KwaZulu is urgently needed. Privatisation, while desirable, is not the answer. There should be

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better remuneration and conditions of service for all health workers in the public sector.

It is well recognised that the gap between per capita income in the developed and the developing world is becoming wider and the developing countries are becoming poorer. South Africa is a land of contrast between a small population with the lifestyle of the developed world and the majority of the population, which has the lifestyle of the developing world. Political ideology, race, colour and creed should be ignored and medicine should be developed for one purpose only, the care of the patient. A unitary, non-racial health system as suggested by Benatar[6] is a solution. Future negotiations will have to fulfil this aim.

Y. K. Seedat

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Opinion/Opinie

Solutions to the crisis at King Edward VIII Hospital

The editorial in this issue of the *SAMJ* by Professor Y. K. Seedat (p. 2) again draws attention to the prospects of an imminent collapse of health services in the province of Natal. We, as heads of the major clinical departments, are seriously concerned about the gravity of the present crisis and feel it imperative to offer, as a matter of urgency, practical solutions that could alleviate the situation.

King Edward VIII Hospital and its associated medical school has earned and maintained an international reputation as an outstanding centre for practical training, clinical teaching and relevant research since its inception in 1951. This has been achieved despite a financial budget comparatively deficient in relation to other academic centres in this country and in the context of overextended and unbalanced health services. The present crisis further jeopardises the future of the medical school. Ultimately, the answers lie in better central planning, with the establishment of a properly funded unitary health service that is equitable, balanced, appropriate and accessible. However, our present concern is strictly with the survival of King Edward VIII Hospital.

The Minister of Health and Population Development should, as a matter of great seriousness, publicly declare King Edward VIII Hospital a 'disaster area or institution', of a magnitude matched by the floods in Laingsburg and Natal. Only then can solutions to the problems at the hospital be formulated within the framework of a special project. We believe that putting the gravity of the situation on this level would secure additional funding from State resources for the hospital. It has been estimated that an immediate capital injection of R49 million is required just to provide the basic equipment needed to bring the hospital up to a minimum but acceptable standard.

The provision of additional funding over and above our equipment requirements would allow us to meet our most pressing needs, including improvements to infrastructural support (e.g. after-hours meals, security, parking, accommodation for junior hospital doctors and an efficient messenger service). In addition, electronic communication is poor and a new switchboard, paging service and telephones are urgently required, and critical care services need to be radically upgraded so that more than 8 patients at a time can be ventilated. It is essential that an advisory committee be appointed to oversee the cost-effective and impartial distribution of funds, assuming these become available. Such a committee must include those involved at the frontline in patient management.

In addition, the annual financial allocation to the hospital budget requires critical review in order to prevent a repetition of the present crisis. King Edward VIII Hospital has deteriorated to a nadir of effectiveness that threatens its continued existence as a teaching institution. The annual budget must take into account recurring costs involved in the employment of greater numbers of messengers, ward clerks, porters and other ancillary health workers. The hospital is hopelessly underprovided with such support staff, with the result that patient care is compromised because health professionals are required to undertake non-professional duties. To compound the problem, it is desperately short of health professionals, such as nurses and doctors. It is