Medical Confidentiality in the Context of Crime Prevention and Criminal Prosecution

A Comparative Study

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Summary

Medical confidentiality is widely recognised as a concept worth protecting. Problems arise, however, when medical confidentiality conflicts with interests that are equally regarded as important, such as the interests of justice; the interest in criminal prosecution; the interest in crime prevention; or defence rights. In order to develop convincing and workable criteria to balance the competing interests in case of a conflict, the different interests at stake must be clearly defined, and their respective importance assessed. Different ethical approaches to the balancing process will be introduced, followed by an analysis of the law of four legal systems, France, Germany, the UK and the U.S.

All four legal systems protect medical confidentiality by the means of private law, but only Germany and the U.S. protect medical confidentiality as part of the constitutional right to privacy. In France and Germany, a breach of medical confidentiality by a physician amounts to a criminal offence. Regardless of these differences, all systems agree that medical confidentiality serves both the privacy interests of the patient, and the public interest in protecting public health.

Fundamental differences materialise with regard to the recognition of medical privilege, which is recognised in France, Germany, and some States in the U.S., but is rejected by other States in the U.S. and by the UK. While in the U.S., defence rights are regarded as more important than medical confidentiality, the same is not true for France and Germany. All systems agree that medical confidentiality can be outweighed by the interest in preventing a crime that might cause serious harm to a third party, but the criteria according to which the competing interests are balanced, differ.

Based on a comparison of the different approaches, criteria for a consistent and morally justified resolution of the conflicts between medical confidentiality and the competing interests will be suggested.

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Chapter 1 - Introduction

Medical confidentiality is a principle which lies at the very heart of the physician-patient relationship and is relevant to all areas of medical law. It is universally recognised as a value worth protecting, and there is widespread agreement that physicians should not, in principle, announce to the world that which the patients have confided in them. This principle was already recognised by the Hippocratic Oath which provided that:

> 'Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets.'

The concept of medical confidentiality is now an integral part of International Conventions, such as the Declaration of Geneva of 1994, and an obligation to maintain medical confidentiality is imposed on physicians by the rules of their profession. Many legal systems guarantee the protection of medical confidentiality in various ways. At the European level, the importance of medical confidentiality was recently confirmed by the European Convention on Human Rights and Biomedicine, and by the Data Protection Directive 1995 addressing the particular threats to the confidentiality of personal (including medical) data which are being processed by automatic or non-automatic means.

Despite the general agreement that medical confidentiality should, in principle, be guaranteed, opinions differ when it comes to explaining why exactly medical confidentiality should be protected. Is medical confidentiality mainly protected in the interests of the patient, and if so, how, exactly, can the patient's interest in medical confidentiality be defined? Or is medical confidentiality mainly protected in the interests of the physician? The physician's job may be made much easier if he/she has the right to refuse any disclosure of confidential patient information, as many patients will only be willing to reveal all information necessary for diagnosis and treatment if they can rely on the physician's silence. Alternatively, is medical confidentiality mainly protected in the public interest, as patients might for example be deterred from seeking medical advice and treatment if they fear the disclosure of their medical secrets? It can easily be seen that the answers to these questions are of more than academic relevance, as the approach adopted towards different problems in the context of medical confidentiality depends largely on the interests

the respective legal systems are aiming to protect. If, for example, the main emphasis were to be placed on the protection of the physician's interests, it would be sensible to give the physician discretion in deciding whether or not to disclose certain confidential patient information, regardless of the wishes of the patient. If, on the other hand, medical confidentiality is mainly protected to pay heed to the interests of the patient, the existence or absence of the patient's consent to disclosure would have a decisive role to play. If the public interest were to be the most significant consideration behind the protection of medical confidentiality, the scope and limits of such protection would mainly depend on an analysis of how these interests could best be secured.

As with many other areas in which there is a general consensus that a particular interest deserves protection, the principle of medical confidentiality is uncontroversial as long as it does not conflict with other interests. Such conflicts can frequently arise where the physician holds confidential patient information which may be relevant for the purposes of crime prevention or criminal prosecution. A physician may, for example, receive information in confidence that the patient has committed a serious crime, or that the patient intends to commit a serious crime. It is also possible that the physician holds confidential information that would exonerate a person who is accused in criminal proceedings, or at least assist that person's defence. In these cases, the interest in medical confidentiality competes with a number of other interests: that of finding the truth in the course of criminal proceedings; the general public interest in crime prevention and criminal prosecution; the interests of parties who are wrongly accused in criminal proceedings; and with defence rights. To resolve such conflicts of interests, a balance must be struck to decide which is to prevail. In other words, it must be decided whether medical confidentiality is important enough to justify the recognition of a medical privilege, that is, the physician's right or even obligation to maintain the patient's confidences in the context of criminal proceedings and of crime prevention.

A balancing test can only be carried out satisfactorily if the interests at stake and their respective value are clearly defined. Therefore, the weight to be accorded to the principle of medical confidentiality as well as the importance of countervailing interests will have to be assessed. Different methods will be used to achieve this

purpose. While this thesis is mainly concerned with a legal analysis, it cannot be overlooked that the law in the area of medical confidentiality is largely based on policy considerations and ethical principles. For a critical assessment of the law's approach to medical confidentiality in general, and to the protection of medical confidentiality in the context of crime prevention and criminal prosecution in particular, it is essential to introduce philosophical principles which justify or even demand, the legal protection of medical confidentiality. It is also necessary to examine philosophical approaches to the conflict of interests underlying medical privilege. This is particularly important in the context of a comparative study, since moral conflicts are the same in all legal systems, and philosophical debate considers these problems in an attempt to find a universally acceptable moral solution, detached from the constraints of any one legal system.

With regard to the legal analysis, a comparative approach will be adopted, as a look across the border can indicate different ways of dealing with the same problem. The comparative analysis of different approaches to a universal problem will help to identify the strengths and weaknesses of different legal approaches, and to develop a more objective and satisfactory attitude towards the problem of medical privilege. Four different legal systems will be analysed to make a meaningful comparison possible. Two common law systems (UK and U.S.) and two civil law systems (France and Germany) will be examined to see whether and how the fundamental differences between those two types of legal systems influence the approach in the area under examination. At the same time, two systems providing constitutional protection for privacy (U.S. and Germany) will be compared with two systems that do not provide such protection (UK and France). These differences among the legal systems under examination will help to identify those factors influencing the approach towards the protection of medical confidentiality in general, and to the resolution of conflicts between medical confidentiality and other interests. Given its importance for three of the four legal systems under examination, the relevant law of the European Union and of the Council of Europe will also be examined briefly.

A comparative study faces many problems, not the least of which is that of how to structure the outline of the different legal systems so as to make a comparison possible, without losing the authenticity of each legal system. Different possibilities

exist to achieve this goal. It would be possible to divide the subject into different problems, and to examine and compare the law of the different legal systems with regard to the approach adopted towards that particular topic. While this structure would have the advantage of a problem-based analysis, it would also entail significant disadvantages. Even though all legal systems are faced with similar problems and therefore have to consider comparable conflicts, they all start from very different premises. The legal protection of medical confidentiality in France, for example, is mainly based on the provisions of the Criminal Code, and the conflicts arising are mostly dealt with by the provisions of the Code of Criminal Procedure. The approach is thus determined by principles and concepts of criminal law. The same is partly true for Germany, with the considerable difference that medical confidentiality is also protected by the Constitution, so that the provisions of the Criminal Code and of the Code of Criminal Procedure have to be interpreted in the light of constitutional principles. In the U.S., medical confidentiality equally has a strong constitutional basis which has widely influenced the legal approach towards medical privilege. However, medical confidentiality is not protected by substantive criminal law, but rather by particular statutes conferring privilege and providing very detailed provisions expressly regulating many of the conflicts between the interests behind medical confidentiality and the interests of justice. In the UK, on the other hand, the protection of medical confidentiality is a creature of case-law and has been mainly developed in the context of private law actions for breach of confidence. It is therefore based on private law principles and concepts. While these differences would complicate a problem-based approach, this would not, in itself, provide sufficient justification for dismissing an otherwise valuable method of comparative analysis. However, the problem-based approach has been rejected here for other reasons.

The protection of medical confidentiality, as well as the resolution of the different conflicts arising in the context of criminal proceedings and crime prevention, require a balancing of competing interests. To understand how the different legal systems approach the balancing test, it is essential to undertake a detailed analysis of the law of each legal system, and in particular of the interplay of different legal provisions and concepts. German law, for example, cannot be understood by isolating the problem of medical privilege, as the scope and application of medical

privilege by German courts depend on constitutional principles and on the interplay between medical privilege and the protection of medical confidentiality by the provisions of the Criminal Code. This example demonstrates that each legal system must be explained as a whole. Without such an approach, solutions to specific problems cannot be meaningfully outlined and discussed. Only on the basis of such an examination of each legal system can a comparative analysis be performed. Moreover, every legal system has its particular problems and emphasises different points. Consequently, a problem-based analysis would often give a distorted picture by giving inadequate attention to the peculiarities of each system.

The examination of each legal system will adopt, as far as practicable, the same structure, in order to facilitate the subsequent comparative analysis. The analysis of each legal system will be divided into two parts. The first part of each of these chapters will examine, the way in which the interest in medical confidentiality is protected by the respective legal system. In particular, the scope of protected information will be discussed, that is, for example, whether the protection is limited to confidences patients expressly communicate to their physician, or whether everything the physician learns in the course of the physician-patient relationship is covered by medical confidentiality. The legal mechanisms used to guarantee this protection will also be looked at, for example by examining whether medical confidentiality is protected by private law and/or criminal law provisions; whether it is a constitutional right; and what remedies are available in case of a breach of medical confidentiality.

The second part of these chapters will concentrate on the particular problems of medical privilege. Different questions will be discussed, such as the question of whether the physician has a right to refuse to give testimony in court regarding confidential patient information, and whether he/she may even be under a duty to refuse to give testimony. The conflicting interests in the context of criminal law and criminal proceedings will be identified. This part will main focus upon the public interest in criminal prosecution; the interests of a person who is wrongly accused in criminal proceedings, be it the physician or a third party; the interest in the guarantee of defence rights, in general; and the interest in crime prevention. The approaches of the different legal systems to a resolution of a conflict between these interests and the interest in medical confidentiality will be examined and the

policy reasons behind these approaches will be discussed. The specific problem of medical records and other confidential material relating to the patient will also be introduced. In this context, it is of particular importance whether the police can lawfully seize such material for the purpose of criminal prosecution, whether it must be made available as evidence in criminal proceedings, and whether the physician has the right voluntarily to submit material to the police or the court for the purpose of criminal prosecution. While an attempt will be made to raise the same issues for all legal systems, this will not always be appropriate. Frequently, a problem which is of particular importance for one legal system and is therefore discussed in great detail, does not cause any specific difficulties in another legal system and therefore does not merit detailed attention.

The ethical and legal analyses will be followed by comparative reflections. Selected legal problems that were introduced in the preceding chapters will be discussed, and the solutions promoted by different legal systems will be evaluated. The main emphasis will be placed upon a comparison of the practical solutions reached in each legal system, rather than upon theoretical differences in approach. This is important for an assessment of whether or not apparent similarities will lead to similar results, and apparent differences to different results. Comparative and ethical reflections will be combined in order to develop workable and ethically justifiable criteria to resolve the conflicts between medical confidentiality, on the one hand, and the interests in criminal prosecution, defence rights and crime prevention, on the other.

Chapter 2. Medical confidentiality and medical privilege – ethical perspectives

Medical confidentiality is the term commonly used to describe the concept that all communications taking place in the course of the professional relationship between physicians and their patients must be confidential. Medical privilege, on the other hand, refers to the specific situation that physicians are exempted from giving testimony in court with regard to confidential patient information, from submitting medical records of their patients, and from disclosing confidential patient information for the purposes of crime prevention. When trying to answer the general question of whether and to what extent the law should protect medical confidentiality, and the more specific question of whether or not medical privilege should be recognised, the importance of policy considerations is obvious. Particularly with regard to medical privilege, where a conflict of interests must be resolved, the solutions favoured in different legal systems are, at least to some extent, based on respective value systems. The outcome of legal disputes will therefore in great measure be determined by the significance accorded to the different interests at stake. Even though in the context of the legal debate, values are rarely expressed with reference to philosophical thought, it is nevertheless clear that the policy decisions, though often only intuitively, reflect philosophical ideas and ethical principles. Legislatures, courts and legal scholars have had recourse to ethical principles when developing and delineating the law in this area. A critical analysis of legislation, case-law and legal argumentation regarding the scope and limits of the legal protection of medical confidentiality and medical privilege therefore requires that some attention be paid to philosophical considerations about the value of medical confidentiality.

In the context of medical ethics, two theories are of particular importance: the utilitarian and the deontological school of thought. While it is conceded that a discussion of these two theories by no means conveys the full spectrum of philosophical debate in this area, any attempt to summarise all different philosophical schools with regard to their attitude towards medical confidentiality would far exceed the scope of this work. Mason and McCall Smith remind us that:

'Contemporary medical ethics is a tapestry in which an array of philosophical theories interweave with one another.'[1] Therefore, it is both inevitable and justified to concentrate on the main strands by focusing on utilitarian and deontological ethics. In contemporary medical ethics, the traditional deontological approaches to some extent have been extended by rights-based and principle-based approaches which will therefore also be introduced.

The purpose of this chapter is not to resolve the conflicts between the different ethical approaches or the inconsistencies inherent in each of them. Rather, its purpose is to establish the theoretical background necessary for a comparative analysis of the law. Ethical thought can be used as a tool for an assessment of the law as it stands. In particular, it can assist in the examination of whether the balancing of interests performed in each legal system and the results achieved can be justified by reference to the predominant ethical theories. As the balancing of interests depends largely on ethical and policy considerations, ethical reasoning can contribute to a more coherent approach to the balancing process, an important attribute in this area of law.

1. Introduction to different theories

1.1. Utilitarianism

For utilitarians, an action is right not because it is inherently good, but rather because it maximises 'utility', that is it produces the maximal positive value, or the best consequences. So-called 'act-utilitarianism' focuses on the utility of every action and holds that actions are right if they promote the best consequences in the individual case. This means that an agent must assess the consequences of his/her acts in a specific situation before pursuing a course of action. 'Rule-utilitarianism', on the other hand, is based on more general considerations when concentrating on the consequences of a rule, rather than on the consequences of an individual act. For a rule-utilitarian, the right act is that which is in accordance with a rule that conforms with the principle of utility, i.e. a rule that is thought to achieve the best consequences for an indeterminate number of cases. To abide by such a rule is more important than to achieve the best result in a particular case.

[1] *Law and Medical Ethics*, at 5.

This is because it is thought by rule-utilitarians that the good that may result from a certain course of action in an individual case may lead to bad consequences in an unpredictable number of cases, if to achieve the good result, a good rule must be disregarded. A rule-utilitarian, when deciding on a course of action, will therefore be guided by general rules that are based on the principle of utility. Bentham and Mill, the early promoters of the principle of utilitarianism, defined utility exclusively by reference to pleasure and happiness,[2] notions which are not unambiguous in their meaning. More recent utilitarians have recognised additional values such as autonomy.[3]

The principle of utility could be summarised as a principle of striving for the greatest happiness for the greatest number. It claims to be objective, in that the determination of whether or not an act or a rule is good or bad depends on a calculation of the pain and pleasure thereby caused. If the pleasure outweighs the pain, then the act or rule is good. However, utilitarian theory is faced with the problem of how to decide what are good or bad consequences and how to measure what are the best consequences to be achieved. If the good of a rule or an act is to be decided according to its consequences, this presupposes an antecedent system of judging and ranking consequences, and thus a pre-existing 'vision of the good'.[4] Another problem which will become apparent in the context of medical confidentiality and medical privilege is that of whether only certain and direct consequences are to be taken into account, or whether and to what extent possible long-term or indirect consequences might weigh in the cost-benefit analysis.

1.2. Deontological theories

1.2.1. A duty-based approach

Deontological theories focus on the rightness or wrongness of an act in itself. They are not concerned with the consequences an act may have, but rather with identifying those features of the act which make it morally acceptable, and they suggest that some acts have an intrinsic value. According to Kant, for example, an agent acts morally only when acting from a sense of duty. This makes it

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[2] Bentham, *An Introduction to the Principles of Morals and Legislation*, at 11-13; Mill, *Utilitarianism*, at 59.
[3] Griffin, *Well-Being: Its Measurement and Moral Importance*, at 67.
[4] Engelhardt Jr., *The Foundations of Bioethics*, at 46.

necessary to identify the duties of the individual. Kant promotes that the individual ought to behave as if the behaviour were to become a universal law, so that only an act that passes the test of universalisability qualifies as a moral act.[5] Another important feature of Kantian ethics is that it is immoral to use others merely as a means to an end. Rather, every person must be treated as an end in him/herself, and have his/her integrity as an individual respected.[6] One important problem medical ethics, based on Kantian views, would have to face is how to resolve conflicts of interests. As a person's duties are absolute, according to Kant, there is no room for conflict resolution or for the balancing of two competing duties. Given the realities of medical practice where conflicts frequently arise, this approach is ineffectual for practical medical ethics.[7]

Other deontologists have tried to overcome this problem. Ross, for example, who argued that 'if there are things that are intrinsically good, it is *prima facie* a duty to bring them into existence rather than not to do so, and to bring as much of them into existence as possible,' nevertheless recognised that a conflict of these duties may arise. According to him:

> 'When I am in a situation, as perhaps I always am, in which more than one of these *prima facie* duties is incumbent on me, what I have to do is to study the situation as fully as I can until I form the considered opinion (it is never more) that in the circumstances one of them is more incumbent on me than any other; then I am bound to think that to do this *prima facie* duty is my duty *sans phrase* in the situation.'[8]

Ross, like Kant, defines morality in terms of obligations. But unlike Kant, he acknowledges that duties are not absolute and can be overridden by more urgent duties, depending on an assessment of all the circumstances in a given case. Even if it avoids the absoluteness of Kantian obligations, this theory nevertheless raises two fundamental problems. First, how is one to determine which of the competing duties is the more urgent one and therefore the duty that will prevail in a given conflict of duties? More importantly, there is the problem of the moral justification of which duties are to be regarded as *prima facie* duties. Ross identifies three qualities that are intrinsically good: virtue, knowledge and pleasure. However, even though he attempts to give a moral justification of this

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[5] Kant, *Foundations of the Metaphysics of Morals*, at 44.
[6] Ibid., at 52-53.
[7] Beauchamp, Childress, *Principles of Biomedical Ethics*, at 60-62; Davies, *Textbook on Medical Law*, at 6.
[8] Ross, *The Right and the Good*, at 16-29.

particular choice of values, for those who do not share his particular value system the determination of certain acts or values as intrinsically good seems to be no more than the announcement of personal preferences,[9] a criticism that can be made equally of other deontological approaches.

1.2.2. A principle-based approach

In contemporary medical ethics, more and more writers have come to realise the inadequacies of traditional ethical theories. In addition to the particular problems inherent to each theory, there is the fundamental problem that monistic theories that are based on a particular vision of the good can only be regarded as binding by those who share the same basic beliefs, and do not deliver sufficient moral justification to be convincing to every individual in a pluralistic society.[10] Furthermore, traditional ethical theories are so complex, and the full understanding and application of any of them requires such an immersion in philosophical ideas, that professionals who are faced with ethical conflicts, such as medical practitioners or lawyers, will frequently not have an adequate philosophical background to approach these conflicts on the basis of the particular ethical theory which suits them best. Nor would such an approach necessarily be justifiable, given the possibility that their patient may have a completely different set of beliefs.[11] Therefore, rather than trying to develop a comprehensive ethical theory, an alternative approach could start from the assumption that workable medical ethics should be based on what Beauchamp and Childress call common morality or shared beliefs. One advantage of this approach is that it is possible to assert that certain beliefs are shared by rival ethical theories.[12] Therefore, principles which are acceptable to the adherents of rival moral theories could be developed on the basis of these beliefs, without any need first to resolve the fundamental philosophical disagreements about the very basis of moral justification, separating them.[13] This approach emphasises and combines the strengths of different moral theories when searching for justifiable ethical principles to be used as guidelines for the resolution of conflicts of interests. It

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[9] Engelhardt Jr., *The Foundations of Bioethics*, at 65.
[10] Ibid., at 65-66.
[11] Schöne-Seifert, 'Medizinethik', in: Nida-Rümelin (ed.) *Angewandte Ethik*, at 564.
[12] Beauchamp and Childress, *Principles of Biomedical Ethics*, at 100.
[13] Ibid., at 22.

acknowledges that moral principles and practical experience are interdependent and that a constant mutual assessment of principles and experience is needed to develop new and to improve existing principles and approaches. Once principles are thus derived from common morality, they will be *prima facie* binding, but can be overridden by other principles. Beauchamp and Childress concede, however, that some conflicts may not be amenable to a resolution by a reference to principles.[14]

This approach, of course, raises the problem of which interests can be identified as being recognised by common morality. While Engelhardt, for example, only works with two principles, permission and beneficence,[15] and holds that the principle of permission is the principle on which all moral authority is based,[16] Beauchamp and Childress identify four principles, autonomy, beneficence, non-maleficence and justice, without giving one of them precedence over the other.[17]

1.2.3. A rights-based approach

Rights-based theories rest on the assumption that morality primarily aims at protecting the interests of individuals, and that rights are the most effective instrument to achieve such protection. If an interest is given the status of a right, the individual has an enforceable claim that his/her interest not be violated. According to Ronald Dworkin, a prominent promoter of the rights-based approach to ethics, to talk of a right means to give an individual interest, in principle, priority over collective goals. Individual rights are thus 'trumps' which cannot be restricted in order to pursue ordinary public or community interests.[18] This is because the concept of individual rights only makes sense if rights cannot be overridden simply by referring to some potential utilitarian gain, as individual rights would then not confer any special protection. Moreover, rights cannot be infringed in the interest of the majority, unless there is a case of special urgency, as individual rights are of particular importance to achieve the protection of the most vulnerable, a purpose which would be completely undermined if majority interests could routinely outweigh these rights. However, the language of rights

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[14] Ibid., at 122-124.
[15] Engelhardt Jr., *The Foundations of Bioethics*, at 119.
[16] Ibid., at 69.
[17] Beauchamp, Childress, *Principles of Biomedical Ethics*, at 38.
[18] Dworkin, *Taking Rights Seriously*, at 92 and 191.

with its emphasis on the interests of the individual, cannot avoid the problem that even rights may have to yield when they are in conflict with other, more important rights, either of third parties or of the public.[19] Thus, rights-based theories need to decide which right has to yield and which right will prevail in case of conflict, It should also be noted that the abstract recognition that an individual's interests should sometimes have the force of a right says nothing about which interests are important enough to justify the recognition of a right. Rights-based moral theories are thus confronted with problems similar to those faced by duty-based ethics.

2. Autonomy, privacy and confidentiality

2.1. Principle of autonomy

While most contemporary moral theories accept the importance of the principle of autonomy and agree that the individual's autonomy deserves protection, the exact scope and meaning of autonomy is far from clear. Autonomy means self-rule, which indicates that autonomy refers to a person's ability of self-determination, that is to determine his/her acts and life plan. Autonomy thus understood presupposes freedom from controlling influences and a capacity to make one's own decisions. If these conditions are met, a person is an autonomous agent. According to some moral theories, autonomy is an intrinsic value and as such deserves protection. Deontological theories state that every individual is under the obligation to respect the autonomy of others;[20] the principle-based approach regards the principle of autonomy as one of the fundamental principles of medical ethics;[21] and according to rights-based theory, the autonomous agent even has a right that his/her autonomy be respected.[22] However, while some utilitarians recognise that respect for autonomy may promote happiness,[23] utilitarian thought nevertheless predominantly maintains that autonomy only requires respect as long as this will produce the best possible consequences, so that according to utilitarian theory, autonomy is only of instrumental value.

Respect for autonomy is required in different ways. The individual must be given

[19] Ibid., at 191 -194.
[20] See, for example, Kant, *Foundations of the Metaphysics of Morals*, at 52-53.
[21] See, for example, Beauchamp, Childress, *Principles of Biomedical Ethics*, at 38.
[22] See, for example, Dworkin, *Taking Rights Seriously*, at 277.
[23] Griffin, *Well-Being: Its Measurement and Moral Importance*, at 67.

space to make autonomous decisions and, consequently, respect for autonomy dictates the principle of non-interference with the individual's autonomous affairs. Positive action may also be required, as the individual will often only be able meaningfully to exercise his/her autonomy with the assistance of others or of the state. According to the terminology of Kant, respect for autonomy demands that others are treated as ends in themselves, rather than being reduced to other people's means.[24] In the light of the growing importance of personal autonomy, this thought has since developed from the mere prohibition to treat people as a means to a requirement that people must be assisted in achieving their ends and in developing their capacity as agents.[25] It has been argued that to respect an autonomous agent requires at a minimum to acknowledge that person's right to hold views, to make choices, and to take actions based on personal values, beliefs and preferences.[26]

2.2. Privacy

When looking at the use of the term privacy by courts and by different writers, it can easily be seen that the term is not given a single meaning, but is used to describe different phenomena. The importance of the right to privacy was already emphasised by Warren and Brandeis in an influential article published in 1890.[27] When the notion of a right to privacy first emerged, the main focus lay on the protection of the individual from unwarranted disclosure of private information. However, this perspective is too narrow, as privacy refers to the entire private sphere of the individual, so that a person's privacy could be defined as the inaccessibility of this person's private sphere to others. In that respect, privacy refers to the physical as well as to the mental sphere as it includes a person's body and bodily products, but also a person's thoughts, and intimate and confidential relationships.[28] This includes, but is not restricted to, the protection of personal information. In the context of contemporary medical ethics, the concept of privacy is said to embrace four different categories of cases: (1) informational privacy regarding access to personal information; (2) physical privacy regarding access to

[24] Kant, *Foundations of the Metaphysics of Morals*, at 52-53.
[25] Herman, (1984) 94 Ethics, at 601; O'Neill, (1989) 72 Monist, at 354-355.
[26] Beauchamp, Childress, *Principles of Biomedical Ethics*, at 125.
[27] Warren, Brandeis, (1890) 4 Harvard Law Review, at 193-220.
[28] Beauchamp, Childress, *Principles of Biomedical Ethics*, at 408.

persons and personal space, a category of privacy that requires, for example, that medical treatment of a competent patient is not administered without the patient's consent; (3) decisional privacy regarding personal choices, which excludes governmental and other third-party interference with such intimate decisions as health care and family planning; and (4) proprietary privacy regarding the appropriation and ownership of interests in human personality.[29] In the context of a study of medical confidentiality, the first and third privacy categories are of particular importance.

It is now widely recognised that privacy is closely linked with autonomy.[30] Privacy is said to be one aspect of the principle of autonomy, as without privacy, the guarantee of personal autonomy would be incomplete.[31] With regard to the individual's interest in informational privacy, the connection between privacy and autonomy focuses on the concept of control over personal information. Informational privacy goes beyond the interest that no information be spread about the individual. It additionally justifies a feeling of security because the individual is in control of his/her private and intimate information. Respect for privacy is essential for developing a sense of self and personhood, as the individual needs private space to develop and formulate autonomous preferences.[32] Control over personal information is thus of fundamental importance to individuals. It not only enables persons to avoid the shame of having embarrassing intimate information disclosed publicly, but it also ensures that they can engage in unconventional behaviour without having to fear negative consequences. Thus, if the principle of autonomy is recognised and respected, then the privacy of the individual must equally be protected, as it must be left to the individual's autonomous choice whether, to whom and to what extent to disclose personal information.[33] Informational privacy could thus be defined as an expression of the right to self-determination in respect of personal information, as the individual retains control over what will be known about him/her.[34] However, it is important to stress that informational privacy is not mainly concerned with

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[29] Allen, 'Genetic privacy: emerging concepts and values', in: Rothstein, *Genetic Secrets*, at 33.
[30] See, for example, Westin, *Privacy and Freedom*, at 33-34; Fried, 'Privacy (A moral analysis)', in: Schoeman, *Philosophical Dimensions of Privacy: An Anthology*, at 219; Henkin, (1974) Columbia Law Review, at 1425; Gostin, (1995) 80 Cornell Law Review, at 513-514.
[31] Beauchamp, Childress, *Principles of Biomedical Ethics*, at 410.
[32] Gostin, (1995) 80 Cornell Law Review, at 514.
[33] Bok, *Secrets*, at 120.
[34] Moore, (1985-86) 36 Case Western Reserve Law Review, at 190.

shielding potentially embarrassing facts from public scrutiny. Rather, privacy is valuable regardless of how the information is viewed by others, as it does not aim at protecting the content of information, but rather at giving the individual the power to control the extent to which others can participate in his/her life. [35] Or, to express this thought differently, the unwanted disclosure of private data can in itself cause harm, so that respect for a person's privacy can be seen as a recognition of the desirability that the individual should be protected against the insult to dignity and the lack of respect for the person such unwanted disclosure might entail.[36] Another important aspect of privacy is to guarantee intimate relationships. Only if individuals are secure in the knowledge of their privacy will they be comfortable to share their confidences with others, and without privacy, intimate human relationships could thus not develop.[37] This is significant for the physician-patient relationship, as privacy protection gives the individual the space to form a confidential relationship with his/her physician in which he/she can disclose medical secrets without the fear that such confidences will be disclosed beyond that relationship.

Decisional privacy is also linked to the principle of autonomy, as the principle of autonomy includes the right to decide what will happen to one's person and one's body.[38] This category of privacy is important for the physician-patient relationship, as without privacy, the patient would not have the opportunity to choose freely whether or not to seek medical advice and treatment and to make autonomous health care decisions without giving up the privacy of all information thus made known to the physician.

For deontologists who see privacy as a part of the principle of autonomy, privacy is a fundamental right which is closely linked to the dignity of human persons.[39] Utilitarians also value privacy, but for different reasons. For them, privacy does not possess any intrinsic value. However, it is acknowledged that privacy promotes personal development and fosters personal or intimate relationships. Privacy is thus said to be of instrumental value in achieving certain personal goals. In the context of the physician-patient relationship, the benefits of privacy

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[35] Orentlicher, 'Genetic privacy in the patient-physician relationship', in: Rothstein, *Genetic Secrets*, at 79.
[36] Gostin, (1995) 80 Cornell Law Review, at 490.
[37] Francis, (1982) 8 JME, at 135.
[38] Beauchamp, Childress, *Principles of Biomedical Ethics*, at 410.
[39] Francis, (1982) 8 JME, at 141.

protection are that it enhances autonomy, prevents embarrassment and promotes effective communication between physician and patient. It therefore promotes health and thereby happiness. Thus, utilitarians recognise that privacy may be important for its consequential effects.[40]

2.3. Medical confidentiality

Although medical confidentiality and privacy are closely linked, some writers stress that they are distinct concepts. Privacy refers to the general interest that the private sphere be shielded from unwanted access. Confidentiality, in contrast, presupposes a relationship of confidence in which certain private information is disclosed or in which a person is given access to one's private sphere. Such a relationship exists where the person who is given access to the private sphere of another makes a promise of keeping all such information confidential, or where the person is under an obligation, legal or ethical, not to disclose the other person's secrets.[41] If this distinction between privacy and medical confidentiality is accepted, medical confidentiality concerns a small part of privacy in that it deals with access to the patient's private sphere in the context of the physician-patient relationship. If understood in this way, a claim for medical confidentiality can only exist in the confined setting of the physician-patient relationship. However, as information related to a person's physical or mental health is regarded as private, confidential medical information is already protected by the general right to privacy. The right to privacy in its connection with the right to personal autonomy also protects intimate personal relationships, so that the right to privacy includes the right to form a relationship with one's physician and to protect this relationship as private. This raises the question of whether, in the context of the physician-patient relationship, the particular protection of medical confidentiality can add anything to the general privacy protection. Some argue that additional protection lies in the fact that confidentiality imposes an obligation on the person who obtained information in confidence not to disclose this information.[42]

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[40] Gostin, (1995) 80 Cornell Law Review, at 514.
[41] Beauchamp, Childress, *Principles of Biomedical Ethics*, at 420; Gillon, (1985) 291 BMJ, at 1635.
[42] Beauchamp, Childress, *Principles of Biomedical Ethics*, at 418 and 423-424.

What, then, are the moral justifications for a protection of medical confidentiality? It could be argued that the confidentiality of the physician-patient relationship does not deserve any protection, as patients usually voluntarily grant their physicians access to their private sphere and thereby voluntarily surrender some degree of privacy. Warwick, for example, argues that confidentiality is not a necessary component of the physician-patient relationship, but that the physician's obligations to maintain the patient's confidences and the patient's expectation of medical confidentiality are rather only artificially created by the physician's promise to that respect. Without this promise, the moral justification for medical confidentiality would disappear. As the argument goes, privacy considerations cannot justify medical confidentiality, as the patient has a free choice between keeping his/her medical secrets to him/herself by not revealing them to the physician and by not allowing the physician to examine him/her, or choosing to disclose such information, thus giving up privacy protection. According to Warwick, it is acceptable that patients must thus decide between privacy and health interests, as 'their health is sacrificed in good cause - that of their individual autonomy', and as 'it would seem that ill-health may be a reasonable price to pay for the maintenance of autonomy.'[43] However, it is submitted that this argument is not convincing, as it is based on a too narrow view of personal autonomy. As was already explained, autonomy protects the self-determination of autonomous agents and requires respect for their free and voluntary choices. One important feature of respecting the individual's autonomy is that the private sphere be protected from unwanted access as well as from interference with personal choices. At least personal autonomy in the form of decisional privacy is inadequately protected by the model suggested by Warwick. While without medical confidentiality, the individual still has a choice between privacy and health, the argument neglects the point that free and autonomous health-care decisions are one important expression of the person's privacy and autonomy. Thus, rather than achieving the alleged purpose of strengthening the patient's autonomy, this opinion gives the patient no more than a choice between exercising one element of autonomy to the detriment of the other, which is not necessarily the best way to enhance autonomy.

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[43] Warwick, (1989) JME, at 184.

One justification for the protection of medical confidentiality is thus based on the premise that it seeks to guarantee respect for a patient's autonomy and privacy when entering a professional relationship with a physician.[44] Physicians and psychotherapists incessantly emphasise the importance of frankness and candour in the course of the medical encounter both for the purpose of a correct diagnosis and for the purpose of effective treatment. A patient who seeks medical or psychological help will regularly have to reveal intimate personal information to the physician or psychotherapist, and whenever a patient allows a medical or psychological examination to take place will he/she necessarily grant the physician or psychotherapist access to his/her personal sphere. Only if the patient can rely on medical confidentiality and knows that the information will not be accessible to third parties or the state beyond the therapeutic relationship, will the patient be free to seek medical or psychological advice and treatment.[45] Only then will the patient have a true choice, as he/she then does not have to sacrifice one aspect of his/her autonomy and privacy for another. An element of trust is therefore said to be essential in order for patients to feel secure when confiding their secrets in the physician.[46] Given the close link between the concept of medical confidentiality and the principles of privacy and autonomy, some of the arguments listed in support of a right to privacy equally justify the recognition of medical confidentiality, and many writers, when trying to give a moral justification for the protection of medical confidentiality, content themselves with the statement that medical confidentiality is based on the patient's privacy interests which are protected as part of the principle of autonomy.[47] Others specify this further. Siegler, for example, argues that medical confidentiality serves a dual purpose. First, it acknowledges respect for the patient's sense of individuality and privacy, as the patient's most personal physical and psychological secrets are kept confidential in order to avoid shame and vulnerability. Secondly, medical confidentiality plays a role in improving the patient's health care. As Emson explained the interplay between autonomy, privacy and medical confidentiality:

[44] Siegler, (1982) New England Journal of Medicine, at 1519.
[45] Kottow, 'Stringent and predictable medical confidentiality', in: Gillon, *Principles of Health Care Ethics*, at 475.
[46] See, for example, Siegler, (1982) New England Journal of Medicine, at 1519; Orentlicher, 'Genetic privacy in the patient-physician relationship', in: Rothstein, *Genetic Secrets*, at 84; Gostin, (1995) 80 Cornell Law Review, at 511.
[47] See, for example, Moore, (1985-86) 36 Case Western Reserve Law Review, at 190.

> 'In the contemporary ethics of Western societies primacy is accorded to autonomy, to the right of the patient to dispose of his or her own body according to personal wishes. Various rights devolve from this and confidentiality is one of them; the right to autonomy includes the right to privacy. The patient, disclosing all freely to the physician, has the right to have the privacy of this information respected by the confidentiality afforded to it.'[48]

Deontologists who accept the significance of the principle of autonomy will usually assert that respect for medical confidentiality is necessary in order to achieve the protection of autonomy and privacy in the health care setting.

For utilitarians, medical confidentiality only deserves protection if, on balance, such protection has beneficial consequences. What, then, are the beneficial consequences that can be promoted by respecting medical confidentiality? The main justification for the principle of medical confidentiality voiced by utilitarians is that confidentiality is thought to encourage patients to disclose fully their symptoms and all confidential and intimate information needed by the physician in order to make a diagnosis and to provide effective medical advice and treatment. Gillon summarised the beneficial consequences resulting from a protection of medical confidentiality as people's health, welfare, the overall good and overall happiness. All of these consequences are more likely to be attained if doctors are fully informed by their patients which in turn is more likely if physicians will not disclose their patient's medical secrets to the state or third parties.[49] As the value of medical confidentiality depends on the consequences the respect for such a principle might entail, the utilitarian justification accordingly rests on the assumption that without a guarantee of medical confidentiality, large numbers of patients would fail to make sufficient disclosure, thereby endangering their own, as well as public, health. Empirical proof would therefore be needed to decide whether or not medical confidentiality is a principle worth protecting. However, no empirical evidence exists to support this assumption, and it is rather questionable whether most patients are even aware of the physician's legal and ethical obligations in the area of medical confidentiality.[50] Utilitarian philosophers nevertheless seem to agree that the mere possibility of deterring a patient from seeking adequate medical advice and treatment is a sufficient justification for the principle of medical confidentiality, given the significance of individual and

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[48] Emson, (1988) JME, at 87.
[49] Gillon, (1985) 291 BMJ, at 1635.
[50] Shuman, (1985) 39 Southwestern Law Journal, at 664-665.

public health.[51] Some utilitarians emphasise, in addition, that medical confidentiality promotes the creation and maintenance of socially valuable relationships.[52] Medical confidentiality would then have to be protected because of the societal value of the physician-patient relationship and the potential injury to that relationship if its confidentiality were not protected. In her summary of the utilitarian view, Hogan states that this theory, which she calls public function theory, is not concerned with the individual suffering that a failure of the relationship might cause, but that it focuses instead on the societal harm caused by such a failure.[53] It is problematic whether utilitarians will also accept that medical confidentiality deserves protection because it enhances patient autonomy and privacy. Utilitarians rarely seem to discuss this question. It is submitted that it is not at all evident that a utilitarian perspective would dismiss this consideration, as a course of action that promotes the individual's autonomy could arguably promote happiness. Gillon introduces this idea when stating that patients who decide to disclose confidential information to their physicians despite a lack of medical confidentiality might feel anxious and unhappy at the prospect of their secrets being made known.[54]

Deontological and utilitarian approaches to medical confidentiality are not mutually exclusive. Nor is it true that every writer who attempts to find a moral justification for the recognition of the principle of medical confidentiality adheres to either a pure deontological or a pure utilitarian approach. Instead, many writers borrow deontological and utilitarian thoughts and combine elements from both philosophies in order to explain the importance of medical confidentiality. Thus, writers who stress the overriding importance of medical confidentiality for an adequate protection of the patient's autonomy and privacy sometimes equally acknowledge that medical confidentiality also lies in the public interest. It is argued, for example, that without medical confidentiality, society will deter precisely those patients from seeking medical advice and treatment whom it is trying to bring under control, for example people displaying deviant and possibly dangerous behaviour, or persons suffering from illnesses such as venereal

[51] Moore, (1985-86) 36 Case Western Reserve Law Review, at 188.
[52] Weisberg, (1978) 30 Stanford Law Review, at 971.
[53] Hogan, (1989) 30 Boston College Law Review, at 420-421.
[54] Gillon, (1985) 291 BMJ, at 1635; see also 'Developments in privileged communications', (1985) 98 Harvard Law Review, at 1555.

diseases, that may be regarded as embarrassing.[55] It is also argued that public health can best be promoted if medical confidentiality is upheld and people are therefore encouraged to seek medical advice and treatment.[56] Sissela Bok suggests that medical confidentiality rests on four premises: (1) individual autonomy over personal information; (2) the legitimacy of sharing personal secrets and the assumption of respect for intimate relationships; (3) respect for a promise of confidentiality; and (4) the utility of professional confidentiality for individuals and society.[57] While the first three justifications are based on deontological thought, the last consideration clearly refers to utilitarian theory.

It can be seen that in spite of the significant conceptual differences between the deontological and the utilitarian approaches to medical confidentiality, both have much in common. Neither regards the principle of medical confidentiality as an intrinsic value. Rather, both approaches regard medical confidentiality as no more than a means to achieve a morally valuable end.[58] Both agree that medical confidentiality serves important functions in that it enhances patient frankness. For the purpose of establishing an initial justification for medical confidentiality, the differences between the two approaches do not seem overly important. This, however, will not necessarily be true in the context of developing a moral justification for the recognition of medical privilege.

3. Medical privilege

In the context of medical privilege, the principle of medical confidentiality must be reassessed in the light of the conflict between the principle of medical confidentiality, on the one hand, and the interests of justice, on the other hand. Thus, while the different moral theories introduced above agree that the protection of medical confidentiality is, in principle, morally justified, this does not necessarily imply that medical confidentiality is an absolute principle that must be upheld under all circumstances and at all costs.

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[55] Kottow, 'Stringent and predictable medical confidentiality', in: Gillon, *Principles of Health Care Ethics*, at 478.
[56] Vickery, (1982) 82 Colorado Law Review, at 1435.
[57] Bok, *Secrets*, at119-122.
[58] Gillon, (1985) 291 BMJ, at 1635.

3.1. Medical confidentiality and the administration of criminal justice

Medical privilege protects medical confidentiality in the context of judicial proceedings, in that physicians are exempted from the general obligation to give testimony in court. A testimonial privilege thus demonstrates the value accorded to the principle of medical confidentiality, as it gives medical confidentiality precedence over the countervailing interests of justice.[59] The recognition of medical privilege accordingly expresses the idea that the possible impairment of the interests of justice is a price worth paying for the protection of the confidentiality of the physician-patient relationship.[60] As the resolution of a conflict of interests is typically based on policy considerations, it is interesting to analyse the problem of medical privilege from a philosophical perspective to develop a better understanding of the ethical concerns at issue.

Criminal proceedings aim at reaching a just decision as to the guilt or innocence of a person who is accused of having committed a criminal offence. To achieve this purpose, it is essential that the truth be established in criminal court, and this is most likely if all relevant evidence is made available to the court. Medical privilege, in contrast with exclusionary rules, aims at the exclusion of evidence, not for the purpose of enhancing the truth-finding function of criminal proceedings, but rather for extra-judicial purposes.[61] Seen in this light, testimonial or communication privileges such as the privilege of a physician or a psychotherapist conflict with the smooth operation of the criminal justice system. As privileges result in withholding evidence from the factfinder, they can lead to grossly incorrect results and as a consequence, miscarriages of justice may occur.[62] The question must therefore be asked:

> 'whether acknowledgement of privilege in respect of confidential communications to members of the medical profession is defensible on the basis of considerations of policy which are sufficiently compelling to relegate the negative effect of exclusion of relevant evidence in judicial proceedings.'[63]

[59] Vickery, (1982) 82 Colorado Law Review, at 1435.
[60] Peiris, (1984) 33 ICQL, at 301.
[61] Hogan, (1989) 30 Boston College Law Review, at 418-420.
[62] Snyder, (1990) 65 Tulane Law Review, at 200-201.
[63] Peiris, (1984) 33 ICQL, at 306.

Only if the ethical analysis shows 'that there is something of merit that requires protection in these communications, something more valuable than the needs of "the law"'[64] can medical privilege be morally justified.

3.1.1. Utilitarian approaches

From a utilitarian point of view, the costs of medical privilege for criminal proceedings seem clear: if medical privilege is recognised, certain information would not be available to the court for the purpose of criminal proceedings if the physician invokes medical privilege and refuses to give testimony. The main benefit arising from medical privilege, on the other hand, is that it encourages communication between patient and physician.

From a utilitarian perspective, the recognition of a medical privilege depends on the outcome of a cost-benefit analysis which must examine to what extent medical privilege causes the loss of relevant information, and whether or not this potential loss is outweighed by the rationale behind granting medical privilege. As both medical confidentiality and the efficient administration of criminal justice can promote good consequences, it must therefore be decided which of the two interests should prevail in case of a conflict, that is which of the two interests promotes greater happiness. Sometimes the utilitarian approach conversely focuses on the minimisation of harm, and medical privilege would then only be justified if the possibility of disclosure of confidential information did in fact deter patients from divulging to their physicians all information that is necessary to obtain adequate medical advice and treatment, and if the harm inflicted by such disclosure outweighed the harm thereby prevented.[65] No empirical evidence exists in support of the view that medical confidentiality promotes the physician-patient relationship. It is rather doubtful whether patients are aware of the applicable law of privilege and consider that law before consulting with a physician.[66] Indeed, empirical studies seem to suggest that patients do not necessarily know whether or not their legal system endorses medical privilege, and what exceptions to such

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[64] Oppenheim, *The Medical Record as Evidence*, at 619.
[65] Moore, (1985-86) 36 Case Western Reserve Law Review, at 192; see also Wigmore, *Evidence in Trials at Common Law*, § 2380, at 829-830.
[66] Shuman, (1985) 39 Southwestern Law Journal, at 664-665.

privilege are recognised.[67] Some utilitarians consequently argue that without such evidence, medical privilege cannot be justified. This opinion rests on the assumption that it is certain that a privilege will impair the fact-finding function of judicial proceedings, while it is not at all established whether and to what extent the physician-patient relationship will be harmed by compelled disclosure of confidential medical information in court. It is followed that medical privilege cannot be justified given the uncertainty of the benefits thereby obtained, and given the costs its recognition entails.[68]

Other utilitarians come to a different result when proposing that the outcome of the cost-benefit analysis should not be determined generally and for all cases, but should be performed on a case-by-case basis, depending on the harm inflicted by disclosure, on the one hand, and the significance of the potential loss of evidence, on the other. It has been argued that, in principle, medical privilege is not highly significant for the physician-patient relationship as most patients will disclose the same information to a physician whether or not a privilege exists.[69] However, even if most communications were made to physicians in the absence of medical privilege, it is possible that some communications would then not take place. On the other hand, not all litigation would suffer from the recognition of medical privilege.[70] Therefore, even if in most cases the balance did strike in favour of disclosure, a different result might be reached in cases in which the information the disclosure of which is sought is not of particular relevance to the proceedings. In such cases, the costs of privilege would not be high. If little or no relevant evidence is lost, and if the physician-patient relationship were seriously impaired by disclosure, the overall balance would lead to a recognition of medical privilege in that particular case. While there is a presumption in favour of disclosure,[71] exceptional circumstances may thus occur in which the protection of medical confidentiality in criminal court is more important than the interest in the administration of justice.

The utilitarian approaches to medical privilege that have been introduced thus far start from the premise that in principle, the interests of justice should prevail over

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[67] Snyder, (1990) 65 Tulane Law Review, at 172.
[68] Wigmore, *Evidence in Trials at Common Law*, § 2380, at 829-830.
[69] Watson, (1992) 71 Nebraska Law Review, at 1131.
[70] Saltzburg, (1980) 66 Virginia Law Review, at 619 note 74.
[71] Ibid., at 648.

the interest in medical confidentiality. However, this opinion is not uncontroversial among utilitarians. It has, for example, been argued that the value of promoting open relations between patients and their doctors outweighs the cost of judicial decisions that are reached without a full disclosure of all relevant facts.[72] Thus, even though medical privilege entails high costs in that it creates a risk of miscarriages of justice, the protection of the confidentiality of the physician-patient relationship is viewed by some as important enough to justify incorrect results in individual cases, as society cannot afford to deter people from seeking medical advice and treatment.[73] For the health of the community, 'medical treatment is so valuable that few would lose it to prevent facts from coming to light in court.'[74]

With regard to the special case of the psychotherapist-patient privilege, it is sometimes suggested that the cost-benefit analysis differs from that to be performed in the context of the ordinary physician-patient relationship, as frankness is even more important for the psychotherapist-patient relationship. Without the patient's willingness to share openly even his/her most secret thoughts and feelings with the psychotherapist, effective psychotherapy would be impossible. Also, the matters discussed in psychotherapy, for example drug abuse, sexual problems or violent tendencies will frequently make the patient particularly anxious about later courtroom disclosures.[75] Among physicians, psychotherapists are therefore particularly adamant that medical confidentiality should be respected.[76] If accepted, these special features would give medical confidentiality more weight in the context of the psychotherapist-patient relationship, as the costs of a disclosure by a psychotherapist would then be higher than the costs a disclosure by a physician would entail. However, it has been countered that no

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[72] Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges,* vol. 2, at 7-8; see also *Lewin v Jackson* 108 Ariz. 27 (1972), at 31; *Leritz v Koehr* 844 S.W.2d 583 (Mo Ct App 1993), at 584; *In re CP* 563 N.E.2d 1275 (Ind 1990), at 1278; *State v Sypult* 304 Ark. 5 (1990); *Clark v District Court* 668 P.2d 3 (Colo 1983), at 8; *State v Mincey* 141 Ariz. 425, at 439.
[73] Snyder, (1990) 65 Tulane Law Review, at 201.
[74] Chafee, (1943) 52 Yale Law Journal, at 609; see also Peiris, (1984) 33 ICQL, at 304.
[75] Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges,* vol. 2, at 7-9 to 7-10.
[76] Advisory Committee's notes on the proposed Federal Rules of Evidence, (1972-73) 56 FRD 183, at 242.

psychotherapist-patient privilege exists in the UK and some parts of Canada, and that no evidence points to adverse consequences for effective therapy.[77]

It can be seen that utilitarian thought does not result in a clear and unequivocal attitude towards medical privilege. Rather, the outcome of the utilitarian cost-benefit analysis largely depends on the weight accorded to the benefits and harms following from a recognition or a rejection of medical privilege. As the cost-benefit analysis seems to be based on empirical evidence, the utilitarian approach conveys the impression of a certain objectivity. However, it should be borne in mind that the utility of medical privilege is not supported by any empirical evidence. It is difficult to assess the consequences of this lack of empirical evidence for utilitarian theory. Does it necessarily mean that medical privilege is not beneficial for the physician-patient relationship, and for the patient's and the public welfare? More importantly, are the benefits arising from a rejection of medical privilege really as certain as frequently purported? Arguably, the costs of a medical privilege are not necessarily equal to the value of the evidence thereby excluded from judicial proceedings, as some evidence presumably exists only because a privilege encouraged its creation.[78] There is at least a possibility that without medical privilege, the communications between patient and physician might change,[79] so that without medical privilege, the physician might not obtain the information the disclosure of which is sought in court. The unavailability of such evidence can then not be regarded as a cost of medical privilege. Thus, any assessment of the costs of medical privilege must take into account the extent to which people would communicate in the absence of the privilege and depends on the same empirically unverified factor that determines the benefits flowing from the privilege. Therefore, even if the proponents of medical privilege fail to offer empirical proof in support of their assumption that medical privilege promotes patient frankness and ultimately individual and public health, the costs that privileges purportedly impose on the truth-finding function of the courts are just as uncertain as the asserted benefits. The whole basis of the utilitarian approach is thus problematic and not very helpful in the context of medical privilege, as neither the costs nor the benefits of medical privilege are amenable to empirical

[77] Shuman, Weiner, (1982) 60 North Carolina Law Review, at 895.
[78] 'Developments in privileged communications', (1985) 98 Harvard Law Review, at 1513; see also Slovenko, *Psychotherapy and Confidentiality*, at 49 for the psychotherapist-patient relationship..
[79] Saltzburg, (1980) 66 Virginia Law Review, at 602.

proof. Absent empirical proof supporting the cost-benefit analysis, the analysis does not weigh the objective consequences of rules or acts, but rather merely the presumed consequences. As the different opinions among utilitarians show, the importance accorded to certain consequences, and the assessment of what is harmful, what is beneficial and how to balance harm and benefits in case of a conflict largely depends on the value attached to the different interests at stake.

The case-by-case approach to medical privilege that has been suggested by some utilitarians is also problematic. If the patient cannot be certain whether in his/her individual case the balance will be struck in favour of or against disclosure, the main purpose of medical confidentiality according to utilitarian thought, i.e. to encourage the patient to receive medical treatment and to disclose all relevant information to the physician, can hardly be achieved.[80]

3.1.2. Deontological approaches

According to the deontological approach, the disclosure of confidences revealed in certain relationships is regarded as wrong because it would violate the patient's privacy and autonomy. Medical privilege is then the legal device through which these interests can be protected in the context of judicial proceedings. But does this necessarily mean that medical confidentiality is important enough to outweigh the public interest in truth-finding in criminal proceedings? For deontologists, the patient's privacy interests are important enough to justify a presumptive right against disclosure. Understood in this way, medical confidentiality has the status of a *prima facie* right which has to be respected unless weightier considerations justify an exception. This means that medical confidentiality must be protected even in criminal court provided that this interest is not exceptionally overridden by a more important right or interest.[81] Accordingly, the recognition of a medical privilege requires a value judgment, as it must be decided whether medical confidentiality or the interest in the unhindered administration of criminal justice is the more important interest and therefore deserves prevalence in case of conflict. As deontologists do not place great weight on the consequences of value

[80] Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges*, vol. 2, at 7-10; Thomas-Fishburn, (1990) 61 University of Colorado Law Review, at 194 regarding the attorney-client privilege; Gurfein, (1981) 49 Fordham Law Review, at 733 also regarding the attorney-client privilege.
[81] Moore, (1985-86) 36 Case Western Reserve Law Review, at 191-194.

decisions, the value judgment that needs to be made does not depend on empirical evidence, but rests, instead, on moral beliefs. If privacy is regarded as the overriding interest, medical privilege is morally justified, and the potential exclusion of relevant evidence is then 'merely a secondary and incidental feature of the privilege's "vitality"',[82] but does not influence the value judgment as such.

It is striking that for most deontologists the outcome of the value judgment in the context of medical privilege so clearly turns in favour of a recognition of medical privilege that hardly any attempts are made to justify such a result. Rather, it seems sufficient justification to stress the importance of medical privilege for the patient's autonomy and privacy,[83] and to state that the threat to the ascertainment of truth resulting from the recognition of medical privilege is not too high a price to pay for the preservation of medical confidentiality.[84] However, given the absence of a moral justification of medical privilege that goes beyond stressing its importance for privacy and autonomy, it is difficult to predict with certainty how the conflict between medical confidentiality and the interests in the administration of criminal justice will be approached in specific cases. It has been argued, for example, that exceptions to medical privilege should be made where the prosecution of serious crimes is at stake,[85] at least if medical information is likely to be central to a successful prosecution, as in most drunk driving and child abuse cases. While a presumption exists in favour of protecting the patient's privacy, the proposed exception would ensure that information is available to the courts where the loss of information entails particularly high costs.[86] This argument combines deontological and consequential elements, as it justifies exceptions to medical confidentiality on the basis of the consequences of a recognition of medical privilege, rather than on the basis that the conflicting interests, here the interest in the prosecution of serious crimes, outweighs the interest in medical confidentiality. It seems to suggest that interests do not necessarily have a fixed value, but rather that the value of an interest must, in case of conflict, be determined with reference to all the circumstances of the individual case, including the consequences of the value decision. This approach, while making it

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[82] Shuman, (1985) 39 Southwestern Law Journal, at 664.
[83] Krattenmaker, (1973) 62 Georgetown Law Journal, at 90.
[84] Louisell, Crippin, (1956) 40 Minnesota Law Review, at 414.
[85] Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges*, vol. 2, at 7-35.
[86] 'Developments in privileged communications', (1985) 98 Harvard Law Review, at 1553.

possible to adopt a more fine-tuned balancing test, is nevertheless problematic, unless criteria are developed to make it subject to reasoned decisions and to exclude arbitrariness.

One attempt to argue generally against the recognition of medical privilege in criminal proceedings was made by Sissela Bok who argued that with regard to criminal prosecution, medical confidentiality must be weighed against interests of social justice and restitution.[87] According to her, medical confidentiality must find its limits where it contradicts the very respect for persons and for human bonds that it was meant to protect.[88] The validity of this argument is questionable. Where confidences of victims or other third parties are concerned, it cannot be said that the patient has disregarded the respect owed to others and thereby forfeited his/her claim to medical confidentiality. However, even where the breach of confidence harms the criminal offender, this argument is problematic, as it is not the maintenance of medical confidentiality that disregards the respect owed to others,[89] but rather the alleged acts of the patient. The argument also presupposes that the accused did in fact disregard the values behind a protection of medical confidentiality, which is impossible to know in the course of criminal proceedings, as the guilt of the accused will only be established at their very end. David Black seems to be right when stating that:

> 'Most people might see the disclosure of confidential information for the purpose of criminal prosecution as a matter of degree, giving preference to autonomy for trivial offences, but becoming skewed to non-maleficence in case of terrorism or other serious crime.'[90]

This demonstrates the main problem of the deontological approach towards medical privilege. that is the difficulty of how to resolve conflicts of interests, as generally agreed upon criteria for establishing priorities among the conflicting interests or for determining when generally accepted priorities must give way to extreme interests do not seem to exist.[91] Rather, the outcome of the balancing exercise seems to depend to a large extent on personal preferences and intuition. The rights-based approach promoted by Ronald Dworkin avoids this problem in the context of medical privilege, as the interests behind criminal prosecution are

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[87] Bok, *Secrets*, at 131.
[88] Ibid., at 135.
[89] Engelhardt Jr., *The Foundations of Bioethics*, at 337.
[90] Black, 'Absolute Confidentiality?', in: Gillon, *Principles of Health Care Ethics*, at 487.
[91] Moore, (1985-86) 36 Case Western Reserve Law Review, at 195.

societal, rather than individual interests. Given that individual rights cannot normally be outweighed by communal interests,[92] medical confidentiality would have to be given prevalence over the interest in criminal prosecution, and the recognition of medical privilege would seem to be the logical conclusion of acknowledging a right to medical confidentiality.

With regard to the special case of psychotherapist-patient privilege, it has been argued that such communications deserve more protection than those between patients and physicians, as matters disclosed in psychotherapy are often much more personal than matters discussed in the course of consultations for physical illnesses.[93] Therefore, the patient's privacy interests are said to have more weight in the context of the psychotherapist-patient relationship.[94] Others reject this distinction, as physicians today cannot focus solely on one aspect of a person's problems, either physical or psychological, as the increase in psycho-somatic illnesses clearly demonstrates.[95] The same need for trust would then exist in both relationships. Given that confidentiality is protected mainly to respect the patient's autonomy, the distinction also seems to overlook that it should be left to the patient to determine which information, whether physical or psychological, he/she regards as particularly sensitive and in need of most protection.

3.2. Medical privilege and the interests of third parties

Another conflict which frequently arises is that between medical confidentiality, on the one hand, and the protection of third parties, on the other. In the context of medical privilege, this may embrace cases in which the patient threatens to inflict harm on third parties, and cases in which physicians hold confidential information that might be beneficial to a person who is accused in criminal proceedings.

Many argue that the disclosure of confidential patient information aimed at preventing a criminal offence is justified, at least where it may help prevent violent crime. For utilitarians, a justification of disclosure seems at first sight rather compelling, as the prevention of violent crime averts significant harm from

[92] Dworkin, *Taking Rights Seriously*, at 92 and 191-194.
[93] Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges*, vol. 2, at 7-9 to 7-10.
[94] Slovenko, *Psychotherapy and Confidentiality*, at 49.
[95] Saltzburg, (1980) 66 Virginia Law Review, at 621.

the potential victim as well as from society, while most utilitarians regard the harm prevented by the maintenance of medical confidentiality as uncertain. However, some writers nevertheless question this approach, arguing that it is difficult to assess whether more lives will be saved by disclosure than by respect for medical confidentiality, as violent patients could be deterred from seeking medical and, in particular, psychological advice and treatment.[96] This, once more, brings to light the problem of how to weigh uncertain and long-term costs and benefits. Engelhardt, for example, argues that:

> 'The fact that a particular disclosure of a patient's dangerousness could have saved the life of a particular third party should not obscure the fact that a general rule requiring disclosure may in fact lead to the deaths of more individuals.'[97]

And Kottow equally opposes the utilitarian argument that disclosure would produce the better consequences in such cases. According to him, a violation of medical confidentiality results in certain harm, as it brings suspicion into the physician-patient relationship, thereby undermining patient frankness and lowering the standard of medical care. At the same time, it seems impossible to perform an adequate risk assessment and to predict with sufficient certainty the harm caused by the threat of violent behaviour. First, there is a possibility that threats of violence issued by patients may never materialise. How can the physician or psychotherapist assess whether the risk is real, potential or fictitious?[98] The threat may only be the expression of a patient's violent fantasy in the course of psychotherapy. Secondly, it was argued that if disclosure for the purpose of crime prevention were allowed, this would not necessarily help to avert harm, as preventive arrest is not lawful, and as other preventive measures will often not be available to ensure that the threat may not be carried out.[99] Also, if individual freedom were regarded as a benefit, the outcome of the cost-benefit analysis in such cases may not be so obvious, given that the breach of medical confidentiality to avert a hypothetical danger would then entail a certain infringement of individual freedom.[100] Therefore, it was argued that as long as a plausible risk-benefit analysis is lacking, the utility of disclosure is not sufficiently

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[96] Moore, (1985-86) 36 Case Western Reserve Law Review, at 193.
[97] Engelhardt Jr., *The Foundations of Bioethics,* at 339.
[98] Kottow, (1986) JME, at 120.
[99] For a critical view see Adshead, (1995) 311 BMJ, at 1619.
[100] Kottow, 'Stringent and predictable medical confidentiality', in: Gillon, *Principles of Health Care Ethics,* at 477.

demonstrated so as to justify a breach of confidentiality.[101] Others, in contrast, argue that the imponderability of the harm prevented or caused by a disclosure should not prevent the physician from nevertheless attempting to assess the value of the interests at stake in every given case.[102]

Deontologists also frequently hold disclosure to be justified where it can prevent violent crime. This attitude is mainly based on two arguments. First, it is often argued that an individual's bodily integrity and life are more important values than privacy, so that the balancing of the competing interests would come down in favour of disclosure.[103] However, the conflict could also be regarded differently. If medical confidentiality promotes a patient's decisional privacy, in that it gives the patient the freedom to make autonomous health care decisions, then medical confidentiality serves the patient's interest in bodily integrity. The overriding importance of the competing third party interest is then no longer obvious. When others argue that the third party interests should at least prevail where there is a risk of serious harm which could not otherwise be prevented,[104] this shows, again, that consequences of actions can be of importance for the balancing of interests. While the patient's autonomy interests may be more important than the avoidance of a very remote risk of slight impairments of a third party's bodily integrity, the outcome of the balancing test might change where the risk is less remote and the potential harm more serious, as the weight of the interest harmed by non-disclosure might be influenced by the potential consequences of non-disclosure. Others focus on the fact that the interest to be impaired by disclosure is the patient's interest in privacy and autonomy. It is argued that a person's autonomy is limited by the autonomy of others and can therefore not go as far as putting others at risk of bodily harm or even risks to their lives.[105] 'Just as no one is granted autonomy when it comes to *doing* violence to others, so there is no reason to concede such autonomy and control for *plans* to do so, once divulged.'[106] Engelhardt suggests a different approach when emphasising that the patient's dangerousness is not increased by the fact that a physician knows about it and that

[101] Ibid., at 475.
[102] Emson, (1988) JME, at 90.
[103] Shuman, (1985) 39 Southwestern Law Journal, at 667; Turkington, (1989) 34 Villanova Law Review, at 888; Watson, (1992) 71 Nebraska Law Review, at 1144.
[104] Beauchamp, Childress, *Principles of Biomedical Ethics*, at 426.
[105] Moore, (1985-86) 36 Case Western Reserve Law Review, at 194-195.
[106] Bok, *Secrets*, at 128-129.

the physician's silence does not injure the potential victim.[107] However, this argument seems to miss the point, as it does not assess the value of the different interests at stake, but rather exclusively concentrates on the question of whether or not additional injury is caused by the fact of non-disclosure. This, however, cannot be a further requirement if the third party's interest outweighs that of the patient.

With regard to the conflict between medical confidentiality and defence rights, the utilitarian cost-benefit analysis would probably come down in favour of disclosure. It is fair to say that the costs of medical privilege would be an impairment of the defence rights of the accused, which might lead to unjust results, and, in the worst case, to a criminal conviction of an innocent person. Given that most utilitarians favour disclosure even where medical confidentiality merely conflicts with the interests in the administration of criminal justice, the reasons supporting disclosure are even more compelling where the defence rights of an accused are at stake. However, those utilitarians who think that a miscarriage of justice is not too high a price to pay for the protection of medical confidentiality would probably equally argue in favour of medical privilege where confidentiality conflicts with defence rights. From a deontological perspective, all depends on the weight accorded to the competing interests, and it is highly likely that most deontologists would argue in favour of disclosure, as the accused's freedom, an interest of very high rank, is at stake.

4. Strict confidentiality?

Utilitarians mostly promote the view that medical confidentiality should only be protected as long as a cost-benefit analysis favours this protection, and deontologists usually argue that medical confidentiality can sometimes be outweighed by other interests of overriding importance. Thus, both philosophical schools agree that medical confidentiality is not an absolute principle that will prevail under all circumstances and trump all other interests. Such relativist views of medical confidentiality make it necessary to define exceptions to the general principle and thereby create their own problems. From a utilitarian perspective which argues that medical confidentiality is needed to promote frankness in the

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[107] Engelhardt Jr., *The Foundations of Bioethics*, at 337.

physician-patient relationship and which therefore rests on the assumption that without medical confidentiality, a patient may be reluctant openly to reveal all the information that enables the physician adequately to advise and treat the patient, every exception to the principle risks to undermine its very purpose. If the patient knows that the privilege is fraught with exceptions, he/she may react by withholding information or by avoiding therapy, just as if no privilege existed at all, as the reassuring function of a privilege loses its value if exceptions are admitted.[108]

From a deontological perspective, pleas for an absolute confidentiality could equally be made. If the principle of medical confidentiality were subject to exceptions, the patient's autonomy would be undermined. Where a patient is enticed to frankness by the assurance that his/her confidences will be kept secret, and that he/she will therefore keep control over confidential information that was shared with the physician, it seems unfair to alter the initial conditions of the physician-patient relationship on the grounds that the content of the information requires disclosure, once the act of confiding has occurred.[109]

However, it was seen that in some situations, it would be equally, if not more problematic strictly to adhere to medical confidentiality, as this would not be justifiable under any moral theory. Even Kottow who is frequently quoted as the promoter of an absolute nature of the principle of medical confidentiality therefore concedes that the principle cannot be absolute, but should only be respected as far as possible.[110] However, if exceptions cannot be avoided, they should at least be clearly and publicly established, so that every patient knows in advance what to expect.[111] To achieve this, it was suggested that physicians should inform their patients at the beginning of every professional encounter of the limits to medical confidentiality.[112] More importantly, exceptions should not only be stated but also be morally justified, in the view of achieving some kind of social consensus as to which exceptions would or would not be acceptable.[113]

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[108] Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges*, vol. 2, at 7-10.
[109] Kottow, (1986) JME, at 118.
[110] Kottow, 'Stringent and predictable medical confidentiality', in: Gillon, *Principles of Health Care Ethics*, at 478.
[111] Ibid., see also Kottow, (1986) JME, at 118
[112] Adams, (1990) JME 196-199, at 198; Beauchamp, Childress, *Principles of Biomedical Ethics*, at 429.
[113] Gillon, (1985) 291 BMJ, at 1635.

5. Conclusion

The preceding analysis has demonstrated the similarities of and differences between the utilitarian and the deontological approaches to medical confidentiality. Both approaches accept that medical confidentiality is important. While utilitarians justify the importance of the principle by reference to the consequences of its recognition, deontologists argue that medical confidentiality is a value to be protected because it is closely linked with personal autonomy and privacy. From these different starting points, both theories provide an initial justification for the principle of medical confidentiality. However, the differences in approach come to light in the context of medical privilege, where conflicts of interests must be resolved. While according to the utilitarian approach, in case of conflict it must be positively demonstrated that medical confidentiality produces better consequences than disclosure, the deontological approach starts from a presumption in favour of medical confidentiality, and each exception to this principle must be justified by the overriding importance of the value which outweighs medical confidentiality. Consequently, the protection awarded to medical confidentiality according to deontological thought is much stronger than its protection by utilitarian theory, as pursuant to the deontological approach, every exception to medical confidentiality requires a careful justification, while for utilitarians, it is the protection of medical confidentiality that must be justified. This fundamental difference may explain why, in the context of medical privilege, most utilitarians favour disclosure while most deontologists favour the maintenance of medical confidentiality.

Both theories have their strengths and weaknesses. Utilitarianism has to face the problem that consequences can frequently not be determined with any certainty, particularly not in the area of medical confidentiality and medical privilege, where a variety of factors interact. A theory that decides on right and wrong according to the consequences of acts or rules will hardly be able to produce satisfactory results where these consequences cannot be adequately determined. More importantly, however, it is problematic that the utilitarian cost-benefit analysis favours the best consequences, which seems to require value judgments about right and wrong independent of the consequences themselves. If happiness is the only value that is accepted, this is rather vague and can be subject to many different interpretations, as it is neither clear whether the focus should lie on

individual or societal happiness, nor what exactly is meant by happiness in the first place. Therefore, utilitarian theory is not free from the reproach that its results in case of conflict resolution are arbitrary, depending on the personal preferences of the respective philosopher. Utilitarian thought as applied by many of its promoters has the additional problem that it seems to be too heavily focused on communal interests to the detriment of individual freedom.

Deontological theory promotes individual freedom by emphasising the intrinsic value of personal autonomy and privacy. However, this approach also seems to be of limited value for the resolution of moral conflicts, as the judgment on the hierarchy of values seems to be based on personal preferences, and not on a coherent system of morally justified considerations. While the importance of autonomy is clearly established, neither the value of conflicting interests, nor guidelines on how to balance competing values are determined with sufficient clarity to assist with the resolution of moral problems. What, for example, should be the place of general considerations of welfare[114] in the context of the deontological balancing exercise? And should consequences of a decision be completely omitted from the balancing process? If so, how can the value of conflicting interests be determined in a given case if the consequences of the decision for each interest cannot be taken into account? If, on the other hand, consequences can be of importance for the outcome of the balancing process, this could be seen as some limited convergence of deontological and utilitarian thought. The two approaches could also be brought more closely together if happiness or beneficial consequences were understood as including individual freedom. At least in liberal societies, individual freedom is of overriding importance not only for the individual concerned, but also for a democratic society as such. Utilitarian analysis would then have to accommodate personal autonomy and privacy when assessing the costs and benefits of certain acts or rules.[115]

In the light of the inadequacies of both theories, it is hardly surprising that neither has succeeded in presenting a satisfactory framework for the resolution of all conflicts of interests. Nancy Moore has therefore rightly remarked that: 'Given the

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[114] For the importance of welfare considerations in the context of criminal law and criminal prosecution see, for example, Ashworth, *Principles of Criminal Law*, at 30-31.
[115] 'Developments in privileged communications', (1985) 98 Harvard Law Review, at 1555.

difficulties in applying both utilitarian and deontological theories, it is obvious that philosophers have by no means solved the problems now confronting the medical profession.'[116] This is not to say that reference to moral theory will not be useful for an analysis of the law regarding medical confidentiality and medical privilege, as ethical principles can provide valuable assistance in formulating policy considerations.[117] The principal questions arising in the context of medical privilege, that is whether or not medical confidentiality is important enough to outweigh conflicting interests in the context of judicial proceedings, are moral, not legal questions. Accordingly, they cannot be addressed without reference to the moral principles introduced in this chapter.

[116] Moore, (1985-86) 36 Case Western Reserve Law Review, at 196.
[117] Beauchamp, Childress, *Principles of Biomedical Ethics*, at 10.

Chapter 3 - Medical confidentiality and medical privilege in European law

1. Protection of Medical Confidentiality

1.1. European Convention on Human Rights

Given that the European Convention on Human Rights has an impact on three of the legal systems under examination, it is important to look into the protection the principle of medical confidentiality receives under the Convention. The relevant article of the ECHR which might embrace the protection of medical confidentiality is Art.8 which states that:

> (1) Everyone has the right to respect for his private and family life, his home and his correspondence.

With regard to the scope of the right to private life, the European Commission on Human Rights stated in *Application No. 6825/74:*[1]

> 'The right to respect for "private life" is the right to privacy, the right to live as far as one wishes, protected from publicity.'

This rather general delineation of the scope of the privacy right under Art.8 ECHR was clarified in *DVO v Belgium*[2] where the Commission stated that:

> 'The disclosure of improper discovery by third persons of facts relating to physical condition, health or personality may undoubtedly interfere with the applicant's privacy and private life.'

Even though the ECJ's interpretation of the ECHR is not binding, it seems worth mentioning that the ECJ has confirmed that Art.8 ECHR awards the right to keep one's health condition secret.[3] It is thus clear that Art.8 ECHR protects health related information from compelled disclosure. This, however, does not answer the question of whether the protection awarded by Art.8 ECHR embraces information that the patient has confided in the physician or which the physician observed in the course of his/her profession, as in such a case, the patient voluntarily releases private medical information from his/her personal sphere by disclosing it to a third party. In *Niemitz v Germany,*[4] the European Court of Human Rights stated to that effect that:

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[1] Decision of 18 May 1974.

[2] Application No. 7654/76, 1 March 1979.

[3] Case C-62/90 *Commission v Germany* [1992] ECR I-2575, para. 23; Case C-404/92P *X v Commission* [1994] ECR I-4737, para. 17.

[4] 16 December 1992, Series A, No.251-B.

> 'The Court does not consider it possible or necessary to attempt an exhaustive definition of the notion of "private life". However, it would be too restrictive to limit the notion to an "inner circle" in which the individual may live his own personal life as he chooses and to exclude therefrom entirely the outside world not encompassed within that circle. Respect for private life must also comprise to a certain degree the right to establish and develop relationships with other human beings.'[5]

In that case, the Court had to decide whether the search of a law firm violated the lawyer's right to private life under Art.8(1) ECHR and came to the conclusion that it did. Thus, the mere fact that someone has communicated information to a third party does not exclude this information from the protection of 'private life' and the lawyer's interest in the secrecy of his/her files is now protected by Art.8(1) ECHR. But does this mean that the physician-patient relationship is equally protected by Art.8 ECHR? This question was, for example, at issue in *M.S. v Sweden.*[6] In that case, the Court had to decide whether a patient's medical records were protected from disclosure to the Social Insurance Office by Art.8 ECHR. The European Court of Human Rights emphasised that the medical records in question contained highly sensitive and personal information about the applicant, including information about an abortion, and that these records were protected under Art.8 of the Convention.[7] This case thus seems to suggest that the protection of medical records is warranted if the information concerned has a particularly sensitive and personal character. A broader discussion of the protection of confidential medical information took place in *Z v Finland.*[8] In that case, the Court was concerned with the compatibility of court orders with Art.8 ECHR. The court orders at issue forced the physicians of the applicant to give evidence in court regarding the applicant's medical condition, *inter alia* relating to her HIV infection, and ordered the seizure of the applicant's medical records. The Court held that :

> 'The protection of personal data, not least medical data, is of fundamental importance to a person's enjoyment of his or her right to respect for private and family life as guaranteed by Article 8 of the Convention. Respecting the confidentiality of health data is a vital principle in the legal systems of all the Contracting Parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical

[5] Ibid., para. 29.

[6] Decision of 27 August 1997, European Court of Human Rights, Reports of Judgments and Decisions, (1997) No.44.

[7] Ibid., at para. 26.

[8] Decision of 25 February 1997, (1998) 25 E.H.R.R. 371.

> profession and in the health services in general. Without such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even, from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community. The domestic law must therefore afford appropriate safeguards to prevent such communication of disclosure of personal health data as may be inconsistent with the guarantees in Article 8 of the Convention.'[9]

The Court went on to stress the particular sensitivity of information relating to a person's HIV status and concluded that interferences with the protection of the confidentiality of such information can only be compatible with Art.8 ECHR if justified by an overriding requirement in the public interest.[10] This decision thus confirms the view that the extent of protection awarded to personal medical data depends on the sensitivity of the information in question. The particular significance of the decision, however, lies in the fact that it discusses the reasons behind the protection of medical data by Art.8 ECHR. According to the Court, the protection is based on the patients' interest in keeping their health information secret, so that the individual's interest in the secrecy of sensitive personal data is obviously regarded as an interest worth protecting. In addition, the patient's confidence in the members of the medical profession is guaranteed. This demonstrates that the protection goes beyond the patient's interest in secrecy, as this interest could be achieved simply by not forcing the patient to reveal his/her medical secrets to a physician. Given that the right to private life guarantees the development of relationships with others, the relationship between physician and patient itself receives protection, and it is recognised that this relationship may be adversely affected if the physician is forced to disclose confidential patient information to the state. The Court goes even further in acknowledging that the protection of medical data is also based on the patients' health interest, as patients, without a guarantee of confidentiality, may be deterred from seeking medical advice and treatment. The reasons thus far summarised demonstrate that the protection of medical confidentiality is based on deontological considerations that the patient's informational and decisional privacy deserve respect. However, the Court also stresses that community interests are at stake, as public health may be adversely affected if patients with transmissible diseases do not seek medical

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[9] Ibid., at para.95.
[10] Ibid., at para.96.

advice or treatment. This demonstrates that the protection is also based on utilitarian concerns.

In *Z v Finland* the Court went beyond an interpretation of Art.8(1) ECHR as protecting the individual from state interference, as the state is not merely prevented from forcing the individual to disclose medical information. The Court rather in addition stated that Art.8 ECHR imposes an obligation on the state appropriately to protect medical information the patient confided in the physician.[11] However, given the limited amount of European case-law on questions of medical confidentiality, it is not at all clear to what extent confidential medical information is protected by Art.8 ECHR.[12]

1.2. European Convention on Human Rights and Biomedicine

It should be noted that medical confidentiality is now also protected under Art.10(1) of the European Convention on Human Rights and Biomedicine, stating that:

> Everyone has the right to respect for private life in relation to information about his or her health.

It thus expressly guarantees the right to respect of medical confidentiality. However, the European Convention on Human Rights and Biomedicine has yet to come into force, and it therefore currently only enjoys `persuasive rather than legal authority.

1.3. Data Protection Directive 95/46/EC

In 1995, the European Parliament and the Council of the European Union issued the Data Protection Directive the twofold aims of which are identified in Art.1 as protection of fundamental individual rights and freedoms, particularly the right to privacy with regard to the processing of personal data, on the one hand, and the prevention of barriers to the free flow of personal data between Member States, on the other. The provisions of the Directive apply to the processing of personal data

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[11] This view has recently been confirmed in *Botta v Italy*, 24 February 1998, (1998) 26 E.H.R.R. 241, at para. 34.

[12] For a discussion of the impact of Art.8 ECHR on the physician-patient relationship, see Hondius, (1997) 4 EJHL 361-388.

by automatic means, and to non-automatic processing of data that form part, or are intended to form part, of a filing system (Art.3). This means that medical records are protected under the Directive, regardless of whether they are computerised or part of a manual filing system that meets the definition of Art.1(c). Medical data receive special protection under Art.8 which applies to data concerning the health of the individual. It has been suggested that the Data Protection Directive will have the effect that the processing of medical data, given their highly sensitive nature, is likely to be subject to particularly careful monitoring by the supervisory authorities.[13]

2. Medical privilege

The right to privacy under Art.8 ECHR is not guaranteed without limits. Art.8(2) ECHR rather qualifies that:

> There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Given this rather extensive restriction of the right under Art.8(1) ECHR, it is important to analyse the decisions of the European Court of Human Rights to determine the impact of the ECHR on the question of medical privilege.

2.1. Criminal prosecution

In *Z v Finland,*[14] a case in which the Court had to assess the compatibility with Art.8 ECHR of court orders forcing the applicant's physicians to give evidence in court regarding the applicant's medical condition, including her HIV infection, the Court held that:

> 'Such interference cannot be compatible with Article 8 of the Convention unless it is justified by an overriding requirement in the public interest. ... At the same time, the Court accepts that the interests of a patient and the community as a whole in protecting the confidentiality of medical data may be

[13] Bainbridge, *EC Data Protection Directive*, at 172.
[14] (1998) 25 E.H.R.R. 371.

> outweighed by the interest in investigation and prosecution of crime and in the publicity of court proceedings.'[15]

States will therefore not violate Art.8 ECHR when giving the interest in the investigation and prosecution of criminal offences prevalence over the interests in medical confidentiality, even though the interest in criminal prosecution is not explicitly mentioned in Art.8(2) ECHR. Consequently, a recognition of medical privilege giving the physician a right to refuse to give testimony in criminal court is not mandated by Art.8 ECHR.

In *Z v Finland*, the physician's evidence served the purpose of establishing at what time X, who was accused of a number of sexual offences and who was found to be HIV positive, had known of his infection, as this knowledge was essential for a conviction for attempted manslaughter in addition to a conviction for rape. Given that the applicant, X's wife, was also an HIV carrier it was seen as important to find out at what time she became aware of her infection, as this could give some indication as to when the accused must have become aware of the risk of his own infection. With regard to the significance of the physician's evidence, the Court argued:

> 'Their evidence had the possibility of being at the material time decisive for the question whether X was guilty of sexual offences only or in addition of the more serious offence of attempted manslaughter in relation to two offences .... There can be no doubt that the competent national authorities were entitled to think that very weighty public interests militated in favour of the investigation and prosecution of X for attempted manslaughter in respect of all of the five offences concerned and not just three of them.'[16]

Thus, even in cases in which the physician's testimony in criminal court was not necessary for the prosecution of an offender as such, but rather only for the prosecution for more serious offences, this interest is still regarded as possibly outweighing the interest behind the protection of medical confidentiality. The Court then emphasised the exceptional circumstances under which Finnish law allows for ordering the physician to give evidence (only in connection with serious criminal offences for which at least 6 years of imprisonment was prescribed) and that the questioning took place *in camera*, that all relevant files were ordered to be kept confidential, and that all those involved in the

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[15] Ibid., paras 96-97.
[16] Ibid., para. 102.

proceedings were under a duty to treat the information as confidential. This led the Court to conclude that:

> 'The various orders requiring the applicant's medical advisers to give evidence were supported by relevant and sufficient reasons which corresponded to an overriding requirement in the interests of the legitimate aims pursued. [The Court] is also satisfied that there was a reasonable relationship of proportionality between those measures and aims.'[17]

It is also interesting to note that the Court saw no reason to question the extent to which the applicant's physicians were ordered to give evidence, as this was a matter to be primarily decided by the national authorities. The Commission had taken a different stance and questioned the proportionality of the measures on this ground, arguing that even if the violation of the privacy right was, in principle, justified, the measures were not proportionate, as no attempt was made to limit the disclosure of confidential information.

It thus seems fair to say that medical confidentiality is not protected under Art.8 ECHR from disclosure by the physician in the course of criminal proceedings. In that respect, Art.10(1) European Convention on Human Rights and Biomedicine does not add any protection, as according to Art 26(1) of the Convention:

> No restrictions shall be placed on the exercise of the rights and protective provisions contained in this Convention other than such as are prescribed by law and are necessary in a democratic society in the interest of public safety, for the prevention of crime, for the protection of public health or for the protection of the rights and freedoms of others.

Art.10(1) can be restricted under the same circumstances as Art.8(1) ECHR. And the Explanatory Report points out with regard to Art.10(1) that a breach of medical confidentiality would for example be justified in order to identify the author of a crime. This result was reached with reference to the exception relating to the prevention of crime. However, it is submitted that the identification of the author of a crime relates to the investigation and prosecution of an offence already committed, and not to the prevention of a future crime.

The Data Protection Directive provides in Art.13 that the Member States may adopt exceptions to the obligations and rights created by the Directive for the purpose of detection and prosecution of criminal offences.

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[17] Ibid., para. 105.

2.2. Conflicting defence rights

If a State decides to recognise medical privilege, a conflict between medical confidentiality, on the one hand, and defence rights of an accused person, on the other hand, may arise. Art.6 ECHR guarantees the right to fair trial and, as part of that right, specifies certain rights of the defence. However, Art.6 ECHR does not award the right to examine witnesses regardless of existing privilege provisions. Rather, it mainly aims at protecting the principle of equality of arms, which means that 'each party must be afforded a reasonable opportunity to present his case in conditions that do not place him at a disadvantage vis-a-vis his opponent.'[18] Thus, a medical privilege which prevents the defence but also the prosecution from examining the physician about confidential patient information and which bars access to medical records does not violate Art.6 ECHR.

2.3. Crime prevention

Art.8(2) ECHR, Art.26 European Convention on Human Rights and Biomedicine and Art.13 Data Protection Directive allow for exceptions to the protection of medical confidentiality for the purpose of crime prevention. However, no clear guidelines are given concerning the possible extent and application of this exception, as long as the principle of proportionality is not disregarded.

2.4. Conclusion

It can be seen that in the area of medical confidentiality and medical privilege, the European Convention on Human Rights provides some fundamental protection of medical confidentiality under Art.8(1), but in Art.8(2) gives the States a broad discretion with regard to exceptions to this principle. A recognition of medical privilege is not mandated by the Convention. The provisions of the European Convention on Human Rights and Biomedicine and of the Data Protection Directive similarly express the attitude that exceptions to the protection of privacy and medical confidentiality are admissible for the purposes of criminal prosecution and crime prevention.

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[18] *Foucher v France* [1998] 25 E.H.R.R. 234, 18 March 1997, para. 34.

Chapter 4 – Medical confidentiality and medical privilege in France

1. Protection of medical confidentiality

1.1. Medical confidentiality as a fundamental right

Two possible sources for awarding medical confidentiality the status of a fundamental right must be examined: the French Constitution, and the European Convention on Human Rights.

1.1.1. Constitutional right

The French Constitution does not provide expressly for constitutionally guaranteed privacy rights. The French Constitutional Court (Conseil Constitutionnel), however, has stressed in various decisions that the Preamble to the 1958 Constitution, together with the Declaration of 1789 and the Preamble to the 1946 Constitution, guarantees individual civil liberties. It is therefore now well-established that certain individual liberties enjoy constitutional protection. In a decision concerning the constitutionality of a statute giving the police broad rights to search vehicles, the Constitutional Court held for example:

> 'Considering that individual freedom constitutes one of the fundamental principles guaranteed by the laws of the Republic, and proclaimed in the Preamble to the Constitution of 1946, and confirmed by the Preamble to the Constitution of 1958;
>
> considering that Art.66 of the Constitution, in reaffirming that principle, entrusts its safeguard in the judicial authorities.'[1]

Art.66 of the Constitution of 1958 states that:

> No person may be detained arbitrarily.
>
> The judiciary, the guardian of individual liberty, ensures respect for this principle in circumstances provided for by law.

One could therefore think that the constitutional protection of individual liberties is limited to the specific situation of detention. The constitutional protection awarded to individual freedom would then not include a guarantee of a general right to privacy. According to a commentary to this decision,[2] however, the Constitutional Court adopts a broad interpretation of individual liberty which

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[1] Conseil Constitutionnel 12 January 1977, AJDA 1978, 215; see also the decision of 16 July 1971, Rec. 29.
[2] Favoreu, Philip, *Les Grandes Décisions du Conseil Constitutionnel*, at 346.

includes the protection of private life. This interpretation is supported by a decision[3] of the Constitutional Court concerning the constitutionality of a statutory provision giving fiscal agents, assisted by police officers, rights of search and seizure in the course of the investigation of tax offences. In that case, the Constitutional Court stated:

> 'Considering that ... such investigations can only be carried out in accordance with art.66 of the Constitution which entrusts all aspects of the safeguard of individual liberty and, in particular, those concerning the inviolability of the home, in the judiciary.'

The constitutional protection of individual freedom goes thus beyond safeguards in the case of detention, and includes rather protection of individual liberty as such. However, given the rather general nature of constitutional protection of individual liberty, it has long been debated whether privacy and medical confidentiality are constitutionally protected. Some authors have argued that the provisions of the French Criminal and Civil Codes dealing with the protection of privacy and of medical confidentiality demonstrate that privacy and medical confidentiality should be included in the guarantee of individual freedom. Those provisions are thus seen as a means to delineate the scope of the constitutional protection of individual rights.[4] Jean Rivero, on the other hand, characterised the Act of 17 July 1970, introducing Art.9 of the Civil Code, the right to respect for one's private life, as introducing a freedom right not recognised by the existing constitutional texts.[5] He thus seems to suggest that the specific protection of private life, and therefore the protection of medical confidentiality, is not based on a constitutional principle, but rather achieved through ordinary law. This view is also endorsed by Eva Steiner who argues that the Declaration of 1789 does not protect the rights set out in Art.8 ECHR.[6] However, in 1995, the Constitutional Court held that privacy is a constitutional principle.[7] Even though the Constitution does not explicitly mention the right to privacy, it is now nevertheless regarded as having constitutional rank.[8] This coincides with a change in the French constitutional debate which only recently recognised the notion of fundamental

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[3] 29 December 1983, Rec. 67.
[4] Favoreu, Philip, *Les Grandes Décisions du Conseil Constitutionnel*, at 346.
[5] *Les Libertés Publiques*, Tome 1, at 153.
[6] 'France', in: Gearty (ed.), *European Civil Liberties and the European Convention on Human Rights, A Comparative Study*, at 281.
[7] Decision of 18 January 1995, Rec. 170.
[8] Picard, 'The right to privacy in French law', in: Markesinis (ed.), *Protecting Privacy*, at 75-76.

rights.[9] It is not clear whether medical confidentiality also benefits from the protection of privacy as a fundamental right. Given the rather narrow scope of constitutional review and constitutional protection of fundamental rights in general, it seems of limited relevance whether medical confidentiality receives constitutional protection. The main effect of constitutional protection of medical confidentiality would be that new parliamentary legislation would then have to accord with that principle in order to be constitutional. In addition, French courts could then control the compatibility of executive acts with this constitutional principle.

1.1.2. European Convention on Human Rights

The European Convention on Human Rights was ratified according to Act 73-1227 of 31 December 1973 and published by decree of 3 May 1974. Once an international treaty is ratified and published, it is incorporated into domestic law. In 1981 France accepted the individual right of petition to the Commission. So what, exactly, is the status of the ECHR in France? Art.55 of the Constitution of 4 October 1958 states that international conventions are of higher rank than ordinary statutes.[10] According to the *Nicolo* decision of the Conseil d'Etat,[11] the highest French Court dealing with administrative matters, international conventions are not only superior to domestic law enacted prior to their ratification, but they are also superior to subsequent national legislation. In its *Confédération nationale des associations familiales catholiques* decision,[12] the Conseil d'Etat applied this principle to the European Convention on Human Rights, stating that all legislation, whether enacted prior or subsequent to the ratification of the ECHR, must be in accordance with the Convention. Even though superior to ordinary statutes, international treaties nevertheless do not have constitutional status, and judicial review examining the compatibility of the challenged statute with an international treaty will be exercised by ordinary courts, not by the Conseil Constitutionnel.[13] This means that French judges who

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[9] See various articles in AJDA 1998, numéro spécial – les droits fondamentaux.
[10] Art.55: Traités et accords internationaux, régulièrement ratifiés ou approuvés, ont, dès leur publication, une autorité supérieure a celle des lois, sous réserve, pour chaque accord ou traité, de son application par l'autre partie.
[11] 20 October 1989, R.190.
[12] Conseil d'Etat 21 December 1990, R.369.
[13] Rivero, *Les Libertés Publiques*, Tome 1, at 150; Turpin, *Droit Constitutionnel*, at 109.

cannot review the constitutionality of legislation, can control the compatibility of a parliamentary statute with the ECHR.[14]

1.2. Protection under criminal law

In France, the discussion of the duty to medical confidentiality mainly focuses on the relevant provisions of the Criminal Code (code pénal), as in French law, a breach of the duty to medical confidentiality is a criminal offence (art.226-13 Criminal Code). This criminal offence was first laid down in art.378 Criminal Code of 1810. Art.378 old Criminal Code stated that:

> Physicians, surgeons and other health officers as well as pharmacists, midwives and all other persons being by their status or their profession or by their temporary or permanent position depositories of secrets confided in them, when revealing these secrets outside those cases in which the law obliges or authorises such a denunciation, will be punished with imprisonment of one month to six months and a fine of 500 F to 15,000 F.[15]

Most members of the medical profession were thus expressly mentioned in art.378 as being under a duty, sanctioned by criminal law, to maintain medical confidentiality. Art.378 old Criminal Code was replaced by art.226-13 when the new Criminal Code came into force in 1994. In the new Criminal Code, the provision was formulated differently. Art.226-13 new Criminal Code states that:

> The disclosure of any secret information confided in a person in connection with his/her social position or profession or on the grounds of a temporary office or mission, will be punished with imprisonment of one year and a fine of F 100,000.[16]

The new provision no longer expressly states that it applies to the members of the medical profession. However, it is difficult to imagine that judges would exclude those professionals who had been listed in art.378 old Criminal Code from the category of persons that have secrets confided in them on the grounds of their

[14] Steiner, 'France', in: Gearty (ed.), *European Civil Liberties and the European Convention on Human Rights, A Comparative Study*, at 281.

[15] Art.378 old Criminal Code:
Les médecins, chirurgiens et autres officiers de santé, ainsi que les pharmaciens, les sages-femmes et toutes autres personnes dépositaires, par état ou profession ou par fonctions temporaires ou permanentes, des secrets qu'on leur confie, qui, hors le cas où la loi les oblige ou les autorise à se porter dénonciateurs, auront révélé ces secrets, seront punis d'un emprisonnement d'un mois à six mois et d'une amende de 500 à 15 000 F.

[16] Art.226-13:
La révélation d'une information à caractère secret par une personne qui en est dépositaire soit par état ou par profession, soit en raison d'une fonction ou d'une mission temporaire, est punie d'un an d'emprisonnement et de 100 000 F d'amende.

status or their profession, as required by art.226-13 Criminal Code.[17] Thus, under the new Criminal Code, medical professionals are still under a duty to maintain medical confidentiality the contravention of which can give rise to a criminal conviction.

For art.226-13 Criminal Code to apply, different requirements have to be fulfilled. First, the revelation must refer to 'information confided in a person in connection with his/her social position or profession or on the grounds of a temporary office or mission' (art.226-13 Criminal Code). In this respect, art.226-13 Criminal Code and art.378 old Criminal Code adopted a similar approach, so that case-law developed under the old Criminal Code, establishing that the obligation to medical confidentiality was not limited to what the patient had confided in the physician, but rather also included everything the physician heard, saw or observed in the course of the exercise of his/her profession[18] is still valid. This clarification of the extent of the protection of medical confidentiality is based on the view that it seems appropriate to protect confidential patient information in cases in which the patient has not expressly shared his/her secret with the physician, but the physician still, on the grounds of his/her profession, gained knowledge of confidential information concerning his/her patient. The Cour de Cassation, the highest French court in civil and criminal matters, for example had to decide a case in which a physician, acting in his capacity as adviser of an insurance company, had obtained access to the hospital records of a road accident victim and later revealed the content of those records to his employer. The Court held that the physician's revelation of the victim's confidential medical information to the insurance company violated medical confidentiality. Even though the victim had not confided any medical information in the physician, the physician had gained access to the medical records by presenting himself as a member of the medical profession. The Court argued that the patient's medical confidences had therefore come to the physician's knowledge in the course of exercising his profession and concluded that he was thus under an obligation not to reveal what he heard, saw or inferred, even in the absence of confidences made by the patient.[19] Another example is a case in which a physician who happened to be at the site of a road accident applied first aid to an accident victim and later

[17] Chomienne, Guéry, ALD.1995.comm.85.
[18] See, for example, 17 Mai 1973, Ch. crim., D.1973.583; 23 January 1996 Ch. crim., Bull. n°37.
[19] 17 Mai 1973, Ch. crim., D.1973.583.

submitted the medical certificate regarding the victim's injuries to the police. According to the court, in doing so, the physician violated his duty to confidentiality.[20] Even though the patient had not confided any medical information in the physician, the physician, in his capacity as a medical practitioner, obtained some knowledge about the patient's health condition, and thus the patient's intimate sphere. This expansion of the scope of medical confidentiality was also approved by legal scholars[21] and seems uncontroversial. Some welcome this approach on the grounds that if the patient's trust in the physician is protected where the patient expressly confides in the physician, the same principle should be applied to the situation that he/she allows the physician to obtain information and to draw certain conclusions by examining the patient.[22] However, this view rests on the assumption that medical confidentiality depends on the patient's express wishes and comes into existence only by virtue of a patient's consent to a medical examination. But the example of the accident victim demonstrates that this would leave unconscious and also incompetent patients who are not in a position to give their consent to a necessary medical examination, unprotected. The approach adopted by French courts thus seems to be based on the consideration that a patient's confidences should be protected regardless of how the physician has come to know them, as long as this knowledge was gained in a professional capacity. This points at a desire either to protect the confidences of the patient as such and thus the patient's privacy, and/or at a desire to protect the confidentiality of the physician-patient relationship.

The information must have come to the knowledge of the person bound by the professional secret in relation with the exercise of his/her profession. This raises the question of whether a distinction must be made between confidential information obtained directly during the exercise of the medical profession, and confidential information otherwise obtained. With regard to the comparable situation of a priest, it has been argued, for example, that information confided in a priest was only acquired in the course of the exercise of his/her profession and protected by his/her obligation to confidentiality if it was confided in him/her in his/her role as a priest, but not, for example, if it was confided in him/her by a

[20] 14 February 1952, JCP.1952.II.7030.

[21] See for example Légal, JCP.1948.II.4141; Véron, *Droit Pénal Spécial*, at 134.

[22] Rassat, D.1989.chron.107.

friend at a social gathering.[23] Others reject this distinction as unworkable, as in the example of the priest, it seems impossible to establish whether or not the secret was shared with this friend on the grounds of his/her role as a friend, and/or that of a priest. For the physician, this means that it is controversial whether or not medical information confided in a physician outside the formal framework of his/her professional activity is protected by the obligation to maintain medical confidentiality.

In addition, the fact revealed by the physician must be a secret. An interpretation of the notion 'secret' encounters two different problems: (1) does all information gathered by the physician in the course of his/her profession necessarily qualify as a secret, or does the information have to be of particular sensitivity to deserve secrecy? And (2) does information merely qualify as secret as long as only the physician knows about it, or is it still a secret even though it might have become known, partly or even in its entirety, to third parties outside the physician-patient relationship? With regard to the first aspect of the question of secrecy, different approaches have been suggested. Some have argued that the information must have a certain quality to it to be considered confidential. Savatier, for example, voiced the opinion that the admission of a patient to a hospital has nothing secret about it and is therefore not protected by the obligation to medical confidentiality.[24] But others, to the contrary, argue that the very fact that the patient has consulted a physician must be covered by medical confidentiality,[25] as often the mere knowledge that a patient has attended a certain medical practice as well as the frequency of attendance may allow for conclusions as to the purpose behind the visits, and to the medical condition of the patient and the illness he/she is suffering from.[26] Another argument brought forward in favour of limiting the scope of protected information is that only information which in itself has a medical aspect deserves confidentiality. Thus facts without medical significance which every person without any medical knowledge could have observed in the same way as the physician, such as the destruction of a will in the room of a patient, would then not be protected as confidential.[27] Others object, however, that all information obtained in relation with the exercise of the medical profession

[23] Ch. crim. 11 May 1959, D.1959.312.
[24] Savatier, JCP.1970.II.16306.
[25] Mazen, *Le Secret Professionnel des Praticiens de la Santé*, at 44.
[26] Pradel, Danti-Juan, *Droit Pénal Spécial*, Tome III, at 232.
[27] Reboul, JCP.1950.I.825.

should be kept secret, regardless of whether the information has medical aspects or not,[28] as the distinction between medical and non-medical information will sometimes be very difficult to make. Also, it is possible that some information that very obviously does not have a medical aspect, such as the place of refuge of a fugitive criminal in need of medical care,[29] will be made known to the physician exclusively for the purpose of enabling him/her to exercise his/her profession and treat the patient. Even though the information is therefore not as such related to the medical condition of the patient, it was nevertheless obtained by the physician in the course of his/her profession, and the trust placed in the physician when revealing this information was based on the patient's medical needs. Some argue that the changes in the perception of illness which led to the situation that an illness in itself is no longer perceived as something shameful that has to be hidden from everybody, require a new definition of medical confidentiality, in that it no longer seems appropriate for the duty of medical confidentiality to embrace all information relating to the patient's health, even though most medical information will not have anything secret attached to it from the patient's point of view.[30] But others object that while the perception of illness might have changed, even a benign illness that according to most people does not have anything indecent attached to it, can nevertheless have an aspect that the patient might want to hide for personal reasons, for example the way in which he/she contracted the illness.[31]

With regard to the second requirement of a secret, i.e. the question whether information can still be regarded as secret even if it is public knowledge, the Courts have decided in several cases that it does not matter that the information had already been made public before any disclosure by the physician because a physician's revelation will often serve as confirmation of what until then was only a rumour,[32] and the physician's disclosure can add a scientific basis to the knowledge of the public. In one case, a physician who had been threatened by a patient over the telephone brought charges, stating that the patient was mentally ill and had aggressive tendencies. According to the physician, these tendencies had manifested themselves for example in the fact that the patient had often threatened his wife. The Cour d'appel of Lyon held that these revelations violated the

[28] Savatier, D.1957.445.
[29] Example given by Savatier, ibid.
[30] Ibid.
[31] Ryckmans, Meert-Van de Put, *Les Droits et les Obligations des Médecins*, Tome 1, at 131.
[32] 23 January 1996 Ch. crim., Bull. n°37; Véron, *Droit Pénal Spécial*, at 134.

physician's duty to maintain medical confidentiality, as the patient's aggressive tendencies, though notorious, were discovered by the physician only in the exercise of his profession.[33] And in another case regarding the obligation of a police officer to maintain the professional secret, the Cour de Cassation held that the obligation applied even to facts that, in all likelihood, were already publicly known.[34]

To comprehend art.226-13 Criminal Code and the scope and limits of medical confidentiality, it is essential to understand whose interests medical confidentiality is aiming to protect. As was already indicated, the French Criminal Code does not award protection against the revelation of every confidence; rather, only information confided in the members of certain professions is protected by criminal law. The reason behind this concept is clear: the confidence placed in so-called necessary confidants, i.e. persons to whom the individual must in some situations reveal confidential information, is seen as important enough to deserve special protection,[35] even protection by the means of criminal law. However, it is not at all clear why this confidence is important enough to justify special protection. While it is widely accepted that medical confidentiality exists in the interest of the patient,[36] it is controversial how exactly the patient's interests can be determined. Some argue that the duty of medical confidentiality protects the interests of those who, when in need of having recourse to the service of someone else, confide information in him/her which they would have kept to themselves but for the need to inform the professional whose help they are seeking.[37] There seems to be widespread agreement that the patient has an interest in being assured that the physician will never reveal any confidential patient information without the patient's consent,[38] as otherwise the patient might not feel confident to share all relevant information with his/her physician.[39] For some, this interest is merely psychological: patients would find it undesirable to see their medical secrets

[33] 17 January 1980, CA Lyon, Gaz. Pal. 1981.2.491.
[34] 8 February 1994, Gaz. Pal.1994.somm.298.
[35] 19 November 1985, Bull n° 364; Waremberg-Auque, Revue de science criminelle et de droit pénal comparé 1978, 237-256.
[36] Waremberg-Auque, Revue de science criminelle et de droit pénal comparé 1978, at 251; Mazen, *Le Secret Professionnel des Praticiens de la Santé*, at 42; Rassat, D.1989.chron.107.
[37] Gulphe, D.1947.109.
[38] Légal, JCP.1948.II.4141; Savatier, D.1957.445.
[39] Albucher, JCP.1954.II.8107; Combaldieu, D.1967.122.

revealed.[40] Others argue that the patient's interest in his/her bodily integrity is concerned, as patients, when holding back essential information,[41] endanger the efficiency of their medical treatment. Some authors suggest that the right to medical confidentiality is part of the patient's personality rights which protect the individual's private and intimate sphere.[42] They argue that the patient's interest in medical confidentiality is comparable to the interest in one's own picture, voice and letters, and they conclude that everybody has the right to consider his/her health and all health related information as confidential. The fact that art.226-13 Criminal Code is part of the book on 'crimes and misdemeanours against the individual', and within that book part of the chapter on 'offences against the personality', also supports the view that the right to medical confidentiality is part of the personality rights.[43] If that is accepted, it follows that an individual who is obliged to reveal intimate details when seeking the advice and help of a medical practitioner should not have to fear indiscretion and a violation of his/her private and intimate sphere.[44] Art.226-13 Criminal Code could then be seen as imposing an obligation on the physician that corresponds to the patient's right under Art.9 Civil Code to keep his/her medical information secret.[45] It has also been suggested that the principle of medical confidentiality, in addition to a protection of the patient's privacy rights, aims at respect for the patient's dignity.[46] All these considerations seem of deontological, rather than utilitarian origin, as they are not concerned with the consequences of a lack of medical confidentiality, but rather recognise that medical confidentiality must be protected in order to guarantee the patient's informational and decisional privacy.

With regard to the question of whether the principle of medical confidentiality also intends to protect the individual physician or the medical profession as such, again many different opinions are voiced. Some infer from the wording of art.378 old Criminal Code that the physician is only the depository of the patient's secret, and that therefore not the physician, but only the patient can be the master of

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[40] Honnorat, Melennec, JCP.1979.I.2936.
[41] Gulphe, D.1947.109.
[42] Mazen, *Le Secret Professionnel des Praticiens de la Santé*, at 28; the same, Gaz Pal 1981.2.491; Melennec, Gaz. Pal. 1980.doct.145.
[43] Mazen, *Le Secret Professionnel des Praticiens de la Santé*, at 27.
[44] Thouvenin, Juris-Classeur Pénal - ancien code pénal, Art.378, note 1.
[45] Mazeau, Chabas, *Leçons de Droit Civil - Les Personnes*, Tome 1, vol. 2, at 394-395.
[46] Flécheux, JCP.1982.II.19721; Mémeteau, Gaz.Pal 1996, 754-759, at 755.

confidential medical information referring to him/her.[47] In the domain of medical confidentiality, physicians would then only have duties, but not rights.[48] Many argue, however, that the members of the medical profession have themselves an interest in the maintenance of medical confidentiality, as the exercise of their profession would be seriously impaired if patients, when not being sufficiently assured of confidentiality, would hold back important information.[49] Physicians could then no longer efficiently fulfil their professional tasks, so that without a protection of medical confidentiality, the interest in the functioning of the medical profession would be adversely affected.[50] Another argument is that since the members of the medical profession see confidentiality as a sacred duty,[51] they accordingly have an interest in not being forced to reveal confidential patient information.[52]

In addition, some refer to the interests of the members of the patient's family in the protection of their intimate sphere as well as in their honour and reputation.[53]

Also, for many authors, society as a whole has an interest in the protection of medical confidentiality.[54] This view is mainly promoted by those who fear that without medical confidentiality, patients would no longer openly reveal all their medical secrets to their physicians, a consequence which could have an adverse effect on public health,[55] as efficient medical treatment would then no longer be guaranteed.[56] They argue that the protection of medical confidentiality mainly lies in the public interest, as the criminal offence of revealing confidential information is not a 'délit privé', but a charge can rather be brought directly by the public prosecutor,[57] even if no individual feels harmed and is interested in pressing charges.[58] Others, however, question whether medical confidentiality really has any significance for the patient's readiness to receive medical advice and treatment, as no evidence supports the view that in countries without protection of

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[47] Savatier, JCP.1967.II.15126.
[48] Melennec, Gaz. Pal. 1980.doct.145.
[49] Gulphe, D.1947.109.
[50] Combaldieu, D.1967.122.
[51] Albucher, JCP.1954.II.8107.
[52] Roujou de Boubée, Bouloc, Fancillon, Mayaud, *Code Pénal Commenté*, at 399.
[53] Albucher, JCP.1954.II.8107; Combaldieu, D.1967.122.
[54] Combaldieu, D.1967.122.
[55] Gulphe, D.1947.109.
[56] Honnorat, Melennec, JCP.1979.I.2936; Savatier, Auby, Savatier, Péquignot, *Traité de Droit Médical*, at no 304.
[57] Gulphe, D.1947.109.
[58] Ryckmans, Meert-Van de Put, *Les Droits et les Obligations des Médecins*, Vol. 1, at 131.

medical confidentiality the patient's behaviour in this respect differs from that of a French patient.[59] This debate equals the utilitarian discussion of whether or not sufficient evidence exists to justify the assumption that a protection of medical confidentiality produces beneficial consequences. Moreover, the public interest could be affected if one accepts that the right to respect for one's private life is a general principle that lies within the public interest,[60] as society has an interest in the protection of the individual and of the freedom of the individual.[61] Another approach suggests that society as a whole has an interest in preserving the physician's discretion with regard to the protection of the individual and the healthiness of the social climate.[62] It could be argued that the mere fact that medical confidentiality is protected by a criminal provision shows that the legislator considers the principle as being in the public interest.[63] Understood in this way, the protection of medical confidentiality in the public interest is justified by reference to deontological considerations in saying that the public has an interest in preserving individual interests that are worth protecting. At the same time, it could also reflect utilitarian thought, if it were accepted that the promotion of individual privacy as such produces beneficial consequences.

To summarise, the predominant opinion promotes the view that the protection of medical confidentiality by the Criminal Code is mainly guaranteed in the interests of the patient, which are identified as the interest in keeping confidential medical information secret, the interest in bodily integrity, and respect for human dignity. However, some argue that medical confidentiality mainly or additionally aims at protecting the interests of the physician or of the medical profession, the interests of the patient's family and the interests of society as a whole.

[59] Mazen, *Le Secret Professionnel des Praticiens de la Santé*, at 22 and 28.
[60] Mazen, Gaz Pal 1981.2.491.
[61] Ibid., at 26.
[62] Mazen, *Le secret professionnel des praticiens de la santé*, at 26.
[63] Flécheux, JCP.1982.II.19721; Mazen, Gaz Pal 1981.2.491.

1.3. Protection under private law

1.3.1. Article 9 Civil Code

The right to the protection of one's private life as guaranteed under art.9 Civil Code, is also of importance in the context of medical confidentiality. According to art.9 Civil Code:

> Everybody has the right to respect for his private life.
> Courts can, without prejudice to the reparation of damage suffered, prescribe all measures, such as sequestration, seizure and others, suitable to prevent or stop an attack on the inviolability of the private life. In case of urgency, these measures can be ordered by temporary injunction.[64]

Art.9 Civil Code was introduced by an Act of 17 July 1970 as a reaction to new threats to the inviolability of private life, for example through new technologies.[65] It enables the courts to protect a person's private life by measures such as injunctive relief, sequestration of printed material etc. so as to prevent the violation of an individual's private life.[66] Under this provision, every person has the right to control the dissemination of personal information and to exclude others from his/her private sphere of life.[67] This includes the protection of the secrecy of one's health condition and of personal medical information.[68] Thus, a patient can apply for an injunction to prevent a violation of his/her medical confidences.

1.3.2. Obligation under contract and tort law

In French law, the physician-patient relationship is usually governed by contract law. The physician is then under a contractual[69] duty to maintain medical confidentiality, and the legal consequences will be dealt with by art.1147 Civil

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[64] Art.9: Chacun a droit au respect de sa vie privée.
Les juges peuvent, sans préjudice de la réparation du dommage subi, prescrire toutes mesures, telles que séquestre, saisie et autres, propres a empêcher ou faire cesser une atteinte à l'intimité de la vie privée; ces mesures peuvent, s'il y a urgence, être ordonnées en référé.
[65] Rivero, *Les Libertés Publiques*, Tome 2, at 85.
[66] See for example Cour d'Appel Paris, 13 March 1996, JCP.1996.22632, a decision regarding the distribution of the book *Le grand secret* revealing details of the late President Mitterand's medical condition.
[67] Mazeau, Chabas, *Leçons de Droit Civil - Les Personnes*, Tome 1, vol. 2, at 397.
[68] Rivero, *Les Libertés Publiques*, Tome 2, at 77.
[69] Honnorat, Melennec, JCP.1979.I.2936; Savatier, Auby, Savatier, Péquignot, *Traité de Droit Médical*, at 303; but according to Anzalec, Gaz Pal 1971.113, the obligation to medical confidentiality is not based on a contract, but is rather a legal obligation based on 'l'ordre public'.

Code, which allows for compensation for any loss, including non-pecuniary loss, suffered as a consequence of the breach of a contractual duty. In principle, a violation of medical confidentiality by a physician could also constitute a tortuous act under art.1382 Civil Code and thereby give rise to a claim for damages under tort law. However, in French law, contractual and delictual responsibility cannot co-exist.[70] A case in which compensation is at issue is either governed by the principles of contract law or by the principles of tort law. This means that in the case of a breach of a contractual obligation, delictual responsibility for the same act is excluded.[71] Given that the physician's obligation to maintain medical confidentiality is usually based on the contract existing between physician and patient, it follows that a breach of that duty can normally only give rise to a claim for compensation under contract law, but not for compensation under art.1382 Civil Code. A claim for compensation under tort law is normally only available if there is no contract between the patient and the physician, for example in the case of a medical examination of an accident victim by a physician at the site of the accident. It should be noted that in civil matters, French courts often do not specify the provision the successful action was based upon, but rather justify their decisions by a general reference to the different Civil Code provisions mentioned. It thus seems as if arts 9, 1147, 1382 Civil Code, and art. 226-13 Criminal Code are being used to deduct the general principle that medical confidentiality is legally protected.[72]

1.4. Professional obligation

The Code of Medical Ethics 1995 (code de déontologie médicale) issued by the medical profession states in art.4(1):

> The professional secret established in the interest of the patient is imposed on every physician according to the conditions stated by law.

Thus, a French physician is under an ethical duty to maintain medical confidentiality. The scope of this obligation is specified in art.4(2) Code of Medical Ethics stating that:

> The secret covers everything that came to the knowledge of the physician in

[70] Terré, Simler, Lequette, *Droit Civil, Les Obligations*, at 681.
[71] Ch. civ. 20 May 1936, D.P.1936.1.88; S.1937.1.321; Ch. Civ., 9 June 1993, JCP 1994.II 22264.
[72] Agostini, D.1996, chron.58.

> the course of his profession, that is it not only covers what was confided in him, but also what he has seen, heard or understood.

The extent of protection awarded medical confidentiality under the professional regulations therefore coincides with the legal protection as developed by the courts.

1.5. Summary

Even if the protection of confidential medical information could be seen as part of the constitutionally protected right to personal freedom, this protection would only be of limited effect, given the narrow system of constitutional protection of fundamental rights in France. Protection of confidential medical information in accordance with Art.8 ECHR is guaranteed and every court can control the compatibility of statutes and executive acts with that provision. Medical confidentiality is also protected under private law, and injunctive relief is available where a violation of this interest is to be feared. Compensation can be claimed under art.1147 Civil Code for a violation of the contractual obligation of medical confidentiality, or, in the absence of a contract between physician and patient, under art.1382 Civil Code. Physicians are also under an ethical obligation to respect their patients' medical secrets, and the violation of that obligation can give rise to disciplinary sanctions. The strongest protection of medical confidentiality, however, is achieved by the means of criminal law, as a violation of the obligation to maintain medical confidentiality by the physician is a criminal offence under art.226-13 Criminal Code.

2. Medical privilege

Given that the physician is under an obligation to maintain medical confidentiality, the question arises of whether this principal obligation also exists in the context of criminal proceedings, or whether in this particular area the interest in medical confidentiality will have to yield to other interests of overriding importance.

2.1. General and absolute obligation

Where a conflict between medical confidentiality and other interests arises, one must be clear about the value of the physician's obligation to maintain medical confidentiality in order to be able to resolve the problem. In this context, it is important to introduce the concept of the 'general and absolute' nature of medical confidentiality which is a fundamental feature of the French approach to medical confidentiality. The formula of the 'general and absolute' nature of the principle of medical confidentiality is mainly promoted by criminal courts. The Chambre criminelle of the Cour de Cassation, for example, stated in its decision of 22 December 1966 that the duty to maintain confidentiality as imposed on physicians by the provisions of the Criminal Code, is general and absolute and that no one can relieve the physician from it.[73]

Several arguments are listed in favour of this approach. Combaldieu, for example, promotes the view that even though there can sometimes be good and even imperative reasons for revealing the secret, it is still true that every exception bears the risk that the duty will be annihilated. He continues that a case by case rather than an absolute approach would have the inconvenience of blurring the content of the duty to maintain confidentiality. Combaldieu concludes that it is preferable to declare the obligation to be of a general and absolute nature, as this concept, though being rigid and inflexible, nevertheless has the merit not only to rely on tradition and precedents, but also to regulate the behaviour in a precise manner.[74] It has also been argued that a relativist concept of medical confidentiality is dangerous for physicians, because it leaves them with a choice of whether or not to reveal the secret; if this choice does not find the approval of their judges, they risk a conviction and disciplinary sanctions. Accordingly, it has been maintained that physicians who find themselves confronted with a criminal provision must know where they stand and need a rule that leaves no room for doubts.[75] The theory seems partly to be based on the rather pragmatic view that medical confidentiality, being imposed as an absolute duty, has been of surprising efficiency and has been rigidly respected by physicians.[76] While this interpretation

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[73] D.1967.122; this formula was used more recently by the Cour de Cassation on 7 March 1989, Bull n° 109 and on 8 February 1994, Gaz. Pal.1994.somm.298.
[74] Combaldieu, D.1967.122.
[75] FlécheuxJCP.1982.II.19721.
[76] Monzein, D.1984.chron.9.

of the 'general and absolute' formula thus suggests that the principle of medical confidentiality should always prevail without allowing for any exceptions, others object that this concept is too rigid, as it can sometimes lead to results that are contrary to morals or to the requirements of justice.[77] A different approach has therefore been suggested, submitting that the theory of an absolute secret does by no means imply that the secret cannot be revealed under any circumstances. Rather, according to this approach, the theory of the general and absolute obligation merely entails that the secret can only be revealed in accordance with the general principles of law and within the framework of the known legal justifications.[78] Thus, medical confidentiality, while deserving absolute protection, could nevertheless in some cases be outweighed by overriding interests.

Others reject the theory of the absolute nature of medical confidentiality altogether and argue that the relative nature of the medical secret is confirmed by legislation imposing on the physician a duty to disclose certain sensitive health information, for example with regard to venereal diseases.[79] If exemptions are possible, it is argued, the secret cannot be absolute.

It will be seen below how the concept of the general and absolute nature of the obligation to maintain medical confidentiality influences the approach towards the different conflicts arising in the context of criminal proceedings.

2.2. Relation between the obligation to medical confidentiality and the obligation to give testimony

In criminal proceedings, the testimony of a witness is an important means to achieve the purpose of such proceedings: finding the truth and ensuring that the offender will be convicted without risking a wrongful conviction of the innocent. This interest, which is sometimes called the interest of justice, is undoubtedly a public interest.[80] Therefore, art.109 Code of Criminal Procedure creates a duty for every citizen to give testimony in court. But the provision contains an exemption for those persons who are under an obligation of professional confidentiality, the

[77] Anzalec, Gaz. Pal. 1971.113.
[78] Rassat, D.1989.chron.107.
[79] Le Roy, D.1963.280; Pradel, JCP.1969.I.2234.
[80] Gulphe, D.1947.109.

violation of which is punishable under arts.226-13 and 226-14 Criminal Code. Art.109 states:

> Every person who was subpoenaed to be heard as a witness is under a duty to appear, to swear an oath, and to testify, subject to the dispositions ... of arts.226-13 and 226-14 Criminal Code.[81]

In the case that a physician is called to give testimony concerning confidential patient information, a conflict between the public interest in finding the truth and the interest in medical confidentiality arises. As art.226-13 Criminal Code (obligation to medical confidentiality) and art.109 Code of Criminal Procedure (obligation to give testimony) impose conflicting duties, it is important to establish how this conflict should be resolved. Should the physician always give testimony, as finding the truth in criminal proceedings is more important than upholding medical confidentiality? Alternatively, should the physician always refuse to give testimony, as medical confidentiality is more important than finding the truth? Or should the physician have the choice to decide the conflict in every individual situation according to the facts of the case and the dictates of his/her conscience?

Different answers to these questions have been provided. As art.109 Code of Criminal Procedure expressly exempts persons who are under an obligation to professional confidentiality from the obligation to give testimony, art.109 must be interpreted as imposing a general duty on a physician to give testimony in court when called as a witness only if the interrogation does not involve confidential information protected by the duty to medical confidentiality.[82] Under art.109, the physician is thus not under an obligation to give testimony in court with regard to confidential patient information. This, however, leaves the question of whether it follows that the physician is not allowed to give testimony, or whether it only means that the physician, while under no obligation to give testimony, can choose to do so and will then be exempt from his/her duty of medical confidentiality under art.226-13 Criminal Code. Art.109 Code of Criminal Procedure is mostly interpreted so as to prohibit any testimony that might violate the obligation to

[81] Art.109:
Toute personne citée pour être entendue comme témoin est tenue de comparaître, de prêter serment et de déposer, sous réserve des dispositions ... des articles 226-13 et 226-14 du Code pénal.
[82] Damien, Gaz Pal.1982.doct.136.

maintain medical confidentiality.[83] As art.109 exempts the physician from the obligation to give testimony, while art.226-13 does not provide for an exemption in the case of testimony in court, the legislator has clearly demonstrated how to resolve the conflict between the two competing duties. According to this interpretation, a physician who decides to give testimony in court will thereby commit the criminal offence of art.226-13, unless, exceptionally, a legal justification in his/her favour applies. Some suggest that case-law leaves the physician a choice between the two obligations,[84] though it must be said that there are no cases directly on this point.[85] Rather, the existing case-law refers to the question of whether the physician has the right or even the obligation to give testimony if the patient has consented to the revelation of confidential information.[86] In that situation, the courts took the stance that it was up to the physician to choose which obligation to fulfil in the particular case. Given the rather narrow scope of this case law, it is thus not at all clear whether the courts would give the physician a choice between giving testimony or maintaining medical confidentiality where the patient has not consented to the revelation. It is submitted that the courts will reject giving the physician discretion to decide whether or not to testify, as such an approach would run counter to the 'general and absolute' nature of medical confidentiality as proclaimed by French courts.

It can be seen that the debate in France mainly concentrates on finding a coherent approach to the interplay between art.226-13 Criminal Code and art.109 Code of Criminal Procedure. As the provisions do not seem to leave much scope for interpretation, it is not surprising that no reference is made to ethical principles.

2.3. Defence rights of the physician

A special problem arises if the physician is accused of professional irregularities and wants to testify about confidential patient information to exonerate him/herself. In such a case, we are no longer merely concerned with a conflict between the interest in medical confidentiality and the general public interest in establishing the truth in criminal proceedings. Rather, in addition to the latter, the

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[83] Mazen, *Le Secret Professionnel des Practiciens de la Santé*, at 130; Vouin, *Droit Pénal Spécial*, at 367.
[84] Chomienne, Guéry, ALD.1995.comm.85; Rassat, *Droit Pénal Spécial*, at 381.
[85] Loiret, *La Théorie du Secret Médical*, at 162; Vouin, *Droit Pénal Spécial*, at 367.
[86] See for example 8 May, 1947, D.1947.109; 5 June 1985, Bull N° 218.

physician's interest in the unobstructed exercise of his/her defence rights is at stake. Given the importance of defence rights as fundamental human rights,[87] there is wide agreement that the physician's defence rights outweigh the interest in medical confidentiality.[88] In a case in which a physician was accused of medical malpractice leading to the death of a patient, and where the physician submitted to the court photos which he had taken in the course of the medical examination and which were useful for his defence, the court for example held that: 'one cannot deny defence rights to anybody, and this fundamental freedom cannot be limited by the principles relating to medical confidentiality.'[89]

In the famous case of the 'King of the Gypsies', the court went even further. In that case the leader of a gypsy community had manipulated two female members to make them act as follows: after having had car accidents, they misled their physicians as to the seriousness of their resulting medical condition and, as a consequence, the physicians certified serious and persistent medical problems. The drivers who had caused the accidents were then asked to pay high amounts of damages. When the grave errors made by the physicians were discovered, they were, in the course of criminal proceedings against the community leader, asked for an explanation. The physicians indicated that they had been influenced by statements made by persons who were close to the victims and by the victims' simulations. The Cour de Cassation held that:

> 'The Court of Appeal was right to state that even though the duty of confidentiality was a strict principle, it could not prevent the physician who was turned into the accessory of a fraud because he delivered a wrong medical certificate from clearing himself in the course of judicial proceedings concerning this fraud, by revealing the details that had led to the delivery of the medical certificate at issue. This is particularly true given that art.160 Criminal Code makes the delivery of a certificate falsely certifying the existence of illnesses a criminal offence'.[90]

Some commentators thought the Court's decision was justified, given that the physicians could not otherwise have cleared themselves from the suspicion of having participated in the fraud.[91] Others went even further and argued that the

[87] Champeil-Desplats, D.1995.chron.323.
[88] See for example Damien, *Le Secret Nécessaire*, at 36; Décheix, D.1983.chron.133; Mazen, *Le Secret Professionnel des Practiciens de la Santé*, at 147; Pradel, JCP.1969.I.2234; Reboul, JCP.1950.I.825; Thouvenin, *Le Secret Médical et l'Information du Malade*, at 99-100.
[89] 26 October 1951, CA Douai (4e Ch. corr.) Gaz.Pal 1951.2.425.
[90] 20 December 1967, D.1969.309.
[91] Lapointe, D.1969.309.

case concerned a physician who was being attacked in court or at least seriously threatened to be attacked, and that therefore the principle of respect for defence rights applied which allows the accused to reveal in court all information necessary for his defence.[92] However, in this case the physicians were not accused of any illegal or unprofessional conduct, as they were asked for the explanation in the course of criminal proceedings against third parties where they were heard as witnesses. It was also clear from the outset that the physicians had acted in good faith. In this case, it is thus rather difficult to justify the result by reference to the physician's defence rights which were not affected. The decision suggests that the simple eventuality of a charge being brought against a physician is sufficient to justify a disregard of art.226-13 Criminal Court.[93]

As could be seen, the courts based their decisions on rather general considerations regarding the conflict between the interest in medical confidentiality and the physician's interest in defending him/herself when accused in criminal proceedings, without any reference to the legal basis of a possible justification. Nevertheless, a short examination of the applicability of legal justifications seems in order. French law mainly offers two different legal justifications that could apply in this context, the first of which is that of self-defence (légitime défense), set out in art.122-5 Criminal Code:

> A person who, in the face of an unjustified attack against himself or a third party, commits, at the same time, an action commanded by the necessities of self-defence or the defence of a third party, is not responsible in criminal law, unless there is disproportionality between the defence measures employed and the seriousness of the attack.[94]

And the necessity defence (état de nécessité) as regulated by art.122-7 Criminal Code, applies under the following conditions:

> A person who, in the face of a present or imminent danger to himself, a third party or an object, commits an action necessary to safeguard the person or the object, is not responsible in criminal law, unless there is disproportionality between the measures employed and the seriousness of the threat.[95]

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[92] Rassat, D.1989.chron.107.
[93] Lapointe, D.1969.309.
[94] Art.122-5: N'est pas pénalement responsable la personne qui, devant une atteinte injustifiée envers elle-même ou autrui, accomplit, dans le même temps, un acte commandé par la nécessité de la légitime défense d'elle-même ou d'autrui, sauf s'il y a disproportion entre les moyens de défense employés et la gravité de l'atteinte.
[95] Art.122-7: N'est pas pénalement responsable la personne qui, face à un danger actuel ou imminent qui menace elle- même, outrui ou un bien, accomplit un acte nécessaire à la sauvegarde de la personne ou du bien, sauf s'il y a disproportion entre les moyens employés et la gravité de la

The opinions are split as to whether the prerequisites of self-defence will be fulfilled where criminal charges are brought against a physician and the physician, as part of his/her defence, discloses confidential patient information. Self-defence presupposes an aggression emanating from the victim who only suffers a wrong because he/she tried to harm another. In the case of a disclosure of confidential medical information, this means that the secret may only be revealed in cases of an attack emanating from the patient, and only to the extent necessary for the refutation of such an attack.[96] Moreover, it will frequently be difficult to allege that the charge against the physician was unjustified, another prerequisite of self-defence, so that in many cases, the requirements of the justification of self-defence will not be fulfilled.[97]

It has also been argued that the necessity defence can be invoked as it justifies revelations limited to what is necessary in the social interest, and it seems to be the most appropriate defence, as it is the most flexible one.[98] The supporters of this view suggest that the harm caused by the physician when revealing confidential information is not punishable because he is trying to avert a more serious danger from himself. However, the requirement of an immediate and imminent danger can sometimes cause a problem. Some argue that this requirement will often not be met as the simple threat of a prosecution does not constitute an imminent danger.[99] Others, in contrast, argue that the requirement of an imminent danger is obviously fulfilled, given that in such a situation the physician is exposed to harm.

The problem at hand does not fit neatly into the framework of the legal justifications recognised by French law. This is why the courts and most legal writers have never referred to the justifications known in criminal law; they always restrict themselves to confirming that the right to defend oneself is a fundamental right outweighing medical confidentiality,[100] without trying to establish the prerequisites of either self-defence or necessity. However, two principles are here in conflict with each other: if confidentiality were given priority over the right to defend oneself, it would mean to accept the risk that an

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menace.

[96] Honnorat, Melennec, JCP.1979.I.2936.

[97] Waremberg-Auque, Revue de science criminelle et de droit pénal comparé 1978, at 252.

[98] Pradel, Danti-Juan, *Droit Pénal*, Tome III, at 241; Rassat, D.1989.chron.107.

[99] Waremberg-Auque, Revue de science criminelle et de droit pénal comparé 1978, at 252.

[100] See, for example, Monzein, D.1984.chron.107.

innocent person who was not given the possibility to exculpate him/herself might be convicted, or to give a guilty person the prerogative of not having to take responsibility for his/her actions. But to give the physician's defence rights priority over medical confidentiality would constitute a crack in the secret and a disloyalty on the part of the physician. It is thus difficult to find a solution. Some have tried to reconcile and optimise both interests, by stating that it seems normal not to deny a physician defence rights, i.e. rights enjoyed by everybody else; but that this does not mean that the physician can divulge everything and under all circumstances. Rather, the revelation must be strictly limited to the needs of the defence.[101] It has also been suggested that the physician can only reveal the secret once an action is started against him, and only if the action was commenced by the patient, as it is only the patient, master of the secret, who can relieve the physician from his/her duty to maintain medical confidentiality.[102] This last opinion can only be understood against the background of the theory that the confidence belongs to the patient and cannot be revealed against the patient's wishes, but that a revelation is possible with the patient's consent. If the patient accuses the physician of an irregularity, some writers suggest that the patient should not be allowed to invoke medical confidentiality, as he/she has dragged his/her medical secrets into the public sphere.[103] But it is not clear whether this consideration is limited to civil litigation, or whether it also applies to criminal law, as it is then not the patient, but the public prosecutor who brings charges. It has also been suggested that the impact of the breach of confidentiality could possibly be mitigated by conducting in chamber proceedings.[104]

The resolution of this conflict of interests can be viewed differently. Some say that the interests of the physician can never legitimise an exception from medical confidentiality, even where the silence requires heroic efforts, as only the law can provide for exceptions to the principle of confidentiality, and as such exceptions can only be justified with reference to the protection of overriding public interests. Therefore, in the absence of such express legislative exceptions in favour of the physician's defence rights, no breach of medical confidentiality by the physician

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[101] Anzalec, Gaz. Pal. 1971.113.
[102] Pradel, JCP.1969.I.2234.
[103] Mazen, Gaz. Pal. 1981.2.491; Honnorat, Melennec, JCP.1979.I.2936; Peytel, Gaz. Pal. 1952.2.doctr.13; different Monzein, D.1984.chron.9.
[104] Loiret, *La Théorie du Secret Médical*, at 121-122.

would be justified.[105] A medical practitioner cannot legitimately breach the professional secret on the grounds of trying to avoid moral harm, e.g. protecting his professional integrity or honour, or to avoid a criminal conviction.[106] This is how the conflict has sometimes been decided in the past, when some courts held that the physician, when being accused of a criminal offence, did not have the right to reveal confidential information necessary for his defence.[107] Others do not go this far but argue instead that only revelations for the mere purpose of avoiding potential liability or for any other reason with regard to purely economic interests of the physician should be punished.[108]

Another opinion states that the physician generally has the right to defend him/herself in court with regard to accusations made by his/her patient without being bound to maintain medical confidentiality, as the opposite conclusion would violate the rights of the parties to court proceedings.[109] The principle of defence rights has a legal foundation in art.171-1 Code of Criminal Procedure and in the European Convention on Human Rights. As a fundamental right, defence rights justify a violation of the medical secret.[110]

It can be seen that many different theories are promoted with regard to the question of whether or not the physician's defence rights outweigh the patient's interests in medical confidentiality. While the courts have adopted a very broad interpretation of defence rights and even justify a disclosure whenever the physician is asked to give an explanation for potential misconduct, the positions of legal scholars mainly fall into three different categories. For some, defence rights always trump medical confidentiality, and this seems so clear that the promoters of this view did not perceive any need to justify their view other than by referring to the human rights status of defence rights. This, however, can hardly be a sufficient explanation, given that medical confidentiality is equally protected as a fundamental human right, for example by the European Convention on Human Rights. For defence rights to outweigh medical confidentiality, it would therefore be necessary to present reasons why defence rights are of higher value. Others take the opposite view and argue that the physician's defence rights

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[105] Savatier, Auby, Savatier, Péquignot, *Traité de Droit Médical*, at 304.
[106] Légal, JCP.1948.II.1582.
[107] Trib corr. d'Amiens, 12 March 1902, D.1902.2.493; CA d'Aix, 19 March 1902, D.1903.2.451.
[108] Anzalec, Gaz. Pal. 1971.113.
[109] Mazen, Gaz. Pal. 1981.2.491.
[110] Thouvenin, *Le Secret Médical et l'Information du Malade*, at 99-100.

can under no circumstances justify a disclosure of confidential patient information. This opinion is based on the rather formalistic view that the Criminal Code does not expressly provide for an exception to the principle of medical confidentiality where it is in conflict with the physician's defence rights. Again, this opinion is difficult to justify on that basis alone, as it is at least arguable that in some cases the breach of medical confidentiality could be justified by the legal justifications of self-defence or necessity, or by overriding fundamental interests of the physician. Given that under French law, in such cases two fundamental interests clash, the third approach which suggests some balancing seems most in line with traditional legal principles. However, such a balancing approach would require an identification of the conflicting interests involved as well as of their respective values. The discussion as outlined above seems to suggest that such an analysis or any agreement on the outcome of such a balancing is lacking, and that most writers rather base their arguments on personal preferences and values, without any reference to ethical principles and theories.

It is interesting to note that the solutions suggested to resolve the conflict seem to be detached from the theories of the absolute or relative nature of the medical secret. Some try to analyse the problem in accordance with the different theories, stating that if medical confidentiality were based on the intention to protect the trust the public invests in the medical profession, it is a rule of l'ordre public and the secret is absolute, so that it has to be respected even if the physician's silence harms his/her own or the patient's interests. If, on the other hand, medical confidentiality aimed to protect the patient who has confided medical secrets in his/her physician, the rule would exist in the private interest of the patient, and the secret would be relative The patient could then relieve the physician from the obligation,[111] but without such consent, a breach of confidentiality would not be justified. According to this analysis, both the theory of an absolute nature of the medical secret and the theory of a relative nature of the medical secret would thus come to the result that the physician's defence rights cannot outweigh medical confidentiality. However, there is one decisive difference between the relativist and the absolutist approach, in that according to the theory of the relative nature of the medical secret, the patient's consent would allow the physician to use

[111] Rassat, *Droit Pénal Spécial*, at 376.

confidential medical information for his/her defence, while this would not be possible under the theory of the absolute nature of the medical secret.

It follows from this debate that the courts, when allowing the physician's defence rights to outweigh the obligation to medical confidentiality, seem to contradict their own view of the absolute nature of the duty to maintain medical confidentiality.[112]

2.4. Effects of the patient's consent

Situations can arise in which a physician is called as a witness and in which the patient consents to the revelation of his/her confidential medical information by the physician in court. The patient may be the accused and may want to prove certain medical facts beneficial to his/her defence, or the patient could be the victim of a criminal offence and may want the physician to give testimony regarding his/her injuries. Even if the patient is neither accused of having committed a crime nor victim of a criminal offence, medical information concerning this patient can still be important for the outcome of a criminal case and the patient might want it to be available to the court through the testimony of his/her physician. Two questions can arise in this context: (1) can the patient validly relieve the physician from his/her obligation to medical confidentiality so as to enable the physician to give testimony with regard to confidential patient information without being subjected to the punishment laid down in art.226-13 criminal code; and (2) if question 1 is answered in the affirmative, can the physician invoke medical confidentiality and deny a revelation of confidential patient information if the patient has consented to or even required that revelation?

With regard to the question of the effect of the patient's consent, opinions are split. To understand the debate, it seems important to mention that in French criminal law, consent of the victim normally does not provide a legal justification for the criminal offence. The reason behind this is that criminal law does not primarily intend to safeguard individual interests, but rather aims at maintaining the social and public order, even though this may indirectly promote individual

[112] 20 December 1967, D.1969.309; see also Damien, *Le Secret Nécessaire,* at 36.

interests.[113] However, in respect of a criminal offence protecting interests that are at the free disposition of the victim, the victim's consent omits one of the constituent elements of the crime, so that the criminal offence cannot be committed where the victim has consented to it.[114] Thus, if medical confidentiality were at the free disposition of the patient, the patient's consent could have the effect of negating one constituent element of the offence of art.226-13 Criminal Code. If, on the other hand, medical confidentiality were not at the free disposition of the patient, the patient's consent could not relieve the physician from the obligation of medical confidentiality, and a physician, revealing confidential patient information with the patient's consent, would still be guilty of the criminal offence under art.226-13 Criminal Code. The attitude of the criminal courts is clear:

> 'The duty to maintain confidentiality, established and sanctioned by art.378 [old Criminal Code] to guarantee the confidence necessary for the exercise of certain professions, is imposed on physicians as a duty in relation with their position, it is general and absolute and no one can relieve the physician from it.'[115]

French courts have made it clear that the notion of 'no one' includes the patient him/herself, so that the physician's obligation to medical confidentiality is not at the disposition of the patient. The patient therefore does not have the right to relieve the physician from his/her duty to medical confidentiality. An important consequence of the principle of the general and absolute nature of the obligation to maintain medical confidentiality is therefore that the criminal offence of breach of secrecy can be committed even if the patient gave his/her consent to the physician's disclosure. In this respect, the criminal courts do not make any distinction between cases in which the patient was accused in criminal proceedings and called the physician as a defence witness, and all other cases including those in which the patient was the victim of a criminal offence.

In its decision of 8 May 1947, the Cour de Cassation had to decide the case of a physician who refused to give testimony in court with regard to observations already laid down in a medical certificate that had been handed out to the victim.

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[113] Stefani, Levasseur, Bouloc, *Droit Pénal Général*, at 318.
[114] Légal, JCP.1948.II.4141; Mazen, Gaz. Pal.1981.2.491; Waremberg-Auque, Revue de science criminelle et de droit pénal comparé 1978, at 246.
[115] See, for example, 8 May 1947, JCP.1948.II.4141; 22 December 1966, D.1967.122; 7 March 1989, Bull n° 109 ; 16 December 1992, Bull n° 424; 8 February 1994, Gaz. Pal.1994.somm.298.

In that case, a physician was called by the parents of a girl, victim of an indecent assault, to examine their daughter. Upon the parents' request, he delivered a medical certificate with regard to his diagnosis and findings, but refused to give testimony in court with regard to the same observations. The Cour de Cassation held that given the general and absolute nature of the physician's obligation to medical confidentiality, he did not have to give testimony even though the victim's parents had consented to the revelation.[116] This was confirmed in a recent decision in which the Cour de Cassation decided that a physician who had examined a rape victim under the age of fifteen, was, when being called as a witness to give testimony with regard to the diagnosis and the medication prescribed, free to decide whether or not to give testimony even though the victim or the victim's parents had consented to the revelation.[117] Critics of these decisions argue that if the requested testimony is no more than a repetition of observations contained in a medical certificate, the physician should not be allowed to refuse to give testimony with regard to the same facts on the grounds that he/she was bound by an obligation to medical confidentiality,[118] particularly bearing in mind that the patient has a right to demand the delivery of such a certificate.[119] It seems here that different problems are being mixed up: the critique seems to be based on the assumption that the information in such a situation is no longer secret, rather than supporting the view that the physician is under an obligation to give testimony where the patient has relieved him/her from his/her duty to medical confidentiality.

Another case the Cour de Cassation had to decide was that of a woman who was accused of having stabbed her husband to death. She called her treating physician as a defence witness and gave her consent to a revelation of the confidential details regarding her medical treatment. When the physician refused to give testimony, invoking his obligation to medical confidentiality, the court repeated its formula of the general and absolute nature of the obligation to maintain medical confidentiality and concluded that the patient's consent to the revelation could not relieve the physician from this obligation.[120] In yet another decision in which a physician was called as a defence witness and in which the accused

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[116] JCP.1948.II.4141.
[117] 16 December 1992, Bull n° 424.
[118] Légal, JCP.1948.II.4141.
[119] Savatier, JCP.II.15126.
[120] 22 December 1966, D.1967.122.

patient had consented to the physician's testimony about confidential medical facts, the Cour de Cassation stated that :

> 'The court cannot determine for the physician in which cases the revelation of confidential information is appropriate. Consent of the accused cannot be seen as a justification taking away the criminal nature of a revelation of confidential information. The refusal of the instance court to force a physician called as a defence witness by the accused to give testimony with regard to confidential information referring to the accused, when the physician invoked the medical privilege, was a correct application of the law. The principle that medical confidentiality is general and absolute ... applies to everybody without any distinction between witnesses of the prosecution and witnesses of the defence.'[121]

An analysis of this decision shows that the Cour de Cassation again confirmed the principle of the general and absolute nature of the medical secret, and that it inferred from this principle that medical confidentiality cannot be at the disposition of the patient, so that the patient cannot validly relieve the physician from this obligation. More importantly, however, the first sentence of the quote could be read as giving the physician a choice to decide whether or not to give testimony in a situation in which the patient has consented to a revelation of his/her confidential medical information and even requested the revelation for his/her defence. Thus, the court seemed to indicate that a revelation would under these circumstances not be regarded as a violation of the principle of medical confidentiality, but that the decision whether or not to give testimony was rather exclusively in the hands of the physician. Legal scholars approving of this case law and trying to explain the reasoning behind it argued that as the protection of medical confidentiality is not exclusively based on the interest of the patient, it follows that the patient cannot have the right to relieve the physician from an obligation that is imposed on him/her in the public interest.[122] If the obligation to medical confidentiality exists in the public interest of protecting the confidence of the public in the secrecy of the medical profession, it does not seem appropriate that the patient can relieve the physician from his/her obligation to confidentiality, as potential patients could be worried when seeing a physician reveal confidential patient information in court.[123] But how can it then be explained that the physician is given the choice between maintaining confidentiality and disclosure? It must

[121] 5 June 1985, Bull n° 218.
[122] Combaldieu, D.1967.122.
[123] Rassat, D.1989.chron.107.

certainly be more worrying for patients if it is left to the physician to decide whether or not to disclose information.

Another argument supporting the view that the patient's consent cannot relieve the physician from his/her duty to confidentiality is that valid consent must be informed and freely given. Therefore, one can only validly relieve someone from a duty of confidentiality with regard to a secret the content of which one knows perfectly well. However, sometimes, for humanitarian reasons, the physician will not reveal the whole truth to the patient so that the patient who relieves the physician from his/her duty to confidentiality cannot fully appreciate the range of this consent.[124] But this problem could be avoided if the physician, when relieved by his/her patient from the duty to medical confidentiality, interpreted this authorisation as only including what is known to the patient.[125] It should also be noted that this rather paternalistic argument loses a lot of force when bearing in mind that the patient has a right of access to his/her medical records, and a right to be informed by the physician about his/her medical condition.

Yet another worry of the opponents of the patient's right to relieve the physician from his/her obligation to medical confidentiality is that it would follow from such a right that a patient's refusal to consent to a revelation could raise suspicions regarding his/her guilt. As a consequence, a patient might feel forced into waiving his/her right to medical confidentiality and allow a revelation just to avoid negative conclusions a court could draw from his/her reluctance to consent to disclosure.[126] Others, admitting this risk, demand that the courts and the law ensure that the patient be free from any pressure to consent to a revelation of his/her medical confidences. They suggest that in situations where the patient is the accused, only the patient him/herself but not the prosecution should have the right to call the physician as a witness. To deny the accused patient to call the physician as a witness, it is argued, would be a violation of his/her defence rights. If, on the other hand, the prosecution or a third party could call the physician as a witness, this would subject the patient to an inadmissible dilemma: either to refuse consent to the revelation, which could give rise to suspicions on the part of the judge or the jury, or to relieve the physician from the obligation of medical

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[124] Combaldieu, D.1967.122; Mazen, *Le Secret Professionnel des Practiciens de la Santé*, at 57.
[125] Fénaux, D.1988.106; Mazen, *Le Secret Professionnel des Practiciens de la Santé*, at 91.
[126] Loiret, *La Théorie du Secret Médical*, at 105.

confidentiality to avoid this risk, thus exposing him/herself to a revelation of information which was covered by a promise of secrecy.[127] It is submitted that the problem could also be resolved by clarifying that the patient's right not to consent to a revelation of confidential medical information by his/her physician is guaranteed by the right to silence, and that no negative conclusions may be drawn from the exercise of that right.

A totally different argument brought forward is that even if as a result of the patient's consent, the criminal offence of breach of confidence disappeared and the confidant, who decided to speak, could not be penalised, consent would nevertheless not free the physician from the moral duty to medical confidentiality. The supporters of the view that this moral dilemma justifies the physician's refusal to give testimony submit that only the physician, in accordance with his/her conscience, can judge whether or not to give testimony, and that, as a consequence, the patient's consent cannot force the confidant into a breach of his/her silence.[128] When called upon to give testimony, the physician must assess the patient's interests according to his/her conscience. If his/her testimony conforms with these interests, the physician should give testimony under the twofold condition that free and voluntary consent of the patient is given and that in the given case medical confidentiality exclusively promotes a private interest. In the opposite case, the physician has to remain silent.[129] However, the whole argument seems dubious. The possible moral dilemma evoked here seems to stem from a very paternalistic view of the physician's role, as it implies that the physician knows better than the patient what the patient's interests are.

For those who support the opinion that medical confidentiality is a principle that aims at protecting the interests of the patient, the patient's consent to a revelation of confidential medical information is of the utmost significance. Some argue that if the patient has consented to the revelation, it is no longer punishable because the revelation no longer concerns a confidential fact.[130] According to this view, consent of the master of the confidence omits one of the prerequisites of the incrimination, the existence of a secret. As the patient can always reveal his/her confidential facts, the patient is the master of his/her medical confidences and the

[127] Savatier, JCP.II.15126; Savatier, Auby, Savatier, Péquignot, *Traité de Droit Médical*, at 303.
[128] Légal, JCP.1948.II.4141.
[129] Pradel, JCP.1969.I.2234.
[130] Mazen, *Le Secret Professionnel des Practiciens de la Santé*, at 90.

only judge of his/her interests. The interest in medical confidentiality is therefore at the free disposition of the patient.[131] Thus, it seems logical to recognise that it lies with the patient alone to release the physician from the obligation to medical confidentiality.[132] To interpret art.226-13 Criminal Code so as to stand in the way of the physician's testimony is contradictory, as the provision only sees the physician as a trustee of the patient's secret so that it should follow that the patient has the right to require from the physician respect for the ownership of his/her confidence.[133] Some therefore conclude that the patient's consent not only authorises the physician to reveal confidential information, but also obliges him/her to do so, so that the physician no longer has the right to refuse to give testimony once the patient has consented to the revelation.[134] According to this view, once the master of the secret has consented to the revelation, there is no longer a duty to confidentiality, and not even a right to maintain medical confidentiality, as there is no longer a secret to be silent about. The professional can only refuse disclosure as long as the constituent elements of the criminal offence are fulfilled.[135] This approach has also been adopted by a civil court that decided on 7 June 1955:

> 'The considerations justifying the general and absolute nature of the medical secret as being in the public interest apply to the relations between the physician and everybody apart from the patient, so that they cannot be invoked with regard to the physician-patient relationship.'[136]

The civil chamber of the Cour de Cassation and also the Conseil d'Etat recognise that the patient may give consent to a disclosure of his/her own medical secrets by the physician. To prove medical facts in front of these courts, the patient can either produce a medical certificate or call the physician as a witness who then does not have the right to hide behind medical confidentiality.[137]

The decisions of the criminal courts have the effect that medical confidentiality is turned directly against the patient instead of working in his/her favour. Not only does this application of the provisions protecting medical confidentiality deny the patient any autonomous decision regarding his/her confidences. Also, this case-

[131] Waremberg-Auque, Revue de science criminelle et de droit pénal comparé 1978, at 246.
[132] Légal, JCP.1948.II.4141; Savatier, Auby, Savatier, Péquignot, *Traité de Droit Médical*, at 303.
[133] Savatier, JCP.II.15126.
[134] Fénaux, D.1988.106.
[135] Waremberg-Auque, Revue de science criminelle et de droit pénal comparé 1978, at 249-251.
[136] Trib. civ. de la Seine, D.1955.588.
[137] Honnorat, Melennec, JCP.1979.I.2936.

law stands in direct conflict to the case-law that upholds the physician's defence rights. Thus, the Cour de Cassation has denied the patient the right to prove his own secrets with the help of the physician, while allowing the physician to defend him/herself by revealing someone else's confidences. Given the fundamental value of defence rights, it is surprising that the promoters of the general and absolute nature of medical confidentiality seem to think that the interests thereby protected are not adversely affected if the physician reveals the secrets to defend him/herself, but that the assessment changes dramatically where the patient wants to defend him/herself with the help of the physician. If medical confidentiality is mainly aimed at a protection of the patient's privacy or health care interests, it is difficult to see a good reason for denying the patient the right to compel the physician to testify in favour of the accused patient regarding the patient's own medical secrets. The patient's privacy and health care interests may rather be adversely affected where the physician reveals the patient's medical secrets in his/her own defence. If medical confidentiality intends to protect the public interest in promoting health, then again it is difficult to see how society or individual patients could lose their trust in the secrecy of members of the medical profession where they disclose confidential information with the patient's consent. Again, the situation may be rather different where the physician makes the disclosure for the purpose of defending him/herself in criminal court. And if medical confidentiality aims to assist the physician in fulfilling his/her role, as without a guarantee of confidentiality, patients may be reluctant to seek advice and help or fully to reveal the information necessary for effective treatment, it is again difficult to understand how this interest can be harmed where the physician discloses secrets with the patient's consent. The only possible reason behind the courts' rulings seems to be the paternalistic view that physicians know better than their patients when to disclose confidential facts and when to refrain from doing so. If this were true, it would make sense to give the physician the choice between protecting medical confidentiality even where the patient has waived his/her interest in keeping the information secret, while the patient should not be in a position to compel the physician to disclose medical secrets. It has been argued, however, that one can expect from the physician, in addition to caring for the body of the patient and to not harming the patient by indiscreet revelations, to protect the patient when at risk and therefore to serve, if need be, as the patient's

witness with regard to the patient's secrets. If the confidence is turned against the patient, this constitutes a real breach of trust on the part of the physician.[138] Some have thus concluded that the case-law very clearly demonstrates the inhuman and inadmissible consequences of attaching a 'general and absolute' nature to the medical secret.[139] The case-law mainly creates two problems: it applies different standards to the defence rights of the physician and to those of the patient, and it disregards the patient's right to decide whether his/her medical secrets should be kept confidential or be disclosed.[140]

2.5. Obligation to disclose certain information

Under certain circumstances, citizens are under a legal obligation, the contravention of which constitutes a criminal offence, to disclose certain facts to the judicial or administrative authorities. In the context of criminal proceedings, three different situations can be of relevance: disclosure for the purpose of crime prevention, disclosure in cases of child neglect and abuse, and disclosure of information regarding the innocence of a person who is under arrest or was convicted for a crime. Where a physician has received such information in the course of exercising his/her profession, a conflict between the obligation to disclose and the obligation to maintain medical confidentiality arises.

2.5.1. Crime prevention

Art.434-1 Criminal Code determines the circumstances under which the non-disclosure of information for the purpose of crime prevention amounts to a criminal offence, in stating that:

> A person who has information about a crime the commission of which can still be prevented or the effects of which can still be limited, or the authors of which are likely to commit future crimes that could be prevented, and does not inform the judicial or administrative authorities will be punished with three years of imprisonment and a fine of F 300 000. ...

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[138] Pradel, JCP.1969.I.2234.
[139] Savatier, JCP.II.15126; see also Mazen, *Le Secret Professionnel des Practiciens de la Santé*, at 90; Merle, Vitu, *Traité de Droit Criminel*, at 183.
[140] Pradel, JCP.1969.I.2234; Waremberg-Auque, Revue de science criminelle et de droit pénal comparé 1978, at 249-251.

> The persons subjected to the professional secret by art.226-13 are exempt from the dispositions of the first paragraph.[141]

It can thus be seen that every citizen is, in principle, under an obligation to disclose information about a criminal offence to the police if its commission, its effect or the commission of future crimes can be averted. The Criminal Code provision introducing this obligation, however, expressly exempts physicians from this duty to disclose. What, then, is the relationship between the obligation to maintain medical confidentiality, on the one hand, and the obligation to disclose, on the other hand? Given that Art.434-1 Criminal Code exempts the physician from the obligation to disclose, while art. 226-13 Criminal Code does not exempt the physician from the obligation to maintain medical confidentiality where a disclosure is necessary for the purposes of crime prevention, one could think that, similar to the conflict between art.226-13 Criminal Code and the obligation to give testimony in criminal court under art.109 Code of Criminal Procedure, there is no real conflict of duties and the obligation of medical confidentiality from which no exemption applies should therefore prevail. However, this is not the solution suggested for this particular conflict. In 1973, the Secretary of Justice, when asked about the application of art.62 old Criminal Code (which laid down an obligation to disclose information for the purposes of crime prevention and in cases of child abuse), declared that:

> 'The legislation wanted to leave it to the person bound by the secret to decide, according to his conscience, which conduct to adopt in every individual case, and to decide whether the obligation to disclose justifies or does not justify the revelation of confidential information. An imperative solution could, in some cases, put at risk the necessary trust in those who receive secrets or confidences, and, in other cases, prevent the denunciation of facts that endanger third parties or the patient himself.'[142]

However, art.62 old Criminal Code did not exempt physicians from the general obligation to disclose, so that the situation differed from the current situation in that under the old Criminal Code, there was in fact a proper conflict of duties for which a solution had to be found. In his report for the Assemblée Nationale,[143] François Colcombet nevertheless voiced the opinion that under the new regime of

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[141] Art.434-1: Le fait, pour quiconque ayant connaissance d'un crime dont il est encore possible de prévenir ou de limiter les effets, ou dont les auteurs sont susceptibles de commettre de nouveaux crimes qui pourraient être empêchés, de ne pas en informer les autorités judiciares ou adminstratives est puni de trois ans d'emprisonnement et de 300 000 F d'amende.

[142] Quoted from Chomienne, Guéry, ALD.1995.comm.85.

[143] JOAN 26 September 1991, at 2244.

arts.434-1, 434-3 and 434-11 Criminal Code it was still desirable to leave the professional the choice to decide according to his/her conscience, in every individual case, which conduct to adopt. At the moment, in the absence of case-law regarding the conflict between the two obligations under the new Criminal Code, it is difficult to assess whether or not the courts would agree and give the physician the free choice between the obligation to maintain the patient's confidence and the obligation to disclose. It is submitted that the only consistent solution would be to accept the legislator's decision that the obligation of medical confidentiality to which no exemption was adopted, should have prevalence over the obligation to disclose information for the purpose of crime prevention. Any disclosure would then be assessed according to the normal criteria, that is it would have to be established whether or not a criminal justification applies.

With regard to disclosure for the mere purpose of criminal prosecution, it was argued that it cannot be the role of the physician to hand the patient over to the police, whatever his/her crime. Every individual must have the possibility of receiving medical treatment without having to fear to be denounced to the police by his/her physician.[144] If the physician holds information regarding the consequences of a crime that has already been committed, he/she has to maintain confidentiality.[145]

2.5.2. Child abuse

Art.434-3 Criminal Code imposes an obligation on every citizen to disclose information about abuse of children or other vulnerable person to the relevant authorities. Again, there is an exemption from this obligation for medical professionals. The provision states as follows:

> A person who has knowledge about ill treatment of or hardship inflicted on a child of less than fifteen years of age or on a person who is not able to take care of him/herself because of his/her age, illness, handicap, physical or mental defect, or pregnancy, and does not inform the judicial or administrative authorities will be punished with three years of imprisonment and a fine of F 300 000.

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[144] Mazen, *Le Secret Professionnel des Praticiens de la Santé*, at 121.
[145] Pradel, JCP.1969.I.2234.

> The persons subjected to the professional secret by art.226-13 are exempt from the dispositions of the first paragraph, unless otherwise stated by law.[146]

This provision must be seen together with art.226-14 Criminal Code which lists certain situations in which a physician is free to disclose confidential information without being subjected to the punishment foreseen in art.226-13. Art.226-14 states to that effect that:

> Article 226-13 is not applicable in cases where the law requires or authorises the disclosure of the secret. In addition, it is not applicable:
>
> 1. to a person who informs the judicial, medical or administrative authorities of any abuse or neglect which has come to his/her knowledge and which was inflicted upon a minor of less than 15 years or upon a person incapable of protecting him/herself on the grounds of his/her age, or physical or mental condition.[147]

The conflict relating to the competing obligations of disclosure and of maintaining confidentiality is thus different from the conflict between the obligation to disclose for the purpose of crime prevention and the obligation of medical confidentiality, as the physician is here exempted from both obligations. In this situation, it can thus not be said that the obligation to maintain confidentiality was regarded as more important by the legislator, and that any disclosure of confidential patient information related to child abuse will constitute a violation of the duty of confidentiality. All authors who have discussed the conflict between arts.226-14 and 434-3 Criminal Code seem to agree that in this case of a real conflict of duties, one should refer to the case-law concerning the provisions of the old Criminal Code[148] and leave the physician the choice as to which obligation to fulfil in each case.[149] This approach has been confirmed by the Cour de Cassation in its decision of 8 October 1997.[150] Thus, if the physician decides to

[146] Art.434-3: Le fait, pour quiconque ayant eu connaissance de mauvais traitements ou privations infligés à un mineur de quinze ans ou à une personne qui n'est pas en mesure de se protéger en raison de son âge, d'une maladie, d'une infirmité, d'une déficience physique ou psychique ou d'un état de grossesse, de ne pas en informer les autorités judiciaires ou administratives est puni de trois ans d'emprisonnement et de 300 000 F d'amende.
Sauf lorsque la loi en dispose autrement, sont exceptées des dispositions qui précèdent les personnes astreintes au secrets dans les conditions prévues par l'article 226-13.

[147] Art.226-14: L'article 226-13 n'est pas applicable dans les cas où la loi impose ou autorise la révélation du secret. En outre, il n'est pas applicable:
1. À celui qui informe les autorités judiciares, médicales ou administratives de sévices ou privations dont il a eu connaissance et qui ont été infligés à un mineur de quinze ans ou à une personne qui n'est pas en mesure de se protéger en raison de son âge ou de son état physique ou psychique.

[148] See, for example, 28 February 1963, CA Aix en Provence, Gaz. Pal. 1963.2.122.

[149] Rassat, *Droit Pénal Spécial*, at 380.

[150] Bull. n°329.

disclose confidential information, he/she will not commit the offence under art.226-13; and if he/she decides to remain silent, he/she will not commit the offence of breaching an obligation to disclose under art.434-3. While disclosure serves as a justification for a violation of confidentiality, the obligation of confidentiality serves as a justification for non-disclosure.[151] Some reach this conclusion by interpreting art.226-14 Criminal Code as giving an authorisation to reveal information, not an order to do so, so that the physician remains free to decide according to his/her conscience whether to speak up or to keep quiet.[152] The decision of giving the physician the free choice between the two competing obligations has been explained by arguing that it is the sole solution that is in conformity with the intention of the legislator and that it is justified by the concern to avoid that the authors of these cruelties not consult a physician for fear of risking a prosecution, thus not seeking medical treatment for the victim. On the other hand, it must be borne in mind that it is in the interest of the victim that the physician has the right to intervene if he/she thinks that it is necessary.[153]

2.5.3. Protection of the innocent

Another obligation to disclose information exists in the following situation. Art.434-11 Criminal Code states:

> A person who has evidence of the innocence of a person who is under arrest for investigation or has been convicted for a crime or misdemeanour, and voluntarily refrains from immediately informing the judicial or administrative authorities will be punished with three years of imprisonment and a fine of F 300 000. ...
>
> The persons subjected to the professional secret by art.226-13 are exempt from the dispositions of the first paragraph.[154]

The legal situation regarding the conflict between medical confidentiality, on the one hand, and the interests of someone who is under arrest for investigation, or has been convicted for a criminal offence he/she did not commit, is similar to that

[151] Roujou de Boubée, Bouloc, Fancillon, Mayaud, *Code Pénal Commenté*, at 767.
[152] Pradel, Danti-Juan, *Droit Pénal*, Tome III, at 237 and 239; Véron, *Droit Pénal Spécial*, at 135.
[153] Roujou de Boubée, Bouloc, Fancillon, Mayaud, *Code Pénal Commenté*, at 404-405.
[154] Art.434-11: Le fait pour quiconque connaissant la preuve de l'innocence d'une personne détenue provisoirement ou jugée pour crime ou délit, de s'abstenir volontairement d'en apporter aussitôt le témoignage aux autorités judiciares ou administratives est punis de trois ans d'emprisonement et de 300 000 d'amende. ...
Sont également exceptées des dispositions du premier alinéa les personnes astreintes au secret dans les conditions prévues par l'article 226-13.

of the conflict between medical confidentiality and disclosure for the purpose of crime prevention. While the physician is exempt from the obligation to disclose information to protect the innocent person, he/she is not for that purpose exempt from the obligation of medical confidentiality. Therefore, here again the preference of the legislator for medical confidentiality seems unequivocal and does not seem to leave the physician any choice.[155] However, while the courts did not as yet have to deal with that question, most scholars agree that the balancing of the interests involved very clearly favours the interests of the innocent and that the obligation to maintain medical confidentiality cannot be used as a justification for the criminal offence of refusing to give testimony in favour of an innocent person. Pradel, for example, argued in his commentary to a decision involving the professional secret of social workers that the only situation in which social workers do not have a choice but rather have to give testimony is where their testimony would allow to establish the innocence of a person unfairly detained or convicted.[156] Even those promoting the view that exceptions to the principle of medical confidentiality can never be justified by the countervailing interests of third parties, not even where silence requires heroic efforts, submit that the only exception acceptable for the benefit of an overriding public interest is the situation where the physician breaches medical confidentiality in favour of an innocent who was wrongly detained and suggest that in such a case, the physician is under no duty to medical confidentiality.[157] Some distinguish: if the patient is the real perpetrator, the revelation is less acceptable than where the perpetrator is a third party, given that a disclosure is then particularly harmful to the patient and, accordingly, cannot be justified.[158] On the other hand, it has been conceded that the physician's silence manifestly violates good morals and l'ordre public and that in order to reconcile the competing interests, the physician would have to disclose those facts establishing the innocence of the detainee, without exposing the identity of the real perpetrator, at least where the patient objects to the denunciation of the real perpetrator.[159] This solution may not always lead to satisfactory results, as the physician's allegation is then not amenable to any proof.

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[155] Rassat, *Droit Pénal Spécial*, at 381.
[156] Pradel, D.1978.354; see also Mazen, *Le Secret Professionnel des Praticiens de la Santé*, at 131.
[157] Savatier, Auby, Savatier, Péquignot, *Traité de Droit Médical*, at 306.
[158] Pradel, JCP.1969.I.2234.
[159] Anzalec, Gaz. Pal. 1971.113.

The opinions voiced with regard to the resolution of the conflict between the protection of the innocent and the medical secret of a patient seem hardly convincing. First, most of the arguments ignore the fact that the physician is not under conflicting legal obligations which allow for a balancing of interests to take place. Secondly, the discussion shows that most commentators are not entirely clear about the value of the conflicting interests at stake. While it is understandable, though not academically convincing as long as no reasons are presented, that some people may value the freedom of a wrongly accused person more than medical confidentiality, it is difficult to comprehend why it makes a difference whether or not it is the patient who committed the crime for which the innocent person is wrongly detained. This view seems to be based on the fear that the physician-patient relationship may be harmed more where the physician denounces the patient than where the physician denounces a third person who stands outside of the physician-patient relationship. But it is submitted that this does not necessarily have to be the case, as the patient may be as interested in protecting a close friend or relative from criminal prosecution as in his/her own protection. This solution also seems to suggest that the reason behind medical confidentiality is neither the patient's interest in controlling the dissemination of confidential personal information, as this interest is as affected where the patient is the perpetrator than where the perpetrator is a third person. Nor can the interest protected be the public interest in encouraging patients to seek medical treatment to enhance public health, as again, the interest the physician has violated is the same in both cases. It could only make a difference who committed the offence if medical confidentiality were to protect the physician from having to breach medical confidentiality where the disclosure might harm the patient. This demonstrates a rather paternalistic approach as it is then not the patient who decides what will or will not harm him/her. It is submitted that if one is of the opinion that the interests of the innocent are more important than the interests in medical confidentiality, and that French law leaves scope for a balancing of interests to take place, it cannot make a difference whether the patient or someone else committed the offence.

The offence of Art.434-11 must be committed voluntarily, which presupposes perfect knowledge of the innocence of the accused.[160]

2.6. Admissibility of the physician's testimony

Courts usually recognise that if the physician's testimony constitutes a breach of the duty to confidentiality, it must be disregarded.[161] Thus, if the physician surpasses the limits of a permissible revelation, the judge can neither accept it as evidence nor use evidence already collected this way, as a classic principle of criminal law excludes all evidence acquired in an illegitimate way.[162] Nevertheless, in a decision of 15 December 1942, the Cour de Cassation accepted medical testimony of a physician because the accused had not voiced any opposition to the interrogation of the witness in the course of the preliminary proceedings.[163]

Not every statement made by a witness who is under an obligation to medical confidentiality violates art.378 and entails the nullity of the record of the statement and of the proceedings. Rather, this consequence only applies if the statement consists of the revelation of protected information.[164]

2.7. Search for and seizure of medical records

The search for and seizure of confidential patient documents are governed by the provisions of the Code of Criminal Procedure. According to art.56 Code of Criminal Procedure, the domicile of third parties to the crime under investigation can be searched by officers of the criminal investigation department for papers, documents and other objects relating to the incriminating facts. He/she is, however, under the obligation to observe all measures necessary to ensure that the professional secret be respected. Given that this provisions is aimed at searches at the residence of persons, it is difficult to imagine that it will frequently be of relevance in cases of a search for a physician's medical records.

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[160] Roujou de Boubée, Bouloc, Fancillon, Mayaud, *Code Pénal Commenté*, at 779-780.
[161] Légal, JCP.1948.II.1582.
[162] Pradel, JCP.1969.I.2234; Thouvenin, *Le Secret Médical et l'Information du Malade,* at 117-118.
[163] Thouvenin, ibid.
[164] 15 September 1987, JCP.1988.II.21047.

The Code also contains provisions specifically designed to regulate the search of a physician's surgery. Thus, art.56-1 Code of Criminal Procedure states in paragraph 2:

> A search in a surgery ... is executed by a magistrate in the presence either of a responsible member of the professional order or organisation to which the person concerned belongs, or of his representative.[165]

And art.97 Code of Criminal Procedure provides:

> If, in the course of the investigation, there is a good reason to search for documents, subject to the needs of the investigation and to the respect, if relevant, for the obligation laid down in paragraph three of the preceding article, the examining magistrate or the officer of the criminal investigation department determined by him are the only persons who have the right to take knowledge of the content before conducting the seizure.[166]

Art.96(3) Code of Criminal Procedure to which art.97 refers states:

> However, [the examining magistrate] is under the obligation first to observe all reasonable measures to ensure that the professional secret be respected.[167]

The legal situation can thus be outlined as follows: If access to confidential medical information is sought in the course of police investigations, the police can seize confidential medical documents outside the physician's surgery under the conditions mentioned in art.56, i.e. only persons of a certain status can read through the confidential papers and documents. Also, the officer, before performing the search and seizure, must take all measures necessary for the respect of the medical secret (art.56(3)). But it is difficult to know what exactly these measures consist of. If search and seizure take place in a surgery, art.56-1 applies, and the operation must be executed by a magistrate in the presence of a member of the professional organisation the physician belongs to. If access to confidential medical documents is sought in the course of investigations of the examining magistrate, he/she is under the obligation to observe all measures necessary for the respect of professional confidentiality (art.96(3)), and the examining magistrate him/herself or the officer of the criminal investigation

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[165] Art.56-1: Les perquisitions dans le cabinet d'un medecin ... sont effectuées par un magistrat et en présence de la personne responsable de l'ordre ou de l'organisation professionnelle à laquelle appartient l'intéressé ou de son représentant.

[166] Art.97: Lorsqu'il y a lieu, en cours d'information, de rechercher des documents et sous réserve des nécessités de l'information et du respect, le cas échéant, de l'obligation stipulée par l'alinéa 3 de l'article précédent, le juge d'instruction ou l'officier de police judiciare par lui commis a seul le droit d'en prendre connaissance avant de procéder à la saisie.

[167] Art.96(3): Toutefois, il a l'obligation de provoquer préalablement toutes mesures utiles pour que soit assuré le respect du secret professionnel et des droits de la défense.

department specifically determined by him/her are the only persons who have the right to read through the confidential documents before conducting the seizure. Thus, confidential medical documents can be seized in the course of investigations by the police or by the examining magistrate, and the relevant provisions of the Code of Criminal Procedure, apart from making special provisions as to who can conduct the search and examine the material, do not protect such information from state access through search and seizure.

Of course, if confidential patient records can be seized and used in the course of criminal investigations, the state will thereby violate the principle of medical confidentiality. The problem mainly arose in three different situations: (1) the investigation was either directed against the patient, and the examining magistrate sought access to confidential medical documents of the accused patient to establish the truth and to use it as evidence against him/her; (2) the patient was not the accused, but the victim, and confidential medical information was needed as evidence against the accused; (3) or the investigation was directed against the physician, and access to confidential patient information was needed in the course of this investigation, mainly with regard to fraud or tax offences.

Some case-law sheds light on the courts' attitude towards the seizure of confidential medical documents of the accused. In the case of a man who was accused of having killed his wife and who pretended that he had lost consciousness during the efforts of saving her from drowning and who had been hospitalised immediately after the event, the examining magistrate had ordered the seizure of the hospital records to establish whether the accused had in fact been unconscious, or whether he had only simulated unconsciousness. With regard to the question of the lawfulness of the seizure, the Court held that:

> 'Under the circumstances, the seizure does not constitute a violation of the law or of defence rights. The duty to confidentiality does not prevent the examining magistrate from the seizure of all documents or objects needed to establish the truth. The powers of the examining magistrate under art.81 Code of Criminal Procedure[168] are in principle unrestricted.'[169]

[168] Art.81: The examining magistrate conducts, in conformity with the law, all investigative acts he thinks are necessary to establish the truth. (Le juge d'instruction procède, conformément à la loi, à tous les actes d'information qu'il juge utiles à la manifestation de la verité.)

[169] 24 April 1969, JCP 1970.II.16306.

This holding very clearly demonstrates the attitude of French courts which is generally approved of by legal scholars.[170] As the Code of Criminal Procedure does not restrict the examining magistrate's rights to search for and seize confidential medical documents, courts refuse to read these limitations into the code. However, the Court of Appeal of Aix en Provence somewhat mitigated the effects of this case-law. An examining magistrate had, after the refusal of hospital directors to hand over the list of women who had stayed in the gynaecological clinic, himself collected these lists for the purpose of investigating women for illegal abortions. The examining magistrate did not have a more specific suspicion against the women than the fact that they had attended a gynaecological clinic. The Court held that the examining magistrate had illegally obtained information which was outside the scope of his mission, as not every woman staying in a gynaecological clinic has necessarily had an abortion. More importantly, the court continued that the examining magistrate was under an obligation to undertake all measures necessary to respect the professional secret and that this obligation was violated when the magistrate proceeded despite the legitimate objections to the seizure voiced by the hospital directors on the grounds of medical confidentiality.[171]

In a decision regarding confidential medical information of a victim rather than of the accused, the Cour de Cassation has held that judges, when introducing hospital records as evidence in court, necessarily expose facts that are covered by medical confidentiality. Therefore, instead of introducing the records as such, the court argued that it would be more protective of medical confidentiality if judges gave medical experts who have to examine the injured person the mandate to examine the hospital records.[172] This case-law has been criticised. Melennec, for example, stated that the court does not have the power to authorise a medical expert to consult the medical records of his/her colleagues, as a simple mission of expertise could then result in circumventing the principle of medical confidentiality, as well as the safeguards provided by the Code of Criminal Procedure. According to him, the only solution for a judge who wants access to confidential documents would therefore be a seizure of the documents.[173] Pradel suggests a different approach,

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[170] See for example Chappart, D.1969.637.
[171] 28 February 1963, CA Aix en Provence, Gaz. Pal. 1963.2.122.
[172] 20 January 1976, Bull n° 23; 16 November 1976, Bull n° 327.
[173] Melennec, Gaz. Pal. 1980.doct.145.

arguing that the procedure promoted by the courts can be lawful, but only if limited to situations in which the court could also obtain the information directly from the treating physician. Under those circumstances, it is argued, the recourse to an expert is justified because the magistrate does not have the technical knowledge to assess the evidence. However, Pradel limits these restrictions to cases in which medical information of someone other than the accused is concerned, as he thinks that if the investigation is directed against the patient, search and seizure are always legitimate.[174] However, no principles seem to support this view.

The approach adopted toward searches for and seizures of confidential patient records seems to depend largely upon the interpretation of art.96(3) Code of Criminal Procedure. This article could be interpreted as supporting the argument that an invocation of medical confidentiality against measures by the examining magistrate restricts his/her powers, given that he/she is under an obligation to take all necessary preliminary measures to guarantee respect for medical confidentiality. But this is not how art.96(3) is normally understood. Instead, that provision is interpreted to impose upon the examining magistrate the restriction that a search of a physicians' practices can only lawfully be performed in the presence of a member of the Medical Council, but not as prohibiting all searches in surgeries. This interpretation is widely accepted, as many agree that in order to establish the truth, the examining magistrate must be able to have recourse to all means the law puts at his/her disposal. Therefore, no restrictions on the examining magistrate's powers that were not mentioned in the Code of Criminal Procedure should be tolerated.[175] Chappart came to the same conclusion, arguing that the law does not guarantee absolute protection of medical confidentiality, and that the necessity to determine the truth justifies an exception from that protection.[176] Others also agree, stating that even though the search of surgeries is sometimes met with indignation, it is difficult to argue that the protection of medical confidentiality by the Criminal Code could be interpreted so as to allow for an impairment of the interests of criminal justice. According to this view, if medical confidentiality were to prevail over the interests of justice, medical confidentiality

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[174] Pradel, JCP.1969.I.2234.

[175] Thouvenin, *Le Secret Médical et l'Information du Malade*, at 118-119.

[176] Chappart, D.1969.637.

would be placed above the law, when it is the law that has institutionalised the medical secret in the first place.[177]

It can be seen that in the realm of investigative measures under the Code of Criminal Procedure, a balancing of the interest in medical confidentiality, on the one hand, with the interests of justice, on the other hand, is performed, and that the predominant opinion very clearly favours the interests of justice. This is rather surprising when compared to the situation of a physician's testimony in criminal court. As outlined above, where the physician's testimony regarding confidential patient information is sought in criminal proceedings, the law has exempted the physician from the obligation to testify. This demonstrates the legislator's view that in case of a conflict between the obligation to testify in the interests of justice, and the obligation to keep the medical secret, the latter prevails. The Criminal Code thus contains a value decision favouring the interest in medical confidentiality over the interests of justice. In the light of this, the above-mentioned arguments that the interests in medical confidentiality cannot outweigh the interests of justice is inconsistent and unconvincing.

Another consideration sometimes mentioned is that confidential patient records could not be seized, the physician would be given too much power, as with regard to confidential information exclusively known to the physician, it would then be up to him/her to decide whether or not truth-finding is possible in the specific case.[178] As the argument goes, the interests of society, and the interests of the individual imperatively request that criminal justice can be accomplished. However, it is also in the interest of society and the individual that the powers of the examining magistrate are strictly confined to those granted by the law. These two imperatives are reconciled, in that while search and seizure are possible in physicians' surgeries, rigid safeguards apply. The physician cannot object to the search and seizure in his/her surgery. The judge, however, cannot indiscriminately seize all confidential records he/she finds, but the seizure must rather be limited to that which is necessary in the circumstances. Waremberg-Auque has argued, however, that the right to establish the truth cannot prevail over medical confidentiality, as the search for the truth can never legitimise the use of unfair

[177] Mazen, *Le Secret Professionnel des Praticiens de la Santé,* at 144; Melennec, Gaz. Pal. 1980.doct.145.
[178] Thouvenin, *Le Secret Médical et l'Information du Malade*, at 135.

means of collecting evidence. The interests of justice and of society can never paralyse the exercise of primordial human rights such as the right to medical confidentiality.[179]

In cases in which the investigation is directed against the physician, slightly different considerations apply. In one case, a physician had tried to use medical confidentiality to escape accountability by unnecessarily entering non-anonymised patient data into medical records so that, besides the facts relevant for bookkeeping, they also contained the name and the diagnosis of the patients. When asked to make his records available, he refused to do so, invoking his obligation to medical confidentiality. The Court decided that the seizure of the records or the examination of the records by tax officers did not constitute the revelation of confidential medical information.[180] In his commentary, Savatier reasoned:

> 'The secret belongs exclusively to the patient, as do all other details of his intimate life. The court seems to have misjudged the respect owed to the autonomous freedom of the patient who is the only master of his confidences when allowing a revelation of the confidences to the administration and the court as a consequence of a concealment by the physician, even though it was unlawful. In this context, the physician's behaviour is of little importance. One should not treat medical confidentiality as being dependent upon the sanctions which the physician is trying to avoid, given that the confidence which is part of the patient's intimate sphere, does not belong to the physician, but rather to the patient, and given that it is based on the public interest. Confidences are therefore not sufficiently protected by ensuring that they will only be revealed to the closed circle of administrators.'[181]

Savatier continued that the boundaries of the medical secret should be insurmountable, and that the judge should reject the admission of medical records, denying that tax fraud committed by the physician could justify a different approach. He concluded that the prosecution should always refuse to collect as evidence those documents that refer to confidential patient information, as medical confidentiality requires that the patient be given the guarantee that his confidences, when revealed to a qualified confidant, will never be transmitted to any third party. Strangely, in the end Savatier nevertheless approved of the outcome of the decision because the information at issue did not concern the

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[179] Waremberg-Auque, Revue de science criminelle et de droit pénal comparé 1978, at 253 and 256.

[180] 11 February 1960, JCP.1960.II.11604.

[181] Savatier, JCP.1960.II.11604.

patient's intimate sphere. Pradel suggests a different approach. According to him, if a seizure of confidential information takes place in the course of an investigation directed against the physician, the right to seizure is uncontested, but it is limited where the patient has expressly requested that his/her data will not be revealed, as search and seizure must stop in front of the intimate sphere the protection of which is a right of the patient. As search and seizure can only be effected where it is essential for the investigation, they should only be allowed under exceptional circumstances.[182] Melennec, on the other hand, argued that it is obvious that a physician cannot invoke medical confidentiality to cover his/her own irregularities, as medical confidentiality was not introduced for the benefit of the physician, but rather as a right aimed at the protection of the patient's personality rights.[183] It is submitted that this argument can only justify a seizure of confidential patient records where the patient has consented to this measure, as otherwise the patient's personality rights are at risk.

Another question is whether a physician can voluntarily submit medical certificates containing confidential patient information. In that respect, it has been decided on 14 February 1952 that:

> 'With the exception of cases in which a physician acts as an expert witness, he cannot, without failing his professional obligation, deliver a medical certificate containing observations about his patient's condition to a third party, given that the patient is the only person who can legitimately claim the issuance of a medical certificate about his condition to use it according to his own wishes. Therefore, a physician who applies first aid to an accident victim and then delivers the medical certificate regarding the victim's injuries to the police station in charge of the inquiry violates his obligation to medical confidentiality.'[184]

When comparing case-law with regard to the physician's testimony in court with that concerning the seizure of confidential patient information, it seems justified to observe that art.96 Code of Criminal Procedure gives the judge the possibility to circumvent the prohibition of forcing the physician to give testimony in court, by seizing the relevant patient records instead. As has already been discussed, this difference in approach cannot satisfactorily be explained with reference to the prevalence of the interests of justice in general. However, it is possible that it is

[182] Pradel, JCP.1969.I.2234.
[183] Melennec, Gaz. Pal.1980.doct.145.
[184] JCP.1952.II.7030.

based on the thought that the interest in medical confidentiality is affected more seriously when the physician is forced to testify in court, as this involves an active participation of the physician in the disclosure of the medical secret, while in the case of a seizure of medical records, the state obtains access to pre-existing records by the use of compulsion, so that it is at least arguable that the harm done to the physician-patient relationship differs in the two situations under examination. This could also explain why medical records can be seized, but the physician cannot voluntarily hand over the very same records without committing a criminal offence. This protects the physician rather than the patient, as the physician does not actively have to breach the medical secret, while the patient's medical information is still available through the means of search and seizure.

2.8. Summary and conclusion

The Courts as well as the majority of legal writers promote the view that the physician's obligation to maintain medical confidentiality is absolute and that no one can exempt the physician from that duty. However, the protection of medical confidentiality is not as absolute as it may seem. First, the law itself has created exemptions from the physician's obligation to keep the patient's medical secrets. Art.226-14 Criminal Code, for example, provides for an exemption in cases of child abuse and the abuse of other vulnerable persons. Where the physician obtains knowledge of such abuse in the course of his/her profession, he/she is free to decide whether or not to report his/her findings or to maintain medical confidentiality. With regard to the physician's role as a witness in criminal court, art.109 Code of Criminal Procedure exempts the physician from the obligation imposed on all citizens to give testimony in court. Thus, the legislator has clearly demonstrated that in case of a general conflict between the interest in medical confidentiality and the interests of truth-finding in criminal procedures, the interest in medical confidentiality prevails. Therefore, the physician is only allowed to testify in criminal court where a legal justification applies to justify the breach of medical confidentiality. However, the situation is entirely different where the physician's defence rights are at stake. In that case, the courts and the predominant opinion among legal scholars give the physician the right to breach medical confidentiality, as defence rights are regarded as more important than

medical confidentiality. It is interesting that the discussion only focuses on the defence rights of the physician, while the defence rights of the patient or of third parties are not considered. With regard to the patient, the situation is dominated by the view that the patient cannot, by giving consent to the physician's testimony, relieve the physician from the obligation to medical confidentiality. As the physician's obligation to maintain medical confidentiality is absolute, no one, not even the patient can relieve the physician from this obligation. Therefore, the patient's consent will not have the effect of negating the physician's criminal responsibility for a breach of medical confidentiality. As case-law shows, this is so even where the patient wants to use the physician's testimony for defence purposes. Thus, medical confidentiality is more important than the patient's defence rights, but not more important than the physician's defence rights.

Arts.434-1, 434-3, and 434-11 Criminal Code create obligations to disclose information about crimes the effects of which can still be prevented or mitigated, about the innocence of a person under arrest or already convicted, and about child abuse. All three provisions contain an exemption from this obligation for physicians. In the case of child abuse, the physician is thus neither under an obligation to maintain medical confidentiality, as art.226-14 Criminal Code contains an exemption from that duty in such a case, nor under an obligation to disclose the information. The physician is then given a choice as to which obligation to fulfil in the individual case. In the cases of disclosure for the purpose of crime prevention or protection of an innocent detainee, the physician is under an obligation to maintain medical confidentiality, as no exemption applies, but not under an obligation to disclose. While this would seem to make clear the legislator's intention to demonstrate the priority of medical confidentiality, this is not the conclusion drawn by legal writers. The predominant opinion rather promotes the view that the physician should be allowed to decide which obligation to fulfil, and that a breach of one of the obligations should be justified by the conflicting obligation the fulfilment of which caused the breach. It can be seen that while the patient cannot relieve the physician from the obligation to maintain medical confidentiality, the physician's conscience decision can justify a breach of this obligation in case of certain conflicts.

Where a patient's medical records are sought in the context of criminal investigations, the physician is not allowed to hand them over to the police

voluntarily. However, they are not exempt from search and seizure. The sole protection medical confidentiality receives in that context is that some safeguards apply to make sure that only certain designated persons can seize and take knowledge of such records. It is interesting to contrast the almost unlimited powers to seize medical records with the fact that the physician cannot even be forced to testify in criminal court at the patient's request. This means that the patient's medical records can be used by the prosecution against the patient. Where the prosecution's case is thus based on the patient's confidential medical information, the patient cannot compel the physician to testify in order, for example, to give explanations of his/her notes that may be favourable to the accused patient.

It is interesting to note that statutory law very clearly outlines the obligations of the physician, including, in most cases of conflict, which obligation should prevail, and that it is always, with the exception of cases of child abuse, the obligation of medical confidentiality that is given precedence. However, courts as well as legal scholars are far from accepting this approach. Indeed, the predominant interpretation of these statutes confers upon the physician the power to decide how to reconcile the conflict between fundamental individual and public interests, even though these conflicts have been addressed by the legislator. Case-law as well as the academic discussion point towards a very paternalistic approach to the physician's role in the physician-patient relationship as well as in society. Only where the physician thinks that the particular physician-patient relationship, the reputation of the medical profession or the interests of society demand that in a given case the respect for medical confidentiality is more important than the competing interests of justice, will the patient's confidences be protected. On the other hand, where the patient does not have an interest in keeping his/her medical information secret and therefore authorises the physician to disclose such information, this decision will not bind the physician and the physician remains free to decide whether or not disclosure is the best approach to adopt in that specific situation.

Chapter 5 - Medical confidentiality and medical privilege in Germany

1. Protection of medical confidentiality

1.1. Medical confidentiality as a fundamental right

1.1.1. Protection under the German Constitution[1]

The right to medical confidentiality is not expressly guaranteed by th German Constitution (Basic Law - BL); neither is the right to privacy. However, the Federal Constitutional Court (Bundesverfassungsgericht), the highest German court dealing exclusively with constitutional questions, inferred the constitutional protection of personality rights, including the right to privacy, from Arts 2(1) and 1(1) BL, stating as follows:

Art.2(1) BL

> Everyone has the right to the free development of his personality, insofar as he does not violate the rights of others or the constitutional order or the moral law.[2]

Art.1(1) BL

> The dignity of the human person is inviolable. It is the duty of all state authority to have regard to it and to respect it.[3]

The Federal Constitutional Court argued that freedom of self-determination as guaranteed by Art. 2(1) BL could only be exercised effectively if the state refrained from interfering with the private sphere of the individual. The Court also stressed the importance of respecting the individual's intimate and private sphere to preserve his/her human dignity. This reference to Art. 1(1) BL considerably strengthens the protection of the personality right, as human dignity is accorded the highest value under the German Basic Law. According to the Federal Constitutional Court, the personality right following from Art. 2(1) in conjunction with Art. 1(1) BL protects every individual's interest that certain personal and

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[1] The translation of Federal Constitutional Court decisions is partly based on Michalowski, Woods, *German Constitutional Law*, at 117-119.

[2] Art.2(1): Jeder hat das Recht auf die freie Entfaltung seiner Persönlichkeit, soweit er nicht die Rechte anderer verletzt und nicht gegen die verfassungsmäßige Ordnung oder das Sittengesetz verstößt.

[3] Art.1(1): Die Würde des Menschen ist unantastbar. Sie zu achten und zu schützen ist Verpflichtung aller staatlichen Gewalt.

intimate information be kept secret and need not be disclosed. As the Court held in its *Personal Diary Decision:*[4]

> 'The personality right as protected by Art. 2(1) in conjunction with Art. 1(1) BL guarantees in principle the right of the individual to decide him/herself when and to what extent to disclose personal facts, a right which follows from the principle of autonomy.'[5]

With regard to the question of what information is protected by the personality right, the Federal Constitutional Court included, *inter alia*, medical records[6] and medical-psychological reports.[7] In its *Medical Records Decision,*[8] the Federal Constitutional Court explained the operation of the constitutional protection of the right to privacy as follows:

> 'The Basic Law grants every individual an inviolate sphere of private life which is free from state encroachment. The constitutional tenet for respect of the intimate sphere of the individual is based on the right to the free development of one's personality which is guaranteed by Art.2(1) BL. When determining the content and scope of that right, the fact that, according to Art.1(1) BL, human dignity is inviolate and must be protected by all state authority must be taken into consideration. ... However, not the entire private sphere falls under the absolute protection of the basic right under Art.2(1) in tandem with Art. 1(1) BL. The individual as a part of a community rather has to accept state interventions which are based on an overriding community interest under strict application of the principle of proportionality, as long as they do not affect the inviolate sphere of private life.'[9]

The Federal Constitutional Court has thus developed a system whereby the private life of the individual is divided into different spheres, and the extent of protection awarded to the individual's private life depends on the sphere affected by the state intrusion. While the intimate sphere of the individual is inviolate, and can thus not be intruded upon by the state under any circumstances, other spheres of private life, though constitutionally protected, are open to restrictions if the intervention aims at the protection of an overriding community interest. To understand the degree of constitutional protection awarded to medical confidentiality, it is thus important to know which sphere within the realm of private life confidential medical information belongs to. The Federal Constitutional Court clarified this point in the above-cited decision by holding that:

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[4] BVerfGE 80, 367 (1989).
[5] Ibid., at 373; see also the *National Census Case*, BVerfGE 65, 1, 42 (1983).
[6] BVerfGE 32, 373 (1972).
[7] BVerfGE 89, 69 (1993).
[8] BVerfGE 32, 373 (1972).
[9] Ibid., at 379.

'As medical records contain statements regarding the case history, the diagnosis and therapeutic measures, even though they do not concern the inviolate intimate sphere, they nevertheless concern the private sphere of the patient. As such, they are protected against state access by the basic right of Art. 2(1) in conjunction with Art. 1(1) BL. This applies in particular to knowledge of the patient's medical condition that the physician gained in the course of his professional duty and which he laid down in writing. It is not important whether these notes refer to illnesses, ailments or problems the disclosure of which would incriminate the patient, would otherwise embarrass him or would be detrimental to his social reputation. Rather, the wish of the individual to keep free from the view of third parties such highly personal matters as the assessment of his physical condition by a physician in general deserves protection.'[10]

The personality right thus not only guarantees that the individual does not have to disclose embarrassing or detrimental information, but further respects the interest of the individual to keep all personal information to him/herself. This is very important, as it demonstrates that the constitutional protection of medical confidentiality in Germany aims to protect the patient's interest in keeping private information to him/herself, regardless of the information's content. The protection thus guarantees the patient's autonomy in deciding which private information to disclose or not to disclose. Even the fact that the patient is suffering from a cold, normally not in itself giving rise to any embarrassment of the patient, is protected by the patient's privacy right, as it is up to the patient to decide whether or not to disclose this information to anyone. In the more recent *Medical-Psychological Reports Decision,*[11] the Federal Constitutional Court had to decide a case in which the complainant's ability to drive motor vehicles was at doubt after he had been caught smoking cannabis. The Road Traffic Authority threatened that his driving licence be withdrawn unless he agreed to a medical-psychological examination and submitted a report to the effect that his ability to drive a motor vehicle was not diminished. In that case, the Federal Constitutional Court summarised the protection awarded by the personality right as follows:

'This right protects generally against the collection and transmission of results regarding [a person's] medical condition, mental condition or character ... . This protection is the more intense, the closer the data are linked with the person's intimate sphere which, as an inviolate sphere of private life, requires respect by and protection against all state authority ... . The report requested by the Road Traffic Authorities presupposes the collection of intimate details

[10] Ibid., at 379-380.
[11] BVerfGE 89, 69 (1993).

> which are protected by the personality right. This not only applies to the medical part of the examination, but even more so to its psychological part.'[12]

Given that the requested report would have included the personal and medical history of the person, the Federal Constitutional Court concluded that its content was even more closely linked with the patient's intimate sphere than purely medical diagnoses and therefore received even stronger protection by Art. 2(1) and Art. 1(1) BL. It can thus be seen that even though all medical information is protected from unwanted disclosure by the personality right, the extent of protection depends on the content of the information, particularly on the degree of intimacy of the relevant information.

The privacy right protects the private sphere from state interference. This guarantee protects the individual against forced disclosure of medical information. In addition, as the protection of medical records shows, it extends to the protection of medical information entrusted to the physician. It could of course be argued that entrusting information to a third party always carries a risk of disclosure, and that protection of confidential personal information can therefore only be ensured as long as the individual keeps this information to him/herself. It would then follow that a patient who confides certain medical secrets in his/her physician would lose the protection of the privacy right by the very fact of this disclosure to the physician, a third party. The Federal Constitutional Court, however, rejected this view, arguing that:

> 'The right to respect for the private sphere imposes limits on the state even where the individual communicates with others. There is often an irrefutable need to attend representatives of certain healing and counselling professions. Efficient help can frequently only be expected if the individual totally reveals himself and makes them accessories of private areas of his life. On the other hand, he has an interest that those facts will not come to the knowledge of third parties. The principal preservation of this interest in secrecy is the necessary prerequisite for the trust, which he must place in the physician for his own sake, and it is also the basis for the successful work of those whose help he requires. Otherwise he would only have a choice between accepting a disclosure of his private sphere or to do without proper treatment and advice.'[13]

In another decision, the Federal Constitutional Court added that:

> 'All the professions [listed in S. 53(1)(3) Code of Criminal Procedure] have in common that their exercise typically includes services which can be

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[12] *Ibid.*, at 82-83.
[13] BVerfGE 33, 367, 375-376 (1972).

> characterised as individual advice in personal, legal, financial and economic matters or as immediately serving the health of the human person (counselling and healing profession). Such services - more frequently and more intensely than other professional activities - touch upon areas in which confidentiality interests of the individual which are worthy of protection must be respected. They are, therefore, particularly dependent upon awarding the client or patient who enlists their help the opportunity to confide in them freely, openly and without inhibition, without having to fear the disclosure of the facts and circumstances that the other party finds out in the course of his profession.'[14]

Also:

> 'A person seeking medical treatment must and can expect that everything the physician learns about his medical condition in the course of exercising his profession will remain secret and will not come to the knowledge of unauthorised persons. Only then can the trust which forms part of the basic prerequisites of medical action, as it increases the chances of healing and therefore - on the whole - serves the purpose of maintaining efficient medical welfare services, be created between the patient and the physician.'[15]

An analysis of this case law shows that according to the Federal Constitutional Court, the state does not have to respect the confidentiality of all information an individual confides in other people regardless of the circumstances. In the context of certain professional relationships including the physician-patient relationship, however, the state must respect the individual's interest in keeping confidential information he/she has entrusted to the members of certain professions, given that the individual, when in need of professional help, would otherwise have to fear the open disclosure of all relevant information, if for example medical records could be seized or the physician be forced to give testimony in court regarding the patient's confidential medical records. The cited case law reveals that the Federal Constitutional Court is trying to preserve a variety of interests when upholding medical confidentiality. First and foremost, the patient's autonomy is protected by this interpretation of the right to privacy. In a situation in which the patient needs medical treatment, patient autonomy would be curtailed were the patient reduced to a choice between seeking treatment and risking disclosure of confidential information, or foregoing medical treatment. Different from other situations in which the individual reveals intimate details to a third party without any particular need to do so, here the patient must confide this information in a third party in order to preserve his/her interest in physical or mental integrity. Under such

[14] BVerfGE 38, 312, 323 (1975).
[15] BVerfGE 32, 373, 380 (1972).

circumstances, the state would drastically infringe upon the patient's right to safeguard his/her interests if medical confidentiality were not upheld. The interest of the patient in controlling the disclosure of personal information is also protected. Accordingly, medical confidentiality is protected to safeguard the individual's informational and decisional privacy, and the considerations on which the constitutional protection is based are mainly deontological. At the same time, the members of the medical profession have an interest in the protection of medical confidentiality, as in the view of the Federal Constitutional Court, without such a guarantee they would not be able to exercise their profession effectively. In addition, there is the public interest in preserving public health, as there is a fear that without medical confidentiality, patients might refrain from seeking medical advice and treatment, thus putting their own health and possibly that of others at risk. This could also have adverse consequences for society. Therefore, under the German Basic Law the state has to respect the confidentiality of the physician-patient relationship as a constitutional value.

How exactly does this constitutional recognition of the confidentiality of a patient's medical information impact on the physician-patient relationship? It is important to note that all state organs, but not citizens, are bound by the basic rights.[16] It follows that physicians are not under any constitutional obligation to maintain the confidences of their patients. However, all state activity, including parliamentary legislation, must comply with constitutional principles. Consequently, given that the state is under a constitutional obligation to protect medical confidentiality, it follows that the law governing the physician-patient relationship must conform to this constitutional tenet.

1.1.2. European Convention on Human Rights

In Germany, the ECHR came into force on 3 December 1953. The competence of the European Court on Human Rights (Art.46 ECHR) and of the Commission to receive individual petitions (Art.25 ECHR) were recognised in 1955. According to the pre-dominant opinion, the ECHR does not enjoy constitutional status, but rather merely has the status of ordinary law.[17] This means that the incompatibility

[16] BVerfGE 7, 198, 204-205 (1958).
[17] Jarass/Pieroth, *Grundgesetz für die Bundesrepublik Deutschland*, 12a to Art.1.

of a statute with provisions of the ECHR cannot be challenged before the Federal Constitutional Court. However, the Federal Constitutional Court takes the stance that statutes and even the Basic Law itself must be interpreted in conformity with the ECHR, as long as such interpretation does not award less protection of the basic rights as would otherwise be awarded under domestic law.[18] Statutes must be interpreted in the light of Germany's obligations under international law, regardless of whether the statutes came into force prior or subsequent to the relevant treaty. Given the extensive protection of basic rights under the Basic Law, it was long felt that the ECHR could only be of limited value in this area of law. However, the European Court of Human Rights in some cases came to the conclusion that Germany insufficiently protected certain Convention rights. In *Niemitz v Germany,*[19] for example, the European Court of Human Rights had to decide a case regarding the search of a law firm in Germany that was based on a search warrant phrased in rather broad terms. The Court came to the conclusion that a breach of Art.8(1) ECHR had occurred. In the same case, the German Federal Constitutional Court had declined to accept a constitutional complaint for adjudication on the ground that it did not offer sufficient prospect of success. It can thus be seen that in some cases, the protection awarded by the ECHR can be wider than that enjoyed under the Basic Law. Therefore, while medical confidentiality receives protection under Arts 2(1), 1(1) BL, recourse to the ECHR may nevertheless be useful in some cases in which the European Court of Human Rights awards more extensive protection than the Federal Constitutional Court.

1.2. Protection under criminal law

A very important provision in the context of the protection of medical confidentiality is s.203 Criminal Code which makes it a criminal offence for members of certain professions to breach their duty of confidentiality:

S.203 - breach of private confidences

(1) A person who, without authorisation, discloses a secret of another, namely a secret that belongs to the private sphere of life or a company or business

[18] See BVerfGE 74, 358, 370 (1987).
[19] (1993) 16 EHRR 97.

secret, that was confided in him or the knowledge of which he obtained in his capacity as

1. physician, dentist, veterinary, pharmacist or member of any other healing profession the exercise or the use of the job title of which is subject to an education regulated by the state,

2. professional psychologist in the possession of an academic degree that is recognised by the state ...

will be punished with imprisonment of up to one year or with a fine.[20]

Thus, physicians and members of the other health care professions listed in s.203(1) Criminal Code commit a criminal offence if they reveal patient confidences under the circumstances mentioned in s.203 Criminal Code. For s.203(1) Criminal Code to apply, the revelation must concern a secret. Facts are secret if they are only known to a limited number of people. If a rumour exists regarding the confidential fact, that is if, for example, several people suspect that a patient might be infected with HIV, and if they gossip about this, the patient's HIV status is still considered a secret as long as those rumours are unconfirmed. The physician's disclosure would then add credibility to the rumour.[21] However, facts are no longer secret if they have been made known publicly.[22] Information is only protected as a 'secret' by s.203 Criminal Code if the person the facts relate to has a reasonable interest in keeping it secret.[23] But this requirement is interpreted extensively, to exclude only situations in which an interest in keeping facts secret seems totally arbitrary.[24] It is therefore not necessary that the information is potentially embarrassing, but it is rather sufficient that the patient wants it to remain confidential.

The physician must have learned about the secret in his/her position as a medical professional. S.203 Criminal Code expressly states that no distinction is made between the protection of facts that were confided in the physician, and facts the

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[20] S.203:
(1) Wer unbefugt ein fremdes Geheimnis, namentlich ein zum persönlichen Lebensbereich gehörendes Geheimnis oder ein Betriebs- oder Geschäftsgeheimnis, offenbart, das ihm als
1. Arzt, Zahnarzt, Tierarzt, Apotheker oder Angehörigen eines anderen Heilberufs, der für die Berufsausübung oder die Führung der Berufsbezeichnung eine staatlich geregelte Ausbildung erfordert,
2. Berufspsychologen mit staatlich anerkannter wissenschaftlicher Abschlußprüfung, ...
anvertraut worden oder sonst bekanntgeworden ist, wird mit Freiheitsstrafe bis zu einem Jahr oder mit Geldstrafe bestraft.

[21] RGSt 26, 5, 7 (1894).

[22] Schönke/Schröder-Lenckner, *Strafgesetzbuch Kommentar*, 6 to s.203.

[23] OLG Düsseldorf JMBlNW 1990, 153.

[24] KG NJW 1992, 2771; Schönke/Schröder-Lenckner, *Strafgesetzbuch Kommentar*, 7 to s.203.

physician found out about in the course of his/her profession. The protection is not restricted to medical facts. Thus, if a patient for example confides in the physician more general facts about his/her private life that are not directly linked to the patient's medical problem, these confidences are still protected by s.203, as they indirectly support the physician-patient relationship and help create the trust necessary for medical treatment.[25] Facts are protected without having been confided in the physician by the patient, if they came to the physician's knowledge in the exercise of his/her profession. Thus, if a physician who was called to the home of a patient overhears a conversation between the patient's relatives, the obligation to medical confidentiality applies, as this knowledge was obtained by the physician in the course of his/her profession. Medical confidentiality is thus not only protected with regard to observations concerning the patient's health, but all other observations linked with the exercise of the medical profession are protected, too, so that for example information related to the car in which a patient came to the doctor, or to the identity of the person who accompanied the patient, is covered by medical confidentiality.[26] The obligation of medical confidentiality begins with the initiation of the physician-patient relationship and embraces the name of the patient and the very fact that and why the patient saw the physician.[27] Medical confidentiality not only encompasses secrets relating to the patient, but also secrets of third parties, if the physician gained knowledge of these secrets in the course of treating his/her patient. Therefore, if a physician is told by his patient that his wife is an alcoholic or that she is having an affair, this information is protected by medical confidentiality and a revelation will constitute a criminal offence under s.203 Criminal Code.[28]

For a breach of medical confidentiality to be a criminal offence, the disclosure must be made without authorisation or legal justification. Thus, no criminal offence can be committed if the patient has waived his/her right to medical confidentiality, as medical confidentiality is only protected by the Criminal Code

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[25] Schönke/Schröder-Lenckner, *Strafgesetzbuch Kommentar,* 14 to s.203.
[26] BGH NJW 1985, 2203, 2204.
[27] BGH NJW 1985, 2203, 2204; Gramberg-Danielsen, Kern, NJW 1998, at 2710; Laufs/Uhlenbruck-Ulsenheimer, *Handbuch des Arztrechts,* at 507; but see LG Oldenburg NJW 1992, 1563, stating that the disclosure of data showing that a person had received dental treatment was not a violation of medical confidentiality.
[28] Müller-Dietz, 'Juristische Grundlagen und Dimensionen der Schweigepflicht des Arztes', in: Jung, Meiser, Müller, *Aktuelle Probleme und Perspektiven des Arztrechts,* at 42.

as long as the person the information relates to, that is in most cases the patient, has an interest in keeping the information secret.[29]

The opinions as to the purpose behind the protection of medical confidentiality and, in particular, behind s.203(1) no.1 Criminal Code are split. While some argue that s.203(1) Criminal Code exclusively[30] or at least mainly[31] aims at the protection of the privacy rights of the individual, others support the view that the main purpose behind s.203(1) Criminal Code is the protection of the public interest in the general trust in members of the medical profession. Medical confidentiality, it is argued, is significant for society, given that if the patient cannot rely on the discretion of his/her physician, public health might be endangered as patients will then be reluctant to seek medical advice and treatment.[32] There is thus a utilitarian argument favouring medical confidentiality. However, the privacy argument is more important. When the current version of s.203(1) Criminal Code was enacted in 1974, the legislator included it in a newly introduced chapter called 'Violation of the personal sphere of life and intimacy,' in which different provisions aiming at the protection of the personal sphere were brought together. This demonstrates that the legislative intent behind the protection of the professional secret was to guarantee the patient's personal and intimate sphere, and it underlines the significance attached to privacy.[33] The Parliamentary debates also show that the legislative purpose behind s.203(1) Criminal Code was the protection of the constitutional privacy interests of the patients guaranteed by Arts.2(1), 1(1) BL.[34] This interpretation is also in line with the constitutional principles explained above. In addition, according to s.205(1) Criminal Code, the offence will be prosecuted exclusively upon request of the person concerned. This only makes sense if the provision is mainly aimed at the protection of the individual interests of the patient, as the protection of public interests that go beyond the interests of the individual cannot be left at the

[29] Schönke/Schröder-Lenckner, *Strafgesetzbuch Kommentar,* 22 to s.203.

[30] Leipziger Kommentar-Jähnke, 14-15 to s.203; Nomos Kommentar-Jung, 3 to s.203; Ostendorf, JR 1981, at 448; Schünemann, ZStW 90 (1978), at 57.

[31] BGH (Civil Senate) JZ 1994, 46; Bay ObLG NJW 1987, 1492, 1493; OLG Oldenburg NJW 1992, 758, 759; Kreuzer, ZStW 100 (1988), at 804; Laufs, NJW 1975, at 1434; Laufs/Uhlenbruck-Schlund, *Handbuch des Arztrechts,* at 505-506.

[32] Schönke/Schröder-Lenckner, *Strafgesetzbuch Kommentar,* 3 to s.203.

[33] Laufs, NJW 1975, at 1433.

[34] BT-Drucksache 7/550, at 235.

discretion of the individual, but will rather normally be prosecuted *ex officio*.[35] While it can be seen that the argument that s.203(1) Criminal Code serves the protection of the patient's privacy rights is more convincing than the public health argument, the pre-dominant opinion in Germany supports the view that s.203(1) Criminal Code protects both the patient's privacy interest and the public interest in preserving public health.[36] Accordingly, the pre-dominant opinion promotes a combination of deontological and utilitarian ideas.

Since s.203 Criminal Code does not sanction the violation of secrets in general, but instead only applies to the members of the professions especially listed, it follows that the provision is not intended to protect the personal and intimate sphere comprehensively against any intrusion, but only awards protection against indiscretions committed by the members of certain professions. When trying to understand the reason behind the special protection awarded to confidences made within the physician-patient relationship, several considerations are possible. One could argue that the physician-patient relationship deserves particular protection, as patients place a special trust in physicians. However, this argument is problematic, as it cannot explain why s.203 Criminal Code applies, for example, to the relationship between a prison doctor and his/her patient, a relationship which is not necessarily based on any particular trust in the physician.[37] It seems more convincing to explain the special protection by the need to reveal personal, intimate facts to a physician as otherwise effective medical treatment might not be possible. S.203 Criminal Code can thus be seen as a reaction of the criminal law to the protection of the patient's privacy interests under Arts 2(1), 1(1) BL. Given that the constitutional protection is only available against state intrusions, s.203 Criminal Code adds to this protection by guaranteeing that the physician keeps the medical secrets of his/her patient. Without this additional safeguard, the protection of medical confidentiality would be incomplete, and the patient would still have to fear a disclosure of his/her medical secrets. The protection of medical confidentiality under s.203 Criminal Code can thus be seen as the protection of intimate facts that had to be revealed to a necessary confidant. It has been argued

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[35] Kreuzer, ZStW 100 (1988), at 803-804; Ostendorf, JR 1981, at 446; Schmitz, JA 1996, at 772.
[36] See for example Bay ObLG NJW 1987, 1492, 1493; Tröndle/Fischer-Tröndle, *Strafgesetzbuch*, 1b to s.203; Kreuzer, ZStW 100 (1988), 786, at 804; Ulsenheimer, *Arztstrafrecht in der Praxis*, at 270.
[37] Laufs/Uhlenbruck-Schlund, *Handbuch des Arztrechts*, at 506.

that in addition to guaranteeing the privacy interests of the patient, s.203(1) Criminal Code also protects the interests the patient pursues when consulting the physician, i.e. the patient's health interests.[38]

1.3. Protection under contract and tort law

In German law, the physician-patient relationship is normally based on a contract for services (s.611 Civil Code).[39] The physician's obligation to medical confidentiality is a contractual duty in the framework of this contract,[40] and a violation of that obligation can result in an obligation to pay compensation, if the prerequisites of the remedy for breach of contract are satisfied.

Medical confidentiality is also protected under tort law by s.823(1) and (2) Civil Code.

S.823 (Duty to compensate for harm)

> (1) A person who intentionally or negligently injures the life, body, health, freedom, property or other right of another unlawfully is obliged to compensate the other for the harm arising therefrom.
>
> (2) The same obligation applies to a person who offends against a statutory provision which has in view the protection of another.[41]

Under s.823(1) Civil Code, compensation for a violation of medical confidentiality is available if the revelation has caused economic or immaterial harm. Even though a violation of the right to privacy is not specifically listed in s.823(1) Civil Code as giving rise to a claim for compensation, the civil courts have interpreted the reference to 'any other rights' in s.823(1) Civil Code so as to include the right to privacy.[42] This protection of the privacy right under private law was developed as a consequence of the constitutional protection of privacy. It is now well-established that information about a person's health belongs to the

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[38] Schmitt, *Die Berücksichtigung der Zeugnisverweigerungsrechte nach §§52, 53 StPO bei den auf Beweisgewinnung gerichteten Zwangsmaßnahmen*, at 124.

[39] Palandt-Putzo, *Bürgerliches Gesetzbuch*, 18 to s.611.

[40] Timm, *Grenzen der ärztlichen Schweigepflicht*, at 37.

[41] S.823 (Schadensersatzpflicht)
(1) Wer vorsätzlich oder fahrlässig das Leben, den Körper, die Gesundheit, die Freiheit, das Eigentum oder ein sonstiges Recht eines anderen widerrechtlich verletzt, ist dem anderen zum Ersatze des daraus entstehenden Schadens verpflichtet.
(2) Die gleiche Verpflichtung trifft denjenigen, welcher gegen ein den Schutz eines anderen bezweckendes Gesetz verstößt.

[42] BGHZ 26, 349 (1958); BGH NJW 1965, 685; BGHZ 39, 124 (1963).

intimate sphere that is protected by s.823(1) Civil Code,[43] so that an unauthorised breach of medical confidentiality amounts to a tort under that provision if the other prerequisites are equally present. Compensation under tort law is also available under s.823(2) Civil Code. The requirements of s.823(2) Civil Code are met in particular where the physician has violated s.203(1) Criminal Code, as the provisions of the Criminal Code are statutory provisions having in view the protection of another in the meaning of s.823(2) Civil Code.

1.4. Professional obligation

The duty to maintain medical confidentiality is a professional duty and as such is laid down in the Code of Medical Ethics issued by the medical profession. S.2 Model Professional Regulations which formed the basis for the Codes of Medical Ethics of the different German States, provides that:

> (1) The physician has to keep silent about everything confided in him or having become known to him in the exercise of his profession. This includes written statements of the patient, patient records, x-rays and other examination results.[44]

It can thus be seen that the professional duty is not limited to information which the patient expressly confided in the physician. A violation of the professional duty to respect patient confidentiality can give rise to disciplinary sanctions.

1.5. Summary

The constitutional protection of medical confidentiality as part of the personality right must be the starting point for any examination of medical confidentiality. Protected is the individual's interest in keeping personal medical information secret as well as the interest in being able to make an autonomous choice as to whether or not to disclose confidential information to the physician. In the light of this constitutional protection which is not all that different from the protection available under Art.8 ECHR, the impact of the ECHR in this area is rather limited. The constitutional protection has also strengthened the protection of medical

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[43] BGH NJW 1988, 1984; Palandt-Thomas, *Bürgerliches Gesetzbuch*, 178 to s.823.

[44] S.2(1) Berufsordnung für die deutschen Ärzte:
Der Arzt hat über das, was ihm in seiner Eigenschaft als Arzt anvertraut oder bekannt geworden ist, zu schweigen. Dazu gehören auch schriftliche Mitteilungen des Patienten, Aufzeichnungen über Patienten, Röntgenaufnahmen und sonstige Untersuchungsbefunde.

confidentiality under private law, as in addition to an action in breach of contract, compensation for a violation of the right to medical confidentiality is also available under tort law according to the civil courts' interpretation of s.823(1) Civil Code, and, under certain circumstances also under s.823(2) Civil Code. The breach of medical confidentiality by the physician also amounts to a criminal offence. This offence exists mainly for the purpose of protecting the patient's privacy interests against disclosure by the physician, but also in the public interest of preserving public health. Finally, physicians are also under an ethical obligation to maintain medical confidentiality imposed by their professional authorities and the violation of that ethical duty can result in disciplinary sanctions.

2. Medical privilege

2.1. A physician's testimony in criminal court

S.53 Code of Criminal Procedure providing for a medical privilege in criminal proceedings states as follows:

> (1) Also entitled to refuse testimony are
>
> 1. priests ...
>
> 2. criminal defence lawyers ...
>
> 3. ... physicians, dentists, psychological psychotherapists, psychotherapists for children and juveniles, pharmacists and midwifes about what has been confided in them or what came to their knowledge in this capacity ... .
>
> (2) The persons listed in subsection 1 Nos. 2 to 3b are not entitled to refuse to give testimony when they have been released from their obligation to remain silent.[45]

The Code of Criminal Procedure in s.53 awards physicians the right to refuse to testify in court about confidential information obtained in the course of their profession. With regard to the interests behind medical privilege, the discussion in German law slightly differs from that in the more general context of medical confidentiality. This may at first sight be surprising, given that medical privilege

[45] S.53
(1) Zur Verweigerung des Zeugnisses sind ferner berechtigt
1. Geistliche ...
2. Verteidiger ...
3. ... Ärzte, Zahnärzte, Psychologische Psychotherapeuten, Kinder- und Jugendpsychotherapeuten, Apotheker und Hebammen über das, was ihnen in dieser Eigenschaft anvertraut worden oder bekanntgeworden ist ... .

could very easily be understood as specifically protecting medical confidentiality in the context of criminal proceedings. It would follow that medical privilege serves exactly the same interests the obligation to medical confidentiality aims to protect, while in addition containing a particular value decision regarding the overriding importance of medical confidentiality when conflicting with the interests in criminal proceedings. However, the legal discussion in Germany is far from unanimous in accepting this view. Most authors as well as the courts recognise that the protection of the patient's privacy rights is at least one important interest behind granting medical privilege in criminal proceedings.[46]

On the other hand, some arguments are submitted in support of the view that medical privilege might aim at different objectives than s.203(1) Criminal Code. A first argument focuses on the wording of s.53 Code of Criminal Procedure. The provision gives the physician the right not to testify in court when called as a witness with regard to confidential patient information, without imposing a corresponding obligation. It could be concluded that the protection of the patient's privacy interests cannot be the main concern behind medical privilege, as such protection could only be guaranteed effectively if the physician were placed under an obligation not to testify, rather than being given a choice between testifying and refusing to testify. Another argument that has sometimes been raised is that medical privilege contains a value judgment, giving the interest in maintaining medical confidentiality in the context of criminal proceedings precedence over the interests pursued by criminal proceedings. Therefore, some have argued that a patient's privacy rights cannot be the main concern behind medical privilege, as they are not important enough to override the interests of justice. The promoters of this view were of the opinion that only significant public interests can justify an infringement of the state interest in criminal prosecution,[47] and for them, the

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(2) Die in Absatz 1 Nr. 2 bis 3b Genannten dürfen das Zeugnis nicht verweigern, wenn sie von der Verpflichtung zur Verschwiegenheit entbunden sind.

[46] BVerfGE 32, 373, 380 (1972); Baier, *Strafprozessuale Zeugnisverweigerungsrechte außerhalb der Strafprozeßordnung als Ergänzung der §§ 52 ff StPO*, at 57; Klöhn, *Der Schutz der Intimsphäre im Strafprozeß*, at 331; Rengier, *Die Zeugnisverweigerungsrechte im geltenden und im künftigen Strafverfahrensrecht*, at 15-16; Schmitt, *Die Berücksichtigung der Zeugnisverweigerungsrechte nach §§52, 53 StPO bei den auf Beweisgewinnung gerichteten Zwangsmaßnahmen*, at 122.

[47] Lenckner, 'Ärztliches Berufsgeheimnis', in: Göppinger (ed.), *Arzt und Recht*, at 161; Schmidt, NJW 1962, at 1747-1748; Steinberg-Copek, *Berufsgeheimnis und Aufzeichnungen des Arztes im Strafverfahren*, at 14-15; Würtenberger, 'Der Schutz des Berufsgeheimnisses und das Zeugnisverweigerungsrecht des Sozialarbeiters', in: Conrad, Jahrreiß, Mikat, Mosler, Nipperdey, Salzwedel (eds.), *Gedächtnisschrift für Hans Peters*, at 926.

protection of the patient's privacy rights was merely an individual private, and not a public interest. It should be noted that this argument has been voiced before the Federal Constitutional Court strengthened the protection of privacy rights. At present, many argue that the protection of the individual's privacy rights is not just a private interest. Society, too, has an interest in the protection of individual freedom, so that the protection of fundamental rights lies in the public interest.[48]

Others who argue that medical privilege cannot primarily be granted to protect the privacy interests of the patient because s.53 Code of Criminal Procedure should otherwise oblige the physician not to testify, infer that s.53 was enacted in the interest of the medical profession. The Federal Constitutional Court has held that the medical profession is a profession the members of which must necessarily rely on medical confidentiality for an unfettered exercise of their profession, as it is typical for their profession that confidential information will be confided in them.[49] This holding has been used to argue that medical privilege is primarily granted in the interest of the members of the medical profession.[50] Without medical privilege, the members of the medical profession could not exercise their profession successfully, so that medical privilege is recognised to guarantee the right to occupational freedom guaranteed by Art.12(1) BL.[51] However, it is difficult to accept that the interests of members of the medical profession in the exercise of their profession are of such overriding importance that they should prevail over the state interest in criminal prosecution. More importantly, it should not be forgotten that the interests of the medical profession are in that respect only indirectly affected. The exercise of the medical profession can only be hindered by the non-existence of medical privilege if without medical privilege, patients are more reluctant to seek medical advice and less forthcoming with information that is essential for effective medical treatment. If that were the case, however, it

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[48] See, for example, Haffke, GA 1973, at 67.

[49] BVerfGE 38, 312, 323 (1975).

[50] Rengier, *Die Zeugnisverweigerungsrechte im geltenden und im künftigen Strafverfahrensrecht*, at 13-14.

[51] See Baier, *Strafprozessuale Zeugnisverweigerungsrechte außerhalb der Strafprozeßordnung als Ergänzung der §§ 52 ff StPO*, at 56. It should be noted that Baier promotes the view that medical privilege exists to protect the interests of the medical profession as well as the privacy interests of the patient.

Art. 12(1) BL states that:

All Germans have the right freely to choose their occupation or profession, their place of work, study or training. The practice of an occupation or profession may be regulated by or pursuant to a law. (Alle Deutschen haben das Recht, Beruf, Arbeitsplatz und Ausbildungsstätte frei zu wählen. Die Berufsausübung kann durch Gesetz oder aufgrund eines Gesetzes geregelt werden.)

would be unconvincing to argue that the indirectly affected medical profession deserves more protection than the directly affected privacy interests of the patient. It can therefore not be said that medical privilege primarily aims at the protection of the interests of the members of the medical profession. It is admitted, however, that historically medical privilege had the purpose to protect the physician from conflicts between the ethical duty to maintain medical confidentiality, and a legal duty to testify about confidential patient information.[52] As physicians were traditionally obliged by the Hippocratic Oath to keep their patients' confidences, an obligation which at present forms part of several International Conventions, as well as of the codes of medical practice, the obligation to testify in court would put physicians in the position either to disregard their professional or their legal obligation. Thus, medical privilege is partly aimed at protecting physicians from this type of conflict.[53] Given that the disclosure of confidential patient information also amounts to a criminal offence under s.203 Criminal Code, it is fair to say that s.53 Code of Criminal Procedure at least partly aims at enabling the physician to fulfil this legal obligation in court.[54]

Another aspect sometimes raised is that medical privilege serves the protection of the *nemo tenetur* principle which has constitutional rank and states that no one can be forced to incriminate him/herself. The argument is that freedom from self-incrimination is circumvented if the patient's right not to testify with regard to confidential facts were undermined by then calling the physician to the witness stand and examine him/her about the same confidential facts.[55] The strength of the argument is mitigated by the fact that s.53 Code of Criminal Procedure not only grants medical privilege with regard to a patient who is accused in criminal proceedings, but also with regard to patients who are for example victims of criminal offences. Freedom from self-incrimination cannot explain the existence of medical privilege in respect of confidential information concerning other persons than the accused.[56]

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[52] Schmitt, *Die Berücksichtigung der Zeugnisverweigerungsrechte nach §§52, 53 StPO bei den auf Beweisgewinnung gerichteten Zwangsmaßnahmen*, at 131.
[53] BGHSt 9, 59, 61 (1956).
[54] Löwe/Rosenberg-Dahs, *Strafprozeßordnung*, 1 to s.53; Welp, JR 1997, at 37.
[55] Klöhn, *Der Schutz der Intimsphäre im Strafprozeß*, at 330; Petry, *Beweisverbote im Strafprozeßrecht*, at 46.
[56] Schmitt, *Die Berücksichtigung der Zeugnisverweigerungsrechte nach §§52, 53 StPO bei den auf Beweisgewinnung gerichteten Zwangsmaßnahmen*, at 122.

As can be seen, s.53(2) Code of Criminal Procedure expressly provides that the physician is no longer free to refuse to testify in criminal court if the patient has released him/her from the obligation of confidentiality. German law is thus based on the premise that medical privilege is no longer justified if the patient has no interest in keeping his/her confidential information secret in the context of criminal proceedings. S.53(2) could support the impression that medical privilege only exists in the patient's interest, as it could be argued that the patient can only waive his/her own privacy rights, not the physician's or the state interest in maintaining confidentiality. This argument must fail, however, because the only interest either the patient, the physician or the state can have in the protection of medical confidentiality is that the doctor is not forced to disclose confidential information against the patient's wish.[57] Thus, where the patient has authorised the physician to testify about confidential information, the physician is no longer in a moral conflict, and the state interest in respecting the privacy right of the patient and the confidential nature of the physician-patient relationship to promote public health are no longer affected.[58] Where the patient has given consent to the disclosure of information by the physician, the doctor has no choice and must testify.[59]

It is thus recognised that medical privilege serves different purposes: according to case-law and the predominant opinion among legal writers, it protects the privacy rights of the patient, the professional integrity of the physician, the physician-patient relationship and the public interest in respecting the individual's basic rights and in promoting public health. However, some conclusive remarks about the main purpose behind medical privilege seem appropriate. The different legal provisions and concepts in Arts. 2(1) and 1(1) BL, s.203(1) Criminal Code and s.53 Code of Criminal Procedure only add up to a coherent system if the medical privilege recognised by s.53 Code of Criminal Procedure is interpreted as a specification of the protection of medical confidentiality. The Federal Constitutional Court has held that:

> 'As far as the right to refuse to testify concerns facts regarding the citizen's private sphere, the protection of the private sphere of the individual was

[57] Lenckner, NJW 1965, at 323; Petry, *Beweisverbote im Strafprozeßrecht*, at 48.
[58] See also Schmitt, *Die Berücksichtigung der Zeugnisverweigerungsrechte nach §§52, 53 StPO bei den auf Beweisgewinnung gerichteten Zwangsmaßnahmen*, at 133.
[59] Karlsruher Kommentar-Senge, 51 to s.53.

accorded precedence over the public interest in fully establishing the truth in criminal proceedings'.[60]

The Federal Constitutional Court thus clearly took the stance that the interests outweighing the state interest in the administration of criminal justice in the context of professional privilege are the constitutionally protected privacy interests of the patient. Only this interpretation of the intention behind s.53 Code of Criminal Procedure is compatible with the purposes identified as underlying s.203 Criminal Code, and with the significance of the patient's right to privacy. Even though medical privilege may incidentally serve the interests of the members of the medical profession, and the public interest in the preservation of public health, the privacy interests of the individual patient lie at the heart of medical privilege and are the foremost value to be protected thereby.

2.1.1. Invocation of medical privilege - right or obligation?

If the privacy interests of the patient are one of the purposes underlying medical privilege, or even its main justification, it is rather surprising that, according to the predominant opinion of German courts and legal writers,[61] physicians are said to have a discretion in deciding whether or not to testify in court about confidential patient information. At first sight, this opinion seems convincing as it is in conformity with the wording of s.53 ('entitled to refuse testimony'). But such literal interpretation of s.53 Code of Criminal Procedure focuses on the physician and his/her protection from a possible conflict between the obligation of confidentiality and the obligation to testify in court and therefore only makes sense if the protection of the physician's interests were the main purpose behind s.53 Code of Criminal Procedure, a view that has already been discussed and rejected above. If, as promoted here, the main purpose behind medical privilege is the protection of the patient's privacy interests, the literal interpretation of s.53 Code of Criminal Procedure must be rejected. As the physician's testimony concerns confidences of the patient, the disclosure of this information cannot be left to the discretion of the physician, but can only lie within the discretion of the patient. It is therefore more consistent to interpret s.53 as imposing upon the

[60] BVerfGE 33, 367, 378 (1972).

[61] See, for example, BGHSt 9, 59, 61 (1956); 15, 200, 202 (1960); 42, 73, 76 (1996); Karlsruher Kommentar-Senge, 7 to s.53 with further references; Kleinknecht/Meyer-Goßner, *Strafprozeßordnung*, 6 to s.53; Laufs/Uhlenbruck-Ulsenheimer, *Handbuch des Arztrechts*, at 511.

physician the obligation not to testify about confidential patient information without the patient's consent, rather than as giving the physician a choice between testifying and refusing to testify.[62] Only this interpretation is consistent with s.203 Criminal Code. As s.53 Code of Criminal Procedure awards the right to refuse to testify, the unanimous opinion is that s.203 Criminal Code also applies to testimony in court. The fact that a physician discloses confidential information in the court room can, therefore, not in itself justify a breach of medical confidentiality.[63] This means that a physician who exercises his/her 'right' under s.53 Code of Criminal Procedure and decides to give testimony about confidential patient information without the patient's consent commits the crime of breach of confidentiality under s.203 Criminal Code.

To interpret s.53 Code of Criminal Procedure as imposing an obligation on the physician not to give testimony only at first sight seems to contradict the wording of the provision. S.53 Code of Criminal Procedure is phrased as awarding a right, rather than as imposing an obligation, because not all persons who are exempt from testifying in criminal court according to s.53 Code of Criminal Procedure are under an obligation to confidentiality imposed by s.203 Criminal Code. Priests, for example, can refuse to testify about penitents' confidences under s.53 Code of Criminal Procedure, but they will not commit a criminal offence if they decide to make use of this discretion, as their profession is not listed in s.203 Criminal Code. Furthermore, the right to refuse to testify in court is broader than the obligation to maintain medical confidentiality under s.203(1) Criminal Code, as s.203(1) only protects 'secrets', while s.53 Code of Criminal Procedure awards the right to remain silent even with regard to confidential patient information that does not qualify as a secret in the meaning of s.203(1) Criminal Code. The physician's 'right' under s.53 could thus be interpreted as merely referring to the choice of whether or not to testify in court about confidential patient information that is not a secret protected by s.203(1) Criminal Code.[64] This interpretation of s.53 Code of Criminal Procedure avoids the unconvincing result of the predominant opinion that the physician can freely decide whether or not to testify, but when exercising this choice in favour of giving testimony, he/she will then be held liable under s.203 Criminal Code for breach of confidentiality. The

[62] Fezer, *Strafprozeßrecht*, at 203.
[63] Roxin, *Strafverfahrensrecht*, at 213.
[64] Welp, JR 1997, at 37-38.

predominant opinion, while pertaining to protect the physician, has the undesirable consequence that the physician is given a choice the exercise of which might result in a criminal prosecution. This opinion adds nothing to the protection of the physician. With regard to a possible conflict between the legal and ethical obligation to maintain patient confidences and the obligation to testify, the physician is protected comprehensively by the existence of s.53 Code of Criminal Procedure which exempts the physician from the duty to give testimony in criminal court. If the physician in certain exceptional situations feels that the disclosure of confidential medical information in criminal court is desirable, for example where it may help a person who is wrongly accused in criminal proceedings, this conflict cannot be resolved with reference to the procedural provision of s.53 Code of Criminal Procedure, as the question of whether or not such a disclosure is permitted will have to be resolved according to the provisions of substantive law which decide questions of possible legal justifications. It thus seems more convincing to say that the physician does not have the free choice as to which information to disclose in court, but is rather bound by criminal law and can only reveal confidential information as long as the revelation does not amount to a criminal offence under s.203 Criminal Code.[65]

Even if the main purpose behind medical confidentiality were not the protection of the patient's privacy rights, but rather the protection of the public interest in promoting public health, or the physician's interest in the exercise of his/her profession, these interests are equally undermined if the physician has a choice as to whether or not to breach medical confidentiality in court. Only if s.53 Code of Criminal Procedure is interpreted as creating an obligation, rather than a right to refuse to testify, can consistency between s.203 Criminal Code and s.53 Code of Criminal Procedure be achieved. The interests behind medical confidentiality can only be satisfactorily safeguarded where the physician has no right to divulge the information without the patient's consent.[66]

The whole discussion may seem somewhat theoretical, as it could be thought that from the point of view of the patient, it does not make any difference whether the physician is only under the general obligation of medical confidentiality imposed

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[65] Tröndle/Fischer-Tröndle, *Strafgesetzbuch*, 30 to s.203.
[66] Lenckner, NJW 1965, at 326; Schmitt, *Die Berücksichtigung der Zeugnisverweigerungsrechte nach §§52, 53 StPO bei den auf Beweisgewinnung gerichteten Zwangsmaßnahmen*, at 145.

by s.203 Criminal Code, or whether s.53 Code of Criminal Procedure creates an additional obligation for the physician not to testify in court, as long as s.203 Criminal Code is applicable to evidence given as a witness in criminal proceedings. However, the different interpretations of s.53 Code of Criminal Procedure have an important impact on the admissibility of the physician's testimony. Criminal courts have taken the stance that as the physician has the right to testify, this testimony is admissible evidence, regardless of whether or not the disclosure in the specific case constitutes a criminal offence.[67] This situation is problematic as it permits the admission of evidence that has possibly come about through the means of a criminal offence.[68] The purpose of criminal proceedings, i.e. to restore peace and justice after the commission of a crime, will be reversed if the witness, in testifying, commits a new criminal offence and, consequently, an additional breach of peace and justice occurs.[69]

2.1.2. Effects of the patient's consent

According to s.53(2) Code of Criminal Procedure, the physician can no longer refuse to testify if the patient has waived his/her right to medical confidentiality and consented to disclosure. In such a case, no criminal offence under s.203 Criminal Code will be committed by the physician if he/she discloses confidential patient information. What causes legal problems in this context is the question of who has the right to waive medical confidentiality, and under which conditions such a waiver is valid. With regard to the first question, the answer is easy where the confidential information at issue exclusively relates to the patient. In such a case, it is clear that only the patient can have the right to consent to the disclosure of confidential information. However, the problem is more complex where the information confided in the physician by the patient relates to a third party, for example where the patient tells the physician confidential details relating to his/her spouse. In such a case, some argue that only the person the information relates to has the right to relieve the physician from the obligation to medical

[67] BGHSt 9, 59, 62 (1956); 18, 146, 147 (1962); BGHR-Schweigepflicht I zu StPO §53 (1995); Karlsruher Kommentar-Senge, 9 to s.53; Löwe/Rosenberg-Dahs, *Strafprozeßordnung*, 11-14 to s.53; for a further discussion see Alternativkommentar-Kühne, 3-6 to s.53.

[68] For a discussion of the controversy see Kleinknecht/Meyer-Goßner, *Strafprozeßordnung*, 6 to s.53 with further references.

[69] Freund, GA 1993, at 63-64; Lenckner, NJW 1965, at 327; Nomos Kommentar-Jung, 35 to 203; Roxin, *Strafverfahrensrecht*, at 213.

confidentiality.[70] Even though there is no physician-patient relationship between the physician and the third party, the protection of s.203 Criminal Code still applies, as the physician has learned confidential information of another in the course of his/her profession, which is the case where the patient confides information relating to a third party in the physician.[71] It seems rather surprising that a third party can consent to the disclosure of confidential information obtained by the physician in the course of a professional relationship with the patient, and that the patient, on the other hand, cannot validly consent to the disclosure of such information. Even if the third party's consent exclusively concerns his/her own secrets, it is difficult to reconcile this view with any of the purposes behind the protection of medical confidentiality. As no physician-patient relationship exists between the physician and the third party, the physician only owes the patient, but not the third party an obligation to maintain medical confidentiality, and it is then difficult to accept that the third party can validly relieve the physician from an obligation not owed to him/her. The courts seem to share these doubts when stating that the third party can have no right that his/her confidential data be protected by someone else's physician, so that the patient's consent should be sufficient to waive medical confidentiality even with regard to information not relating to him/her.[72]

Valid consent presupposes capacity. This capacity is not subject to any age limits, but rather exclusively refers to the ability to understand the general nature and scope of the act consented to and the faculty to assess the consequences of giving consent at least in a general manner.[73] This means that for example an eleven-year-old child could validly consent to the breach of medical confidentiality as long as it understands the general features of this waiver. Consent must also be given freely and voluntarily. Voluntariness is not excluded merely because the patient feels in a real dilemma and consents to the disclosure only to avoid an even more serious disadvantage. Rather, to exclude voluntariness, the patient must be under such pressure that he/she no longer has any meaningful choice between consenting and refusing to consent.

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[70] Karlsruher Kommentar-Senge, 46 to s.53; Göppinger, NJW 1958, at 243.
[71] OLG Hamburg NJW 1962, 689, 691.
[72] OLG Köln NStZ 1983, 412, 413; Schönke/Schröder-Lenckner, *Strafgesetzbuch Kommentar*, 23 to s.203; Göppinger, NJW 1958, at 243.
[73] BGHSt 12, 379, 382 (1959); 23, 1, 4 (1969).

It is problematic whether the patient's consent is only valid with regard to information he/she is aware of, as it is possible that the physician has not fully informed the patient about his/her health condition. Thus, if a patient consents to the physician's testimony in court, he/she might not be able to predict the content of such testimony with certainty. The Higher Regional Court of Hamburg argued that it should be sufficient that the physician indicates the possibility that the patient might not be aware of the full extent of the physician's knowledge. If the patient then still consents to the disclosure, this consent is valid.[74]

2.1.3. Criminal prosecution

It has already been established that a physician who discloses confidential patient information either in court or in the context of police investigations commits the criminal offence of s.203(1) Criminal Code, except where a legal justification applies. Unless the patient consented to the disclosure, the most important legal justification applicable to cases of breach of the professional secret is the necessity defence. S.34 Criminal Code provides in that respect:

> 'A person who commits an offence in present danger, that cannot be otherwise averted, to life, body, freedom, honour, property or another legal interest, in order to protect himself or another from that danger, does not act unlawfully if, on balancing the conflicting interests, particularly the legal interests concerned and the degree of the dangers to them, the protected interest significantly outweighs the interest impaired. This only applies insofar as the offence is an appropriate means to avert the danger.'[75]

For the necessity defence to apply in the context of a breach of medical confidentiality, the physician's disclosure of confidential patient information must be aimed at protecting the physician him/herself or a third party from a present or imminent danger. This means that the testimony cannot be justified if it is merely given for the purpose of criminal prosecution, as in that case, the danger has already materialised and there is no longer any present or imminent harm to an individual. Even where the most serious crimes are under investigation, the right

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[74] OLG Hamburg NJW 1962, 689, 690.

[75] *S.34 Rechtfertigender Notstand*
'Wer in einer gegenwärtigen, nicht anders abwendbaren Gefahr für Leben, Leib, Freiheit, Ehre, Eigentum oder ein anderes Rechtsgut eine Tat begeht, um die Gefahr von sich oder einem anderen abzuwenden, handelt nicht rechtswidrig, wenn bei Abwägung der widerstreitenden Interessen, namentlich der betroffenen Rechtsgüter und des Grades der ihnen drohenden Gefahren, das geschützte Interesse das beeinträchtigte wesentlich überwiegt. Dies gilt jedoch nur, soweit die Tat ein angemessenes Mittel ist, die Gefahr abzuwenden.'

of the victim was already violated and there is no longer a present danger as required by s.34.[76] If the physician wants to testify because he/she thinks that the perpetrator is likely to commit future crimes, a breach of confidence would under these circumstances not serve the purpose of prosecuting the relevant crime, but rather the purpose of crime prevention which is a different problem. The general risk that someone who has committed a crime might do so again is not sufficient to justify a breach of confidence under the necessity defence.[77]

Another argument supports the finding that a breach of medical confidentiality cannot be justified under the necessity defence for the mere purpose of criminal prosecution. The legislature, when introducing the right not to testify, did not distinguish between different offences according to their seriousness, but rather awarded this right independent from the nature of the crime at trial. This means that the legislature, when resolving the conflict between the public interest in criminal prosecution and truth-finding, on the one hand, and the private and public interests in medical confidentiality, on the other hand, balanced the competing interests as required by s.34 Criminal Code and came to the conclusion that the interest in medical confidentiality outweighs the interests in criminal prosecution.[78] This means that a physician who breaches medical confidentiality in the interest of criminal prosecution does not protect an interest that significantly outweighs the interest impaired, as required by s.34 Criminal Code. In addition, the necessity defence only applies where the violation of medical confidentiality is an adequate means to achieve the intended purpose, i.e. to ensure criminal prosecution. It is often possible that the confidential information the physician can testify about will not in itself be sufficient for a successful prosecution, so that the requirements of the necessity defence would then not be fulfilled.

As can be seen, the necessity defence is for various reasons not available as a legal justification for a violation of medical confidentiality when the physician gives testimony in court. Some authors find it hard to accept that as a consequence, a breach of medical confidentiality for the purpose of criminal

[76] Baumann, Weber, Mitsch, *Strafrecht Allgemeiner Teil*, at 332; Haffke, GA 1973, at 69.
[77] Leipziger Kommentar-Jähnke, 89 to s.203.
[78] BVerfGE 33 367, 378 (1972); Baier, *Strafprozessuale Zeugnisverweigerungsrechte außerhalb der Strafprozeßordnung als Ergänzung der §§ 52 ff StPO*, at 117; Haffke, GA 1973, at 69; Kramer, NJW 1990, at 1763; Ostendorf, DRiZ 1981, at 11; Schilling, JZ 1976, at 620; Steinberg-Copek, *Berufsgeheimnis und Aufzeichnungen des Arztes im Strafverfahren*, at 60; Sydow, *Kritik der Lehre von den "Beweisverboten"*, at 115.

prosecution will always amount to a criminal offence. To avoid this result, it has been suggested that a justification of conflicting duties should be recognised so that in every case of a breach of medical confidentiality by a physician the duty to protect the intimate sphere of the patient should be balanced against the public interest in an effective administration of justice, an interest which is equally of constitutional rank as it follows from the constitutional principle of the rule of law.[79] This is, however, problematic. First, the physician is not under any legal duty to assist the state in the prosecution of crime. The only legal duty imposed on individuals in this context is the duty to give testimony in criminal court, an obligation from which s.53 Code of Criminal Procedure exempts the physician. It is thus incorrect to speak about a conflict of duties which could justify the breach of one of these obligations. It seems as if the promoters of the view that a breach of medical confidentiality can be justified by a conflict of duties rather have a conflict of interests in mind, when they argue that this justification should only apply to the prosecution of serious offences, as the public interest in such cases is said to outweigh medical confidentiality.[80] Given that the legislator has not created any exemptions from the obligation to keep the medical secret for the purpose of assisting the prosecution of serious offences, there is no legal basis for such a balancing of interests outside of the necessity defence.[81]

2.1.4. Testimony to establish the innocence of an accused

A different problem arises where the physician has information about the innocence of an accused person, for example where the real perpetrator is a patient of the physician and has confessed his/her guilt to the doctor in the course of medical treatment, or where the physician has made observations regarding his/her patient's guilt. First, it should be noted that under German law, the accused does not have a right to compel the physician to give testimony in his/her favour, as such a right is barred by medical privilege, unless the accused is a patient and consents to the disclosure of his/her own medical secrets according to s.53(2) Code of Criminal Procedure. The only controversial problem is whether or not the physician would be allowed to testify voluntarily. In this situation, again, the

[79] Laufs/Uhlenbruck-Ulsenheimer, *Handbuch des Arztrechts*, at 514.
[80] Kohlhaas, GA 1958, at 74.
[81] Schmitz, JA 1996, at 953.

breach of confidentiality can only be justified if all requirements of the necessity defence are met. The first question therefore must be whether or not a present and imminent danger exists in such a scenario. This is not problematic where the innocent person has already been convicted and the punishment is currently being executed or its execution is imminent, but the danger is no longer imminent where the execution of punishment is already terminated, for example where a person who was wrongly convicted to imprisonment has been released. The danger is equally imminent where the proceedings have reached a stage approaching a conviction. The situation is problematic, however, if the evidence does not unequivocally point to the guilt of the accused, as it is then more difficult to decide at which point there is an imminent danger to the liberty of the wrongly accused. Even where a conviction is not imminent so that an imminent danger exists neither with regard to the assets nor with regard to the liberty of the innocent person, it could be argued that there is an imminent risk that he/she is subjected to unwarranted criminal prosecution.

If the requirement of a present or imminent danger is met, the justification depends on the outcome of a balancing of interests, as the necessity defence only applies where the interests pursued with the criminal offence at issue outweigh the interests violated thereby. The criteria to be applied to the balancing process depend on whether the innocent is the patient, a third party or the physician him/herself. If the physician possesses confidential information about his/her patient which could establish the patient's innocence when being accused in criminal proceedings, for example information that the patient was in hospital when the crime was committed, or that a certain physical condition of the patient excludes him/her as the perpetrator, the physician's testimony to that regard can never be justified. This is because in such a situation, the patient, when wishing evidence to be made available to the court, could easily release the physician from his/her duty to confidentiality with the consequence that the physician, according to s.53(2) Code of Criminal Procedure, would then be obliged to testify. If the patient does not want to do this, either because he/she wants to protect a third party, or because he/she values privacy more than his/her liberty, it is not up to the physician to disregard the patient's preferences and to substitute his/her judgment for that of the patient.

If the physician's testimony could exonerate a third party wrongly accused in criminal proceedings, many scholars argue that the necessity defence should apply to justify a breach of confidentiality. They argue that the interests of the wrongly accused not to be convicted outweigh the interests of the perpetrator in the protection of his/her medical confidences.[82] Others reject such a justification completely, because a doctor is bound only by the patient's well-being, without owing any obligation to a third party or to the public to prevent incorrect court decisions.[83] This is not convincing, as in the context of the necessity defence, it is not important whether or not the physician has an obligation to protect the interests at issue. Once the physician has decided to violate medical confidentiality to protect the interests of an innocent third party, the only consideration can be whether the protected interest outweighs the violated interests as required by s.34 Criminal Code. In that respect, some argue that only issues of liberty rank higher than the maintenance of professional confidentiality so that a breach of confidentiality would only be justifiable where the accused is at risk of imprisonment.[84] The importance of the loss of money after a conviction to a fine will probably differ according to the special circumstances of each case and it is questionable whether financial interests can prevail over the privacy interests of the patient. However, other interests also have to be taken into account. A criminal conviction or even the threat of a criminal conviction can entail a loss of reputation as well as bring about consequences in respect of the exercise of certain professions. To decide whether or not a breach of confidentiality can be justified under s.34 Criminal Code, it thus has to be decided in each case whether these consequences affect interests of such overriding importance that the interest in medical confidentiality will have to yield. A case-by-case approach seems thus most appropriate, and also conforms with the objectives of the necessity defence which aims at enabling a just and fair decision in a particular case.

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[82] OLG Celle NJW 1965, 362, 363; Baier, *Strafprozessuale Zeugnisverweigerungsrechte außerhalb der Strafprozeßordnung als Ergänzung der §§ 52 ff StPO*, at 117; Tröndle/Fischer-Tröndle, *Strafgesetzbuch*, 31 to s.203; Dahs, *Handbuch des Strafverteidigers*, at 32; Flor, JR 1953, at 368-369, Leipziger Kommentar-Jähnke, 90 to s.203; Schmitt, *Die Berücksichtigung der Zeugnisverweigerungsrechte nach §§52, 53 StPO bei den auf Beweisgewinnung gerichteten Zwangsmaßnahmen*, at 153; Schönke/Schröder-Lenckner, *Strafgesetzbuch Kommentar*, 1 to s.203.
[83] Woesner, NJW 1957, at 692.
[84] Müller, MDR 1971, at 970.

If it is the physician who is wrongly accused in criminal proceedings, in addition to the considerations made in the context of the prosecution of an innocent third party, the physician's defence rights are also at issue. Defence rights are of constitutional rank and many argue that they must prevail over the interest in medical confidentiality.[85] When others suggest that the physician must wait for a conviction before being allowed to reveal confidential information,[86] it should not be forgotten that the danger is already imminent before the actual conviction takes place, and that the physician's defence rights can no longer be exercised effectively once the conviction has occurred. This argument can thus not be sustained in the context of the necessity defence.

2.1.5. Crime prevention

Another question is whether a breach of confidentiality can be justified where there is a real risk that someone will commit a crime. In this context, it is first of all important to look at ss.138, 139 Criminal Code which impose an obligation to disclose to the relevant authorities information for the purpose of crime prevention.

S.138 Criminal Code states that:

> (1) A person who has plausible knowledge regarding the plan or the carrying out of
>
> 1. preparations for a war of aggression (s.80),
>
> 2. high treason in the cases of ss.81 to 83(1),
>
> 3. treason or an endangerment of the external security in the cases of ss.94 to 96, 97(a) or 100,
>
> 4. counterfeiting of money or bonds in the cases of ss.146, 151, 152 or counterfeiting of credit or bank cards or of forms for Eurocheques in the cases of s.152(a)(1) to (3),
>
> 5. aggravated trafficking in human beings in the cases of s.181(1) nos. 2 or 3.
>
> 6. murder, manslaughter or genocide (ss.211, 212 or 220(a)),
>
> 7. an offence against personal freedom in the cases of ss.234, 234(1), 239(a) or 239(b),
>
> 8. robbery (ss.249 to 251 or 255) or

[85] BGHSt 1, 366, 368 (1951); KG JR 1985, 161, 162; Tröndle/Fischer-Tröndle, *Strafgesetzbuch*, 31 to s.203; Leipziger Kommentar-Jähnke, 83 to s.203; Schönke/Schröder-Lenckner, *Strafgesetzbuch Kommentar*, 33 to s.203.
[86] Systematischer Kommentar-Samson, 45 to s.203.

9. a criminal offence endangering the public safety in the cases of ss.306 to 306(c) or 307(1) to (3), 308(1) to (4), 309(1) to (5), 310, 313, 314 or 315(3), 315(b)(3) or 316(a) or 316(c)

at a time when the commission of the offence or its consequences could still be averted, and omits timely to inform the authorities or the potential victim, will be punished with imprisonment of up to five years or with a fine.

(2) Similarly will be punished every person who plausibly learns about the plan or the carrying out of an offence under s.129(a) [forming of a terrorist organisation] at a time when the commission can still be prevented and omits to inform the authorities immediately.[87]

And s.139 Criminal Code states:

(3) A person who omits to make a report on a relative, remains free from punishment if he seriously endeavoured to prevent him from committing the offence or to avert its consequences, unless the offence in question was

1. murder or manslaughter (ss.211 or 212),

2. genocide in the cases of s.220(a)(1) No.1, or

3. kidnapping (s.239(a)(1)), hostage-taking (s.239(b)(1)) or an assault on air or sea traffic (s.316(c)(1)) by a terrorist organisation (s.129(a)).

Under the same conditions, a solicitor, criminal defence lawyer or physician is under no obligation to report that which was confided in him in his professional capacity.[88]

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[87] S.138 Nichtanzeige geplanter Straftaten
(1) Wer von dem Vorhaben oder der Ausführung
1.einer Vorbereitung eines Angriffskrieges (§ 80),
2. eines Hochverrats in den Fällen der §§ 81 bis 83 Abs. 1,
3. eines Landesverrats oder einer Gefährdung der äußeren Sicherheit in den Fällen der §§ 94 bis 96, 97a oder 100,
4. einer Geld- oder Wertpapierfälschung in den Fällen der §§ 146, 151, 152 oder einer Fälschung von Zahlungskarten und Vordrucken für Euroschecks in den Fällen des § 152a Abs. 1 bis 3,
5. eines schweren Menschenhandels in den Fällen des § 181 Abs. 1 Nr.2 oder 3,
6. eines Mordes, Totschlags oder Völkermordes (§§ 211, 212 oder 220a),
7. einer Straftat gegen die persönliche Freiheit in den Fällen der §§ 234, 234a, 239a oder 239b,
8. eines Raubes oder einer räuberischen Erpressung (§§ 249 bis 251 oder 255) oder
9. einer gemeingefährlichen Straftat in den Fällen der §§ 306 bis 306c oder 307 Abs. 1 bis 3, des § 308 Abs. 1 bis 4, des § 309 Abs. 1 bis 5, der §§ 310, 313, 314 oder 315 Abs. 3, des § 315b Abs. 3 oder der §§ 316a oder 316c
zu einer Zeit, zu der die Ausführung oder der Erfolg noch abgewendet werden kann, glaubhaft erfährt und es unterläßt, der Behörde oder dem Bedrohten rechtzeitig Anzeige zu machen, wird mit Freiheitsstrafe bis zu fünf Jahren oder mit Geldstrafe bestraft.
(2) Ebenso wird bestraft, wer von dem Vorhaben oder der Ausführung einer Straftat nach § 129a zu einer Zeit, zu der die Ausführung noch abgewendet werden kann, glaubhaft erfährt und es unterläßt, der Behörde unverzüglich Anzeige zu erstatten.

[88] S.139 Straflosigkeit der Nichtanzeige geplanter Straftaten
(3) Wer eine Anzeige unterläßt, die er gegen einen Angehörigen erstatten müßte, ist straffrei, wenn er sich ernsthaft bemüht hat, ihn von der Tat abzuhalten oder den Erfolg abzuwenden, es sein denn, daß es sich um
1. einen Mord oder Totschlag (§§ 211 oder 212),
2. einen Völkermord in den Fällen des § 220a Abs. 1 Nr.1 oder
3. einen erpresserischen Menschenraub (§ 239a Abs. 1), eine Geiselnahme (§ 239b Abs. 1) oder einen Angriff auf den Luft- und Seeverkehr (§ 316c Abs. 1) durch eine terroristische Vereinigung

Thus, while individuals are normally under an obligation to report all of the offences listed in s.138 (Criminal Code) for the purpose of crime prevention, physicians are under the more narrow obligation to report only those offences that are listed in s.139(3) Criminal Code, but do not have to report information regarding the other offences listed in s.138 Criminal Code as long as they seriously tried to prevent the commission of the offence or to avert its consequences. Even if these attempts fail, the physician cannot be held criminally liable for not reporting the planned commission of the offence. A physician who reports a planned criminal offence to the relevant authorities in accordance with his/her obligations under ss.138, 139 Criminal Code will not be liable for a breach of his/her obligation to medical confidentiality.[89] For a small number of criminal offences, the legislator has thus made the decision that the interest in medical confidentiality is outweighed where such offences can be prevented by a breach of confidence.

In all other cases, the conflict between medical confidentiality and crime prevention must be resolved according to the criteria of the necessity defence. The necessity defence can again only be invoked successfully if harm to other individuals is present or imminent, and even then only where the balancing of all interests involved points towards a precedence of the interest protected by the breach of confidentiality and no less intrusive means are available to prevent the commission of the crime. Danger is defined as a situation in which the likelihood with which the violation of a right can be expected exceeds the general risks of life.[90] The 'imminent danger' requirement can be problematic. It is without doubt fulfilled, if the patient tells his/her physician that he/she will commit a crime the details of which are already specified. However, it is difficult to draw the line between an imminent danger and the mere possibility that the patient might commit a crime which is not sufficient to justify a breach of medical confidentiality under the necessity defence. It is thus questionable whether an imminent danger exists when the patient informs the physician about his/her intentions to commit a future crime without any specifications with regard to time,

(§ 129a)
handelt. Unter denselben Voraussetzungen ist ein Rechtsanwalt, Verteidiger oder Arzt nicht verpflichtet anzuzeigen, was ihm in dieser Eigenschaft anvertraut worden ist.

[89] Schönke/Schröder-Cramer, *Strafgesetzbuch Kommentar*, 23 to s.138.

[90] Jakobs, *Allgemeiner Teil*, at 415.

place, intended victims etc., or where the mental condition of the patient gives rise to general worries that the patient might commit a crime. While Lenckner would answer this question in the affirmative, as he argues that a danger in the meaning of s.34 exists in a situation in which the permanent dangerousness of a person could at any time lead to the commission of a criminal offence,[91] in none of the above-mentioned cases exists a danger that exceeds the general risks of life. It is thus submitted that an imminent danger presupposes that the intention to commit a criminal offence or the dangerous mental condition are sufficiently specified. In most cases, even if the prerequisite of an imminent danger is met, the necessity defence will still not succeed, as a breach of medical confidentiality will often not be a suitable means to avert the danger, given that the disclosure of such information will only rarely prevent the commission of the crime.

In those cases in which exceptionally all the prerequisites of the necessity defence are met, the success of the necessity defence depends on the outcome of a balancing exercise. The patient's interest in medical confidentiality has to be balanced against the interests of the potential victims and the state interest in crime prevention. Factors to be taken into account when balancing the competing interests are for example the seriousness of the intended criminal offence and the value accorded to the endangered rights. Thus, the result of the balancing test may be influenced by factors such as whether the patient intends to commit a serious assault with a weapon, or whether he/she merely wants to slap someone. It is also important whether there is a risk to the life of a third party, or a risk to property or financial interests, and whether the patient plans to cause considerable damage or whether he/she rather intends to steal some flowers. Given these rather vague considerations, the question arises whether some general criteria should be developed to facilitate the balancing exercise. One possibility could be to borrow the criteria provided by the legislator in ss.138, 139 Criminal Code for the conflict between the state interest in the prevention of certain serious crimes and the interest in medical confidentiality. It has been suggested that it follows from these provisions that the legislator values medical confidentiality more than the disclosure of intended crimes that are not listed in s.139. Some go even further and argue that the disclosure by the physician of an intended criminal offence can never be justified under the necessity defence unless the physician is under an

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[91] Schönke/Schröder-Lenckner, *Strafgesetzbuch Kommentar,* 17 to s.34.

obligation to disclose pursuant to ss.138, 139.[92] However, it is rather problematic to interpret ss.138, 139 Criminal Code, the purpose of which is to create an obligation to disclose intended serious criminal offences, as excluding the application of the necessity defence which aims at the resolution of specific conflicts of interests and requires to take into account all the circumstances of the individual case. The legislator is reluctant to impose obligations on the citizen, so that it does not seem appropriate to interpret the rather narrow obligations imposed on the physician by ss.138 and 139 Criminal Code so as to limit his/her right to refer to the necessity defence in the case of a conflict between the obligation to maintain confidentiality and the necessity to prevent a criminal offence by the way of disclosure. Ss. 138, 139 should therefore not be seen as strict rules for the balancing process in the context of s.34 Criminal Code, but rather only as guidelines concerning the value of the rights protected by different criminal provisions. Consequently, the disclosure of criminal offences that are not listed in ss.138 and 139 Criminal Code will normally not be justified, but a justification of a breach of medical confidentiality under the necessity defence with regard to such offences remains possible under exceptional circumstances.[93]

2.2. Confidential material exempt from search and seizure

Police access to confidential patient information is governed by s.97 Code of Criminal Procedure stating that:

> (1) Are exempt from seizure
>
> 1. written communications between the accused and persons entitled to refuse to give testimony under s.52 or s.53(1) number 1 to 3b;
>
> 2. documents prepared by the persons listed in s.53(1) number 1 to 3b relating to information confided in them by the accused or relating to other information the right to refuse to give testimony refers to;
>
> 3. other material, including the results of medical examinations, the right to refuse to give testimony awarded to the persons listed in s.53(1) number 1 to 3b refers to.
>
> (2) These restrictions only apply if the material is in the custody of the person who has the right to refuse to give testimony. ... The restrictions to seizure do not apply when the person who has a right to refuse to give testimony is suspected of aiding and abetting, of acting as an accessory after the fact, of

[92] Kielwein, GA 1955, at 231.

[93] Schönke/Schröder-Lenckner, *Strafgesetzbuch Kommentar,* 31 to s.203; Maurach/Schroeder/Maiwald, *Besonderer Teil 1,* at 293.

obstruction of criminal prosecution, or of handling or receiving of stolen goods .... .[94]

It can be seen that patient information is comprehensively protected, in that not only written patient communication and documents are exempt from seizure, but also other material the physician holds in confidence, which, for example, includes bullets removed from the patient's body.[95]

S.97 Code of Criminal Procedure must be seen in the context of confidentiality protection. If the physician could be forced to hand over confidential patient material, the right not to testify in criminal court would lose much of its protective effect, as the information which is protected by s.53(1) Code of Criminal Procedure would then be available to the state by the means of seizure. S.97 Code of Criminal Procedure thus aims at preventing a circumvention of the physician's right under s.53(1) Code of Criminal Procedure to refuse to give testimony in criminal court about confidential patient information,[96] and the provision accordingly intends to guarantee the same rights s.53 Code of Criminal Procedure is designed to protect, i.e. mainly the privacy right of the patient.[97] This conforms with the Federal Constitutional Court's holding that medical records, as they contain information on anamnesis, diagnosis and therapeutic measures, belong to the private sphere of the patient, and are protected by Art.2(1) and Art.1(1) BL against state access.[98] In addition, s.97 Code of Criminal Procedure serves the protection of the physician's interest in an unimpeded exercise of his/her

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[94] S.97:
(1) Der Beschlagnahme unterliegen nicht
1. schriftliche Mitteilungen zwischen dem Beschuldigten und den Personen, die nach § 52 oder § 53 Abs. 1 Nr. 1 bis 3b das Zeugnis verweigern dürfen;
2. Aufzeichnungen, welche die in § 53 Abs. 1 Nr. 1 bis 3b Genannten über die ihnen vom Beschuldigten anvertrauten Mitteilungen oder über andere Umstände gemacht haben, auf die sich das Zeugnisverweigerungsrecht erstreckt;
andere Gegenstände einschließlich der ärztlichen Untersuchungsbefunde, auf die sich das Zeugnisverweigerungsrecht der in § 53 Abs. 1 Nr. 1 bis 3b Genannten erstreckt.
(2) Diese Beschränkungen gelten nur, wenn die Genestände im Gewahrsam der zur Verweigerung des Zeugnisses Berechtigten sind. ... Die Beschränkungen der Beschlagnahme gelten nicht, wenn die zur Verweigerung des Zeugnisses Berechtigten einer Teilnahme oder einer Begünstigung, Strafvereitelung oder Hehlerei verdächtig sind .... .

[95] Karlsruher Kommentar-Nack, 14 to s.97.

[96] BVerfGE 32, 373, 385 (1972); BGHSt 38, 144, 145 (1991); OLG Frankfurt StV 1982, 64, 65; Karlsruher Kommentar-Nack, 1 to s.97.

[97] BVerfGE 44, 353, 373 (1977); BVerfGE 32, 373, 380 (1972); Klöhn, *Der Schutz der Intimsphäre im Strafprozeß*, at 331; Lorenz, MDR 1992, at 315-316; Rengier, *Die Zeugnisverweigerungsrechte im geltenden und im künftigen Strafverfahrensrecht*, at 15-16; Schmitt, *Die Berücksichtigung der Zeugnisverweigerungsrechte nach §§52, 53 StPO bei den auf Beweisgewinnung gerichteten Zwangsmaßnahmen*, at 122.

[98] BVerfGE 32, 373, 380 (1972).

profession and in not having to contribute to the patient's criminal conviction.[99] Moreover, s.97 Code of Criminal Procedure aims at a protection of the confidential physician-patient relationship,[100] and at promoting public health.[101] It can thus be seen that the purpose behind s.97 Code of Criminal Procedure accords with the purpose behind s.53 Code of Criminal Procedure and s.203 Criminal Code.

2.2.1. Protection of the accused

S.97(1) and (2) Code of Criminal Procedure expressly refer to the protection of a patient who is accused in criminal proceedings. This gave rise to the controversial debate on whether only confidential information of an accused patient is protected from seizure, and how the non-accused patient can be protected. While a small minority of legal scholars argue that s.97 Code of Criminal Procedure not necessarily must be interpreted so as to apply exclusively to information relating to the patient who is accused in criminal proceedings,[102] this view seems inconsistent with the express wording of s.97 Code of Criminal Procedure which only refers to the accused and does not mention the protection of other persons.[103] S.97 Code of Criminal Procedure thus leaves witnesses' or victims' confidential medical documents without protection from search and seizure. This is difficult to explain, given that the predominant opinion sees a protection of the patient's privacy rights as one, if not the most important rationale behind s.97 Code of Criminal Procedure. If s.97 Code of Criminal Procedure is designed to prevent a circumvention of s.53, this goal cannot be achieved if the protection is limited to accused patients, because s.53 Code of Criminal Procedure gives the physician a right not to testify regardless of whether the confidential information concerns an accused, a witness or a third party not at all related to the criminal proceedings.[104]

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[99] BVerfGE 38, 312, 323 (1975); LG Koblenz MDR 1983, 779, with regard to the lawyer-client relationship; Schlüchter, *Das Strafverfahren*, at 289; Weyand, wistra 1990, at 5-6.
[100] LG Köln NJW 1959, 1598.
[101] Amelung, DNotZ 1984, at 198-199; Rengier, *Die Zeugnisverweigerungsrechte im geltenden und im künftigen Strafverfahrensrecht*, at 22-23.
[102] Amelung, DNotZ 1984, at 207; Krekeler, NStZ 1987, at 201.
[103] OLG Celle NJW 1965, 362, 363; LG Hildesheim NStZ 1982, 394, 395; LG Hamburg NJW 1990, 780; LG Fulda NJW 1990, 2946, 2947; Löwe/Rosenberg-Schäfer, 3a to s.97; Schmitt, *Die Berücksichtigung der Zeugnisverweigerungsrechte nach §§ 52, 53 StPO bei den auf Beweisgewinnung gerichteten Zwangsmaßnahmen*, at 117; Welp, JZ 1974, at 423.
[104] Amelung, DNotZ 1984, at 207; Alternativkommentar-Amelung, 14-15 to s.97.

The restriction of s.97 Code of Criminal Procedure to the protection of confidential medical documents of an accused patient is thus inconsistent with s.53 Code of Criminal Procedure and s.203 Criminal Code.[105] Some therefore argue that s.97 Code of Criminal Procedure only serves the purpose that evidence gained in the course of the confidential physician-patient relationship should not be used against the accused and relate this purpose to the privilege against self-incrimination.[106] If this were the purpose behind s.97 Code of Criminal Procedure, confidential material would have to be protected from seizure regardless of whether it is in the possession of the patient, or the physician. However, s.97(2) Code of Criminal Procedure clarifies that the protection from seizure only applies to material that is in the possession of the physician.[107]

It is difficult to accept that a victim's or other third party's interest in the confidentiality of medical information deserves less protection than the privacy interests of the accused. As a way around the insufficient protection of medical records of the non-accused patient from seizure under s.97 Code of Criminal Procedure, courts increasingly refer to constitutional principles as a basis for a prohibition to seize patient records. Under German constitutional law, every statute and every act by a state authority must be compatible with the provisions of the Basic Law. Given the constitutional protection of medical confidentiality and of medical records, the courts therefore have to examine whether the seizure of confidential patient information that is in the possession of a physician is compatible with the right to privacy. The Federal Constitutional Court held that there are different spheres of intimacy which deserve different degrees of protection. While the core of the intimate life of the individual is inviolate, private spheres outside of this core are also constitutionally protected, but can be subject to restrictions. If a state act violates the private sphere, a balancing between the interests pursued by the state and the privacy interest of the individual has to take place, and only if the state pursues a legitimate interest, which cannot be achieved by less intrusive means and which is not outweighed by the privacy interest, is the act compatible with the Basic Law. As medical records do not belong to the core

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[105] OLG Celle NJW 1965, 362, 363; LG Hildesheim NStZ 1982, 394, 395.

[106] Rudolphi, NStZ 1998, at 473; Welp, JZ 1974, at 423.

[107] Weinmann, 'Die Beschlagnahme von Geschäftsunterlagen des Beschuldigten bei Zeugnisverweigerungsberechtigten', in: Hanack, Rieß, Wendisch (eds.), *Festschrift für Hans Dünnebier*, at 208.

of the intimate sphere, but rather form part of the private sphere which can be restricted subject to the requirements mentioned, in the case of a seizure of confidential medical records the public interest in criminal prosecution must be balanced against the privacy interests of the patient. According to the Federal Constitutional Court the interest in the prosecution of a crime committed by the patient the confidential information relates to is, in principle, not sufficient to justify a violation of the privacy right.[108] Recent case law of the German Supreme Court, the highest court in criminal and civil matters, seems to suggest that this court now uses the constitutional balancing test for a broad interpretation of s.97 Code of Criminal Procedure. In a case of rape in which the victim had consented to the physician's testimony regarding her physical examination after the event, and the defence wanted access to other medical records of the victim to establish that she had alcohol and psychological problems, the court rejected this motion on the grounds that it was not supported by a sufficient showing that the victim's medical records were material to the case. The Court continued:

> 'The Senate can leave open the question of whether medical records which do not concern the accused but a witness, are in general protected by the prohibition of seizure under s.97 Code of Criminal Procedure and are therefore inadmissible in court ... or whether such a principal exemption from seizure which would correspond with the general right to refuse to testify under s.53 Code of Criminal Procedure cannot be considered ... .[109] Under the circumstances of this case, a seizure and use of medical records through procedural measures against the wishes of the victim and against the wishes of the physician must be ruled out ... as a disproportionate intrusion upon a particularly sensitive area of the private sphere.'[110]

In another case, however, in which the regional court had decided that the seizure of a victim's medical records was unlawful as it disproportionately interfered with the victim's personality right, the Court disagreed and held that:

> 'The prohibition of a seizure which is not unlawful according to the provisions of the Code of Criminal Procedure can follow directly from the Basic Law, if ... it intrudes upon the constitutionally protected sphere and violates the principle of proportionality ... . However, the intrusion upon the personality right of the person concerned by a seizure for the purpose of securing evidence is only disproportionate if the personality right outweighs the needs of effective criminal prosecution and crime prevention, following from the principle of the rule of law. ... The patient's personality right does not necessarily exclude the seizure of third parties' medical records ... . Rather, the seriousness of the

[108] BVerfGE 32, 373, 381 (1972).
[109] See also BGH NStZ 1998, 471, 472.
[110] BGH NStZ 1997, 562.

> offence must be considered in the balancing process ... so that in cases of serious crime the seizure of third parties' medical records can be lawful.'[111]

The Court then excluded the seizure on other grounds.

This case law is interesting as the Federal Supreme Court in both decisions left open the question of whether or not s.97 Code of Criminal Procedure protects the medical records of the non-accused patient. Given that until very recently, those who interpreted s.97 Code of Criminal Procedure as protecting the medical records of all patients were in a small minority, the express reference to this minority opinion and the statement that this controversy does not have to be decided in the specific case suggests that the minority opinion gains some weight with the courts. The case law also shows that the Supreme Court is willing to protect medical records of a victim at least as long as the materiality of their content was not sufficiently established by the defence. Furthermore, the Court now expressly holds that in the case of medical records of a non-accused patient, a balancing test has to be performed. According to the Supreme Court the patient's personality rights will not automatically prevail over the state interest in criminal prosecution. Rather, the personality rights may have to yield in cases concerning the prosecution of serious offences.[112] The regional court of Hamburg, on the other hand, decided that where the privacy interest of a witness conflicted with the state interest in establishing facts which could potentially incriminate the accused, the privacy interest of the witness had to prevail and the seizure of the witness' medical records was unconstitutional, even though not prohibited under s.97 Code of Criminal Procedure.[113] While the recent developments in the Federal Supreme Court's case law must be welcomed, it is nevertheless submitted that the protection awarded to medical records of non-accused patients does not go far enough and that the view of the regional court of Hamburg is to be preferred. If a patient's confidences are protected by the provisions of the Criminal Code, the provisions of the Code of Criminal Procedure and by constitutional principles, and if in other cases of conflict between the right to medical confidentiality and the state interest in criminal prosecution for various reasons the latter has to yield, regardless of the seriousness of the offence under investigation, it seems inconsistent to allow the seriousness of the crime to be determinative in deciding

[111] BGH NStZ 1998, 471, 472.
[112] See also LG Fulda NJW 1990, 2946.
[113] LG Hamburg NJW 1990, 780, 781.

whether or not the medical records of a non-accused patient may lawfully be seized. Rather, the balancing process now performed by the courts should follow the principles outlined above in the context of a breach of medical confidentiality by the physician.

Another problem sometimes arising in this context is that of whether or not the patient's interest in medical confidentiality outweighs the interest in an effective exercise of defence rights. The Higher Regional Court of Celle[114] had to decide a case in which a physician was accused of negligently causing the death of a patient. The court held that the interest of the physician in presenting exonerating evidence should prevail over the privacy interest of the deceased patient. The court considered whether it was less intrusive and more appropriate to reconcile the competing interests by maintaining medical confidentiality and assuming the truthfulness of the assertions of the defence, but rejected this solution on the grounds that even if this procedure resulted in the acquittal of the physician, without full exploration of the evidence he would still be tormented by doubts as to whether his behaviour had contributed to the patient's death. While it is at least arguable that the interest of the accused in not being subjected to a criminal penalty without having the possibility of presenting exonerating evidence can be important enough to outweigh even the privacy interest of a patient, it is submitted that moral problems of the physician cannot be of higher value than constitutionally guaranteed privacy rights.

Another problem in this context is caused by seizures of confidential patient records in the course of investigations against the physician, for example investigations for tax fraud or for medical malpractice. As s.97 Code of Criminal Procedure is only applicable where the patient is accused in criminal proceedings, in such a situation s.97 Code of Criminal Procedure will not provide any protection against search for and seizure of confidential patient records.[115] In its famous *Memmingen* decision, the German Supreme Court held that the seizure of patient records in the course of criminal investigations against a physician for illegal abortions was lawful.[116] In support of this view it has been argued that in such a situation the physician-patient relationship is no longer worthy of

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[114] NJW 1965, 363.
[115] Karlsruher Kommentar-Nack, 6 to s.97.
[116] BGHSt 38, 144, 146 (1991).

protection,[117] that otherwise the physician would be in the situation of abusing the confidential physician-patient relationship for committing crimes without having to fear discovery, and that in this particular situation the seizure of confidential patient records is therefore justified.[118] It is submitted, however, that the confidentiality of the physician-patient relationship is mainly protected to guarantee the patient's privacy rights and that those rights do not deserve less protection just because the physician has abused this relationship as a cover for criminal activities.[119] As a way around the fact that the physician does not have to fear discovery, the police could seek the patient's consent to the seizure of his/her medical records, which will in many cases probably be given, particularly if a considerate use of these data were guaranteed. If, as already demonstrated, the patient's interest in medical confidentiality always outweighs the state interest in criminal prosecution, this must also apply to the criminal prosecution of physicians.

It is submitted that the current legal situation regarding the application of s.97 Code of Criminal Procedure to the seizure of medical records of non-accused patients needs clarification, given that there is a lack of clear guidelines as to the operation of the balancing test and the weight to be accorded to the principle of medical confidentiality within that process.[120] The privacy rights of the patient who is not accused in criminal proceedings are thus not sufficiently safeguarded under present law. The situation needs to be changed, in that the restriction of the protection of s.97 Code of Criminal Procedure to the accused should be abolished, and all patients should be protected against disclosure of their confidential medical records for the mere purpose of criminal prosecution.[121] This is the only way to reconcile the law with the objectives underlying s.97 Code of Criminal Procedure and to put an end to the existing inconsistencies between s.97 Code of

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[117] Schlüchter, *Das Strafverfahren*, at 289.

[118] Weyand, wistra 1990, at 6.

[119] See also Lorenz, MDR 1992, at 316 who argues that the fact that the seizure violates the patient's privacy rights is an important factor in the context of the balancing exercise.

[120] For an example of how difficult it is for German courts to make sense of this confusing situation see most recently LG Bielefeld, StV 2000, 12, and the commentary by Samson, StV 2000, 55-56.

[121] See also Krekeler, NStZ 1987, at 201; Muschallik, *Die Befreiung von der ärztlichen Schweigepflicht und vom Zeugnisverweigerungsrecht im Strafprozeß*, at 138; Schmitt, *Die Berücksichtigung der Zeugnisverweigerungsrechte nach §§ 52, 53 StPO bei den auf Beweisgewinnung gerichteten Zwangsmaßnahmen*, at 128.

Criminal Procedure and s.53 Code of Criminal Procedure and s.203 Criminal Code.

2.2.2. Custody requirement

S.97(2) Code of Criminal Procedure limits the protection of confidential medical documents to records that are in the possession of the physician, thus excluding medical documents that are in the possession of the patient him/herself. It follows that medical records of an accused patient cannot be seized at the physician's surgery, but a copy of the same documents can be seized when found in the patient's possession. It is difficult to find a justification for this restriction. One attempt to explain the rationale behind s.97(2) Code of Criminal Procedure is to say that if the medical records are no longer in the possession of the physician, the patient's privacy has already been invaded, so that it can no longer have the same weight in the balancing process. Even if this were the case where the medical records are in the possession of a third party, the privacy interests of the patient are not diminished by the fact that the confidential material is in the possession of the patient, rather than the physician.[122] The rationale behind the custody-requirement seems to be that if protection is awarded to information obtained in the framework of a protected relationship, for example that of physician and patient, there is no longer a justification for this protection where the material has left the confidential context. Thus, where confidential material is no longer in the possession of the physician and third parties have access to this information, the purpose behind the protection of medical confidentiality can no longer be achieved, and, most importantly, the information is no longer confidential. But where the material is in the possession of the patient, it is still within the confidential setting of the physician-patient relationship, and it is as worthy of protection as if it were in the physician's possession.[123] Of course one could object that s.97 Code of Criminal Procedure only wants to protect the physician-patient relationship insofar as it would be seriously undermined if the patient were to fear that all information given to the doctor, and no longer under the patient's exclusive

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[122] Welp, 'Die Geheimsphäre des Verteidigers in ihren strafprozessualen Funktionen', in: Lackner, Leferenz, Schmidt, Welp, Wolff (eds.), *Festschrift für Wilhelm Gallas zum 70. Geburtstag*; at 416, for the lawyer-client privilege.

[123] See also Schmitt, *Die Berücksichtigung der Zeugnisverweigerungsrechte nach §§52, 53 StPO bei den auf Beweisgewinnung gerichteten Zwangsmaßnahmen*, at 154-157.

control, might be available to the police. It could thus be said that patient documents in the hand of the patient do not need extended protection, as they are under the patient's control. But this leads to the unfortunate result that a physician must be conscious of the danger involved when handing documents or copies of documents over to patients. As the patient has a right of access to his/her medical records, this means that the doctor has to draft those documents very carefully. This could result in sketchy, incomplete or even inaccurate records, as physicians might want to ensure that the confidential information obtained will not leave the confidential sphere. To prevent these unfortunate results, it has been suggested that s.97 Code of Criminal Procedure should be interpreted so as to protect medical records from search or seizure regardless of whether they are in the possession of the physician or of the patient, as this is the only way to ensure that the inviolability patient's medical confidences is guaranteed.[124] Others, while being of the opinion that s.97(2) Code of Criminal Procedure does not leave room for such an interpretation, demand an amendment of the provision to this effect.[125]

2.2.3. Effect of the patient's consent

Yet another question is that of the effect the patient's consent in the context of s.97 Code of Criminal Procedure. As the purpose behind s.97 Code of Criminal Procedure is to prevent a circumvention of s.53 Code of Criminal Procedure, it is widely argued that medical documents are no longer exempt from seizure once the patient has consented to the physician's testimony in respect of confidential information, as according to s.53(2) Code of Criminal Procedure such consent excludes the physician's right to refuse to testify.[126] Göppinger, however, argues that medical documents drawn up by the physician are not identical with the patient's confidences, as they contain the physician's observations, diagnosis etc., and concludes that the patient cannot validly make dispositions with regard to these documents. He therefore suggests that a seizure of confidential medical documents cannot be justified by reference to s.53(2) Code of Criminal

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[124] Bandisch, NJW 1987, at 2201.

[125] Muschallik, *Die Befreiung von der ärztlichen Schweigepflicht und vom Zeugnisverweigerungsrecht im Strafprozeß*, at 138; Petry, *Beweisverbote im Strafprozeßrecht*, at 53.

[126] OLG Hamburg NJW 1962, 689, 690; Karlsruher Kommentar-Nack, 5 to s.97.

Procedure.[127] But it is submitted that it should be the responsibility of the autonomous patient to make sure that he/she fully understands the implications of such a consent.

2.2.4. The physician's right voluntarily to submit confidential material

Another question is whether the physician is allowed voluntarily to submit the material protected by s.97 Criminal Procedure Code to the police or the court, a question which the predominant opinion answers in the affirmative. As according to the predominant opinion, the physician can freely decide to give testimony with regard to the patient's confidences, the same should apply to s.97 Code of Criminal Procedure which aims at preventing a circumvention of s.53 Code of Criminal Procedure.[128] The voluntary submission of medical records is seen as a waiver of the physician's right, and the material is admissible in court even where the doctor's behaviour constitutes a breach of confidence under s.203 Criminal Code,[129] which will always be the case unless a legal justification applies. This approach must be rejected for the same reasons for which it has been argued that the physician does not have a right to decide to give testimony in court about confidential patient information.

2.3. Summary and conclusion

The situation in Germany is characterised by the attempt to create a coherent protection of privacy and medical confidentiality. The main problem consists in trying to interpret all the provisions relevant in this context coherently. As medical confidentiality is protected as part of the constitutional personality right, medical privilege equally serves this purpose, though it is argued that medical privilege additionally aims at protecting the physician's interest in the exercise of his/her profession and the state interest in preserving public health. However, the wording of s.53 Code of Criminal Procedure gives the physician the right, rather than imposing an obligation to refuse to testify in criminal court. The predominant opinion concludes that it lies in the physician's discretion whether or not he/she

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[127] Göppinger, NJW 1958, at 245.

[128] Karlsruher Kommentar-Nack, 2 to s.97.

[129] BGHSt 18, 227, 230; Kleinknecht/Meyer-Goßner, *Strafprozeßordnung*, 5 to s.97.

exercises this right. If the physician decides to give testimony, however, he/she will commit the criminal offence of breach of confidentiality, unless the patient has consented to the disclosure of the confidential information, or the prerequisites of the necessity defence are fulfilled. The predominant interpretation of s.53 Code of Criminal Procedure thus leads to the unconvincing result that the physician is given a choice the exercise of which will regularly amount to a criminal offence. Given the interplay of s.53 Code of Criminal Procedure with s.203 Criminal Code as well as the purpose behind medical confidentiality and medical privilege, it seems compelling to argue that no such right can exist and that the physician is rather under an obligation not to testify in criminal court.

S.97 Code of Criminal Procedure further complicates the situation, in that it prohibits the seizure of medical documents, but restricts this protection to the patient who is accused in criminal proceedings and to material that is in the possession of the physician. As s.97 Code of Criminal Procedure intends to prevent a circumvention of s.53 Code of Criminal Procedure, it would seem consistent to interpret both provisions the same way and to extend the protection under s.97 Code of Criminal Procedure to all patients. The courts, while leaving open whether or not in the future they might be willing to interpret s.97 Code of Criminal Procedure extensively, instead adopt the approach that a seizure of medical documents relating to non-accused patients is admissible only subject to a balancing test which is based on the principles of constitutional law. Even if a seizure is not prohibited under s.97 Code of Criminal Procedure, it is thus only admissible if the privacy right is in the particular case outweighed by the competing interest.

A breach of medical confidentiality can only be justified if a legal justification applies. The only justification sometimes available in cases of such a breach is the necessity defence of s.34 Criminal Code which requires, *inter alia*, that the interest promoted by the breach must considerably outweigh the interest which is thereby impaired. While this can never be the case where medical confidentiality conflicts with the interest in criminal prosecution, as the existence of a statutory privilege shows the legislative intent that the interest in medical confidentiality is prevalent, the situation can be different where medical confidentiality conflicts with the interest in crime prevention, with defence rights or with the interests that the innocent will not be prosecuted and convicted. The same principles and

considerations apply to the question of whether the physician is allowed voluntarily to submit patient records to the police.

While the legal system provides for a rather strict protection of medical confidentiality, it can be seen that there are many inconsistencies and that the existence of statutory provisions does not make a reference to broader principles and a balancing of interests superfluous.

Chapter 6 - Medical confidentiality and medical privilege in England

1. Protection of medical confidentiality

1.1. Protection of medical confidentiality as a fundamental right

1.1.1. Constitutional right

The UK does not have a Bill of Rights listing fundamental rights and freedoms of the individual and providing them with constitutional rank. The Interdepartmental Working Group Concerning Legislation on Human Rights, with Particular Reference to the European Convention described the English approach to the protection of basic rights as follows:[1]

> 'The effect of the United Kingdom system of law is to provide, through the development of the common law and by express statutory enactment, a diversity of specific rights with their accompanying remedies. ... The rights that have been afforded in this way are for the most part negative rights to be protected from interference by others, rather than positive rights to behave in a particular way. Those rights which have emerged in the common law can always be modified by Parliament.'

This means that in order to determine which individual rights are protected by the English legal system, reference must be made to the common law and to statutes.[2] As the protection of fundamental rights is thus left to the principles of ordinary law, it follows that neither privacy in general, nor medical confidentiality in particular, are protected as fundamental individual right of constitutional rank.

1.1.2. European Convention on Human Rights and Human Rights Act 1998

As the UK takes a dualist approach towards international law, the ratification of the ECHR by the UK did not in itself have the effect of making it part of domestic law.[3] The Convention has not as yet been incorporated into national law and is therefore not directly applicable by English courts. A violation of Art.8 of the Convention by English legislation or administrative acts is therefore not actionable before an English court. In *R v Khan,*[4] for example, when deciding on

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[1] (1976-77) HL 81.
[2] Fenwick, *Civil Liberties*, at 1.
[3] Gearty, 'The United Kingdom', in: Gearty (ed.), *European Civil Liberties and the European Convention on Human Rights, A Comparative Study*, at 65.
[4] [1996] 3 All ER 289.

the admissibility of evidence of a conversation that had been taped without the accused's knowledge, Nolan LJ stated:

> 'The argument that the evidence of the taped conversation is inadmissible could only be sustained if two wholly new principles were formulated in our law. The first would be that the appellant enjoyed a right of privacy, in terms similar to those of art 8 of the convention, in respect of the taped conversation. ... The objection to the first of these propositions is that there is no such right of privacy in English law.[5] ... Under English law, there is, in general, nothing unlawful about a breach of privacy.'[6]

Both Browne-Wilkinson, LJ, and Nicholls, LJ, however, stressed that it was unnecessary for the court in that case to decide whether or not a privacy right existed under English law, as the result in that particular case would not have changed had such a right been recognised.[7] Even though the rights guaranteed by the provisions of the ECHR are not applicable, courts frequently express the view that British law does not, in fact, contravene the Convention rights. In *John v MGN Limited*[8], for example, Bingham MR emphasised that:

> 'The European Convention on Human Rights is not a free-standing source of law in the United Kingdom. But there is ... no conflict or discrepancy between art.10 and the common law: We regard art.10 as reinforcing and buttressing the conclusions we have reached and set out above. We reach those conclusions independently of the convention, however, and would reach them even if the convention did not exist.'[9]

At present, therefore, the ECHR does not accord individual rights directly enforceable in English courts. However, the state is under an international obligation to respect the Convention rights and the Convention therefore has some impact on English case law. In *Derbyshire County Council v Times Newspapers Ltd*,[10] for example, the Court of Appeal held that the courts must have regard to the implications of the ECHR if the case concerns a legal problem that has not been clearly resolved under English law.

It remains to be discussed how the situation is going to change with the coming into force of the Human Rights Act 1998. In Art.8, the Act guarantees the right to respect for private and family life, stating that:

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[5] Ibid., at 297-298.
[6] Ibid., at 301.
[7] Ibid., at 291 per Browne-Wilkinson, LJ, and at 302, per Nicholls, LJ.
[8] [1996] 2 All ER 35 (CA).
[9] Ibid., at 58
[10] [1992] 3 WLR 28.

(1) Everyone has the right to respect for his private and family life, his home and his correspondence.

The text of Art.8 Human Rights Act 1998 is identical with Art.8 European Convention on Human Rights. As the Act will not come into force before the year 2000, it has yet to be seen what impact it is going to have.[11] Under s.2(1) Human Rights Act, in determining a question that has arisen in connection with a Convention right, a court must take into account decisions of the European Court of Human Rights and opinions of the Human Rights Commission. Accordingly, it is likely that in the future, British courts will widely follow the case law of the European Court of Human Rights with regard to the protection of Convention rights. In all likelihood, therefore, British courts will award medical confidentiality the same protection which the principle receives according to the case-law of the European Court of Human Rights to Art.8(1) ECHR. The expectation has been voiced that the Human Rights Act will result in the gradual recognition of a general right to privacy with horizontal effect.[12] This, of course, would be of particular importance for the principle of medical confidentiality, as it mainly arises in the relationship between physician and patient, rather than between the state and the patient. Only if the right to privacy is given horizontal effect will it impact on the physician-patient relationship. Given that at present, no right to privacy is guaranteed, the Human Rights Act will considerably strengthen the privacy rights of the individual.

1.2. Criminal offence and statutory obligation

In English law, the violation of the obligation to medical confidentiality is, in principle, not a criminal offence. Statutory duties of confidentiality are limited to special circumstances such as, for example, venereal diseases,[13] abortion,[14] and some activities under the Human Fertilisation and Embryology Act.[15] A more general statutory regime concerning the processing of computerised data as well as of non-computerised data that are kept as part of a qualifying filing system is

[11] For a discussion, see, for example, Hunt, (1998) Public Law 423-443; Laws, (1998) Public Law 254-265; Lord Irvine of Lairg, (1998) Public Law 221-236; Klug, (1999) Public Law 246-273.
[12] Neill, 'Privacy: A challenge for the next century', in: Markesinis (ed.), *Protecting Privacy*, at 21.
[13] S.2 NHS (Venereal Diseases) Regulations 1974.
[14] S.5 Abortion Regulations 1991.
[15] S.33 Human Fertilisation and Embryology Act 1990.

provided by the provisions of the Data Protection Act 1998, and the Act makes certain abuses of computerised and manual files containing personal data a criminal offence.[16] Data related to a person's health receive particular protection under Schedule 3 of the Act. Under the first principle of data protection as laid down in Schedule 1, personal data shall be processed fairly and lawfully, which excludes the processing of data to which an obligation of confidentiality applies.[17] The Health Act 1999 makes it a criminal offence under certain circumstances without lawful authority to disclose information the Commission for Health Improvement has obtained in exercising its functions.[18]

1.3. Contractual obligation

If the physician-patient relationship is based on a contract, the doctor is under a contractual obligation to maintain the patient's secrets[19] and it must then be decided whether in the individual case disclosure amounted to a breach of contract giving rise to a claim for compensation. However, within the framework of the NHS, no direct contract between the physician and the patient is concluded, and a physician is therefore not under a contractual obligation to keep the medical confidences of an NHS-patient.[20] However, some argue that an independent contract, to the effect that the physician owes the patient an obligation to maintain medical confidentiality, could exist between the physician and the NHS-patient and that the provision of information to the physician by the patient could be sufficient consideration.[21] This view suggests that the provision of information is made primarily for the benefit of the physician, an interpretation that is difficult to sustain. It is therefore submitted that the mere disclosure of information cannot be regarded as adequate consideration for an independent contract about the confidentiality of medical information passed on to the physician.[22] Also, this concept would provide the patient only with rather limited protection, as it could only protect the information volunteered by the patient, without encompassing every observation made by the physician in the course of the physician-patient

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[16] See, for example, s.55 Data Protection Act 1998.
[17] Jay, Hamilton, *Data Protection Law and Practice*, at 47.
[18] S.24 Health Act 1999.
[19] *Parry-Jones v Law Society and Others* [1969] 1 Ch 1, at 9 per Diplock, LJ.
[20] Grubb, Pearl, (1986) Family Law, at 240.
[21] Montgomery, (1987) Family Law, at 101.
[22] Grubb, Pearl, (1986) Family Law, at 240.

relationship, unless one is prepared to argue that it is sufficient consideration that the patient allows the physician to make observations related to his/her private and intimate sphere in the course of the physician-patient relationship. Thus, as far as the relationship between physicians and NHS patients is concerned, the physician is not under any contractual obligation to respect the patient's confidences. However, where patients are seeking private health care which is normally provided within a contractual relationship, the contract includes the obligation to maintain medical confidentiality, and a breach of that duty could then give rise to the remedies for breach of contract.

1.4. Common law duty

In English law, the most important legal basis for the protection of medical confidentiality is the common law duty of a doctor to respect the confidences of his/her patient. This is surprising, given that English law does not recognise a general common law right to privacy. With regard to the protection of such a right, it has been said that: 'The protection afforded to privacy by English law is piecemeal, incomplete and indirect. There is no general right to privacy.'[23] This view was recently confirmed in *Kaye v Robertson*[24] per Glidewell LJ, when stating that:

> 'It is well-known that in English law there is no right to privacy, and accordingly there is no right of action for breach of a person's privacy. The facts of the present case are a graphic illustration of the desirability of Parliament considering whether and in what circumstances statutory provision can be made to protect the privacy of individuals.'[25]

And Bingham LJ stated in the same case:

> 'The defendants' conduct towards the plaintiff here was "a monstrous invasion of his privacy" ... . It is this invasion of privacy which underlies the plaintiff's complaint. Yet it alone, however gross, does not entitle him to relief in English law.'[26]

The only possibility for the plaintiff in such cases is therefore to demonstrate the prerequisites of one of the well-established rights of action in the domain of a violation of privacy, such as breach of confidentiality. An important case

[23] Bailey, Harris, Jones, *Civil Liberties*, at 517.
[24] [1991] FSR 62 (CA).
[25] Ibid., at 66.
[26] Ibid., at 70.

establishing the common law protection of confidences is *Argyll v Argyll.*[27] In that case, the Duke of Argyll, the former husband of the Duchess of Argyll, had published, without her consent, articles revealing details of their married life. Ungoed-Thomas J analysed the existing case law in that area and came to the conclusion that:

> 'These cases, in my view, indicate ... (2) that a breach of confidence or trust or faith can arise independently of any right of property or contract other, of course, than any contract which the imparting of the confidence in the relevant circumstances may itself create; (3) that the court in the exercise of its equitable jurisdiction will restrain a breach of confidence independently of any right at law.'[28]

This case thus demonstrates that the courts are willing to protect confidential relationships by referring, if need be, to the instruments of equitable relief. However, the question remained under what circumstances such legal protection should materialise. In *Coco v A N Clark (Engineers) Ltd,*[29] Megarry J identified the prerequisites of a common law duty to maintain confidentiality as follows:

> 'Three elements are normally required if, apart from contract, a case of breach of confidence is to succeed. First, the information itself, in the words of Lord Greene MR in the *Saltman* case [*Saltman Engineering Co Ltd v Campbell Engineering Co Ltd* [1963] 3 All ER 413, at 415] must "have the necessary quality of confidence about it." Secondly, that information must have been imparted in circumstances importing an obligation of confidence. Thirdly, there must be an unauthorised use of that information to the detriment of the party communicating it.'[30]

It seems sensible to look at the second requirement laid down in the *Coco* case first to establish whether the physician-patient relationship is normally of such a nature that it is safe to conclude that the physician is under an obligation to maintain the confidences of the patient. To that effect, Keith LJ held in *Attorney General v Guardian Newspapers Ltd and others* (2)[31] in the House of Lords that:

> 'The law has long recognised that an obligation of confidence can arise out of particular relationships. Examples are the relationships of doctor and patient. ... The obligation may be imposed by an express or implied term in a contract but it may also exist independently of any contract on the basis of an independent equitable principle of confidence.'[32]

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[27] [1967] Ch 302.
[28] Ibid., at 322.
[29] [1969] RPC 41.
[30] Ibid., at 47.
[31] [1988] 3 All ER 545.
[32] Ibid., at 639.

And Donaldson MR held in the same case in the Court of Appeal :

> 'The right can arise out of a contract. ... But it can also arise as a necessary or traditional incident of a relationship between the confidant and the confider, e.g. priest and penitent, doctor and patient, lawyer and client, husband and wife.'[33]

Thus, the relationship between physician and patient was expressly mentioned as a relationship giving rise to a duty of confidentiality, independent from any contractual duty to maintain confidentiality. The reasons for the recognition of such a common law obligation can be inferred from the statement by Goff LJ that:

> 'A duty of confidence arises when confidential information comes to the knowledge of a person (the confidant) in circumstances where he has notice, or is held to have agreed, that the information is confidential, with the effect that it would be just in all the circumstances that he should be precluded from disclosing the information to others.'[34]

Given the wide-spread recognition of the principle of medical confidentiality, the physician can be said to have notice that the information imparted to him by the patient is confidential and should therefore not be disclosed to others. Thus, the physician is, in principle, under a common law duty to maintain patient confidences.

To conform with the first requirement set out in *Coco*, it must be established whether the information has the necessary quality of confidence about it. As Greene MR put it in *Saltman Engineering Co Ltd v Campbell Engineering Co Ltd (1948)*:[35]

> 'The information to be confidential must ... have the necessary quality of confidence about it, namely it must not be something which is public property and public knowledge.'

This means that the physician is only under a duty of confidentiality as long as the information this obligation refers to can still be regarded as confidential. While this seems to be a straightforward prerequisite of a duty of confidentiality, the interpretation of what is or is not public knowledge can prove difficult and controversial. Such a problem arose in *Stephen v Avery*.[36] In that case, the plaintiff had confided details of her sex life to the first defendant and the first defendant had disclosed this information to a newspaper. The court had to decide whether

[33] Ibid., at 595 (CA).
[34] Ibid, at 658.
[35] [1963] 3 All ER 413, at 415.
[36] [1988] 2 All ER 477, per Nicolas Browne-Wilkinson V-C (Ch D).

the fact that the sexual conduct at issue was evidently known to the sexual partner of the plaintiff meant that it did not qualify as confidential information. The court held:

> 'The mere fact that two people know a secret does not mean that it is not confidential. If in fact information is secret, then in my judgment it is capable of being kept secret by the imposition of a duty of confidence on any person to whom it is communicated. Information only ceases to be capable of protection as confidential when it is in fact known to a substantial number of people.'[37]

This holding seems to suggest that information does not lose its confidential character merely because it was confided in or known by a third party. Thus, the patient's medical information does not lose its confidential character by the fact that the physician gains knowledge of it, and it remains confidential even if the patient confides his/her medical secret in a limited number of people, for example close relatives or friends. Contrast the so-called *Spycatcher* case.[38] In that case the question arose whether information that had become widely known to the public due to the defendant's disclosure, still had the necessary quality of confidentiality to it so that the confidant was still under an obligation to maintain confidentiality. In that case, a former member of the British security service, in breach of his duty of confidentiality, wrote his memoirs. After the book had been published in the US and had been disseminated in many countries, it was held with regard to whether the information still had the necessary quality of confidence:

> 'The reason why the duty of confidence is extinguished is that the matter is no longer secret and there is therefore no secrecy in relation to such matter remaining to be preserved by the duty to confidence. It is meaningless to talk of a continuing duty of confidence in relation to matters disclosed world-wide. It is meaningful only to discuss the remedies available to deprive the delinquent confidant ... of benefits flowing from the breach, or in an appropriate case to compensate the confider.'[39]

And Goff, LJ equally stressed that:

> 'The principle of confidentiality only applies to information to the extent that it is confidential. In particular, once it has entered what is usually called the public domain (which means no more than that the information in question is so generally accessible that, in all the circumstances, it cannot be regarded as confidential) then, as a general rule, the principle of confidentiality can have no application to it. ... The confidential information, as confidential information,

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[37] Ibid., at 481.
[38] *Attorney General v Guardian Newspapers Ltd and others* (2) [1988] 3 All ER 545.
[39] Ibid., at 647, per Brightman, LJ.

> has ceased to exist, and with it should go, as a matter of principle, the obligation of confidence.'[40]

Donaldson MR held in the Court of Appeal:

> 'That which has no character of confidentiality because it has already been communicated to the world, i.e. made generally available to the relevant public, cannot thereafter be subjected to a right of confidentiality. ... However, this will not be the case if the information has previously only been disclosed to a limited part of that public.'[41]

The facts of this case were obviously rather extreme, in that the information had literally been published almost world-wide. Applied to the context of medical confidentiality, the holdings seem to suggest that once the patient's medical secrets have become the subject of wide-spread publication, they cease to be confidential, and the physician can then no longer be under a duty to keep this information to him/herself. But where to draw the line between information that is so widely known as to lose its confidential status and information that is only known to a limited part of the public and therefore still confidential? In *Bunn v British Broadcasting Corporation and another,*[42] Lightman J had to decide a case in which the plaintiff sought an injunction to stop the disclosure of statements he had made during a police interview under caution. In the course of the criminal trial against the plaintiff, the judge's attention was drawn to the statement which the judge read to himself. Lightman J decided that even though the statement made by the plaintiff had enjoyed confidentiality, its confidential status had ended because the contents of the statement were already in the public domain. To that effect, he held that:

> 'The reading of the statement by Phillips J in open court would appear to me to be sufficient for this purpose. I do not think that it is realistic to draw a distinction between a document which the judge reads and a document which is read to the judge. The distinction is artificial today when it is a matter of taste for the individual judge whether he requires a document to be read or reads it himself (consider RSC Ord 24, r 14A). But in any event Mr Suckling, referring the judge to the statement, stated its substance (the element in it for which protection is sought in these proceedings) in open court. Whether or not the prosecution is over and a matter of the past and the restraint on publication lifted, any confidentiality expired when the contents of the statement were disclosed in open court.'[43]

[40] Ibid., at 660-661.
[41] Ibid., at 595.
[42] [1998] 3 All ER 552 (Ch D).
[43] Ibid., at 557.

It must be questioned whether this holding is compatible with Donaldson's statement in *Attorney General v Guardian Newspapers Ltd and others* (2), as it is doubtful whether the fact that the substance of the statement was summarised in open court, means that it loses its confidential character. The information is then still only known to a part of the public, but not to the public in general. The fact that the judge has read the statement to him/herself can hardly be used to terminate the confidential quality of the information. If the judge reads the confidential information to him/herself and it is not read to him/her in open court, only the judge takes actual knowledge of its content. As long as other members of the public do not obtain knowledge of the content of the statement, this can hardly suffice to say that the information is now known to the public. However, if this holding represents the law, it follows that as soon as reference to a patient's medical secrets is made in open court, this information loses its confidential quality.

According to Goff, LJ, the duty of confidence applies neither to useless information, nor to trivia.[44] In the medical context, the definition of trivial or useless information is not necessarily clear. Thus, some people may regard the information whether or not a patient has consulted a certain physician as trivial, but others might attach a different significance to the same information. Information referring to some illnesses, for example a simple cold, may seem trivial to some people and important enough to deserve confidentiality to others. And many people might accord significance to the mere fact that a specialist clinic, such as an abortion clinic or a clinic for venereal diseases, has been attended.[45]

The third and last requirement formulated in the *Coco* decision was that the confidential information must have been used without authorisation and to the detriment of the confider. This clarifies two points. First of all, confidential information is only protected from unauthorised use. Thus, if the physician discloses confidential medical information with the patient's consent, there is no breach of the obligation to confidence. Secondly, the disclosure must be

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[44] *Attorney General v Guardian Newspapers Ltd and others* (2) [1988] 3 All ER 545, at 659.
[45] See *R v Cardiff Crown Court, ex parte Kellam* [1994] 16 BMLR 76, at 79-80.

detrimental to the confider. In *Attorney General v Guardian Newspapers Ltd and others* (2),[46] the court had to struggle with this requirement. Keith LJ argued:

> 'It is worthy of some examination whether or not detriment to the confider of confidential information is an essential ingredient of his cause of action in seeking to restrain by injunction a breach of confidence. Presumably that may be so as regards an action for damages in respect of a past breach of confidence. If the confider has suffered no detriment he can hardly be in a position to recover compensatory damages. However, the true view may be that he would be entitled to nominal damages. ... There may be no financial detriment to the confider since the breach of confidence involves no more than an invasion of personal privacy. ... Information about a person's private and personal affairs may be of a nature which shows him in a favourable light and would by no means expose him to criticism. ... I would think it a sufficient detriment to the confider that information given in confidence is to be disclosed to persons whom he would prefer not to know it, even though the disclosure would not be harmful to him in any positive way.'[47]

The court thus adopted a broad interpretation of detriment, as no financial harm is required. Rather, the disclosure of confidential information in itself seems to be sufficient to establish some sort of detriment, as long as the confider had an interest in keeping the information secret, regardless of whether or not the information would shed a negative light on or embarrass the confider.

After thus having established that medical confidentiality can be protected under the common law, the question arises of how to delineate the exact scope of an obligation to maintain medical confidentiality. In that respect, it may be helpful to refer to the words of Boreham J who stated in *Hunter v Mann*[48] that:

> 'The doctor is under a duty not to disclose, without the consent of the patient, information which he, the doctor, has gained in his professional capacity.'

This holding suggests that the physician's obligation to maintain confidentiality not only encompasses information confided by the patient in the physician, but rather includes confidential information that came to the knowledge of the physician by any other means, for example the physician's own observations, as long as these observations were made in the course of the physician-patient relationship. The common law duty thus not only protects all information revealed to the doctor by the patient in the course of medical treatment, but the protection rather also includes observations made by the doctor in connection with the

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[46] [1988] 3 All ER 545.
[47] Ibid., at 639-640.
[48] [1974] 2 All ER 414, at 417.

treatment of a patient.[49] This was confirmed by Bingham LJ in *W v Egdell,*[50] when stating that:

> 'We were referred, as the judge was, to the current advice given by the General Medical Council to the medical profession pursuant to s 35 of the Medical Act 1983. Rule 80 provides:
>
> "It is a doctor's duty, except in the cases mentioned below, strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient which he has learnt directly or indirectly in his professional capacity as a registered medical practitioner ..."
>
> I do not doubt that this accurately states the general rule as the law now stands.'[51]

The position is less clear in respect of information the physician received outside of a physician-patient relationship, for example if the patient tells a physician his/her medical secrets at a social gathering. Kristina Stern argues in favour of an extension of the physician's obligation of confidence to such situations. According to her, there is a strong argument that any information about a patient which the doctor receives should be subject to a duty of confidentiality in order to maintain the essential relationship of trust upon which the effective provision of medical treatment depends.[52] This argument may have some value as long as a physician-patient relationship exists between the two parties. If, however, no such professional relationship exists, it is difficult to see how the physician can be under any duty of confidence by the force of his/her profession, and how the disclosure of information confided in him at a party could undermine the trust governing a physician-patient relationship.

If all of the above-mentioned criteria for a common law duty to maintain medical confidentiality are met, protection in case of a breach of such duty is available under equity as well as under tort law, and the patient can get injunctive relief or compensation. In 1981, the Law Commission issued a report on *Breach of Confidence*[53] and recommended that the protection of confidence developed by the courts be strengthened by the introduction of a statutory tort of breach of confidence.[54] However, this recommendation has not been acted upon.

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[49] See for example Gurry, *Breach of Confidences*, at 148; Kennedy, Grubb, *Medical Law*, at 639.
[50] [1990] 1 All ER 835.
[51] Ibid., at 849.
[52] 'Confidentiality and Medical Records', in: Kennedy, Grubb (eds.), *Principles of Medical Law*, at 499.
[53] Cmnd. 8388.
[54] Ibid., at 103.

It should be added that no duty of medical confidentiality exists where the information directly refers to a crime, as there is no confidence in iniquity[55] and information about the commission of a crime therefore does not have confidential status.[56] This applies to past as well as to future crimes.[57]

Attention will now be drawn to the reasons behind the legal recognition of an obligation to maintain confidentiality. Most English courts that have had to discuss problems of confidentiality emphasised that the protection of confidentiality was granted in the public interest.[58] In *Attorney General v Guardian Newspapers Ltd and others* (2)[59] Keith, LJ put it as follows:

> 'The right to privacy is clearly one which the law should in this field seek to protect. ... As a general rule it is in the public interest that confidences should be respected, and the encouragement of such respect may in itself constitute a sufficient ground for recognising and enforcing the obligation of confidence.'[60]

And Goff, LJ stated:

> 'The existence of this broad principle reflects the fact that there is such a public interest in the maintenance of confidences that the law will provide remedies for their protection. ... The basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by law. ... In the case of private citizens there is a public interest that confidential information should as such be protected.'[61]

In the Court of Appeal, Donaldson MR had taken a similar stance:

> 'There is an inherent public interest in individual citizens and the state having an enforceable right to the maintenance of confidence. Life would be intolerable in personal and commercial terms, if information could not be given or received in confidence and the right to have that confidence respected supported by the force of law.'[62]

According to the different holdings in *Attorney General v Guardian Newspapers Ltd and others* (2), the protection of confidences is thus an important societal goal. However, the reasons behind the public interest in the protection of confidences are not formulated very clearly. One of the main considerations

[55] *Initial Services Ltd. v Putterill* [1968] 1 QB 396, at 405 per Denning MR.
[56] Gurry, *Breach of Confidence*, at 329.
[57] Ibid., at 331 with further references.
[58] See for example *Lion Laboratories Ltd v Evans* [1984] 2 All ER 417, at 422 per Stephenson LJ.
[59] [1988] 3 All ER 545.
[60] Ibid., at 639-640.
[61] Ibid., at 658-660.
[62] Ibid., at 596.

seems to be that of fairness, as the protection of confidences lies in the public interest where the confider had a reasonable expectation and interest in keeping the relevant information secret, while the confidant knew that the information was disclosed to him/her in confidence. It is important to note that the protection of confidential information is not restricted to secrets that were disclosed in the course of certain professional relationships. Therefore, it seems fair to say that the general interest in keeping personal information that has been disclosed in confidence secret is the subject of protection and the value the law is aiming to protect.

The more general point that the preservation of a person's confidences lies in the public interest was applied to cases specifically dealing with confidential medical information. In *X v Y and others,*[63] a case concerning medical practitioners suffering from AIDS, Rose J held that:

> 'Confidentiality is of paramount importance to such patients, including doctors. ... If it is breached or if the patients have grounds for believing that it may be or has been breached they will be reluctant to come forward for and to continue with treatment and, in particular, counselling. ... If treatment is not provided or continued the individual will be deprived of its benefit and the public are likely to suffer from an increase in the rate of spread of the disease. The preservation of confidentiality is therefore in the public interest.[64] ... It is in the public interest that actual or potential AIDS sufferers should be able to resort to hospitals without fear of this being revealed, that those owing duties of confidence in their employment should be loyal and should not disclose confidential matters and that, *prima facie,* no one should be allowed to use information extracted in breach of confidence from hospital records even if disclosure of the particular information may not give rise to immediately apparent harm.'[65]

From this judgment, it becomes clear that the recognition of a public interest in preserving medical confidentiality is based on several considerations. According to Rose J, the public interest seems to rest on the supposition that without medical confidentiality, patients will be reluctant to seek medical advice and treatment. It follows that the absence of medical confidentiality would harm the individual's health. Society as a whole could then suffer the adverse consequences if the individual were discouraged to seek medical advice and treatment, as this might lead to a spread of disease. Medical confidentiality is thus based on utilitarian considerations. It is not entirely clear whether Rose J's holding also recognises

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[63] [1988] 2 All ER 648 (QBD).
[64] Ibid., at 656.
[65] Ibid., at 660.

that the protection of the individual's health and privacy lie in the public interest, as the interests of the individual are not analysed separately, but rather only in their relation to the interests of society at large. However, the broad protection of confidences outside the medical context seems to suggest that the holding in *X v Y and others* is mainly aimed at providing some additional considerations to bolster the protection of confidential medical information, rather than at reducing the reasons behind that protection to the interests of society. Interpreted this way, confidential patient information is protected in the public interest in guaranteeing the confidentiality of relationships worthy of protection, which seems very closely related to general privacy considerations.

Another case in which the patient's interest in medical confidentiality has been discussed is that of *W v Egdell.*[66] W had been detained for shooting and killing five people and for wounding two others. After ten years of detention, his solicitors instructed Dr. Egdell, a consultant psychiatrist, to examine W and report on his mental health with a view to using the report to support W's application to a mental health review tribunal to be discharged. In his report Dr. Egdell came to the conclusion that W should not be discharged because his long-standing interest in firearms and explosives caused a great danger for society. When the solicitors received the report, they did not forward it to the tribunal but withdrew W's application. Dr. Egdell then forwarded his report to the hospital where W was detained and the hospital, with Dr. Egdell's prompting, sent the report to the Secretary of the State who forwarded it to the tribunal. In that case, Rose J's statement in *X v Y* was embraced by the Court of Appeal, where Stephen Brown, P held that:

> 'Of course W has a private interest, but the duty of confidence owed to him is based on the broader ground of public interest described by Rose J in *X v Y*'.[67]

And according to Bingham LJ:

> 'The decided cases very clearly establish (1) that the law recognises an important public interest in maintaining professional duties of confidence. ... W of course had a strong personal interest in regaining his freedom ... . So he had a personal interest in restricting the report's circulation. But these private considerations should not be allowed to obscure the public interest in maintaining professional confidences. The fact that Dr Egdell as an independent psychiatrist examined and reported on W as a restricted mental

[66] [1990] 1 All ER 835 (CA).
[67] Ibid, at 846.

patient under s.76 of the Mental Health Act 1983 does not deprive W of his ordinary right to confidence, underpinned, as such rights are, by the public interest.[68]

Counsel for W ... drew our attention to a number of features ...:

(1) Section 76 of the Mental Health Act 1983 shows a clear parliamentary intention that a restricted patient should be free to seek advice and evidence for the specified purposes from a medical source outside the prison and secure hospital system. ... The examination may be in private so that the authorities do not learn what passes between doctor and patient.

(2) The proper functioning of s.76 requires that a patient should feel free to bare his soul and open his mind without reserve to the independent doctor he has retained. This he will not do if the doctor is free, on forming an adverse opinion, to communicate it to those empowered to prevent the patient's release from hospital. ...

(5) It is contrary to the public interest that patients such as W should enjoy rights less extensive than those enjoyed by other members of the public. ...

Of these considerations, I accept (1) as a powerful consideration in W's favour. A restricted patient who believes himself unnecessarily confined has, of all members of society, perhaps the greatest need for a professional adviser who is truly independent and reliably discreet. (2) also I, in some measure, accept, subject to the comment that if the patient is unforthcoming the doctor is bound to be guarded in his opinion. If the patient wishes to enlist a doctor's wholehearted support for his application, he has little choice but to be ... frank. ... As to (5), I agree that restricted patients should not enjoy rights of confidence less valuable than those enjoyed by other patients save in so far as any breach of confidence can be justified under the stringent terms of r 81(g).'[69]

This case also gives some interesting guidance for an analysis of the interests behind a protection of medical confidences. First, the holding makes it entirely clear that the fact that a patient has his/her own individual and private reasons for seeking the protection of his/her medical secrets does not mean that the patient's interest should be qualified as a private and not a public interest. Thus, the protection of the patient's private goals may very well be dictated by the public interest. In holding that the protection of the confidentiality of the physician-patient relationship in the context of an examination under s.76 Mental Health Act 1976 lies in the public interest, it becomes obvious that the public has an interest in the protection of some individual concerns, such as the concern that a person detained under the Act should have the possibility to seek independent medical advice. The public interest identified by Rose J in *X v Y* is of no relevance here, as the protection of medical confidentiality in the context of *Egdell* does nothing to

[68] Ibid., at 848-849.
[69] Ibid., at 851-852.

promote public health. There is thus a public interest in the fair and equal treatment of a person detained under the Act which requires the protection of medical confidences to enable this person to pursue his/her private interests of seeking a court order to be released.

In the academic debate, it has been suggested that in the context of personal information, the paramount principle behind a protection of confidentiality seems to be the notion of privacy and the case-law was interpreted so as to allow a person to control the flow of personal information about him/herself.[70] Medical confidentiality is said to empower the patient to make informed choices about matters vital to their life and health, thereby promoting the patient's health as well as his/her autonomy.[71] The importance of general privacy considerations in the context of medical confidentiality has recently been stressed by the Court of Appeal in *Source Informatics Limited*,[72] when Simon Brown, LJ argued in the context of the pharmacist-patient relationship that 'the concern of the law here is to protect the confider's personal privacy'; and:

> 'If ... his only legitimate interest is in the protection of his privacy and if that is safeguarded, I fail to see how his will could be thought thwarted or his personal integrity undermined [by the anonymisation or the processing of anonymised medical information].'

This seems to suggest that a wide range of privacy concerns, including the patient's autonomy, lie at the heart of the obligation to protect patient confidences.

1.5. Professional obligation

The duty of medical confidentiality is imposed on every physician as a professional duty. In 1995, the General Medical Council (GMC) issued guidelines on confidentiality which provide as follows:

> 1. Patients have a right to expect that you will not disclose any personal information which you learn during the course of your professional duties, unless they give permission.[73]

According to s.36 of the Medical Act 1983, the GMC has the power to impose disciplinary measures on a physician who was judged by the Professional Conduct

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[70] Gurry, *Breach of Confidence*, at 98.
[71] Boyd, (1992) 18 JME, at 173 and 178; Gillon, (1985) 291 BMJ, at 1636.
[72] Decision of 21 December 1999, not yet published.
[73] *Confidentiality: Guidance from the General Medical Council.*

Committee as being guilty of serious professional misconduct. A breach of medical confidentiality can amount to serious professional misconduct and trigger disciplinary sanctions.[74] The guidelines issued by the GMC, though obviously possessing considerable authority among members of the medical profession, nevertheless do not have the force of law and therefore do not bind the courts which reserve the right to strike down professional regulations that are unreasonable.[75] However, as can be seen, for example, from the statement of Bingham, LJ in *W v Egdell,*[76] the courts refer to those guidelines and, with regard to medical confidentiality, have decided that the rules set out by the GMC adequately reflect the law. The exact extent of the professional duty to maintain medical confidentiality is open to interpretation. It has been argued that the scope of that obligation varies in different areas of medical practice, as in some areas, for example in psychiatric medicine, confidentiality can be of greater importance than in general medicine.[77]

1.6. Summary

In English law, medical confidentiality is not protected as an individual fundamental right, and the protection awarded to medical confidentiality under Art.8 ECHR is not directly enforceable as the ECHR does not form part of domestic law. However, this situation will change with the coming into force of the Human Rights Act 1998 which incorporates Art.8 ECHR into domestic law. A breach of medical confidentiality is, in principle, not a criminal offence. The main discussion of the protection of medical confidentiality takes place in the context of the common law duty to respect confidences. While privacy as such is not protected under English law, certain specific aspects of privacy, such as confidences, receive protection and the courts have developed a common law duty to keep confidences as long as there is an expectation of secrecy. Medical confidentiality forms part of this protection, and in case of a breach, injunctive relief or compensation are available. The courts mostly adopted a pragmatic approach towards actions for breach of confidence. Rather than trying to classify the action to make it fit into one of the existing categories of law, they made use

[74] Kennedy, Grubb, *Medical Law*, at 579.
[75] Newdick, (1996) 3 EJHL, at 373.
[76] [1990] 1 All ER 835 (CA), at 852.
[77] McHale, (1989) 52 MLR, at 717.

of the existing categories such as contract, equity, property and torts to develop what Gurry describes as a *sui generis* action for breach of confidentiality.[78] Medical confidentiality can also be protected by contract law, but only in the very limited situations in which a contractual relation between physician and patient exists. In addition, the medical profession has imposed an obligation on their members to maintain patient confidences, the violation of which may give rise to disciplinary sanctions.

It is interesting to note that while the protection of medical confidentiality lies in the public interest, the legal protection of confidentiality was mainly developed in the area of private law to regulate conflicts between private parties. Thus, the state provides the individual with legal remedies where a breach of confidentiality has occurred or is about to occur, but does not react with the threat of criminal sanctions to a breach of the obligation of medical confidentiality, save under exceptional circumstances.

It should be added that the protection of medical confidentiality has recently received a lot of attention through the report of the Caldicott Committee which had been established to review the transmission of identifiable patient information from one NHS body to another.[79] The provisions of the Data Protection Act 1998 also contain safeguards for confidential medical information with regard to the specific situation of processing of such information. These developments show the increasing concern for the protection of privacy.

2. Medical privilege

2.1. Medical privilege in criminal court

The meaning of privilege was explained by Diplock LJ in *Parry-Jones v The Law Society*[80] who stated that:

> 'Privilege is irrelevant when one is not concerned with judicial or quasi-judicial proceedings because strictly speaking, privilege refers to a right to withhold from a court, or a tribunal exercising judicial functions, material which would otherwise be admissible in evidence.'

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[78] Gurry, *Breach of Confidence*, at 26 and 58.
[79] www.doh.gov.uk/confiden.htm (1997).
[80] [1969] 1 Ch 1, at 9.

Thus, the question of privilege can only arise in the context of judicial proceedings. The definition of privilege given by Diplock LJ already points to the problem that the existence of a privilege against disclosure of information in judicial proceedings will always conflict with the interest in an unimpeded administration of criminal justice. The decision to award a privilege can be said to contain a general pronouncement of how to balance these competing interests. In the words of the court in *Grant v Downs*:[81]

> 'The existence of the privilege reflects, to the extent to which it is accorded, the paramountcy of this public interest over a more general public interest, that which requires that in the interests of a fair trial litigation should be conducted on the footing that all relevant documentary evidence is available.'

Procedural law rests on the premise that the public interest in the administration of justice is the overriding consideration in the context of court proceedings.[82] This interest is mainly specified as an interest that the truth be established in court proceedings, a purpose which can only be achieved if, in principle, all existing evidence is available to the court when making a decision.[83] A privilege has the effect of undermining this principle by depriving the court of evidence that would otherwise be available. However, the interests in the administration of justice are not limited to the interest in finding the truth in criminal proceedings. Rather, they also include the unimpeded exercise of defence rights by the accused,[84] and the interest in the dissipation of unfounded suspicions against the innocent.[85] Privilege can thus be seen as an exception to the general rule that in the context of court proceedings, the interests in the administration of justice are paramount, as the existence of a privilege indicates that in the situation to which the privilege applies, the interest in the administration of justice must yield to the interest that is protected by the privilege. Therefore, privilege is only granted in very exceptional cases in which it is felt that the conflicting interests at stake are of even higher rank than the public interest in the administration of justice.[86] To decide whether or not to recognise a privilege in a given case, it is therefore of utmost importance to be clear about the conflicting interests and their respective values. The only

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[81] [1976] 135 C.L.R. 674, at 685 per Stephen, Mason and Murphy, JJ.
[82] *Home Office v Harman* [1983] 1 AC 280, at 308 per Kinkel LJ.
[83] See, for example, *Campbell v Tameside Council* [1982] 1 QB 1065 (CA), per Ackner LJ.
[84] See, for example, *Re K and others (Minors) (Disclosure)* [1994] 1 FLR 377 (FD), per Booth J; see also Corker, (1998) 38 Med. Sci. Law, at 138-141.
[85] In *Re W (Minors) (Social Workers: Disclosure)* [1999] 1 WLR 205, at 215 per Butler-Sloss LJ.
[86] *Cross and Tapper on Evidence*, at 451-452.

privilege recognised in English law is that of the legal profession.[87] It is felt that this privilege is justified as the protection of the confidentiality of the lawyer-client relationship directly benefits the administration of justice. As the argument goes, a client might be inhibited in telling his/her lawyer the full truth unless he/she can be certain that the lawyer will treat the information imparted in him/her with the strictest confidentiality. This privilege therefore does not stand in direct conflict to the interests in the administration of justice, but is rather one aspect of this interest, just as the interest that the truth be established, and the House of Lords has even held that legal professional privilege is a fundamental condition on which the administration of justice as a whole relies.[88] Legal professional privilege accordingly does not reflect a decision that the confidentiality of certain relationships as such is more important than considerations of justice, but rather only demonstrates the conviction that justice can best be served by protecting the confidentiality of this particular professional relationship.[89] The recognition of legal professional privilege is thus based on a utilitarian cost-benefit analysis.

English law does not, however, provide for a privilege for physicians in respect of the disclosure of confidential information obtained by them in the course of the professional relationship with their patients.[90] Edgedale J held in *Nuttall v Nuttall and Twynan*[91] that what a person said to his doctor in a professional consultation was not privileged and that the doctor in the witness box must either give evidence or be committed to be sent to prison for contempt of court. This does not necessarily mean, though, that the physician-patient relationship does not receive any protection from disclosure in criminal proceedings. But it means that the physician cannot, as a matter of right, refuse to give testimony in criminal court where the testimony concerns confidential patient information. Boreham J held in *Hunter v Mann*[92] that although a doctor has no right to refuse the disclosure of confidential information in the course of judicial proceedings, in certain

[87] See, for example, *Attorney-General v Mulholland* [1963] 2 QB 477 (CA), at 489 per Lord Denning.
[88] See, for example, *R v Derby Magistrates' Court, ex parte B* [1996] AC 487 (HL), at 507 per Taylor, LJ; and at 510 per Nicholls LJ; see also *Re D (Adoption Reports: Confidentiality)* [1995] 2 FLR 687 (HL), at 512 per Mustill LJ.
[89] McHale, *Medical Confidentiality and Medical Privilege*, at 16-18.
[90] *Attorney-General v Mulholland* [1963] 2 QB 477 (CA), at 489 per Lord Denning; *Hunter v Mann* [1974] 2 All ER 414-420, at 417 per Boreham J; *Goddard v Nationwide Building Society* [1986] 3 All ER 264, at 271 per Nourse LJ.
[91] *Nuttall v Nuttall and Twynan* [1964] 108 Sol J 605.
[92] *Hunter v Mann* [1974] 2 All ER 414, at 417.

circumstances the judge may refuse to compel him to do so. And Wilberforce LJ held in *British Steel Corp. v Granada Television Ltd*[93] that:

> 'As to information obtained in confidence, and the legal duty, which may arise, to disclose it to a court of justice, the position is clear. Courts have an inherent wish to respect this confidence, whether it arises between doctor and patient ... or in other relationships. ... But in all these cases the court may have to decide, in particular circumstances, that the interest in preserving this confidence is outweighed by other interests to which the law attaches importance.'

This raises the question of how this discretion to exclude evidence should be exercised. Can it be said that even evidence that is relevant and necessary for a decision in criminal court can be excluded merely on the grounds that the information the disclosure of which is sought was imparted in the physician under the cloak of confidentiality? The suggestion that confidentiality should be recognised as a separate heading of privilege was expressly rejected by the House of Lords in *Alfred Crompton Amusement Machines Ltd v Commissioners of Customs and Excise (No.2).*[94] In *D v N.S.P.C.C.*[95] the House of Lords further developed the law in this area. Hailsham LJ stated that confidentiality by itself did not give any ground for immunity,[96] Diplock LJ confirmed that view and rejected the proposition that 'the basis of all privilege from disclosure of documents or information in legal proceedings is to prevent the breaking of confidence.'[97] Simon LJ argued similarly:

> 'I do not think that confidentiality of the communication provides in itself a satisfactory basis for testing whether the relevant evidence should be withheld. ... It is undesirable that exclusion should be conferred by confidentiality irrespective of the public interest. ... For the reasons I have given I do not myself think that confidentiality in itself establishes any public interest in the exclusion of relevant evidence, but rather that it may indirectly be significant where a public interest extrinsically established (for example, provision of professional legal advice or effective policing) can only be vindicated if its communications have immunity from forensic investigation.'[98]

Edmund-Davies LJ balanced the interest in the administration of justice, on the one hand, and the interest in protecting confidentiality, on the other hand, and came to the following conclusion:

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[93] [1980] 3 WLR 774, at 821.
[94] [1974] AC 405, at 433-434 per Cross LJ.
[95] [1978] AC 171 (HL).
[96] Ibid., at 230.
[97] Ibid., at 220.
[98] Ibid., at 237-239.

> 'It is a serious step to exclude evidence relevant to an issue, for it is in the public interest that the search for truth should, in general, be unfettered. Accordingly, any hindrance to its seekers needs to be justified by a convincing demonstration that an even higher public interest requires that only part of the truth should be told. ... But it is established in our law that the mere fact that information is imparted in confidence does not, of itself, entitle the recipient to refuse disclosure of the identity of the informer. ... Accordingly, it would be unthinkable to vest the judiciary with the power to exclude in its discretion evidence relevant to the issues in civil proceedings merely because one side wants it kept out and the judge thinks that its disclosure is likely to prove embarrassing. In other words, the exclusion of evidence always calls for clear justification. ... No reported case supports the proposition ... that a judge is entitled to direct a doctor not to disclose information regarding his patient's health.'[99]

He emphasised that the physician-patient relationship cannot be treated as equivalent to the lawyer-client relationship and summarised the law as follows:

> '(I) In civil proceedings a judge has no discretion, simply because what is contemplated is the disclosure of information which has passed between persons in a confidential relationship (other than that of lawyer and client), to direct a party to that relationship that he need not disclose that information even though its disclosure is (a) relevant to and (b) necessary for the attainment of justice in the particular case. If (a) and (b) are established, the doctor or the priest must be directed to answer if, despite the strong dissuasion of the judge, the advocate persists in seeking disclosure. ...
>
> (II) But where (i) a confidential relationship exists (other than that of lawyer and client) *and* (ii) disclosure would be in breach of some ethical or social value involving the public interest, the court has a discretion to uphold a refusal to disclose relevant evidence provided it considers that, on balance, the public interest would be better served by excluding such evidence. ...
>
> (V) The mere fact that relevant information was communicated in confidence does not necessarily mean that it need not be disclosed. But where the subject matter is clearly of public interest, the *additional* fact (if such it be) that to break the seal of confidentiality would endanger that interest will in most (if not all) cases probably lead to the conclusion that disclosure should be withheld. ...
>
> (VI) The disclosure of all evidence relevant to the trial of an issue being at all times a matter of considerable public interest, the question to be determined is whether it is clearly demonstrated that in the particular case the public interest would nevertheless be better served by excluding evidence.'[100]

It is thus clear that a physician is not exempt from giving testimony in criminal court simply on the ground that the information he/she is called to testify upon refers to confidential patient data, as the fact that the confidentiality of the physician-patient relationship is protected outside of court proceedings is not in

[99] Ibid., at 242-244.
[100] Ibid., at 245-246.

itself sufficient to override the competing interest in finding the truth. The judge's discretion to exempt the physician from the duty to give testimony seems to be subject to an analysis of the relevance and the value of the information in judicial proceedings. Thus, as long as the physician's testimony is relevant and necessary to the proceedings, the judge cannot permit the non-disclosure of such information merely on the basis of its confidentiality, if the other side insists on full revelation of all relevant facts. According to Edmund-Davies LJ's opinion in *D v N.S.P.C.C.*, even where information is relevant and necessary, the judge still has the discretion to direct non-disclosure if in addition to the confidentiality of the information, other reasons point towards on overriding interest in non-disclosure. *D v N.S.P.C.C.* was a case concerning public interest immunity, and in accordance with that decision, it seems now possible that a judge directs non-disclosure of confidential information if, besides the general interest in maintaining confidentiality, there is an additional interest, for example the public interest in protecting the informants of the N.S.P.C.C. so as to enable that organisation to function and effectively to protect children. Only the existence of such an additional public interest can achieve what confidentiality alone could not, namely to outweigh the public interest in the administration of justice.[101] Scarman LJ expressed this thought as follows:

> 'The confidential nature of a document does not, by itself, confer "public interest immunity" from disclosure. The confidential nature of a document or of evidence is no ground for a refusal to disclose the document or to give evidence, if the court requires it. I do not see the process of the decision as a balancing act. If the document is necessary for fairly disposing of the case, it must be produced, notwithstanding its confidentiality. Only if the document should be protected by public interest immunity, will there be a balancing act. And then the balance will not be between "ethical or social" values of a confidential relationship involving the public interest and the document's relevance in the litigation, but between the public interest represented by the state and public service, i.e. the executive government, and the public interest in the administration of justice. ... It does not follow that, because we are outside the field of public interest immunity, the confidential nature of the documents is to be disregarded by the court in the exercise of its discretionary power to order discovery of documents. ... The factor of confidence ... militates against general orders for discovery and does impose upon the tribunal the duty of satisfying itself ... that justice requires disclosure.'[102]

[101] See also, for example, *Campbell v Tameside Council* [1982] 1 QB 1065 (CA).
[102] *Science Research Council v Nassé* [1980] AC 1028 (HL (E)), at 1087-1089.

Thus, confidentiality of information the disclosure of which is sought in criminal proceedings does not as such give rise to a balancing of the interest in confidentiality and the interests of justice. Confidentiality is, however, protected as the courts should only order the disclosure of confidential information that is relevant to the case at issue. This is in line with the decision in *A.G. v Mulholland*[103] where Lord Denning had tried to mitigate the effects of the lack of medical privilege by holding that judges will respect confidences and not direct a doctor to answer unless not only is it relevant, but in the course of justice it also is a proper and necessary question to be put and answered. Once the relevance of the information is established, however, the court no longer has any discretion to allow non-disclosure merely based on the confidentiality of the information. With regard to the protection of medical confidentiality in criminal proceedings, it can therefore be stated that neither the patient nor the physician have the right to insist on non-disclosure of confidential information, and that no protection exists for confidential medical information that is relevant and necessary for judicial proceedings. In such a case, not even a balancing exercise will be performed to decide on a case by case basis whether the interest in medical confidentiality or that in the administration of justice should prevail in the individual case. Rather, the interest in the administration of justice always prevails over the interest in maintaining the secrecy of medical information that is relevant and necessary for criminal proceedings.

It is submitted that this conclusion is difficult to justify. As the protection of medical confidentiality lies in the public interest, in all cases in which the disclosure of confidential medical information is sought in criminal court, two public interests are in conflict with each other and it is therefore difficult to see why the public interest in the protection of medical confidentiality can be outweighed without any balancing of interests taking place. However, given the courts' holdings, the only possibility to have medical information protected from disclosure in court proceedings would be to convince the courts that there is a public interest in the protection of such information that goes beyond the general interest in confidentiality and therefore deserves protection under the principles laid down in *D v N.S.P.C.C.*

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[103] [1963] 2 QB 477.

Even if confidential information is relevant and its disclosure necessary and no public interest immunity applies, confidentiality will still be protected as far as possible. In *Taylor v Serious Fraud Office,*[104] it has been argued that it was a matter of fairness and justice that the privacy and confidentiality of those whose confidential information was needed in judicial proceedings, was not invaded more than absolutely necessary for the purposes of justice. Thus, only that part of confidential information that is relevant and necessary for the proceedings will have to be disclosed, and the information can normally not be used outside the judicial proceedings in which it had been revealed.

Where does this leave the physician who is called upon to testify as a witness in criminal proceedings and who feels that his/her testimony would constitute a breach of the legal as well as of the ethical obligation to maintain the medical confidences of his/her patient? With regard to the legal obligation, the law was clearly stated by Diplock LJ in *Parry-Jones v The Law Society:*[105]

> 'What we are concerned with here is the contractual duty of confidence, generally implied though sometimes expressed, between a solicitor and client. Such a duty exists not only between solicitor and client, but, for example, between banker and customer, doctor and patient, and accountant and client. Such a duty of confidence is subject to, and overridden by, the duty of any party to that contract to comply with the law of the land. If it is the duty of such a party to a contract, whether at common law or under statute, to disclose in defined circumstances confidential information, then he must do so.'

It is thus clear that the physician is only under an obligation to maintain the medical secrets of his/her patient as long as this obligation is not overridden by law. Given that the physician is under a legal obligation to give testimony in judicial proceedings and that this obligation is regarded as more important than the general obligation to respect medical confidentiality, when a physician is called upon to testify he/she is not faced with conflicting legal duties, but is rather only under the legal duty to give testimony, to which the legal duty to maintain medical confidentiality must yield. Thus, while a patient could obtain an injunction to prevent the physician from disclosing confidential medical information outside judicial proceedings,[106] the same information is no longer protected from disclosure when it becomes relevant in the context of litigation.[107]

[104] [1998] 3 WLR 1040, (HL (E)), at 1049 per Hoffmann LJ.
[105] [1969] 1 Ch 1, at 9.
[106] See, for example, *Goddard v Nationwide Building Society* [1986] 3 All ER 264, per Nourse LJ.
[107] *W v Egdell* [1990] 1 All ER 835, (CA) at 848 per Bingham LJ; *Cross and Tapper on Evidence,*

However, this does not necessarily resolve a potential conflict between the legal obligation to testify and the ethical obligation to maintain confidentiality. In *Hunter v Mann*,[108] Widgery LJ described the physician's situation as follows:

> 'If a doctor, giving evidence in court, is asked a question which he finds embarrassing because it involves him talking about things which he would normally regard as confidential, he can seek the protection of the judge and ask the judge if it is necessary for him to answer. The judge, by virtue of the overriding discretion to control his court which all English judges have, can, if he thinks fit, tell the doctor that he need not answer the question. Whether or not the judge would take that line, of course, depends largely on the importance of the potential answer to the issues being tried.'[109]

And in *Garner v Garner*, [110] the judge expressly recognised the conflict the obligation to testify would impose on the physician, but was confident that the physician would appreciate that 'in a Court of Justice there were higher considerations than those which prevailed with regard to the position of medical men.' It has also been argued that the good sense and tact of the judiciary have prevented the need of awarding privilege to medical practitioners[111] and that the courts recognise the public interest in upholding confidential relationships and will therefore not lightly make a decision that could potentially damage the relationship or the reputation of a profession, particularly if no good purpose would be served thereby.[112] One commentator even suggested that the *de facto* protection awarded by the courts goes so far that solicitors will normally not even attempt to get a court order compelling the physician to disclose confidential patient information, as such an undertaking is doomed to failure unless there is an overwhelming reason for seeking disclosure.[113] There is thus a tendency to suggest that the interest in medical confidentiality is sufficiently, or even overly, protected by the discretion of the courts. The Criminal Law Revision Committee seems to have adopted the same position when it decided against recommending any extension of professional privilege to include the physician-patient relationship[114] because it was regarded as unlikely that any difficulties would

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at 494; Matthews, (1981) 1 Legal Studies, at 93.

[108] [1974] 2 All ER 414 (QBD).

[109] Ibid., at 420.

[110] [1920] 34 The Law Times Report 196, per McCardie J.

[111] Anonymous, (1974) BMJ, at 391.

[112] *Murphy on Evidence*, at 386; see also McHale, *Medical Confidentiality and Medical Privilege*, at 15; but see Harvard, (1985) 11 JME, at 9, who argues that there is very little evidence that the courts are anxious to protect medical confidentiality.

[113] Samuels, (1986) 26 Med. Sci. Law, at 237.

[114] Eleventh Report, Cmnd 4991, para.272-276.

occur in practice. The Committee argued that a broad medical privilege allowing the physician to refuse to testify in criminal court about every confidential aspect of the physician-patient relationship would be undesirable, as the interests of justice will often outweigh the public interest in medical confidentiality, for example where a physician obtained information about a criminal offence committed by his/her patient. Even in the case of the psychiatrist-patient relationship no privilege was recommended, as it was seen as unnecessary. May supports this analysis, arguing that in most cases the prosecution will not even be aware of the confidential information and therefore not be able to seek its disclosure. Even in cases in which the prosecution does know about this information, he thinks it unlikely that it will be attempted to compel the physician to give testimony.[115]

However, it should not be forgotten that the courts' discretion largely rests on the question of the relevance and usefulness of the evidence, a consideration that is not likely to alter the physician's perception of his/her ethical obligation. Accordingly, a physician, though under a legal obligation to give testimony, may nevertheless feel very strongly that he/she ought to uphold the principle of medical confidentiality,[116] regardless of whether or not the evidence in question is relevant to the outcome of the proceedings.

A possibility to exclude medical evidence could exist under s.78 PACE 1984 which provides that:

> (1) In any proceedings the court may refuse to allow evidence on which the prosecution wishes to rely to be given if it appears to the court, having regard to all the circumstances, including the circumstances in which evidence was obtained, the admission of the evidence would have such an adverse effect on the fairness of the proceedings that the court should not admit it.

It could be argued that the admission of evidence that came about in the course of the confidential physician-patient relationship would adversely affect the fairness of the proceedings and should therefore not be admitted. In *R v McDonald*,[117] the exclusion of a psychiatrist's report based on s.78 was rejected, but the Court nevertheless held that only on rare occasions or in exceptional circumstances

[115] May, *Criminal Evidence*, at 13-43.
[116] See also *Cross and Tapper on Evidence*, at 496.
[117] [1991] Crim LR 122 (CA) per Stuart Smith LJ.

would the prosecution seek to adduce evidence of what a defendant had said to his doctor if the issue before the court was not a medical one.

So far, the emphasis was placed on the position of the physician as a witness in criminal proceedings, and therefore on his/her oral testimony in criminal court. It must be added that in criminal proceedings, orders to produce documents can be made according to ss.31 and 32 Administration of Justice Act 1970. While special rules apply to protect confidential patient information from seizure in the course of police investigations,[118] there are no statutory provisions protecting confidential medical records from production at the trial stage. This means that in addition to the physician's oral testimony about confidential patient information, confidential medical documents are also not protected against disclosure in court, as the same principles as outlined above apply.

2.2. Public interest immunity

Confidential medical information may sometimes fall within the domain of public interest immunity, and a balancing exercise must then be performed to decide whether or not relevant information is to be disclosed to the court. This question mainly arises in the context of wardship proceedings and proceedings under the Children Act 1989. Frequently, medical documents form part of such proceedings, for example where the children concerned were examined for possible child abuse, or the parents for potential medical problems, such as drug abuse, that might affect their ability to look after their children. Particularly in child abuse cases, criminal proceedings may follow and the evidence that was available to the wardship court, which often includes medical reports, may then be of the greatest relevance to the police or the court. However, public interest immunity applies to evidence obtained in wardship proceedings, and judges who have to decide whether or not to allow disclosure in such a case are faced with a situation in which the information the disclosure of which is sought is not only confidential, but in addition, non-disclosure is in the public interest. In such a case, the court must, in the exercise of its discretion of whether or not to permit disclosure, conduct a balancing exercise. The importance of confidentiality in wardship proceedings and the frankness which it engenders in those who give evidence to

[118] Ss.9, 11, 12 Police and Criminal Evidence Act 1984.

the wardship court must be balanced against the public interest in seeing that the ends of justice are properly served by making available relevant and material information for the purposes of a criminal trial.[119] Several court decisions have made it clear that the balancing act is not only called for once criminal proceedings are taking place, but will rather also have to be performed where the police is seeking disclosure in the course of investigations with the view to a possible criminal trial. At the stage of police investigations, the public interest weighing in favour of disclosure was described as the 'public interest that requires that no obstacle be placed in the way of the police in the course of their criminal investigations.'[120] In *Re C (A Minor),*[121] Swinton Thomas LJ called it:

> 'the public interest in the prosecution of serious crime and the punishment of offenders, including the public interest in convicting those who have been guilty of violent or sexual offences against children. There is a strong public interest in making available material to the police which is relevant to a criminal trial.'[122]

In that case it was also argued that the weight of the public interest depends, *inter alia*, on the nature and seriousness of the criminal offence at issue. In the words of the court:

> 'This was a very grave crime involving the killing of a very small child. In those circumstances, the public interest in the administration of justice, by proper investigation and the prosecution of a crime of such gravity, are very weighty factors indeed favouring disclosure.'[123]

With regard to the specific questions at issue, i.e. the disclosure of medical reports and the father's admission that he had caused injuries to his daughter which had resulted in her death, the court came to the conclusion that:

> 'The medical report and the medical evidence are of first importance in establishing the time of SC's death, which is crucial, and the manner in which her injuries were inflicted, which is also crucial. In preparing for trial and shaping their case, in particular in preparing their medical evidence, it seems to me to be of first importance that the prosecuting authorities should have available the medical evidence and know with precision the admissions that were made by the father.'[124]

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[119] *Re D (Minors) (Wardship: Disclosure)* [1992] 1 FCR 297 (CA), at 301-302 per Stephen Brown P; *Re A (Care Proceedings: Disclosure of Information)* [1996] 1 FCR 533 (CA), at 537 per Butler-Sloss LJ.

[120] *In re S (Minors) (Wardship: Police Investigations)* [1987] Fam 199, at 203 per Booth J.

[121] [1997] Fam 76 (CA).

[122] Ibid., at 85.

[123] Ibid., at 86.

[124] Ibid.

For the outcome of the balancing exercise, the seriousness of the criminal offence under investigation or prosecution seems to be a decisive factor. In the case of public interest immunity, the privilege of confidentiality is that of the court, not of the child, and the primary purpose of the privilege is to protect the court in the exercise of its paternal powers.[125] Confidential medical information is only incidentally protected in the context of public interest immunity, and the fact that the information to be disclosed regards medical secrets does not, in the course of the balancing process, give more weight to the interest in non-disclosure. In most public interest immunity cases in the context of wardship proceedings in which a balancing exercise was performed, the balance came down in favour of disclosure where the evidence to which public interest immunity applied was relevant and material for criminal investigations or in criminal court.

In cases in which the disclosure is sought as part of the defence,[126] Mann LJ held in *R v Governor of Brixton Prison, Ex parte Osman*,[127] a case in which public interest immunity was claimed to protect communications between the magistrate's court and the Home Office, and between the Home Office and other government departments:

> 'Where the interests of justice arise in a criminal case touching and concerning liberty or conceivably on occasion life, the weight to be attached to the interests of justice is plainly very great indeed. ... In those cases, which establish a privilege in regard to information leading to the detection of crime, there are observations to the effect that the privilege cannot prevail if the evidence is necessary for the prevention of a miscarriage of justice. No balance is called for. If admission is necessary to prevent miscarriage of justice, balance does not arise.'[128]

In one case of public interest immunity regarding the disclosure of confidential information relating to an abortion which enjoys special confidentiality under the provisions of the Abortion Act 1967 and the Abortion Regulations 1968, the court decided, however, that in case of a conflict between public interest immunity and defence rights, defence rights did not necessarily prevail. Rather, a balancing exercise would have to be performed which in that case led to a decision in favour

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[125] *Re X, Y and Z (Wardship: Disclosure of Material)* [1992] 1 FLR 84, at 86 per Waite J.

[126] *Re D (Minors) (Wardship: Disclosure)* [1992] 1 FCR 297 (CA), at 302-303 per Stephen Brown P; *Peter Clowes and Others* [1992] 95 Cr App R 440, at 453-454 per Phillips J; *Re K and others (Minors) (Disclosure)* [1994] 1 FLR 377 (FD), at 380-382 per Booth J.

[127] [1991] 1 WLR 281 (DC).

[128] Ibid, at 288 and 290; see also *Re D (Minors) (Wardship: Disclosure)* [1992] 1 FCR 297 (CA), at 301-302 per Stephen Brown P.

of non-disclosure, as the court was of the opinion that the documents' value for the defence was only slim.[129] In *Peter Clowes and Others*,[130] the judge held that the outcome of the balancing exercise depended on the gravity of the offence, so that disclosure upon request of the defendant would be more likely the more serious the offence with which he/she is charged. Court decisions in this area also seem to imply some materiality test. In *R v K (DT) (Evidence)*,[131] for example, a case in which a father applied for disclosure of a video tape of an interview which had taken place with a large part of the family in a hospital for therapeutic purposes, and in which the hospital raised public interest immunity, the court argued that:

> 'The exclusion of the evidence without an opportunity of testing its relevance and importance amounted to a material irregularity. ... This court recognises the hospital's legitimate concern that interviews which are conducted on a confidential basis for therapeutic purposes ought not, unless the interests of justice so require, to be disclosed outside the family circle of those who are the subject of the case conference and the service which is conducting it. However, where the liberty of the subject is in issue, and disclosure may be of assistance to a defendant, a claim for disclosure will often be strong. In the present case we decided that it was necessary for us to see the video, so as to be able to consider whether there was material which might have been of assistance to this appellant on his trial. ... We are quite satisfied, having done so, that nothing took place at the therapeutic case conference which was filmed on the video could have afforded assistance to the defence had it been ordered to be disclosed. ... We are therefore satisfied that in this case it would not have been appropriate to order disclosure. After seeing the video there really would have been no meaningful balancing exercise for the judge to do, because there was no advantage for the appellant to balance against the claim of public interest immunity. ... It would not be appropriate for us to order that it be disclosed, even for the purpose of allowing counsel to see it.'[132]

Another case in which the Court of Appeal explained how the balancing of interests in such cases operated was *R v Keane*.[133] It was again Taylor LJ who observed that:

> 'If the disputed material may prove the defendant's innocence or avoid a miscarriage of justice, then the balance comes down resoundingly in favour of disclosing it. But how is it to be determined whether and to what extent the material ... may be of assistance to the defence? ... The judge has to perform the balancing exercise by having regard on the one hand to the weight of public

[129] *Morrow, Geach and Thomas v D.P.P.; Secretary of State for Health and Social Security; British Pregnancy Advisory Service* [1994] Crim. L.R. 58.
[130] [1992] 95 Cr App R 440, at 454 per Phillips J.
[131] [1993] 2 FLR 181 (CA), per Taylor, LJ.
[132] Ibid., at 184-185.
[133] [1994] 1 WLR 746.

> interest in non-disclosure. On the other hand, he must consider the importance of the documents to the issues of interest to the defence, present and potential ... . Accordingly, the more full and specific the indication the defendant's lawyers give of the defence or issues they are likely to raise, the more accurately both prosecution and judge will be able to discuss the value to the defence of the material.'[134]

Public interest immunity will thus only in very rare cases protect confidential medical information from disclosure to the police or in criminal proceedings. Even where such information is protected by public interest immunity, if it is relevant and material for the purposes of criminal prosecution or a criminal trial, the balance will normally be struck in favour of disclosure. The materiality test seems to be less strict where the information is sought as part of the defence of someone who is accused in criminal proceedings. However, if the confidential medical information is not relevant and material, it is already protected as the courts will then normally uphold the confidentiality of the physician-patient relationship regardless of whether or not public interest immunity applies. Public interest immunity thus does not seem to award much additional protection to confidential medical information.

2.3. Legal professional privilege

Under certain circumstances confidential medical information may be protected against disclosure in the courtroom by legal professional privilege. If, for example, a medical examination takes place in order for the results to be used in litigation, the report of the physician will then be covered by legal professional privilege. The fact that communication between the physician and the solicitor had taken place is, as such, not protected by legal privilege. However, the physician's report to the patient's solicitor is privileged. In a case in which the defendant had been charged on counts of rape, incest and indecent assault, and a scientist had carried out a DNA test at the request of the defence solicitor on a blood sample provided by the defendant for that purpose, the Court of Appeal has held, for example, that the sample constituted privileged material and could therefore not be admitted in evidence without the defendant's consent.[135] Where confidential medical information is protected by professional legal privilege, it

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[134] Ibid., at 751-752.
[135] *R v R* [1994] 1 WLR 758.

receives absolute protection from disclosure, as the House of Lords held in its controversial decision in *R v Derby Magistrates' Court, ex parte B.*[136] This absolute protection is based on the following considerations:

> 'The principle ... is that man must be able to consult his lawyer in confidence, since otherwise he might hold back half the truth. The client must be sure that what he tells his lawyer in confidence will never be revealed without his consent. ... It is a fundamental condition on which the administration of justice as a whole rests. ... Once any exception to the general rule is allowed, the client's confidence is necessarily lost. The solicitor, instead of being able to tell his client that anything which the client might say would never in any circumstances be revealed without his consent, would have to qualify his assurance. He would have to tell the client that his confidence might be broken if in some future case the court were to hold that he no longer had "any recognisable interest" in asserting his privilege. One can see at once that the purpose of the privilege would thereby be undermined. ... But it is not for the sake of the applicant alone that the privilege must be upheld. It is in the wider interests of all those hereafter who might otherwise be deterred from telling the whole truth to their solicitors. For this reason, I am of the opinion that no exception should be allowed to the absolute nature of legal professional privilege, once established.'[137]

The House of Lords is thus of the view that only through the absolute protection of legal professional privilege which does not allow for any exception can its purpose be achieved. This is based on the utilitarian thought that the good consequences pursued with the protection of confidentiality can only be achieved if there is an absolute certainty that confidentiality will be upheld under all circumstances. Given that the protection of confidentiality in judicial proceedings is limited to legal professional privilege, the costs of an absolute privilege seem to be outweighed by the benefits flowing from confidentiality which is seen as a particularly important principle in the context of the lawyer-client relationship. At the same time, the view that only an absolute privilege can achieve its purpose is likely to stand in the way of any expansion of privileges to other confidential relationships, such as the physician-patient relationship.

2.4. Police access to confidential medical information

While at trial stage, English law does not make a distinction between documents and the oral testimony of a witness, so that a physician can be compelled to give

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[136] [1996] AC 487.

[137] Ibid., at 507-509, per Taylor LJ; for a critique see, for example, Uglow, *Evidence*, at 207-208.

testimony in court as well as forced to submit confidential medical reports and other evidence, the situation is different at the pre-trial stage. As far as the physician's duty to disclose information to the police is concerned, the principle is laid down in *Rice v Connolly:*[138] there is no legal duty to assist the police and every individual has the right to refuse to answer questions put to him/her by a police officer. At pre-trial stage, therefore, the physician cannot normally be compelled orally to disclose confidential patient information. However, a few statutory provisions impose an obligation on every citizen to disclose information to the police. In the case of traffic offences, for example, s.168 Road Traffic Act 1972 provides that everybody must, upon request by the police, provide any evidence he/she has which may lead to the identification of the driver involved. While physicians tried to argue that they should be exempt from this obligation given their duty to maintain the patient's confidences, the court in *Hunter v Mann*[139] rejected this view. The Medical Defence Union interprets this provision as imposing an obligation to supply the name and address of the patient only, but is of the opinion that no medical information has to be disclosed.[140]

Special provisions apply to state access to confidential medical documents in the course of police investigations. The police powers to search for and seize material in the course of a criminal investigation are governed by the provisions of the Police and Criminal Evidence Act 1984 (PACE). The Act contains special provisions regarding state access to certain categories of confidential information.

2.4.1. Definition of excluded material

Under s.11 of the Act, personal records and human tissue and tissue fluid taken for the purpose of diagnosis or medical treatment are defined as excluded material. According to s.12, personal records are all documentary and other records concerning an individual who can be identified from them and which relate to, *inter alia*, his physical or mental health. This embraces patient records kept by doctors or hospitals. Even hospital records of patients' admissions and discharges are excluded material because they relate to the physical and mental health of persons who could be identified from them. This was explained in *R v*

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[138] [1966] 2 All ER 649, at per Lord Parker CJ.
[139] [1974] 2 All ER 414.
[140] Medical Defence Union, *Confidentiality*, at 7.

Cardiff Crown Court, ex parte Kellam,[141] a case in which the police, in the course of investigating a murder, sought details from a psychiatric hospital about patients who were absent from the hospital on the day in question. The hospital had kept records of the patients' movements for the purposes of national insurance payments, so that the information was, in fact, available. Morland J argued as follows:

> 'Section 11 of the Police and Criminal Evidence Act 1984 ... must be given [its] ordinary and natural meaning. ... The definition, in my judgment, is very widely drawn and embracing. The 'records relating to physical or mental health' are not confined to clinical, nursing or surgical notes or treatment. The definition is expressly directed to the identifiability of the patient from the record. Often records of admission and discharge from a hospital or clinic will reveal the aspect of health for which a person is a patient, e.g. mental or maternity hospital, VD clinic or accident and emergency department. Records relating to admission or discharge of a patient from a hospital or clinic exist solely because he is a patient. That applies equally to the secondary records in this case of authorised discharges or leaves of the patient. ... He is a patient because he is suffering or is suspected to be suffering from physical or mental ill-health. He is discharged either permanently or temporarily because either he has recovered his health or temporary discharge is therapeutic or nothing more can be done to help him. In my judgment the records of discharge sought in this case (and the same would apply to unauthorised absences) concern an identifiable patient, in his capacity of being a patient, and are related to his mental health and are therefore 'excluded material' as defined by s 11.'[142]

As objects removed from the human body, for example bullets, are not human tissue, they are not excluded material under the Act.[143] If a crime victim is examined for forensic reasons and for example swabs and smears or blood samples are taken, this material is not being taken for the purpose of medical diagnosis or treatment and is therefore outside the scope of excluded material. But it could be argued that this material is held in confidence by the doctor or hospital, thus being special procedure material under s.14 of the Act.[144]

Another requirement for qualifying as excluded material is that the material is held in confidence. Excluded material thus consists of confidential material which is held by a third party who would normally be in breach of an obligation of confidentiality when voluntarily submitting that material to the police. The seizure

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[141] [1994] 16 BMLR 76 (QBD).
[142] Ibid., at 79-80.
[143] Bevan, Lidstone, *The investigation of crime*, at 158.
[144] Ibid., at 158-159.

of such material is excluded because it would constitute an interference with contractual or ethical confidentiality obligations.[145]

2.4.2. Application for an order giving access to excluded material

The police are not completely prevented from access to excluded material, but they have to comply with a certain procedure when seeking access to it. According to s.9(1) PACE, a circuit judge may, upon application by the police, issue an access order for the purpose of a criminal investigation if the conditions set out in Schedule 1, para.3 to the Act are met, i.e. there must be reasonable grounds to believe that excluded material can be found on the premises for which, prior to the enactment of s.9(2), the issuance of a search warrant would have been appropriate and available under a statutory provision. The effect of s.9(2) thus is that excluded material in regard to which, before the enactment of the Police and Criminal Evidence Act 1984, a search warrant would have been available under a statute, is now available only where the specific conditions outlined in Schedule 1, para.3 of the Act regarding an access order are met. As the search warrant powers in existence before the enactment of the Police and Criminal Evidence Act 1984 did not refer to situations normally relevant to the physician-patient relationship, e.g. s.26 Theft Act 1968 referring to stolen goods, only in very rare cases will the conditions for issuing an access order be met as far as confidential patient information is concerned. *R v Cardiff Crown Court, ex parte Kellam,*[146] for example, concerned an investigation for murder. As prior to the enactment of PACE, there was no statutory power for the police to obtain a search warrant in relation to a murder investigation, the disclosure of the excluded material to which the police sought access could not be compelled. Once it is established that the seizure concerns 'excluded material' and that the prerequisites of an access order are not met, there is no leeway as to a balancing of interests depending on the seriousness of the criminal offence under investigation. As Morland J explained:

> 'Section 11 of the Police and Criminal Evidence Act 1984 ... must be given [its] ordinary and natural meaning. This is so even if the result may seriously impede police investigations into a terrible murder and allow a very dangerous man to remain at large and a real risk to others. Parliament defines 'excluded material', as a matter of public policy, presumably, because it considered that

[145] See Powell, Magrath, *Police and Criminal Evidence Act 1984,* at 32-33.
[146] [1994] 16 BMLR 76 (QBD).

> the confidentiality of records of identifiable individuals relating to their health should have paramountcy over the prevention and investigation of crime.'[147]

Given the broad interpretation of 'excluded material' in this decision, virtually every document that might be made in respect of a patient, be it clinical or administrative, is now covered by the Act. This outcome has been welcomed as reflecting Parliament's intention as well as being the most practical solution, given that it makes any distinction between different types of records held by physicians obsolete.[148] However, s.9(2) of the Act does not apply to statutory powers of search created after the 1984 Act unless the creating statute explicitly refers to it. It would, therefore, be possible to introduce new search powers regarding confidential patient information by enacting a statute authorising the search for such information in a certain context, for example medical records establishing drug abuse or gunshot wounds, if such a statute did not include a reference to the special procedure set out in PACE.

An exception to the general rule of inaccessibility of excluded material is contained in Schedule7, para.3(5) of the Prevention of Terrorism (Temporary Provisions) Act 1989, which allows an application to a circuit judge for access to excluded material where the judge is satisfied that (a) a terrorist investigation is being carried out and that there are reasonable grounds for believing that the material is likely to be of substantial value to the investigation, and (b) that there are reasonable grounds for believing that it is in the public interest that the material should be produced. It follows that, in the course of terrorist investigations, the police could get access to confidential patient information if all of the above mentioned requirements are fulfilled. But as far as police investigations for other than terrorist offences are concerned, confidential information held by a doctor will not be available to the police, since at least one of the prerequisites of an access order to obtain excluded material, i.e. the existence of pre-PACE powers to issue a warrant, will almost never be met.

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[147] Ibid., at 79-80.
[148] Grubb, [1994] Med L Rev, at 371.

2.4.3. Access to excluded material without court order

Under certain circumstances, excluded material can be subject to search and seizure without prior application for an access order. Excluded material can be seized according to s.19 PACE in the course of the execution of a search warrant or post-arrest powers in any circumstances in which the police officer is lawfully on the premises. This means that where a police officer has obtained a warrant, he/she can seize excluded material, if the other requirements of s.19 are met. But it could be argued that almost no situations are conceivable in which the requirements of s.19(2) will be satisfied, as there must be reasonable grounds for believing that it is necessary to seize the material in order to prevent the material being concealed, lost, altered or destroyed. Therefore, s.19 PACE is only of very limited, if any, relevance in the context of the physician-patient relationship.[149]

Under s.32(2)(b) PACE, a police officer is allowed to search the premises on which the suspect was arrested or where he/she was immediately before the arrest provided that there are reasonable grounds to believe that evidence of the offence for which he/she was arrested is to be found on the premises. If, therefore, a suspect is arrested when leaving the hospital after having been treated for injuries supposedly sustained while committing a serious arrestable offence, the police can legally seize the patient records of said suspect if they have reasonable ground to believe that the records will contain evidence that the suspect has committed the offence he/she is being arrested for.[150]

Thus, in the situations governed by ss.19 or 32 respectively, the special protection provided for excluded material ceases to be effective. These exceptions give the police the possibility to circumvent the otherwise strict rules in respect of the accessibility of excluded material. They hardly seem to be compatible with the principle that excluded material is not accessible in the course of police investigations save in circumstances especially provided for by the 1984 Act and subject to careful considerations by circuit judges. It is particularly worrying that police officers are awarded the power to make a decision on the seizure of confidential and often sensitive material, and that they have to make this decision

[149] Ibid.
[150] Bevan, Lidstone, *The investigation of crime*, at 164.

in situations which barely leave any time for a careful balancing of all interests involved.

2.5. Voluntary disclosure by the physician

Where the physician is called upon to give testimony in court, or where the disclosure of a physician's medical documents is compelled by a court order or they are seized under the provisions of PACE, the physician does not have a choice but rather must comply with the court order or tolerate the seizure, unless he/she is prepared to accept the consequences of disobeying the law. A different question altogether is whether or not it is lawful for the physician voluntarily to submit confidential patient records or to convey other confidential patient information to the police and/or the courts. Given that the physician is, in principle, under an obligation to maintain medical confidentiality, a voluntary disclosure would normally constitute a breach of confidentiality. However, in the context of criminal investigations and proceedings it is at least possible that in certain situations such a breach could be justified. Different possible justifications for a disclosure by the physician can be distinguished.

2.5.1. Voluntary submission of medical records to the police

It follows from the almost complete exclusion of confidential patient material in the hands of a physician from seizure that the question of whether the doctor has the right voluntarily to submit excluded material in the course of a criminal investigation is of particular importance to the police. The only English case directly on this point is *R v Singleton.*[151] In that case, the court had to decide whether a dentist could, without consent of his patient, voluntarily submit dental records to the police to assist with the investigation of a serious crime. As these records were excluded material under s.11 PACE, they could not have been lawfully seized by the police. The answer largely depends on an interpretation of the purpose behind the protection awarded by the provisions of PACE. If the special protection given to confidential medical records were intended to protect the private sphere of the patient, then only the patient could waive this protection,

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[151] *R v Singleton* [1995] Crim LR 236.

and without the patient's consent, the physician would then not be allowed to hand the material over to the police. If, on the other hand, the holder of the information were to be protected, the physician holding confidential patient records would be protected and would then, accordingly, be in the position to waive the protection by voluntarily handing over excluded material to the police. According to the court in *R v Singleton*, s.11 PACE does not aim to protect the patient, but rather intends to protect the physician from the seizure of patient records. Consequently, the doctor has the right to waive the protection given to him/her. A voluntary disclosure of excluded material to the police was held to exempt the police from obtaining a s.9(2) order which would not have been available in *R v Singleton* because the requirements under PACE were not fulfilled. Unfortunately, the court did not explain the considerations on which this holding was based. Nevertheless, this case-law seems to be largely accepted.[152] In favour of the court's approach, it has been argued that the seizure of excluded material is prohibited because it would interfere with the physician's contractual or ethical confidentiality obligations.[153] This approach seems to imply that the confidentiality obligations of the confidence holder, rather than the confidentiality interests of the patient, should be protected against state interference. According to this view, while there is an interest in protecting the physician from search and seizure as long as he/she wants the confidential information to be protected, no such interest is involved where the physician voluntarily submits the material to the police, thereby waiving the interest in the confidentiality of the patient records. The courts have, in a different context, confirmed the interpretation of the relevant PACE provisions as serving the protection not of the patient's, but of the physician's interests in the maintenance of confidentiality in the physician-patient relationship, as courts have held that it is the person in possession of the material (the physician), not the suspect (the patient), who has to be notified of an application for an access order.[154]

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[152] See Feldman, *Civil Liberties & Human Rights in England & Wales*, at 454; Mason, McCall Smith, *Law and Medical Ethics*, at 206-207.
[153] See Powell, Magrath, *Police and Criminal Evidence Act 1984*, at 32-33.
[154] *R v Crown Court at Leicester, ex parte Director of Public Prosecutions* [1987] 3 All ER 654; *R v Crown Court at Manchester, ex parte Taylor* [1988] 2 All ER 769; *Barclays Bank plc v Taylor* [1989] 3 All ER 563 (CA), at 567.

Much can be said, however, for reading the relevant PACE provisions as protecting the right of privacy of the person the information relates to.[155] The purpose of the new procedure was to improve the protection of confidential material. It follows that the procedure was not designed as a safeguard for the material holder, but rather for the individual's interests in his/her confidential information. This view is supported by an analysis of the interests balanced by the provisions on access to excluded material. In *R v Crown Court at Lewes,*[156] Bingham LJ identified the different interests as follows:

> 'The Police and Criminal Evidence Act governs a field in which there are two very obvious public interests. There is, first of all, a public interest in the effective investigation and prosecution of crime. Secondly, there is a public interest in protecting the personal and property rights of citizens against infringement and invasion. There is an obvious tension between these two public interests because crime could be most effectively investigated and prosecuted if the personal and property rights of citizens could be freely overridden and total protection of the personal and property rights of citizens would make investigation and prosecution of many crimes impossible or virtually so. The 1984 Act seeks to that effect a carefully judged balance between these interests and that is why it is a detailed and complex Act.'[157]

If the PACE provisions are interpreted that way, it is difficult to argue that they are meant to protect the personal interests of the physician rather than those of the patient, as the information relates to intimate details of the patient's, not of the physician's life.[158] However, the conclusion that the physician who merely holds someone else's confidential information should not have any discretion voluntarily to submit such information to the police, given that the legislature has expressed its view that this information should be excluded from state access even in the situation of investigations for a serious criminal offence, does not logically follow from this interpretation. The Act only protects against state access through search and seizure, but does not envisage the situation of voluntary submission of excluded material by the physician. It therefore seems a better approach to argue that the question of whether or not the physician is allowed voluntarily to submit excluded material cannot be answered by an interpretation of the provisions of the Act, but must instead focus on whether or not a legal justification for the disclosure existed, a question which will be addressed below. Where this is not

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[155] Zuckerman, (1990) Crim LR, at 475.
[156] *R. v. Crown Court at Lewes, ex parte Hill* [1991] 93 Cr App R 60.
[157] Ibid., at 65-66.
[158] Zuckerman, (1990) Crim LR, at 475.

the case, a doctor who by such an action breaches patient confidences may be liable to compensation under tort law.[159] The only question that may be answered with regard to the purpose behind the provisions of PACE is the question of whether or not the police should be allowed to accept and use excluded material that was submitted by a physician.

2.5.2. Disclosure for the purpose of criminal prosecution

Where a physician has information which could be useful in the course of a criminal trial, but which is protected by the physician's obligation to medical confidentiality, a conflict between the interest of medical confidentiality, on the one hand, and the interests of justice, on the other hand, may arise. As was already examined above, in the context of criminal proceedings the conflict was decided in favour of disclosure, i.e. the interest in criminal prosecution does have priority where a physician is assumed to have information that is relevant and material for a criminal trial and is called upon to testify. In the context of excluded material under PACE, on the other hand, the protection of confidential material always prevails over the interest in prosecuting even the most serious criminal offence. It remains to be seen how the law deals with situations in which the provisions of PACE are not applicable and in which no court order is issued or sought to compel the disclosure of confidential information by the physician. This can, for example, become relevant where the physician holds information that may be material for the purposes of a criminal investigation or a criminal trial, but where the fact that the physician has such knowledge is unknown to the public authorities so that no court order can compel disclosure. The physician is then obviously not in any legal conflict, as he/she is under a legal obligation to maintain patient confidences, while there is no competing legal obligation to disclose confidential medical information. Thus, the possible conflict is of moral rather than of legal nature. The professional guidelines provided for an exception to the obligation of medical confidentiality where the disclosure is made for the purpose of public prosecution, as para. 81 (g) of the GMC's Blue Book stated that:

> Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by the police of a grave or very serious crime, might override the doctor's duty to

[159] See Bevan, Lidstone, *The investigation of crime*, at 159.

maintain his patient's confidence.

Thus, according to these guidelines, there would be no disciplinary action if a medical confidence was disclosed in the course of investigations into serious crimes, that is for the purpose of criminal prosecution.[160] However, the guidelines have since been changed, now stating that:

> Rarely, cases may arise in which disclosure in the public interest or in the interests of an individual may be justified, for example, a situation in which the failure to disclose appropriate information would expose the patient, or someone else, to a risk of death or serious harm.[161]

The amended version no longer refers to the situation of criminal prosecution, as once a crime has been committed, there is no longer a risk of death or serious harm that could be averted by disclosure. However, there nevertheless seems to be wide agreement that the voluntary disclosure of confidential patient information by a physician should sometimes be justified for the purposes of criminal prosecution. Some have argued that a physician is expected to act according to his/her 'conscience as a citizen of standing' and that disclosure to the authorities of attendance resulting from firearm injuries, murder, armed robbery or offences against the State should therefore not pose any difficulties.[162] The provisions of the Health Act 1999[163] for the particular obligation of medical confidentiality created under the Act, provide for an exception for the purposes of the investigation of a serious arrestable offence. According to Schedule 5, Part I to PACE, serious arrestable offences are treason, murder, manslaughter, rape, kidnapping, incest with a girl under the age of 13, and indecent assault which constitutes an act of gross indecency. It thus seems fair to state that prosecution of criminal offences can justify voluntary disclosure of confidential patient information to the police by the physician, but only where the disclosure is necessary for the investigation or prosecution of serious criminal offences, whereas the disclosure for the purpose of prosecuting less serious offences would not be justified.[164] This leaves the problem of how to determine what is or is not an offence serious enough to justify disclosure. It should also be noted that such a

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[160] See also Schutte, (1989) Journal of the Medical Defence Union, at 21; Anonymous, (1974) BMJ 399-400.
[161] GMC, *Professional Conduct and Discipline: Fitness to Practise*, 1993, rule 86.
[162] Marsden, (1992) 85 Journal of the Royal Society of Medicine, at 188.
[163] See, for example, s.24(6)(e).
[164] See also McHale, *Medical Confidentiality and Medical Privilege*, at 91; Taylor, *Medical Malpractice*, at 78.

distinction between different offences according to their seriousness stands in contradiction to the solution the law provides for disclosure in court, where the physician must testify regardless of the seriousness of the offence, and the solution favoured under PACE, where confidential material is excluded from police access regardless of the seriousness of the offence under investigation. S.29 Data Protection Act 1998 which provides for exceptions from data protection provisions and principles where the data are processed for the purpose of the detection of crime or the apprehension or prosecution of offenders, does not distinguish between serious and less serious offences.

The attitude of parts of the judiciary towards the value attached to privacy, on the one hand, and to the public interest in criminal prosecution, on the other hand, can be illustrated by a quote from *R v Khan.*[165] In that case, Nolan LJ observed that:

> 'It would be a strange reflection on our law if a man who has admitted his participation in the illegal importation of a large quantity of heroin should have his conviction set aside on the grounds that his privacy has been invaded.'[166]

Even though this statement stems from an entirely different context, it nevertheless reflects the prevalent view that the interest in criminal prosecution normally outweighs the interest in privacy or confidentiality. It can therefore be concluded that it is very unlikely that the voluntary disclosure by a physician of confidential patient information that is relevant for the purpose of criminal prosecution will be found to violate the physician's obligation to maintain medical confidentiality, at least where the crime at issue is not of total insignificance.

2.5.3. Conflicting defence rights or interests of a person wrongly accused

Another conflict that may occasionally arise is the conflict between medical confidentiality, on the one hand, and defence rights of an accused or the interests of a person who is wrongly under suspicion of having committed a criminal offence, on the other hand. Given that no medical privilege is recognised in criminal proceedings, the defendant can easily get access to confidential material that may be useful for his/her defence, as long as the relevance and materiality of the material can be established.[167] It remains to be discussed, in the present

[165] [1996] 3 All ER 289.
[166] Ibid., at 302.
[167] For the specific problem of the production of confidential documents upon request of the

context, whether or not the physician is allowed to disclose confidential patient information where the defendant does not know of its existence and can therefore not demand disclosure, but where the physician nonetheless has information the disclosure of which may be of interest to the defence or to someone who is under suspicion of having committed a criminal offence. There is no case-law directly to this point. However, as case-law in other areas shows, most courts that had to balance confidentiality interests against defence rights argued that the defence rights of someone who is accused of an offence in criminal proceedings necessarily outweigh the interest in confidentiality.[168] The reason behind this outcome of the balancing of interests is that the interests of the accused in his/her liberty are of a very high rank.[169] For a long time, courts even held that defence rights prevailed over the confidentiality interest underlying legal professional privilege.[170] However, *R v Derby Magistrates' Court, ex parte B*[171] made it clear that even where the defence rights of an innocent person are concerned, the importance of legal professional privilege does not allow for any exceptions to the principle of non-disclosure. This seems to be a victory of utilitarian over deontological considerations. Nicholls LJ discussed the difficulties any balancing exercise would have to overcome:

> 'The court would be faced with an essentially impossible task. ... How does one equate exposure to a comparatively minor civil claim or criminal charge against prejudicing a defence to a serious criminal charge? How does one balance a client's risk of loss of reputation, or exposure to public opprobrium, against prejudicing another person's possible defence to a murder charge? But the difficulties go much further. Could disclosure also be sought by the prosecution, on the ground that there is a public interest in the guilty being convicted? If not, why not? ... There is no evident stopping place short of the balancing exercise being potentially available in support of all parties in all forms of court proceedings. This highlights the impossibility of the exercise. What is the measure by which the judges are to ascribe an appropriate weight, on each side of the scale, to the diverse multitude of different claims, civil and

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accused under s. 66 of the Criminal Procedure and Investigations Act 1996 see Corker, (1998) 38 Med. Sci. Law 138-141.

[168] See, for example, *Taylor v Serious Fraud Office* (HL (E)) [1998] 3 WLR 1040, at 1049 per Hoffmann LJ.

[169] See, for example, *R v Governor of Brixton Prison, ex parte Osman* [1991] 1 WLR 281 (DC), per Mann LJ; *Vincent Raymond Agar* [1990] 90 Cr App R 318 (CA), per Mustill LJ; *Timothy John Hennessey and Others* [1978] 68 Cr App R 419, per Lawton LJ; *Mark v Beyfus* [1890] 25 Q.B.D. 494, per Lord Esher MR; see also Barnett, (1997) Fam Law, at 493.

[170] See, for example, *R v Barton* [1973] 1 WLR 115, at 118 per Caulfield J; *R v Ataou* [1988] 2 All ER 321 (CA), at 327.

[171] [1996] AC 487 (HL), per Lloyd LJ.

criminal, and other interests of the client on the one hand and the person seeking disclosure on the other hand?'[172]

While this argument is interesting in that it sheds some light on the problems arising when having to balance competing interests the respective values of which are very difficult to ascertain and qualify, it should nevertheless be added that courts perform such balancing exercises in many different areas, and that the difficulties inherent in the exercise themselves do not seem to give sufficient weight to the conclusion that one of the two competing interests should be awarded absolute status so as to make any balancing of interests obsolete. Also, even Nicholls LJ would limit his statement to the conflict between legal professional privilege, on the one hand, and defence rights of a third party, on the other hand, but he is very unlikely to extend this principle to all cases of potential conflicts of interests.

While the cases looked at so far can do no more than clarify the value that courts have attached to the different interests at stake, none of these cases concerned the voluntary disclosure of confidential information to assist an accused with his/her defence. A case which touches upon that question, though in the context of adoption proceedings rather than in the area of medical confidentiality, is *Note Re an Adoption Application*.[173] In that case, an originating summons was brought *ex parte* by a local authority, acting as adoption agency. A few years after a schoolgirl's child had been placed for adoption, she asserted that her stepfather had sexually abused her and he was charged with rape and other sexual offences. The prosecution case depended entirely on the girl's evidence. The stepfather's defence had been that the father of the child and the perpetrator of the offences had been a schoolfriend of hers. The stepfather was convicted and sentenced to a long term of imprisonment. He appealed and was allowed to apply for blood tests to establish whether or not he was the father of the baby. The local authority was required to look at their files in order to find out where the baby was. In doing so, the local authority found out that the account of the girl as to how she became pregnant was compatible with the stepfather's defence. The local authority sought the assistance of the court in deciding whether or not to disclose this information. Under Rule 53(3) Adoption Rules 1984, any person who obtains any information

[172] Ibid., at 511-512.
[173] [1990] 1 FLR 412 (FD), per Ewbank J.

in the course of, or relating to adoption proceedings shall treat that information as confidential and shall only disclose it if the disclosure is necessary for the proper exercise of his/her duties. The court argued as follows:

> 'The information which is now available may be relevant, in the interests of justice, in the Court of Appeal, Criminal Division. In my judgment, a further disclosure of this information to the Attorney-General is necessary for the proper exercise of the social worker's duties. The Attorney-General will be able to decide to what extent the information should be passed on, either to the court or to any other person. I, accordingly, direct that the local authority should inform the Attorney-General of the circumstances of this case and of the information which is available in their files, for him to consider further.'[174]

In this case the court did not weigh the different interests, i.e. the interest in the confidentiality of adoption proceedings, on the one hand, and the interests of the wrongly convicted, on the other hand, but rather decided in favour of disclosure by interpreting the exception provided by the Adoption Rules in a very liberal way. However, this case is a very good example of the interests that can weigh in favour of a breach of confidentiality obligations. If the only possibility to exonerate the accused, or, in this case, the wrongly convicted, is to disclose confidential information relating to the offender or a third party, many will agree that it lies in the public interest to prevent a miscarriage of justice as well as in the accused's interest in freedom from unjust punishment that a breach of confidentiality for this purpose be justified. The importance of defence rights of the person accused in criminal proceedings was one of the main reasons for the Criminal Law Revision Committee to reject the introduction of medical privilege.[175]

2.5.4. Crime prevention

The physician is under no obligation, and cannot normally be compelled to disclose confidential medical information for the purpose of crime prevention. Therefore, in the context of crime prevention, voluntary disclosure by the physician is of particular importance. The leading case dealing with the voluntary disclosure by a physician of confidential medical information for the purpose of crime prevention is *W v Egdell*.[176] That case, which has already been discussed in

[174] Ibid., at 413.
[175] Eleventh Report, Cmnd 4991, para.272-276.
[176] [1990] 1 All ER 835 (CA).

a different context in this chapter,[177] did not concern the disclosure of confidential patient information to the police. However, the decision nevertheless provides a detailed discussion of the different interests to be balanced where the physician's obligation to confidentiality conflicts with the public interest in the prevention of criminal offences, and the physician decides to disclose the relevant information. As Bingham LJ put it, the crucial question was how the balance should be struck between the public interest in maintaining professional confidences and the public interest in protecting the public against possible violence. According to Stephen Brown P, the balance came clearly down in favour of disclosure. The main reason for this was the number and nature of the killings W had committed, as they:

> 'must inevitably give rise to the gravest concern for the safety of the public. ... It is clear that Dr Egdell did have highly relevant information about W's condition which reflected on his dangerousness. In my judgement the position came within the terms of r 81(g) of the General Medical Council's rules. ... The suppression of the material contained in his report would have deprived both the hospital and the Secretary of State of vital information, directly relevant to questions of public safety. ... The judge in fact based his conclusion on what he termed "broader considerations", that is to say the safety of the public. I agree with him.'[178]

Bingham LJ also made some interesting observations:

> 'Counsel for W contended that ... there was ... no question of W's release, whether absolutely or conditionally, in the then foreseeable future. ... I do not find these points persuasive. When Dr Egdell made his decision to disclose, one tribunal had already recommended W's transfer to a regional secure unit and the hospital authorities had urged that course. The Home Office had resisted transfer in a qualified manner but on a basis of inadequate information. It appeared to be only a matter of time, and probably not a very long time, before W was transferred. The regional secure unit was to act as staging post on W's journey back into the community. While W would no doubt be further tested, such tests would not be focused on the source of Dr Egdell's concern, which he quite rightly considered to have received inadequate attention up to then. Dr Egdell had to act when he did or not at all. There is one consideration which in my judgment ... weighs the balance of public interest decisively in favour of disclosure. It may be shortly put. Where a man has committed multiple killings under the disability of serious mental illness, decisions which may lead directly or indirectly to his release from hospital should not be made unless a responsible authority is properly able to make an informed judgment that the risk of repetition is so small as to be acceptable. A consultant psychiatrist who becomes aware, even in the course of a confidential relationship, of information which leads him, in the exercise of what the court considers a sound professional judgment, to fear that such decisions may be

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[177] *Supra.*, 1.4.
[178] [1990] 1 All ER 835 (CA), at 846.

made on the basis of inadequate information and with a real risk of consequent danger to the public is entitled to take such steps as are reasonable in all the circumstances to communicate the grounds of his concern to the responsible authorities. I have no doubt that the judge's decision in favour of Dr Egdell was right on the facts of this case.'[179]

It is also interesting to note that Bingham LJ made reference to Art.8 European Convention on Human Rights. This is of particular significance, as his statements to that point may give an indication on how the Human Rights Act is likely to be interpreted by English courts. According to his Lordship, the situation in *Egdell* fell squarely within the exception envisaged by Art. 8(2), as Dr. Egdell's conduct was necessary in the interests of public safety and the prevention of crime.[180]

To summarise the holding in *Egdell*, the court seems to suggest that disclosure may be made only to those to whom it is necessary to convey the information in order to protect the public interest and that only a risk involving the danger of physical harm justifies disclosure.[181] The very abstract danger that someone who committed crimes due to a certain psychological disposition might be dangerous in the future seems to be sufficient for the public interest justification to apply. Based on its decision in *Egdell*, the Court of Appeal held in *Peter Michael Anthony Crozier*[182] that a psychiatrist who was of the firm belief that a patient suffered from a psychopathic disorder and continued to be a danger to the public acted reasonably and responsibly when disclosing this information, as the strong public interest in the disclosure of his views overrode his duty of confidence to the appellant.

The approach adopted by the Court of Appeal was mostly welcomed.[183] Michael Jones,[184] for example, in principle approved of the decision. He suggested, however, that the very wide scope of the public interest defence under *Egdell* should be limited. A possible limitation could be based on the requirement of a 'real' risk of a danger to the public. However, the word 'real' leaves some scope for interpretation ranging from a probability of the risk to a mere possibility, the latter seemingly having been sufficient in *Egdell*. The interpretation the concept of 'real' risk has received in *Egdell* does not do much to limit the scope of disclosure

[179] Ibid., at 852-853.
[180] Ibid., at 853.
[181] Kennedy, Grubb, *Medical Law*, at 657.
[182] [1990] 12 Cr App R (S) 206.
[183] See, for example, Mason, McCall Smith, *Law and Medical Ethics*, at 196-197.
[184] Jones, (1990) 6 PN 16- 24.

in the public interest. Given the facts of the case, there was no imminent risk of W's release, let alone any risk that he might harm anybody. And the disclosure of the diagnosis was no more than the opinion of one physician,[185] and other reports would have been looked at before making a final decision on W's release. The mere fact that other doctors may not have focused on the same aspects of W's personality and may therefore possibly have come to a conclusion that differed from that of Dr Egdell seems hardly sufficient to justify a breach of the confidential relationship between patient and physician in this case. Another question in need of an answer is what exactly amounts to a danger to the public and here, in particular, whether or not a risk to a single individual would be sufficient to qualify as a danger to the public. It has been suggested that the risk to an individual should be enough to trigger the public interest defence, as the public has an interest in the protection of its members from violence which is affected by a real risk of danger to the bodily integrity of one individual.[186] It should also be noted that there must be a risk of 'physical' harm, and that a risk of non-physical harm would not be sufficient to justify disclosure.[187] This case-law leaves the physician in the undesirable position of having to perform a risk assessment, especially as to whether or not the risk is real and whether or not it involves a danger to the public. Some commentators, while conceding that the result in *Egdell* may be right in that the public needs to be protected from potentially dangerous persons, nevertheless expressed some unease as to the casualness with which the court was prepared to disregard the confidentiality interests of the patient.[188]

Another case in which the court's decision was based on considerations that bear some similarity to those applicable to cases of voluntary disclosure of medical confidences in the context of crime prevention was *Re C (A Minor) (Evidence: Confidential Information)*.[189] The former GP of a mother who had handed her child to social workers for adoption and then changed her mind one day before the hearing, had volunteered information relating to her addiction to sleeping pills and her inability to bring up the child. The Court of Appeal not only came to the conclusion that the affidavit should be admitted given its relevance to the

[185] Kennedy, Grubb, *Medical Law*, at 657.
[186] Jones, (1990) 6 PN, at 19.
[187] Kennedy, Grubb, *Medical Law*, at 657.
[188] McHale, (1989) 52 MLR, at 719.
[189] [1991] 2 FLR 478 (CA).

proceedings. Stephen Brown P also added that in his opinion, the doctor had not breached medical confidentiality when making her evidence available, as her behaviour was fully justified.[190] He did not, however, specify what considerations had led to this analysis, apart from the fact that the disclosure was restricted to the judicial setting and had not been made to the public at large. Mann LJ, in the same case, reasoned that:

> 'Mr Kallipetis's argument was that the principle here involved was that where there is a public interest in protecting the confidentiality of the relationship between doctor and patient, that interest should only be set aside where it can be said, on balance, that the public interest in the achievement of justice overweighs the public interest in confidentiality. Such, it is said, is the situation even when the doctor's evidence is volunteered. Let it be assumed, and I do not decide, that such is the law in regard to the admission of a doctor's evidence which is relevant to an issue before the court. If it be the law, the judge who is asked to admit the evidence of the doctor in regard to treatment of his patient has to perform a balancing exercise. However, before undertaking the balance, he must consider whether the evidence which is proposed to be tendered would involve a breach of the duty of confidence which it is in the public interest to preserve. In this case, where the evidence is relevant to the future of the child, and the dissemination of the material is limited to those with an interest in its future, I have some doubt as to whether there would be a breach of duty.'[191]

Of course, again, the decision is of limited value in the context of voluntary disclosure for the purpose of general crime prevention, as the case concerned a risk to a specific child. However, it can be seen that the courts are likely to hold that a physician who discloses confidential medical information for the purpose of avoiding a risk to a child is either justified in breaching the obligation to maintain the patient's confidences, or will not even breach such duty thereby, as Mann LJ tried to argue in *Re C*.

The General Medical Council's guidelines on professional confidence[192] specify that:

> Rarely, cases may arise in which disclosure in the public interest may be justified, for example a situation in which the failure to disclose appropriate information would expose the patient, or someone else, to a risk of death or serious harm.

It can be seen that the question of crime prevention as such does not expressly appear either in the relevant case-law, or in the professional guidelines. Rather,

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[190] Ibid., at 483.
[191] Ibid., at 485-486.
[192] GMC, *Professional Conduct and Discipline: Fitness to Practise*, rule 86.

the focus always lies on the protection of either the public or individuals from certain risks, regardless of whether or not the risk thus created would amount to a criminal offence. Where such a risk can be identified, disclosure always seems to be justified. In *Re S (Minors) (Wardship: Police Investigations),*[193] a case that arose in the context of wardship proceedings, and in which the police applied for leave of the court to permit disclosure to the police of the medical records and video recordings made by a child abuse clinic, Booth J specifically referred to the balancing of interests in cases of crime prevention when stating that:

> 'The protection afforded to a child by the exercise of the wardship jurisdiction should not be extended to the point where it gives protection to offenders against the law and, indeed, offenders against the wards themselves. The court must take into consideration, as a matter of public policy, the need to safeguard not only its wards but other children against the harm they may suffer as the result of recurring crimes by undetected criminals. The likely outcome and its effects upon a ward of granting an application such as the police now make must be considered in each and every case. But when balanced against the competing public interest which requires the court to protect society from the perpetration of crime it could only be in exceptional circumstances that the interests of the individual ward should prevail. In this case, although the results may be far-reaching and unpleasant for these young and damaged children, their interests are secondary to that greater public need. I am satisfied that on the facts this application is wholly justified and that the police should have the leave they seek in respect of the medical records and video recordings now in the possession of Great Ormond Street Hospital.'[194]

In this case, the considerations of crime prevention and of criminal prosecution seem to be mixed up, as the argument is based on the thought that it is necessary to prosecute a person who has committed an offence in order to protect the public from the perpetration of crime. In its generality, this argument is problematic, as it can hardly be said that the fact that someone who committed past crimes and is still at large necessarily poses a real risk to individuals or society.

Re V (Sexual Abuse: Disclosure); Re L (Sexual Abuse: Disclosure)[195] are two cases which shed some light on the question of risk assessment and remoteness of risk. In *Re L,* the local authority wished to disclose to another local authority, in the area of which L now lived, the judge's finding that L posed a considerable threat to the children of single female adults with whom he might cohabit. L had previously been charged with counts of sexual abuse, and acquitted. In *Re V,* the

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[193] [1987] Fam 199.
[194] Ibid., at 203-204.
[195] [1999] 1 FLR 267 (CA), per Butler-Sloss, LJ.

local authority wished to disclose to the football league the judge's finding that W, who coached the junior teams at the local football club, had committed an indecent assault, and developed an unusual and unhealthy relationship with a 14-year-old. Butler-Sloss argued that:

> 'In Mr L's case ... it would be difficult to keep the information truly confidential if it is to be of use and its use might well be oppressive, unless a child was actually at risk. ... [In the case of Mr W] For it to be effective they would presumably have to circulate some information to all clubs with which Mr W might be associated. ... Almost inevitably it would have to be passed on probably to numerous people. ... If the dissemination is to be effective, and possibly even if it is not effective, the information provided is likely to be oppressive and consequently unjust to Mr W. Those considerations illustrate the problem for the court when faced with an application to authorise disclosure of information in a case where the risk cannot be related to a particular child or children - because it is not known whether any, or which, children are actually at risk from time to time. ... The balance comes down firmly in favour of non-disclosure in each case.'[196]

It can thus be seen that the Court of Appeal was not prepared to hold that a risk the existence of which can mainly be inferred from the past behaviour of the person concerned, and which is not the least bit specified as to the potential victims, or any other features on how it might materialise, can be sufficient to justify the disclosure of confidential information. The two cases also show that proportionality considerations have a role to play in this context. Where, because of the vague nature of the risk, the interests of the individual that are affected by disclosure will have to be violated to a considerable extent, such a measure does not seem acceptable.

While there seems to be widespread agreement that the disclosure of confidential medical information for the purposes of crime prevention should be justified under the conditions discussed above,[197] the overriding importance of the interests protected by disclosure seems so obvious that only rarely an attempt is made to explain this view. In cases of crime prevention, it has been argued that a breach of confidentiality could be justified if this is the only way to protect another's autonomy. Thus, if medical confidentiality were mainly based on patient autonomy, a breach might be justified as that autonomy finds its limits in the

[196] Ibid., at 274.

[197] See also s.29 Data Protection Act 1998 which provides for an exception for processing of data for the purpose of crime prevention.

autonomy of others.[198] However, if medical confidentiality additionally or mainly served the public interest in preserving public health, it must be borne in mind that the breach of confidentiality to protect the integrity of one individual may harm society,[199] a factor that was not at all considered by the courts.

2.5.5. Child abuse

The guidelines of the GMC provide that:

> Deciding whether or not to disclose information is particularly difficult in cases where a patient cannot be judged capable of giving or withholding consent to disclosure. One such situation may arise where a doctor believes that a patient may be the victim of abuse or neglect. In such circumstances the patient's interests are paramount and will usually require the doctor to disclose relevant information to an appropriate, responsible person or an officer of a statutory agency.[200]

The Medical Defence Union[201] equally advises that where a healthcare worker has reasonable grounds to suspect child abuse the paramount responsibility is with the infant patient and that it is perfectly legitimate to supply information to the appropriate authorities to ensure that the child is protected. Thus in cases of suspected child abuse, the interest in medical confidentiality is outweighed by the interest in protecting the child.

2.6. Summary and conclusion

No medical privilege exists in criminal proceedings so that a physician who is called upon to testify in a criminal court has no right to refuse to give testimony. This rejection of medical privilege is mainly based on the consideration that the interests of justice override any interest in confidentiality, unless this interest is supported by public interest immunity. Thus the fact that the maintenance of medical confidentiality lies in the public interest is not a sufficient reason for the recognition of medical privilege. It is very important to stress that an introduction of medical privilege into English law is widely seen as undesirable and superfluous, as many are of the opinion that medical confidentiality receives

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[198] See, for example, Jones, (1990) 6 PN, at 22.
[199] Boyd, (1992) 18 JME, at 173 and 178.
[200] *Professional Conduct and Discipline: Fitness to Practise*, rule 83.
[201] *Confidentiality*, at 14.

adequate protection in criminal court, given that the courts have a discretion to exclude medical evidence where it is not relevant and material. There also seems to be some distrust in the desirability of creating a statutory privilege, probably partly based on the view that privilege necessarily relates to a conflict of interests. It is felt that such a conflict should not be resolved in a general and abstract manner, but that it should rather be left to the courts to balance the competing interests in the individual case.[202] However, under current case-law the courts will only exercise any discretion to exclude medical evidence when it can be established that the evidence is neither relevant nor material to the case. Therefore, at present, not every case of conflict between the interests of justice and the interest in medical confidentiality calls for a balancing of the conflicting interests. Instead, it is clear that the interests of justice are automatically given precedence where the evidence is necessary for the trial.

Confidential medical information can in rare cases be protected from disclosure in court by the concept of public interest immunity, notably where patient information which was disclosed in wardship proceedings is to be used for police investigations or criminal prosecution. However, public interest immunity only very rarely adds anything to the protection of confidential medical information in court, as the courts are likely to override public interest immunity where the information the disclosure of which is sought is relevant or material for criminal prosecution purposes. Medical information can be protected by legal professional privilege, the only privilege recognised, where medical examinations took place or medical advice was sought as part of the defence strategy.

Medical records that are not protected by public interest immunity or legal privilege must be produced in criminal court under the same conditions under which the physician has to give testimony and are thus normally only protected if the content is thought to be irrelevant or immaterial. Where the police seek access to medical records in the course of investigations, the provisions of the Police and Criminal Evidence Act 1984 apply. As medical records qualify as 'excluded material' police access to them is only possible where the conditions of an access order are met, which will only rarely be the case. Thus, in the course of police investigations, confidential medical material receives far-reaching protection which stands in stark contrast to the almost non-existing protection at trial stage.

[202] See, for example, May, *Criminal Evidence*, at 13-43.

This discrepancy may be based on the view that, in principle, the confidentiality of the physician-patient relationship is valued more than the interest in investigating and prosecuting crimes, so that the police cannot violate the interests protected by medical confidentiality in order to get access to information that may assist in their investigations. However, once a case has come to court, the interests involved slightly change. At stake is not only the interest in prosecuting a criminal, but also the interest in the integrity of the judicial system as such. If the court does not have all information at its disposal to establish the truth, miscarriages of justice may occur and the trust in the legal system may be thereby impaired.

With regard to the question of whether the physician may voluntarily disclose confidential patient information to the police or the courts, different situations must be distinguished. Courts have decided that the physician is not prevented by the provisions of PACE voluntarily to hand over confidential patient records to the police. There is also wide-spread agreement that disclosure is justified for the purpose of criminal prosecution, at least where the information relates to serious criminal offences. Also, the physician will be justified in breaching medical confidentiality where the breach assists a person who is wrongly accused of a criminal offence, or where it assists the exercise of defence rights. Where the disclosure aims to prevent the commission of criminal offences, it will be justified if it helps avert a real risk of danger to an individual or society at large. The risk must be sufficiently specified, that is the mere possibility that a person who committed a criminal offence may continue to do so in the future will not provide enough justification for disclosure.

As the law is entirely based on case-law, a case-by-case approach has been adopted so that it is difficult to identify more general policy considerations underlying the decisions regarding the question of when medical confidentiality should be protected, and when it should yield to more important interests. It is striking that in the case of voluntary disclosure by the physician, which will normally violate his/her obligation of medical confidentiality, the question of possible legal justifications is mostly not regarded as very important. The justification usually applied, that is the public interest defence, is not carefully delineated and court decisions are mainly based on broad considerations of which interest seems more important in a given case.

Chapter 7 – Medical confidentiality and medical privilege in the U.S.

1. Protection of medical confidentiality

1.1. Constitutional protection

The US Constitution does not expressly protect the right to privacy or the right to medical confidentiality. With regard to the protection of a general privacy right, the US Supreme Court had to struggle to find a constitutional basis for such a guarantee. As Justice Douglas stated in *Griswold v Connecticut:*[1]

> 'Specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance. ... Various guarantees create zones of privacy. ... The Fourth Amendment explicitly affirms the "right of the people to be secure in their persons, houses, papers, and effects against unreasonable searches and seizures." The Fifth Amendment in its Self-Incrimination Clause enables the citizen to create a zone of privacy which government may not force him to surrender to his detriment. The Ninth Amendment provides: "The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people." The Fourth and Fifth Amendments were described ... as protection against all governmental invasions "of the sanctity of a man's home and the privacies of life." We recently referred ... to the Fourth Amendment as creating a "right to privacy, no less important than any other right carefully and particularly reserved to the people."'[2]

Under the US Constitution privacy can thus be protected by different Amendments.

1.1.1. Fifth Amendment (Self-Incrimination Clause)

The relevant part of the Fifth Amendment reads as follows:

> Nor shall [any person] be compelled in any criminal case to be a witness against himself.

In *Fisher v U.S.*,[3] the Supreme Court discussed whether the Fifth Amendment protected a person's privacy interests in general and rejected that interpretation of the Amendment on the following grounds:

> 'It is true that the Court has often stated that one of the several purposes served by the constitutional privilege against compelled testimonial self-incrimination is that of protecting personal privacy. ... But the Court has never suggested that

[1] 381 U.S. 479 (1965).
[2] Ibid., at 484-485.
[3] 425 U.S. 391 (1976).

> every invasion of privacy violates the privilege. ... The Framers addressed the subject of personal privacy directly in the Fourth Amendment. ... They did not seek in still another Amendment - the Fifth - to achieve a general protection of privacy but to deal with the more specific issue of compelled self-incrimination. We cannot cut the Fifth Amendment loose from the moorings of its language and make it serve as a general protector of privacy. ... Insofar as private information not obtained through compelled self-incriminating testimony is legally protected, its protection stems from other sources, the Fourth Amendment's protection ... or evidentiary privileges as the attorney client privilege. We adhere to the view that the Fifth Amendment protects against "compelled self-incrimination, not [the disclosure of] private information."'[4]

According to the Supreme Court in *Fisher*, the Fifth Amendment does not protect privacy interests as such.[5] Instead, its application is limited to protecting the individual from being compelled to give evidence against him/herself. This was also discussed in *Doe v U.S.*,[6] where it was held that:

> 'It is the "extortion of information from the accused", ... the attempt to force him "to disclose the contents of his own mind," ... that implicates the Self-Incrimination Clause. ... It is consistent with the history of and the policies underlying the Self-Incrimination Clause to hold that the privilege may be asserted only to resist compelled explicit or implicit disclosures of incriminating information. ... These policies are served when the privilege is asserted to spare the accused from having to reveal, directly or indirectly, his knowledge of facts relating him to the offence or from having to share his thoughts and beliefs with the Government.'[7]

And in *Couch v U.S.*,[8] it was explained that:

> 'The basic complaint of petitioner stems from the fact of divulgence of the possibly incriminating information, not from the manner in which or the person from whom it was extracted. Yet such divulgence, where it does not result from coercion of the suspect herself, is a necessary part of the process of law enforcement.'[9]

The Fifth Amendment thus mainly protects a person from having to give testimonial evidence against him/herself. With regard to confidential medical facts, this means that the patient is only protected against the compelled production of confidential documents that may incriminate him/her. However,

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[4] Ibid., at 399-401 per Justice White.
[5] See also, for example, *States v Doe* 465 U.S. 605 (1983), at 618 per Justice O'Connor, concurring ('The Fifth Amendment provides absolutely no protection for the contents of private papers of any kind. The notion that the Fifth Amendment protects the privacy of papers originated in *Boyd* ..., but our decision in *Fisher* ... sounded the death knell for *Boyd*.').
[6] 487 U.S. 201 (1988).
[7] Ibid., at 211-213, per Justice Blackmun.
[8] 409 U.S. 322 (1973).
[9] Ibid., at 329 per Justice Powell.

private documents that were voluntarily prepared are not protected under the Fifth Amendment, regardless of how private their content might be, as the Fifth Amendment only protects against having to create incriminating private documents, but not against state access to private documents that an individual had prepared without any state compulsion.[10] Another court, while agreeing in principle, qualified this statement by arguing that in such a case the Fifth Amendment could only protect the contents of the papers 'where compelled disclosure would break the heart of our sense of privacy.'[11] Confidential medical information thus does not receive any specific protection under the Fifth Amendment. The Supreme Court nevertheless argued that the Fifth Amendment can indirectly protect the confidentiality of privileged relationships, as the privilege would be undermined if the person bound by the privilege could be compelled to produce evidence which would be protected by the Fifth Amendment while in the possession of the persons in whose interest the privilege was awarded.[12] For the physician-patient relationship, this only means that the physician cannot be compelled to produce confidential medical records that were protected from production while in the possession of the patient. However, the effects of this constitutional protection are rather limited, given that it depends on the existence of a physician-patient privilege which is not recognised under federal law,[13] and given that only rarely will the requirements for Fifth Amendment protection be met in the person of the patient.

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[10] See, for example, *In Re Grand Jury Subpoena Duces Tecum* 1 F.3d 87 (2nd Cir. 1993), at 92-93 per Lumbard Circuit Judge; *Senate Select Committee on Ethics v Packwood* 845 F.Supp. 17 (D.D.C. 1994), at 23 per Jackson, District Judge; *In re: Grand Jury Subpoenas* 144 F.3d 653 (10th Cir. 1998), at 663 per Stephen H. Anderson, Circuit Judge; *In re: Grand Jury Witnesses* 92 F.3d 710 (8th Cir. 1996), at 712 per Loken, Circuit Judge; *Aviation Supply Corp. v R.S.B.I. Aerospace, Inc.* 999 F.2d 314 (8th Cir. 1993), per Loken Circuit Judge; but see, on the other hand, *U.S. v North* 708 F.Supp. 402 (D.D.C. 1989), at 404 per Gesell, District Judge.

[11] *U.S. v Feldman* 83 F.3d 9 (1st Cir. 1996), at 14 per Selya Circuit Judge; see also *In re Grand Jury Subpoena* 973 F.2d 45 (1st Cir. 1992), at 51 per Curiam.

[12] *Couch v U.S.* 409 U.S. 322 (1973), at 335-336 per Justice Powell; *Fisher v U.S.* 425 U.S. 391 (1976), at 403-404 per White Justice.

[13] See for example *Hancock v Dodson* 958 F.2d 1367 (6th Cir. 1992), at 1373 per Contie, Senior Circuit Judge; *U.S. v Bercier* 848 F.2d 917 (8th Cir. 1988), at 920 per McMillan, Circuit Judge; *U.S. v Burzynski Cancer Research Inst* 819 F.2d 1301 (5th Cir. 1987), at 1311 per Rubin, Circuit Judge; *U.S. v Meagher* 531 F.2d 752 (5th Cir. 1976), at 753 per Morgan, Circuit Judge.

1.1.2. Fourth Amendment (Unreasonable search and seizure)

The relevant part of the Fourth Amendment provides:

> The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated.

The protection of the privacy right available under the Fourth Amendment is limited to certain specific situations. As the Supreme Court stated in the leading case of *Katz v U.S.*:[14]

> 'The Fourth Amendment cannot be translated into a general constitutional "right to privacy". That Amendment protects individual privacy against certain kinds of governmental intrusion. ... But the protection of a person's *general* right to privacy - his right to be let alone by other people - is, like the protection of his property and of his very life, left largely to the law of the individual States.'[15]

It is thus important to note that the protection awarded under the Fourth Amendment is restricted in two ways. First, it is only directed towards protection against the state, but does not include protection against a privacy violation by other individuals. In the context of medical confidentiality, this means that medical information may be protected against state access, but not against voluntary disclosure by the physician. Secondly, the individual's privacy is not protected as such. Rather, the protection of privacy from governmental intrusions under the Fourth Amendment works as follows:

> 'My understanding of the rule that has emerged from prior decisions is that there is a twofold requirement, first that a person have exhibited an actual (subjective) expectation of privacy, and, second, that the expectation be one that society is prepared to recognise as "reasonable".'[16]

Given the widespread agreement among American courts that at least some aspects of medical confidentiality deserve constitutional protection as part of the privacy right of the individual,[17] it is fair to say that a patient has an expectation

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[14] 389 U.S. 347 (1967).

[15] Ibid., at 350-351 per Justice Steward.

[16] Ibid., at 361 per Justice Harlan; see also, for example, *Smith v Maryland* 442 U.S. 735 (1979), at 740 per Justice Blackmun.

[17] See, for example, *Whalen v Roe* 429 U.S. 589 (1977); *Behringer Est. v Princeton Medical Center* 592 A.2d 1251 (N.J.Super.L. 1991); *Caesar v Mountanos* 542 F.2d 1064 (9th Cir. 1976); *Falcon v Alaska Public Offices Commission* 570 P.2d 469 (Alaska 1977); *Hawaii Psychiatric Soc. Dist. Branch v Ariyoshi* 481 F.Supp. 1028 (D. Hawaii 1979); *Mann v University of Cincinnati* 824 F.Supp. 1190 (S.D. Ohio 1993); *Schachter v Whalen* 581 F.2d 35 (2nd Circuit 1978); *U.S. v Westinghouse Electric Corporation* 638 F.2d 570 (3rd Cir. 1980); *Woods v White* 689 F.Supp 874 (W.D. Wis. 1988); but see also, for example, *Felber v Foote* 321 F.Supp. 85 (D. Conn. 1970) in

that the medical confidences entrusted in the physician will remain confidential and that this interest must be recognised as reasonable. In principle, then, the Fourth Amendment protects the patient from unreasonable state intrusions in the confidentiality of the physician-patient relationship. There is not much case law in this area, so that it is difficult to delineate the exact scope of this protection. In *State v Summers*,[18] for example, a case in which a police trooper, after learning that the defendant had obtained drug prescriptions from different physicians, had called several physicians and asked whether they knew the defendant and for which medical problem the drug had been prescribed, the court came to the conclusion that the Fourth Amendment had not been violated, for:

> 'Trooper Wiggin's actions did not constitute a search for purposes of the State Constitution. ... The physician-patient privilege does not apply to the information obtained here. ... The legislature revoked the privilege in precisely the circumstances alleged here by providing that "information communicated to a practitioner in an effort unlawfully to procure a controlled drug, or unlawfully to procure the administration of any such drug, shall not be deemed a privileged communication." RSA 318-B:21 (1995).'[19]

The court thus came to the conclusion that the protection under the Fourth Amendment was excluded because of the content of the State's privilege statute. This reasoning is probably based on the consideration that the limitations contained in the privilege statute destroyed any otherwise existing expectation in the confidentiality of this information. If this is the case, the protection of medical confidentiality under the Fourth Amendment is subject to ordinary State legislation.

1.1.3. Fourteenth Amendment (Substantive due process)

In contrast to the rather limited constitutional protection of certain aspects of medical confidentiality under the Fourth and Fifth Amendments, broader protection is available under the Fourteenth Amendment, the relevant part of which provides:

> Nor shall any State deprive any person of life, liberty, or property, without due process of law.

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which constitutional protection of medical privilege was rejected.

[18] 702 A.2d 819 (N.H. 1997).

[19] Ibid, at 821-822 per Johnson, Justice.

In *Griswold v Connecticut,*[20] the Supreme Court decided that the right to privacy is protected by substantive due process under the Fourteenth Amendment, which prohibits the States from abridging fundamental liberties. In *Griswold,* for example, the Supreme Court held that a statute prohibiting the use of contraceptive methods by and the prescription of contraceptives to married couples violated the right to privacy. As the right to privacy in the marital relation was recognised as a fundamental right, it was protected under the due process clause of the Fourteenth Amendment. This view was later confirmed in the abortion case of *Roe v Wade*[21] where Justice Blackmun held that:

> 'This right of privacy, whether it be founded in the 14th Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, ... is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.'[22]

Justice Stewart in the same case outlined the constitutional protection of privacy in broader terms, when stating that:

> 'The "liberty" protected by the Due Process Clause of the 14th Amendment covers more than those freedoms explicitly named in the Bill of Rights. ... Several decisions of this Court make it clear that freedom of personal choice in matters of marriage and family life is one of the liberties protected by the Due Process Clause.'[23]

And Justice Douglas held:

> 'Many [of the rights acknowledged by the Ninth Amendment] in my view come within the meaning of the term "liberty" as used in the 14th Amendment:
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> ... Second is freedom of choice in the basic decisions of one's life respecting marriage, divorce, procreation, contraception and the education and upbringing of children. ... Third is the freedom to care for one's health and person, freedom from bodily restraint or compulsion.'[24]

The constitutional right to privacy thus protects interests in secrecy as well as autonomy in personal matters. For this concept to apply in the area of medical confidentiality, it must be demonstrated that medical information is recognised as a personal matter deserving constitutional protection. The patient's privacy interest in his/her medical secrets was readily recognised by many American

[20] 381 U.S. 479 (1965).
[21] 410 U.S. 113 (1973).
[22] Ibid., at 153.
[23] Ibid., at 168-169.
[24] Ibid., at 210-211.

courts.[25] In *US v Westinghouse Electric Corporation*,[26] for example, a case concerning the powers of the National Institute for Occupational Safety and Health (NIOSH) to conduct health hazard investigations, and to be given access to a company's medical records of employees potentially affected by the substances under investigation, the Court argued:

> 'There can be no question that an employee's medical records, which may contain intimate facts of a personal nature, are well within the ambit of materials entitled to privacy protection. Information about one's body and state of health is a matter which the individual is ordinarily entitled to retain within the "private enclave where he may lead a private life". It has been recognised in various contexts that medical records and information stand on a different plane than other relevant material. ... This difference in treatment reflects a recognition that information concerning one's body has a special character.'[27]

Thus, medical records as well as medical information in general can qualify as personal matters receiving constitutional privacy protection, but American courts seem to have developed a case by case approach to decide whether specific medical information is or is not constitutionally protected. In *Woods v White*[28], for example, the court held that a patient had a privacy interest in his medical records containing details of his HIV status. And in *Mann v University of Cincinnati*,[29] the Court explained:

> 'The student health services file ... includes Ms Mann's answers ... to the following inquiries: history of possible diseases; family history of diseases; ... age at time of first intercourse. ... Additional Student Health Services and University Hospital records contain documents relating to Ms Mann's medical treatment which ... occurred prior to the events alleged in this case. ... There can be no question that the aforementioned information is of such a private nature that a constitutional right to privacy exists.'[30]

This decision suggests that the privacy protection depends on the character of the information, so that medical information is constitutionally protected only if it is of a particularly private nature. Similar reasoning can be inferred from *US v*

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[25] See, for example, *Whalen v Roe* 429 U.S. 589 (1977); *Behringer Est. v Princeton Medical Center* 592 A.2d 1251 (N.J.Super.L. 1991); *Caesar v Mountanos* 542 F.2d 1064 (9th Cir. 1976); *Falcon v Alaska Public Offices Commission* 570 P.2d 469 (Alaska 1977); *Hawaii Psychiatric Soc. Dist. Branch v Ariyoshi* 481 F.Supp. 1028 (D. Hawaii 1979); *Mann v University of Cincinnati* 824 F.Supp. 1190 (S.D. Ohio 1993); *Schachter v Whalen* 581 F.2d 35 (2nd Circuit 1978); *U.S. v Westinghouse Electric Corporation* 638 F.2d 570 (3rd Cir. 1980); *Woods v White* 689 F.Supp 874 (W.D. Wis. 1988).

[26] 638 F.2d 570 (3rd Cir. 1980).

[27] Ibid., at 577 per Sloviter, Circuit Judge.

[28] 689 F.Supp. 874 (W.D. Wis. 1988), at 876 per Crabb, Chief Justice.

[29] 824 F.Supp. 1190 (S.D. Ohio 1993).

[30] Ibid., at 1198-1199 per Steinberg, U.S. Magistrates Judge.

Westinghouse Electric Corporation.[31] There, the Court had to perform a balancing exercise to decide whether or not the violation of privacy was justified in the particular case. The Court's considerations in that respect are important, as they give some indication as to the different degrees of privacy protection. According to the Court:

> 'The factors which should be considered in deciding whether an intrusion into an individual's privacy is justified are the type of record requested, the information it does or might contain, the potential for harm in any subsequent non-consensual disclosure ... the adequacy of safeguards to prevent unauthorised disclosure. ... Westinghouse has not produced any evidence to show that the information which the medical records contain is of such a high degree of sensitivity that the intrusion could be considered severe or that the employees are likely to suffer any adverse effects from disclosure to NIOSH personnel. Most, if not all, of the information in the files will be results of routine testing, such as X-rays, blood tests, pulmonary function tests, hearing and visual tests. This material, although private, is not generally regarded as sensitive.'[32]

According to the Court in *Westinghouse*, the degree of protection thus depends, *inter alia*, on the degree of sensitivity of the medical information concerned, and the court suggests an objective test to determine the degree of sensitivity when arguing that certain routine examinations are not generally regarded as sensitive. The reasoning also suggests that the constitutional protection of privacy and therefore medical confidentiality aims at protecting the patient from the adverse consequences of disclosure rather than at protecting the patient's privacy interests as such. This seems to be in line with the decision in *Falcon v Alaska Public Offices Commission*[33] which also discusses the scope of privacy protection attached to medical information:

> 'The decisions both of this court and the United States Supreme Court clearly establish that certain types of information communicated in the context of the physician-patient relationship fall within a constitutionally protected zone of privacy. The nature and weight of a privacy interest in an individual's identity as a patient or client, however, presents a more difficult issue. ... Where an individual visits a physician who specialises in contraceptive matters or whose primary practice is known to be giving abortions and the fact of a visit or rendering of services becomes public information, private and sensitive information has, in our view, been revealed. Even visits to a general practitioner may cause particular embarrassment or opprobrium where the patient is a married person who seeks treatment without the spouse's knowledge ... . Similar situations would be presented where, because of a

[31] 638 F.2d 570 (3rd Cir. 1980).
[32] Ibid., at 578-579 per Sloviter, Circuit Judge.
[33] 570 P.2d 469 (Alaska 1977).

specialised practice, the disclosure of the patient's identity also reveals the nature of the treatment ... . Some examples would include the patients of a psychiatrist, psychologist or of a physician who specialised in treating sexual problems or venereal disease. ... In emphasising these examples, we reiterate that situations involving specialised practice of psychiatry or venereal disease present the exception rather than the general rule and that, ordinarily, identification as a patient of a general practitioner who also engages in some of these functions does not infringe a significant privacy interest.'[34]

The privacy protection of medical information is thus not guaranteed in general, but the constitutional protection rather depends on the highly personal character of the information with particular emphasis on the protection of information the disclosure of which might cause embarrassment to the patient. Another consideration can be whether the disclosure of information to the public is at stake, or whether the information will only have to be revealed to a limited number of health care officials. This was, for example, one of the problems raised by the Supreme Court in *Whalen v Roe*.[35] In that case, the Court had to decide on the constitutionality of a statute that, responding to the concern that drugs were being diverted into unlawful channels, classified potentially harmful drugs and provided that prescriptions for the most dangerous legitimate drugs be prepared on an official form. One copy of the form which required identification of the prescribing physician, dispensing pharmacy, drug and dosage, and patient's name, address and age had to be filed with the State Health Department and retained for five years. As to the possible violation of a constitutional right to medical confidentiality through this procedure, the Court first established that the risk of a public disclosure of the medical information was too remote to invalidate the statute, given that adequate safeguards against such a disclosure were in place. The Court went on:

'Even without public disclosure, it is, of course, true that private information must be disclosed to the authorised employees of the New York Department of Health. Such disclosures are not ... meaningfully distinguishable from a host of other unpleasant invasions of privacy that are associated with many facets of health care.'[36]

It seems again that the privacy protection concerns the effects of the disclosure rather than the patient's interest in non-disclosure as such, as it cannot otherwise

[34] Ibid, at 478-480 per Chief Justive Boochever.
[35] 429 U.S. 589 (1977).
[36] Ibid., at 602 per Justice Stevens.

be explained why it makes a difference whether or not the disclosure was made to the employees of the health department or to the public.

In *Whalen v Roe,* the Supreme Court identified two different possibilities for a state measure to violate the individual's interests in medical confidentiality as protected by the Fourteenth Amendment: the interest in avoiding disclosure of personal matters, and the interest in making certain kinds of important decisions independently. It seems as if the secrecy strand of the privacy right, that is the interest in keeping medical information secret, is very closely linked to the question, discussed above, of whether or not a matter is private enough so as to deserve constitutional protection.[37] If this is answered in the affirmative, then the individual has a constitutionally protected interest in keeping this information secret and in controlling the disclosure of such information. However, the constitutional protection is not absolute, but can rather be outweighed by a compelling state interest in disclosure.

The autonomy interest in the protection of medical confidentiality was, for example, explained in *Hawaii Psychiatric Soc. Dist. Branch v Ariyoshi,*[38] a case which was concerned with the relationship between psychiatrists and patients:

> 'The Supreme Court has recognised an individual's right to make decisions free from unjustified governmental interference on matters relating to marriage. ... An individual's decision whether or not to seek the aid of a psychiatrist and whether or not to communicate certain personal information to that psychiatrist, fall squarely within the bounds of this "cluster of constitutionally protected choices". ... The Supreme Court has consistently been concerned with protecting individuals against governmental intrusion into matters affecting the most fundamental personal decisions and relationships. ... No area could be more deserving of protection than communication between a psychiatrist and his patient. Such communications often involve problems in precisely the areas previously recognised by the Court as within the zone of protected privacy, including family, marriage, parenthood, human sexuality, and physical problems. Constitutionally protected privacy must, at a minimum, include the freedom of an individual to choose the circumstances under which, and to whom certain of his thoughts and feelings will be disclosed. ... This right to choose confidentiality is particularly crucial in the context of communications between patient and psychotherapist. ... The court holds that the constitutionally protected right of privacy extends to an individual's liberty to make decisions regarding psychiatric care without unjustified governmental interference.'[39]

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[37] See, for example, *Mangels v Pena* 789 F.2d 836 (10th Cir. 1986).
[38] 481 F.Supp. 1028 (D. Hawaii 1979).
[39] Ibid., at 1038-1039 per Byrne, District Judge.

In this decision, the main aspect behind protecting patient autonomy through a guarantee of medical confidentiality seems to be that the patient can only seek meaningful medical, and, in particular, psychological advice and treatment when openly disclosing personal information that is subject to the privacy protection. If the privacy protection were reduced to protecting the patient's interest in not having to disclose this information, it would not go far enough. The patient would then only have the choice between keeping confidential information to him/herself by not seeking medical advice and treatment, or, alternatively, seeking medical treatment and advice, and, as a consequence, giving up any privacy protection. As was explained in *Mann v University of Cincinnati:*[40]

> 'If patients have a genuine concern that their private medical information will become publicly known and may adversely affect their reputations or embarrass them, they will be reluctant to seek medical assistance. Thus, patients' interest in making decisions vital to their health care may be impaired by unwarranted disclosures. ... These same reasons support a doctor-patient privilege. Medical care providers ... who create and maintain such information have a concomitant duty to avoid unwarranted disclosures. We believe that duty has its roots in the Constitution.'[41]

Thus, autonomy in making personal choices means that the individual must be given the opportunity to decide whether or not to seek help for medical conditions without a fear that his/her secrets may be disclosed to parties outside the physician-patient relationship. Both decisions seem to suggest that the autonomy strand of the right to privacy is, in the context of medical confidentiality, very closely linked to the right to make health care decisions and to the patient's interest in bodily integrity. If the patient cannot be sure that medical information revealed to the physician will be kept secret, he/she may be inhibited to disclose frankly such information to the physician, which may adversely affect the medical treatment available to the patient. A patient who can seek medical advice and treatment only on the basis that the state may be given access to this information can no longer make health care decisions free from state interference, as this possibility may affect and influence the decision the patient is going to take. Not only informational, but also decisional privacy is thus protected, and the argumentation behind such protection is deontological, rather than utilitarian, as it

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[40] 824 F.Supp. 1190 (S.D. Ohio 1993).
[41] Ibid., at 1199 per Steinberg, U.S. Magistrates Judge.

concentrates on the value of privacy and autonomy as such, rather than on the possible consequences of disclosure.

In *US v Westinghouse Electric Corporation*.[42] the court very briefly touched upon another aspect which may explain why medical confidentiality is given constitutional protection, when arguing that:

> 'The factors which should be considered in deciding whether an intrusion into an individual's privacy is justified are ... the injury from disclosure to the relationship in which the record was generated ... . Since Westinghouse's testing and NIOSH's examination of the records are both conducted for the purpose of protecting the individual employee from potential health hazards, it is not likely that the disclosures are likely to inhibit the employee from undergoing subsequent periodic examinations required of Westinghouse employees.'[43]

The physician-patient relationship is thus also regarded as deserving protection, but the reasons behind this consideration are not further specified.

So far, the protection of privacy rights under the Federal Constitution has been demonstrated, but it should be noted that some State constitutions explicitly recognise a privacy right. This raises the question of whether express constitutional protection of privacy rights adds to the constitutional protection already existing under the Federal Constitution. The California Constitution is one example of a constitution that explicitly protects the right to privacy. The leading Californian case in this area is *In Re Lifschutz*.[44] Dr Lifschutz was imprisoned after refusing to obey an order directing him to answer questions and produce records relating to communications with a former patient. The Court first discussed whether or not the forced disclosure of medical information violated a privacy right of members of the medical profession, in this case a psychiatrist, and rejected this view. With regard to the patient's privacy interest the Court then held:

> 'A patient's interest in keeping such confidential revelations from public purview, in retaining this substantial privacy, has deeper roots than the Californian statute and draws sustenance from our constitutional heritage. The confidentiality of the psychotherapeutic session falls within the constitutionally guaranteed zones of privacy. Even though a patient's interest in the

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[42] 638 F.2d 570 (3rd Cir. 1980).
[43] Ibid., at 578-579 per Sloviter, Circuit Judge.
[44] 85 Cal.Rptr. 829 (Sup. 1970).

confidentiality of the psychotherapist-patient relationship rests, in part, on constitutional underpinnings, all state interference with such confidentiality is not prohibited.'[45]

This holding does not seem to add any protection not already existent under federal constitutional principles. A similar conclusion could be drawn from *Division of Medical Quality v Gherardini*,[46] where it has been argued:

> 'While the amendment [to the California Constitution] does not prohibit all incursions into individual privacy, any such intervention must be justified by a compelling interest ... and any statute authorising invasion of such area of privacy must be subject to strict scrutiny.'[47]

However, in *Pagano v Oroville Hospital*,[48] the Court held:

> 'California ... has adopted an explicit constitutional right to privacy, and recognised application of this right to patient medical records. ... The California Supreme Court has interpreted this state constitutional right to be inalienable ... and broader than the federal privacy right. ... The right protects against invasions of privacy by private citizens as well as by the state.'[49]

This decision is interesting as it specifies that under California law, the constitutional right to privacy not only creates a right against state interference, but also correlates in a duty of non-disclosure imposed on the physician. This surpasses the protection awarded under the U.S. Constitution. However, the court at the same time rejected the compelling interest test as too rigid and suggested a less stringent test for the justification of intrusions on the privacy right, which takes away some of the additional protection. It can be concluded that while the privacy right recognised by the U.S. Constitution sets the minimum standard for all American States, some State constitutions provide additional constitutional protection in certain areas of privacy protection.

1.2. Statutory obligations

In US law, a criminal offence penalising a physician's breach of his/her duty to maintain medical confidentiality does not exist, so that medical confidentiality is not, as such, protected by criminal law. In some States, the disclosure of particularly sensitive information, for example the HIV status of a patient,

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[45] Ibid., at 431-432 per Tobriner, Justice.
[46] 156 Cal.Rptr. 55 (1979).
[47] Ibid., at 61 per Staniforth, Acting Presiding Judge.
[48] 145 F.R.D. 683 (E.D.Cal 1993).
[49] Ibid., at 696-697 per Hollows, U.S. Magistrate Judge.

amounts to a criminal offence.[50]

1.2.1. Privilege statutes

In the U.S., privilege statutes are an important means to introduce a statutory obligation of medical confidentiality. At the federal level, no statutory medical privilege exists. However, forty-one States in the U.S. now have some form of statutory physician-patient privilege,[51] and in all States, the communication between psychiatrists and patients is privileged by statute. The psychiatrist-patient privilege is more widely accepted, as it is often argued that the information imparted to a psychiatrist is more personal and intimate than the medical information disclosed to a physician and therefore more deserving of privacy protection.[52] The scope of the physician-patient privilege varies from State to State. A few State statutes granting medical privilege will now be introduced to give some idea of the nature and scope of such statutes.

In some States, the privilege statutes are formulated so as to give the patient the right to prevent the disclosure of confidential medical information. The Arkansas Uniform Rules of Evidence 503 (1976), for example, state:

> (b) General Rule of Privilege. A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment of his physical, mental or emotional condition, including alcohol or drug addiction, among himself, physician or psychotherapist, and persons who are participating in the diagnosis or treatment under the direction of the physician or psychotherapist, including members of the patient's family.

And Art.510 Louisiana Code of Evidence provides as follows:

> C.(1) General rule of privilege in criminal proceedings. In a criminal proceeding, a patient has a privilege to refuse to disclose and to prevent another person from disclosing a confidential communication made for the purpose of advice, diagnosis or treatment of his health condition between or among himself, his representative, and his physician or psychotherapist, and their representatives.

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[50] See for example §199.21 California Health and Safety Code (West Supp. 1990); Wis. Stat. Ann. §146.025(9) (West 1989); Idaho Code §39-606 (Supp. 1989).

[51] Alabama, Connecticut, Florida, Kentucky, Maryland, Massachusetts, South Carolina, Tennessee and West Virginia do not have a statutory physician-patient privilege; see 'Developments in privileged communications', (1985) 98 Harvard Law Review, at 1532.

[52] *Jaffee v Redmont* 518 U.S. 1 (1996), at 10-12 per Justice Stevens; *In Re Doe* 964 F.2d 1325 (2nd Cir. 1992), at 1328 per Winter, Circuit Judge; *Lora v Board of Education* 74 F.R.D. 565 (E.D.N.Y. 1977) at 574-575.

In other States, the privilege statute is, on the other hand, formulated so as to impose an obligation on the physician not to disclose confidential patient information. D.C. Code Ann. §14-307 (1981), for example, provides:

> (a) In the Federal courts in the District of Columbia and District of Columbia courts a physician or surgeon or mental health professional ... may not be permitted, without the consent of the person afflicted, or of his legal representative, to disclose any information, confidential in its nature, that he has acquired in attending a client in a professional capacity and that was necessary to enable him to act in that capacity, whether the information was obtained from the client or from his family or from the person or persons in charge of him.

And Mich. Comp. Laws Ann. §600.2157 (West 1986) similarly states that:

> No person duly authorised to practise medicine or surgery shall be allowed to disclose any information which he may have acquired in attending any patient in his professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon.

Privilege statutes thus give the patient control over the disclosure of confidential medical information by either giving him/her the right to prevent the physician from disclosing such information, or by formulating a prohibition, addressed to the physician, to disclose such information without the patient's consent. However, the protection awarded by such privilege statutes is not as comprehensive as it may seem. First, it must be noted that privilege statutes apply only in the context of judicial proceedings, so that they do not impose any obligation on the physician not to reveal confidential patient information outside of the judicial setting.[53] Also, it must be determined what is meant by 'communication' that is protected under the different statutes, as that term can be defined in an extensive or in a very narrow way. Some statutes expressly define the term. The Texas statute, for example, provides in Art.4495b Public Health Act:

Sec.5.08 - physician-patient communication

> (a) Communications between one licensed to practice medicine, relative to or in connection with any professional services as a physician to a patient, is

[53] See, for example, *Steinberg v Jensen* 534 N.W.2d 361 (Wis. 1995), at 370 per Steinmetz, Justice. It should be noted, however, that some courts have used the policy expressed in the privilege statute to create an obligation of medical confidentiality beyond judicial proceedings. See, for example, *Saur v Probes* 476 N.W.2d 496 (Mich.App. 1991), per Kelly, Judge, at 498; see also *Berry v Moench* 331 P.2d 814 (Sup. Ct. of Utah 1958) per Crockett, Justice; *Schaffer v Spicer* 215 N.W.2d 134 (Sup. Ct. S.D. 1974), per Biegelmeier, Chief Justice.

> confidential and privileged and may not be disclosed except as provided in this section.
>
> (b) Records of the identity, diagnosis, evaluation, or treatment of a patient by a physician that are created or maintained by a physician are confidential and privileged and may not be disclosed except as provided in this section.

Thus, the protection is not only awarded to oral communications, but also includes medical records. The Louisiana statute is even broader in providing:

> (b) "Confidential communication" includes any information, substance, or tangible object, obtained incidental to the communication process and any opinion formed as a result of the consultation, examination, or interview and also includes medical and hospital records made by health care providers and their representatives.

With regard to the Louisiana statute, Lottinger, Chief Judge, concluded in *Sarphie v Rowe*[54] that when an individual walks into a doctor's office and opens his mouth, everything spilling out of it, whether it be his identity or his false teeth (a tangible object) is presumptively privileged and beyond the reach of discovery. In *Matter of Commitment of W.C.,*[55] however, this rather extreme statement was somewhat mitigated. There, the court argued that although the definition of confidential communication under LSA-C.E. art. 510 was broad, inherent in the definition was the concept of something being expressed by one person to another and an intent that this information not be disclosed to others. Consequently, the court argued that the definition of "confidential communication" was not broad enough to include an observation of the patient's behaviour by health care personnel in a situation where the patient was making no attempt to communicate with anyone. Thus, if a patient is seen to strike other patients or if the patient's failure to provide for his/her basic physical needs is observed, these observations aare not regarded as privileged communication. This holding was based on the court's interpretation of the purpose behind the provisions of the privilege statute. The court argued that the privilege statute aimed to protect the confidences a patient communicates to his/her health care provider and to give heed to the fact that disclosure of the patient's confidences could be detrimental to the health care provider-patient relationship.

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[54] 618 So.2d 905 (La.App. 1 Cir. 1993), at 908.
[55] 685 So.2d 634 (La.App. 1 Cir. 1996), at 638 per Whipple, Judge.

Another case delineating the scope of medical confidentiality is *People v Maltbia.*[56] A driver was arrested for speeding and lost consciousness before he was put in the squad car. The officers called an ambulance and the physician, Dr Lovell, wanted to analyse the urine of the defendant for the presence of drugs and to check the kidneys for an indication of internal injuries. When the defendant's underwear was removed in order to insert the catheter, Dr Lovell found a bag containing illicit drugs. At that time, no police officers were present. The court argued that the discovery of the drugs on the defendant's person resulted from a medical procedure necessary to diagnose and treat the defendant, and therefore occurred while Dr. Lovell was rendering necessary medical treatment to the defendant. Accordingly, the court concluded that the bag and the drugs contained therein constituted privileged information within the meaning of section 8-802 Code of Civil Procedure, stating in subsection (8) that:

> No physician or surgeon shall be permitted to disclose any information he or she may have acquired in attending the patient in a professional character, necessary to enable him or her professionally to save the patient.

In States the privilege statutes of which do not provide a definition of the communication which is thereby protected, the exact scope of the physician's obligation must be determined by the courts, and courts in different States have adopted different approaches in so doing. Most courts decided that 'communication' was not limited to the oral statements of the patient, but also included medical records.[57] Another question is whether the protection of 'communication' includes observations made by the physician in the course of exercising his/her profession. Most courts have adopted a broad approach. *State v Schroeder,*[58] for example, is a case in which this issue had to be decided. In that case, a patient was brought to the hospital by the police for treatment of a head injury. In the course of the examination of the patient for this purpose, the treating physician made the observation that his patient seemed to have been under the influence of alcohol and the question arose whether or not this observation was protected communication under North Dakota's privilege statute. The court argued as follows:

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[56] 653 N.E.2d 402 (Ill.App. 3 Dist. 1995), at 405-407 per McCuskey, Justice.
[57] See, for example, *Behringer Estate v Princeton Medical Centre* 592 A.2d 1251 (N.J.Super.L. 1991), per Crachman, J.S.C.; *Comonwealth v Kobrin* 479 N.E.2d 674 (Mass. 1986), per Abrams, Judge; *In Re Search Warrant* 810 F.2d 65 (3rd Cir. 1987), per Becker, Circuit Judge.
[58] 524 N.W.2d 837(N.D. 1994).

'The privilege authorised by N.D.R.Evid.503 is not limited to verbal statements, but applies to communications. Although N.D.R.Evid.503 does not define communications, it defines when a "communication is confidential" to include "the consultation, examination or interview," and "the diagnosis and treatment". That definition suggests that the term has a broader meaning than verbal statement. Additionally, Webster's New World Dictionary ... defines "communication" as "the act of transmitting" and "a giving or exchanging of information, signals, or messages by talk, gestures, writing, etc." That plain, ordinary, and commonly understood meaning of communications is not restricted to verbal statements and also supports a broader meaning for the term. We follow the ordinary meaning of "communications" and hold that the physician-patient privilege authorised by N.D.R.Evid.503 applies to information and observations made by a physician for purposes of diagnosis or treatment of the patient's medical condition.[59]

This approach was also adopted in *Sims v Charlotte Liberty Mutual Insurance Co*,[60] where the court argued that communication, in addition to the patient's oral statements, also included any information which the physician or surgeon acquired in attending the patient in a professional character, and which is necessary to enable him to prescribe for or treat the patient.[61] The court based its consideration on the purpose behind the privilege statute which it thought could only be achieved by a broad interpretation of 'communication'. It has been suggested, however, that protected 'communications' should be limited to information which is somehow related to the medical treatment. If an accident victim seeks medical treatment, those details of the accident that have nothing to do with the injuries sustained would then not be protected.[62]

In *Re The June 1979 Allegheny County Investigating Grand Jury*,[63] the court took a very narrow approach. Eagen, Chief Justice, explained:

'Concerning the statutory physician-patient privilege, our case law has drawn a distinction between information learned by a physician through communication to him by a patient and information acquired through examination and observation. ... The distinction is rooted in the purpose of the privilege, merely to create a confidential atmosphere in which the patient will be encouraged to disclose all possible information bearing on his or her illness so that the physician may render effective treatment. Much information acquired by the physician acting in a professional capacity may relate back in some way to an initial communication by a patient, for example, a report of sickness or pain in a particular area of the body. However, the privilege is limited to information

[59] Ibid., at 840-842.
[60] 125 S.E.2d 326 (N.C. 1962).
[61] Ibid., at 329-330 per Moore, Justice.
[62] Vilensky, (1994) 66 New York State Bar Journal, at 39.
[63] 415 A.2d 73 (Sup. Ct. Pa 1980).

> which would offend the rationale of the privilege, i.e. information directly related to the patient's communication and thus tending to expose it.'[64]

The court concluded that information gained from an analysis of tissue samples was not 'communication' and therefore not protected by the privilege statute. It can thus be seen that the interpretation of the privilege statute largely depends on the court's view of the purpose behind such a statute. If the purpose of the statute is to encourage frank communication, it seems at first sight sufficient to protect oral communication. However, as the other cases cited above have demonstrated, this approach is rather controversial, as it could be argued that from the patient's point of view, it does not make any difference whether or not the physician obtains confidential information the patient wants to keep secret through direct communication or through an examination of the patient's body or tissue samples etc. A patient who is concerned about secrecy of medical information may not allow the physician to examine him/her if only direct communication is confidential, but other information the physician acquires in the course of the physician-patient relationship is not protected.

Another question is whether the privilege should only attach to potentially embarrassing information.[65] In *Re The June 1979 Allegheny County Investigating Grand Jury,*[66] the question was answered in the affirmative when the court argued that:

> 'To fall within the terms of the statute, communications must tend to blacken the character of the patient. Here, the subpoenaed tissue reports contain no statutorily privileged communications. While identifying data such as patient's name and address would tend to reveal communications by the patient, such communications would in no way tend to blacken the character of a patient.'[67]

Even though far less stringent, a comparable reasoning can be found in other decisions. In *Falcon v Alaska Public Offices Commission,*[68] for example, a decision already discussed in the context of constitutional privacy protection, the court argued that in situations involving specialised practice of psychiatry or venereal disease, the identification as a patient of such a specialist could in itself

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[64] Ibid., at 76-77.
[65] For a discussion see, for example, Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges,* vol. 2, at 7-24.
[66] 415 A.2d 73 (Sup. Ct. Pa 1980).
[67] Ibid., at 77 per Eagen Chief Justice.
[68] 570 P.2d 469 (Alaska 1977), per Chief Justive Boochever.

constitute protected information, while the same did not apply to patients of a general practitioner. Thus, the mere facts that the patient received medical treatment and when and where treatment has been administered are normally not protected by medical privilege.[69] In *Weisbeck v Hess*[70], the court decided differently in stating that the privilege should cover any form of communication made as a part of the therapeutic relationship and therefore included name confidentiality. However, this was a case in which a husband attempted to discover a list of a psychiatrist's patients. As the consultation of a psychiatrist still has an embarrassing aspect attached to it, it is difficult to use the statement made in this case to support the view that name confidentiality should be protected in principle, regardless of the nature of the treatment sought or received.

The privilege does not include information that is unrelated to medical treatment.[71] The results of medical examinations that did not take place for treatment or diagnostic purposes are not privileged. This general rule refers, for example, to cases where the patient seeks a medical examination for insurance purposes,[72] or where the examination is ordered by a court[73] or is performed at the request of police officers or prosecutors. Therefore, the results of blood tests exclusively taken for a determination of the blood alcohol level, and not for diagnosis or treatment purposes are not protected by medical privilege.[74] In a recent decision, it was even held that the psychotherapist-patient relationship between a police officer who was ordered by his employer to attend counselling sessions and his psychotherapists who were expected to provide reports and recommendations to the employer was not covered by privilege.[75] However, the results of medical tests performed on a defendant for the purposes of diagnosis or treatment, and not at the request of a law enforcement officer or prosecutor, are privileged. This applies, for example, to blood alcohol tests obtained as part of the

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[69] See also, for example, *Benton v Superior Court Navajo County* 897 P.2d 1352 (Ariz.App.Div.1 1994), per Kleinschmidt, Judge; *National Stop Smoking Clinic-Atlanta v Dean* 190 Ga App 289 (1989); *State v Sypult* 304 Ark. 5 (1990).

[70] 524 N.W.2d 363 (S.D. 1994), at 366 per Henderson, Retired Judge.

[71] Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges*, vol. 2, at 7-20 to 7-21.

[72] *Bouligny v Metropolitan Life Ins Co* 133 S.W.2d 1094 (Mo. Ct. App. 1939).

[73] Snyder, (1990) 65 Tulane Law Review, at 172-173.

[74] *Collins v Howard* 156 F.Supp 322 (1957), *State v Erickson* 241 N.W.2d 854 (N.D. 1976), per Sand, Judge.

[75] *Barrett v Vojtas* 182 F.R.D. 177 (W.D.Pa. 1998), at 181 per Cindrich, District Judge.

patient's treatment at a hospital.[76] When a treating physician undertakes actions for purposes other than treatment, e.g. drawing of a blood sample to be used in a police investigation, the privilege may be held to be inapplicable,[77] but if the test was performed at the direction of the treating physician rather than at the request of law enforcement officials, the privilege will generally be found to apply.[78]

For the privilege statute to apply the protected communication must be confidential, a term which again leaves some scope for interpretation. Under some privilege statutes,[79] a communication is 'confidential' if it is not intended to be disclosed to third persons, except persons present to further the interests of the patient, or persons who are participating in the diagnosis or treatment under the direction of the physician or psychotherapist, including members of the patient's family. In *Hinzman v State*,[80] the court concluded on this basis that if a psychiatrist had explained to the patient before the session that he would report his findings to the prosecuting attorney's office and the Department of Human Services, the communications during those sessions were not privileged. Even a clearly professional consultation can lose its privileged status in many States if it takes place in the presence of third parties. Even where statutes do not contain a confidentiality requirement, courts have often imposed such a rule.[81] It is argued that when third parties are casually present, their very presence neutralises the confidential character and the privilege should not attach.[82] In *State v George*,[83] a case in which a patient, while in police custody, demanded to be seen by his treating physician for a head injury, and then, in the presence of two police officers and his treating physician, performed dexterity tests for the purpose of establishing whether or not he was under the influence of alcohol, the court distinguished as follows: While the examination for the head injury and the observations made as a result of it took place in confidence and were thus privileged, the information acquired from observing the test performances was not, as it could not only be observed by the physician, but also by the police

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[76] *State v Smorgola* 50 Ohio St.3d 222 (1990).
[77] *State v Waring* 779 S.W.2d 736 (Mo. Ct. App. 1989), at 740-741.
[78] *State v Elwell* 132 NH 599 (1989); *State v McElroy* 553 So.2d 456 (La 1989), at 458.
[79] See, for example, Ark.R.Evid. 503(a)(4).
[80] 922 S.W.2d 725 (Ark.App. 1996), per Rogers, Judge.
[81] *State v Thomas* 78 Ariz. 52 (1954); *State v Burchett* 302 S.W.2d 9 (Mo. 1957), at 17; *People v Christopher* 101 A.2d 504 (1984), at 530; but see also *People v Decina* 2 N.Y.2d 133 (1956), at 138.
[82] *State v Thomas* 78 Ariz. 52 (1954), at 63.
[83] 575 P.2d 511(Kan. 1978).

officers. The mere presence of police officers or other third parties, however, does not necessarily exclude the confidential character of a medical examination. The presence of police officers does, for example, not affect the confidentiality of a medical examination the results of which they cannot observe.[84] In *State v Deases*[85] the court emphasised that the presence of a third person during an otherwise confidential communication does not destroy the privilege if the third person is present to assist the physician in some way or the third person's presence is necessary for the defendant to obtain treatment. Thus, if a person under suspicion of having committed a serious crime needs medical treatment and police officers are present to protect the treating physician, their presence does not negate the privilege. The law is unclear as to whether information received from family members of the patient or other persons is privileged.[86] In *Grosslight v Superior Court*[87] it was held that the privilege established in s.1014 Evidence Code Cal. includes all relevant communications to psychotherapists by intimate family members of the patient. And the court in *Edington v Mutual Life Ins Co*[88] held that protected communications include knowledge acquired from the statements of others who surround the patient at the time. The rule thus seems to be that the privilege extends to information from any source as long as it is given for purposes of treatment.[89]

1.2.2. Licensing statutes

In some U.S. States, the licensing statutes for physicians impose upon the physician an obligation to maintain the patient's confidences. The Oregon licensing statute, for example, provides for the disqualification of or other disciplinary sanctions against a physician for 'wilfully or negligently divulging a professional secret'.[90] And the Alabama licensing statute provides in Title 46, §257(21) Code of Alabama 1940, that:

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[84] Ibid., at 516 per Miller, Justice.
[85] 518 N.W.2d 784 (Iowa 1994), at 788 per Ternus, Justice.
[86] See *Grosslight v Superior Court* 72 Cal. App. 3d 502 (1977); *Edington v Mut Life Ins Co* 67 N.Y. 185 (1876), at 194; *State v Parker* 149 Vt. 393 (1988).
[87] *Grosslight v Superior Court* 72 Cal. App. 3d 502 (1977).
[88] *Edington v Mut Life Ins Co* 67 N.Y. 185 (1876), at 194.
[89] Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges*, vol. 2, at 7-18.
[90] See *Humphers v First Interstate Bank* 696 P.2d 527 (Sup. Ct. Or. 1985), at 534-535 per Linde, Justice.

> The state licensing board for the healing arts shall have the power and it is its duty to suspend for a specified time, to be determined in the discretion of the board, or revoke any license to practice the healing arts or any branch thereof in the state of Alabama whenever the licensee shall be found guilty of any of the following acts or offences;
>
> ... (14) Wilful betrayal of a professional secret.

This means that such licensing statutes impose on the physician an obligation of medical confidentiality the violation of which can give rise to temporary suspension or even permanent revocation of the license to practice medicine.

1.3. General obligation of medical confidentiality

Given that privilege and licensing statutes only create an obligation of medical confidentiality under rather limited circumstances, it shall now be examined how some courts have used the narrow statutory obligations as a starting point for developing a general duty to keep the patient's medical secrets. Courts have used both the privilege statutes and the licensing statutes to infer a broader state policy favouring medical confidentiality. In *Saur v Probes,*[91] for example, the court discussed the conclusions to be drawn from the privilege statutes existing in Michigan for out-of court disclosure of medical patient information by the physician. According to the court, while the privilege statutes cannot be applied directly, as they only address evidentiary disclosures and do not create civil liability for extrajudicial disclosures, they can nevertheless be interpreted as exhibiting a public policy of protecting physician-patient confidences absent a superseding public or private interest. The court was thus of the opinion that even though not directly imposing a general obligation on the physician to maintain medical confidentiality outside of legal proceedings, the privilege statutes give a strong indication that the State is dedicated to the protection of medical confidences. In support of this conclusion, the court, in addition, relied on the State licensing statute which also prohibits the disclosure of confidential information by the physician.

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[91] 476 N.W.2d 496 (Mich.App. 1991), at 498 per Kelly, Judge; see also *Berry v Moench* 331 P.2d 814 (Sup. Ct. of Utah 1958) per Crockett, Justice; *Schaffer v Spicer* 215 N.W.2d 134 (Sup. Ct. S.D. 1974), per Biegelmeier, Chief Justice.

It is also interesting to examine the approach adopted in States that do not recognise a general medical privilege. In *Horne v Patton,*[92] the Alabama Supreme Court argued that the absence of a privilege statute does not indicate that medical confidentiality is not protected, as privilege statutes only deal with the limited question of disclosure of medical confidentiality in the judicial setting. Given the existence of State licensing statutes protecting medical confidentiality, the court concluded that a medical doctor is under a general duty not to make extra-judicial disclosures of information acquired in the course of the physician-patient relationship. In *Alberts v Devine,*[93] the court similarly held that the absence of privilege statutes does not indicate that no public policy favouring a patient's right to confidentiality exists, as the principle that society is entitled to every person's evidence in order that the truth be discovered may require a physician to testify in court about information obtained from a patient in the course of treatment, but has no application to disclosures made out of court. It can thus be seen that privilege statutes have an impact surpassing their direct applicability. While the existence of a testimonial privilege can be used as supporting the view that the relevant State favours the protection of medical confidentiality, so that the protection is then not limited to the judicial setting, the absence of a privilege statute by no means implies that the State does not protect medical confidentiality outside the judicial setting. It rather only expresses the State legislature's attitude that medical confidentiality is outweighed by the state interest in an unhindered administration of criminal justice. Privilege statutes and licensing statutes taken together, or licensing statutes alone in the absence of privilege statutes, have thus been used as a basis for creating a general obligation to maintain medical confidentiality.

1.4. Obligation under contract law and tort law

With regard to the question of whether or not the physician is under an obligation towards the patient to maintain medical confidentiality the breach of which would give rise to a claim in private law, different courts in different States have adopted different approaches, so that it is difficult to paint the full picture. However, some selected cases will be presented to introduce some of the arguments discussed by

[92] 287 So.2d 824 (Sup. Ct. Alabama 1973), at 827-829 and 832 per Bloodworth, Justice.
[93] 479 N.E.2d 113 (Mass. 1985), at 119-120 per O'Connor, Justice; see also *South Carolina Board of Medical Examiners v Hedgepath* 480 S.E.2d 724 (S.C. 1997), per Finney, Chief Justice.

American courts.

In principle, in American law the physician-patient relationship is often based on a contract. In *MacDonald v Clinger,*[94] for example, the court held that the physician-patient relationship is contractual in nature. It is thus in principle possible that the physician is under a contractual obligation to maintain the patient's medical secrets. However, such an obligation will usually not be an express term of the contract which leaves the courts with the difficulty of deciding whether, absent such an express term, the physician can nevertheless be under a contractual obligation not to reveal the patient's confidences. Some courts have decided in favour of such an obligation. In *Hammonds v Aetna Casualty & Surety Company*,[95] for example, it was argued that the physician, as an implied condition of the medical contract, guarantees that any confidential information gained in the course of the physician-patient relationship would not be released. A breach of the duty to maintain medical confidentiality is then a violation of the physician's obligation under the medical contract. The court inferred this implied condition on the ground that the public has a right to rely on the code of ethics adopted by the medical profession which imposes on the physician an obligation to keep medical confidences, on the privilege statute and on the State Medical Licensing Statute which seals the doctor's lips in private conversation. A similar conclusion, based on similar considerations was reached in *MacDonald v Clinger*[96] and in *Doe v Roe.*[97] There, it has been specified that the physician impliedly covenants to keep in confidence all disclosures made by the patient concerning the patient's physical or mental condition as well as all matters discovered by the physician in the course of an examination or treatment. In the case of breach, the patient has the possibility to ask for injunctive relief or for compensation.

The problem with an action under contract law is that the plaintiff's recovery is limited to economic loss flowing directly from the breach and that recovery for mental distress, loss of employment etc. would be precluded. Given these inadequacies, the Court concluded in *MacDonald v Clinger* that the physician-patient relationship contemplates an additional duty springing from but extraneous to the contract and that the breach of such duty is actionable as a tort. According

[94] 446 N.Y.S.2d 801 (Sup. Ct 1982), at 802-804 per Denman, Justice.
[95] 243 F.Supp. 793 (N.D. Ohio 1965), at 797-802 per Connell, Chief Judge.
[96] 446 N.Y.S.2d 801 (Sup. Ct 1982), at 802-804 per Denman, Justice.
[97] 400 N.Y.S.2d 668 (Sup. Ct. 1977), at 674-675 per Stecher, Justice.

to the Court, the relationship of the parties was one of trust and confidence out of which arose a duty not to disclose. In *Hammonds v Aetna Casualty & Surety Company*[98] the Court came to a similar conclusion in stating that:

> 'If a doctor should reveal any of these confidences, he surely affects an invasion of the privacy of his patient. We are of the opinion that the preservation of the patient's privacy is no mere ethical duty upon the part of the doctor; there is a legal duty as well. The unauthorised revelation of medical secrets or any confidential communication given in the course of treatment, is tortious conduct which may be the basis for an action in damages.'[99]

In *Fairfax Hosp. v Curtis,*[100] the court held that a health care provider owes a duty of reasonable care to the patient which includes an obligation to preserve the confidentiality of patient information which was communicated to the health care provider or discovered during the course of treatment. In the absence of a statutory command to the contrary, or absent the patient's authorisation, a violation of this duty gives rise to an action in tort. The Court then decided that the recovery of damages for humiliation, embarrassment, and similar harm to feelings, although unaccompanied by actual physical injury, was possible under tort law where a cause of action existed independently of such harm. A similar reasoning can be observed in *McCormick v England,*[101] where the court argued that although South Carolina does not recognise the physician-patient privilege, the confidentiality of the physician-patient relationship is an interest worth protecting and that a violation of the physician's obligation can give rise to an action in tort. An action for damages in tort can also sometimes be based on a breach of the general obligation of medical confidentiality inferred from privilege statutes and licensing statutes as outlined above. In *Schaffer v Spicer,*[102] for example, the court decided that the breach of this general duty by an unauthorised disclosure of confidential information may give rise to liability to the patient for resulting damages. In *Horne v Patton,*[103] the Alabama Supreme Court also argued that a medical doctor is under a general duty not to make extra-judicial disclosures of information acquired in the course of the doctor-patient relationship and that a breach of that duty will give rise to a cause of action.

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[98] 243 F.Supp. 793 (N.D. Ohio 1965).
[99] Ibid., at 801-802 per Connell, Chief Judge.
[100] 492 S.E.2d 642 (Va. 1997), at 644-647 per Hassell, Justice.
[101] 494 S.E.2d 431 (S.C.App. 1997), at 432-438 per Anderson Judge.
[102] 215 N.W.2d 134 (Sup. Ct. S.D. 1974), at 136 per Biegelmeier, Chief Justice.
[103] 287 So.2d 824 (Sup. Ct. Alabama 1973), at 827-829 and 832 per Bloodworth, Justice.

Some courts have based the patient's action on the breach of a fiduciary duty. In *Petrillo v Syntex Laboratories, Inc.,*[104] for example, the court held that there exists, between a patient and his treating physician, a fiduciary relationship founded on trust and confidence. According to the Court:

> 'The existence of this fiduciary relationship indicates that there is more between a patient and his physician than a mere contract under which the physician promises to heal and the patient promises to pay. There is an implied promise, arising when the physician begins treating the patient, that the physician will refrain from engaging in conduct that is inconsistent with the good faith required of a fiduciary.'

In *Brandt v Medical Defence Associates,*[105] the court inferred from the fact that privilege statutes provide for specific exceptions to the physician's fiduciary duty of confidentiality that:

> 'In the absence of such an exemption, there would be a breach of this duty, which in turn, constitutes a recognition by the legislature of the existence of the physician's fiduciary duty of confidentiality. We believe that a physician has a fiduciary duty of confidentiality not to disclose any medical information received in connection with his treatment of the patient. This duty arises out of a fiduciary relationship that exists between the physician and the patient. If such information is disclosed under circumstances where this duty of confidentiality has not been waived, the patient has a cause of action for damages in tort against the physician.'

The situation can thus be summarised as follows: while American courts agree that the physician owes a duty to the patient to keep the patient's medical confidences, and that a violation of such duty gives rise to a claim for compensation and that, depending on the circumstances, injunctive relief may also be available, differences can be observed as to the legal basis for such an action. While some courts mainly consider an action for breach of an implied contractual duty, some courts concentrate on an action in tort law, either as the only cause of action, or as an additional action to the claim under contract law. Other courts argue that the breach of medical confidentiality by the physician constitutes the breach of a fiduciary duty, and while some courts seem to suggest that this in itself gives rise to an action, others support the view that the breach of such a fiduciary duty results in a claim under tort law.

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[104] 499 N.E.2d 952 (Ill.App.1 Dist. 1986), at 961 per Linn, Presiding Justice.
[105] 856 S.W.2d 667 (Mo.banc 1993), at 470 per Thomas, Judge.

1.5. Professional obligation

The ethical duty owed by physicians is generally set forth in the Hippocratic Oath, the American Medical Association's Principles of Medical Ethics, and the Current Opinions of the Judicial Council of the American Medical Association. This ethical duty generally prohibits a patient's treating physician from disclosing confidential information without the patient's consent. §5.05 American Medical Association Principles of Medical Ethics state to that effect:

> Information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. ... The physician should not reveal confidential communications or information without the express consent of the patient, unless required by law to do so.

In some cases, this ethical duty to maintain patient confidences may be broader than the legal duty to do so.[106]

1.6. Summary

While it is uncontested in the United States that a physician is under an ethical obligation to keep patient confidences, the legal basis of such an obligation is more controversial. To some extent, confidential medical information is protected by the U.S. Constitution. Constitutional protection is available under the Fourth Amendment which protects an individual's right of privacy against unreasonable search and seizure, if the patient justifiably relied on an expectation of privacy,[107] which will be the case at least where the relevant information is protected by medical privilege. This means that the protection available under the Fourth Amendment depends on the law of the State in which the case is to be decided. More general protection of medical confidentiality is awarded under the Fourteenth Amendment and its interpretation as protecting substantive due process. According to the Supreme Court, the individual's interest in privacy embraces an interest in controlling the dissemination of private information about him/herself, including the constitutional protection of communications made by patients to physicians. The Supreme Court also recognised the individual's interest in being free from government intrusion when making important personal

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[106] *Steinberg v Jensen* 534 N.W.2d 361 (Wis. 1995), at 370-371 per Steinmetz, Justice; *Falcon v Alaska Public Offices Commission* 570 P.2d 469 (Alaska 1977), at 478 per Boochever, Chief Justice.

[107] 'Developments in privileged communications', (1985) 98 Harvard Law Review, at 1545-1546.

decisions concerning matters relating to marriage, procreation, contraception, family relationships, and child rearing. In addition, the Supreme Court has recognised a privacy interest in the inviolability of one's body. Compelled disclosure of information concerning one's body, although a less direct intrusion than a forced physical violation of the body, also interferes with an individual's interest in controlling what happens to his/her body. The right of privacy is thus a fundamental personal right, emanating from the totality of the constitutional scheme,[108] and it encompasses the right to withhold intimate information and communications about oneself, particularly when one's physical condition is at issue, and to have the confidentiality of the physician-patient relationship protected.

In addition, 41 American States have enacted privilege statutes, guaranteeing, to varying degrees, the confidentiality of patient information from disclosure in court proceedings. In some States, licensing statutes for the medical profession also impose a statutory obligation on the physician to maintain medical confidentiality. Some courts have developed a general legal obligation of a physician to respect patient confidences, mainly based on existing licensing statutes, and partly also based on privilege statutes. While most courts agree that compensation should be available where the physician has breached his/her obligation of medical confidentiality, different solutions are suggested as to the legal basis for such a claim.

2. Medical privilege

Given that medical confidentiality is, in principle, legally protected, the question arises of whether or not the physician's obligation to maintain the patient's confidences even applies in the context of criminal proceedings, that is whether or not there is a medical privilege protecting confidential medical information from disclosure in criminal court. As there is no uniform American law on the question of medical privilege, federal law and the law of different States have to be examined independently.

[108] *Griswold v State of Connecticut* 381 U.S. 479 (1965), at 494 per Justice Goldberg.

2.1. Federal law

It has been demonstrated above that the confidentiality of the physician-patient relationship receives protection under different principles of the U.S. Constitution. This does not, however, mean that medical privilege equally receives constitutional protection. Courts have rather always emphasised that the recognition of a medical privilege is not based on the Constitution, but is instead merely a question of statutory or common law. In *Branzburg v Hayes*,[109] for example, the Supreme Court has held that the only testimonial privilege rooted in the Federal Constitution was that of the Fifth Amendment. This means that the state is not under a constitutional obligation to recognise a medical privilege, but that it is at the discretion of the legislature whether or not to introduce a medical privilege. Rule 501 of the Federal Rules of Evidence (FRE) which are applicable in proceedings before federal courts provides that:

> Privileges are to be governed by principles of the common law as they may be interpreted ... in the light of reason and experience, except that in civil actions, as to claims or defences grounded in state law, the federal courts are to decide questions of privilege in accordance with applicable state law.

As, traditionally, common law did not recognise a medical privilege,[110] this provision has been interpreted as recognising a medical privilege before a federal court only where the court has to apply State law and where the relevant State law provides for a medical privilege. In contrast, where a federal court has to apply federal law, no physician-patient privilege is recognised.[111] Although FRE 501 allows the courts to protect information from disclosure if they consider it advisable in the light of reason and experience, federal courts have been reluctant to introduce any form of physician-patient privilege in cases in which federal law

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[109] 408 U.S. 665 (1972); see also, for example, *Felber v Foote* 321 F.Supp. 85 (D. Conn. 1970), at 87; *Pagano v Oroville Hosp.* 145 F.R.D. 683 (E.D.Cal. 1993), per Hollows, U.S. Magistrate Judge; *State v Beatty* 770 S.W.2d 387 (Mo.App. 1989), at 391 per Greene J; *State v Boehme* 430 P.2d 527 (Wash. 1967) per Hamilton, Judge.

[110] *Benton v Superior Court, Navajo County* 897 P.2d 1352 (Ariz.App.Div.1 1994), at 1355 per Kleinschmitt J; *Brandt v Medical Defence Associates* 856 S.W.2d 667 (Mo.banc 1993), at 669, per Thomas, Judge; *Fox v Gates Corp.* 179 F.R.D. 303 (D. Colo. 1998) at 305 per Coan, U.S. Magistrate Judge; *Galarza v U.S.* 179 F.R.D. 291 (S.D.Cal. 1998), at 294 per Battaglia, U.S. Magistrate Judge; *Hancock v Hobbs* 967 F.2d 462 (11th Cir. 1992); *Pagano v Oroville Hosp.* 145 F.R.D. 683 (E.D.Cal. 1993), per Hollows, U.S. Magistrate Judge; *State v Hardin* 569 N.W.2d 517 (Iowa App. 1997), at 580, per Vogel, Judge; *State v Smith* 496 S.E.2d 357 (N.C. 1998), at 361, per Whichard, Justice.

[111] *Hancock v Dodson* 958 F.2d 1367 (6th Cir. 1992), at 1373 per Contie Senior Circuit Judge; *U.S. v Bercier* 848 F.2d 917 (8th Cir. 1988), at 920 per McMillan, Circuit Judge; *U.S. v Burzynski Cancer Research Inst* 819 F.2d 1301(5th Cir. 1987), at 1311 per Rubin, Circuit Judge; *U.S. v Meagher* 531 F.2d 752 (5th Cir. 1976); *U.S. v Pierce* 5 F.3d 791 (5th Cir. 1993).

is determinative. Thus, there is no physician-patient privilege in federal court proceedings unless the question at issue is to be decided according to State law, and the relevant State provides for a physician-patient privilege.[112] In the words of the court in *Meagher*: 'At common law, no physician-patient privilege existed, and therefore, we recognise no such privilege in federal criminal trials.'[113] The only authorities supporting the existence of a physician-patient privilege in federal proceedings are *Rosenberg v Carroll,*[114] stating in dictum that such a privilege is applicable before a federal grand jury, and *Mann v University of Cincinnati,*[115] in which the court stated that: 'The federal courts have also recognised a federal common law privilege in the doctor-patient relationship.'

The situation is rather different when it comes to the question of a psychotherapist-patient privilege. Even though FRE 501 equally applies, the considerations of the courts that had to deal with the problem were influenced by the fact that the recognition of a federal psychotherapist-patient privilege had been recommended by the Advisory Committee on the Federal Rules of Evidence.[116] The legislator's failure to enact the recommended provision guaranteeing a psychotherapist-patient privilege in federal proceedings did not express a rejection of such a privilege. Instead, in *Trammel v U.S.*,[117] the Supreme Court explained the legal situation as follows:

> 'In rejecting the proposed Rules and enacting Rule 501, Congress manifested an affirmative intention not to freeze the law of privilege. Its purpose rather was to provide the courts with the flexibility to develop rules of privilege on a case-by-case basis.'[118]

Recently, in *Jaffee v Redmont,*[119] the Supreme Court reaffirmed its holding in *Trammel* by stating that:

> 'Rule 501 of the Federal Rules of Evidence authorises federal courts to define new privileges by interpreting "common law principles ... in the light of reason and experience." ... The Rule thus did not freeze the law governing the privilege of witnesses in federal trials at a particular point in our history, but

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[112] 'Developments in privileged communications', (1985) 98 Harvard Law Review, at 1533.
[113] *U.S. v Meagher* 531 F.2d 752 (5th Cir), at 753 per Morgan, Circuit Judge.
[114] 99 F.Supp. 629 (S.D.N.Y. 1951); see also Klieman, *Representation of Witnesses Before Federal Grand Juries,* at 10.36.
[115] 824 F.Supp. 1190 (S.D. Ohio 1993), at 1197, per Steinberg, U.S. Magistrates Judge.
[116] 'Advisory Committee's notes on the proposed Federal Rules of Evidence', 56 F.R.D. 183, at 242.
[117] 445 U.S. 40 (1979).
[118] Ibid., at 47, per Burger, C.J.
[119] 518 U.S. 1 (1996).

rather directed federal courts to continue the evolutionary development of testimonial privileges.[120] ... In rejecting the proposed draft that had specifically identified each privilege rule and substituting the present more open-ended Rule 501, the Senate Judiciary Committee explicitly stated that its action should not be understood as disapproving any recognition of a psychiatrist-patient privilege contained in the proposed rules.'[121]

The Court then considered the significance of a psychotherapist-patient privilege and argued in favour of such a privilege on the following grounds:

'That it is appropriate for the federal courts to recognise a psychotherapist privilege under Rule 501 is confirmed by the fact that all 50 States and the District of Columbia have enacted into law some form of psychotherapist privilege. We have previously observed that the policy decisions of the States bear on the question whether federal courts should recognise a new privilege or amend the coverage of an existing one. ... Because state legislators are fully aware of the need to protect the integrity of the fact-finding functions of their courts, the existence of a consensus among the States indicates that "reason and experience" support recognition of the privilege. ... The uniform judgment of the States is reinforced by the fact that a psychotherapist privilege was among the nine specific privileges recommended by the Advisory Committee in its proposed privilege rules. ... Because we agree with the judgment of the state legislatures and the Advisory Committee that a psychotherapist-patient privilege will serve a public good transcending the normally predominant principle of utilising all rational means for ascertaining the truth ... we hold that confidential communications between a licensed psychotherapist and her patients in the course of diagnosis or treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence.'[122]

Until this decision of the Supreme Court, the federal courts had been divided between those that accepted a psychotherapist-patient privilege[123] and those that did not.[124] In *U.S. v Corona,*[125] for example, the court had held that no psychotherapist-patient privilege existed in federal criminal trials as neither common law nor statutory law provided for any type of physician-patient privilege in criminal matters. And the court in *Re Grand Jury Proceedings*[126] expressed the view that it was up to Congress to introduce and define such a

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[120] Ibid., at 8-9, per Stevens, C.J.
[121] Ibid., at 15.
[122] Ibid., at 12-15.
[123] *Covell v CNG Transmission Corp.* 863 F.Supp. 202 (M.D. Pa. 1994), per McClure, District Judge; *Cunningham v Southlake Ctr for Mental Health, Inc* 125 F.R.D. 474 (N.D. Ind. 1989), at 477; *In Re Doe* 964 F.2d 1325 (2nd Cir. 1992), per Winter, Circuit Judge; *In re Grand Jury Subpoena* 710 F.Supp. 999 (D.N.J. 1989), at 1012-1013; *In re Zuniga* 714 F.2d 632 (6th Cir.), at 639; *U.S. v D.F.* 857 F.Supp. 1311 (E.D. Wis. 1994), per Stadtmueller, District Judge.
[124] *Hancock v Hobbs* 967 F.2d 462 (11th Cir. 1992); *In re Grand Jury Proceedings* 867 F.2d 562 (9th Cir.), at 565; *U.S. v Corona* 849 F.2d 562 (11th Cir. 1988), at 567; see also *U.S. v Burtrum* 17 F.3d 1299 (10th Cir. 1994), per Kelly, Circuit Judge for cases of child abuse.
[125] 849 F.2d 562 (11th Cir. 1988), at 567.
[126] 867 F.2d 562 (9th Cir.).

privilege, and not the task of a court. Those courts that accepted the existence of a federal psychotherapist-patient privilege did so on the grounds that 'reason and experience' (FRE 501) showed that the interests protected by such privilege outweighed the interest in the administration of justice.[127]

Given the constitutional protection of medical confidentiality under substantive due process principles, it is rather surprising that courts and legal commentators almost unanimously subscribe to the view that medical privilege is not mandated by the Constitution. As medical privilege is an attempt to resolve the conflict between the interests in medical confidentiality and the interests of justice, this opinion expresses the value judgment that the Constitution does not stand in the way of favouring the interests of justice over the interests in medical confidentiality. However, the Constitution does not prevent the statutory recognition of medical privilege, either. It can thus be followed that the Constitution is neutral with regard to the conflict between the interest in medical confidentiality and the interests of justice. In respect of the particular conflict between the confidentiality of the psychotherapist-patient privilege, on the one hand, and the interests of justice, on the other hand, the Constitution favours the precedence of the interest in confidentiality, as it is thought that in the context of the psychotherapist-patient relationship, the patient's privacy interests are affected far more than in the context of the ordinary physician-patient relationship.

2.2. State law

2.2.1. Statutory recognition of medical privilege

Forty-one states in the U.S. now have some form of statutory physician-patient privilege,[128] and in all States, the communication between psychiatrists and patients is privileged by statute. The scope of the physician-patient privilege varies from State to State. It is first of all important to examine whether or not a privilege statute protecting a patient's confidences from disclosure in court

[127] See, for example, *In re Grand Jury Subpoena* 710 F.Supp. 999 (D.N.J. 1989); *In re Zuniga* 714 F.2d 632 (6th Cir.), at 639.

[128] Alabama, Connecticut, Florida, Kentucky, Maryland, Massachusetts, South Carolina, Tennessee and West Virginia do not have a statutory physician-patient privilege.

proceedings is applicable in criminal court.[129] In some States, privilege statutes expressly provide that there is no privilege in criminal proceedings.[130] Other States exclude medical privilege in cases of serious crimes. In Kansas, for example, medical privilege only applies in cases of a prosecution for a misdemeanour.[131] In Illinois, the physician-patient privilege is inapplicable 'in trial for homicide when the disclosure relates directly to the fact or immediate circumstances of the homicide.'[132] In the District of Columbia, there is no medical privilege in criminal cases where 'the accused is charged with causing the death, or causing injuries upon, a human being, and the disclosure is required in the interests of public justice.'[133] In other States, the privilege statute expressly provides for a privilege in criminal proceedings. Art.510 Louisiana Code of Evidence (1993), for example, provides that:

C.(1) General rule of privilege in criminal proceedings.

> In a criminal proceeding, a patient has a privilege to refuse to disclose and to prevent another person from disclosing a confidential communication made for the purpose of advice, diagnosis or treatment of his health condition between or among himself, his representative, and his physician or psychotherapist, and their representatives.

Connecticut and Maryland, two States that do not recognise a physician-patient privilege, but only a psychotherapist-patient privilege, expressly provide for the applicability of that privilege in criminal proceedings.[134] Other privilege statutes award a general privilege and remain silent as to the question of the applicability of the statute to criminal proceedings and it is then up to the courts to decide whether they will read non-statutory exceptions into the statute. In some of those States, the courts refuse to apply the privilege in the criminal context.[135] But other courts[136] have held that it is for the legislature to determine exceptions to the medical privilege. For example, in *People v Reynolds*[137] the court held that

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[129] With regard to this problem, see Slovenko, *Psychotherapy and Confidentiality*, at 156.
[130] See, for example, §998 Medical Records Act (Cal.) for California; Mo. Ann. State. §337.636 for Missouri; Pa. State. Ann. §5929 for Pennsylvania.
[131] Kan. State. Ann. §60-427(b).
[132] Ill. Comp. State. Ch. 735 5/8-802.
[133] D.C. Code Ann. §14-307.
[134] Conn. Gen. State. §52-146c; Md. Code Ann. Cts. & Judic. Proc. §9-109(b).
[135] *People v Doe*, 107 Misc.2d 605 (Sup Ct 1981); *People v Lowe*, 96 Misc.2d 33 (1978).
[136] See, for example, *Clark v District Court* 668 P.2d 3 (Colo. 1983); *In the Matter of a Grand Jury Investigation of Onondaga County* 59 N.Y.2d 130 (1983); *People v Murphy* 101 N.Y. 126; *People v Decina* 2 N.Y.2d 133 (1956); *State v Boehme* 430 P.2d 527 (Wash. 1967) at 533 per Hamilton J.
[137] *People v Reynolds* 195 Colo. 386 (1978).

nothing in the statutory physician-patient privilege[138] suggested that the afforded privilege did not apply in criminal cases. Absent such language, the court declined to infer such a broad and conclusive exception to the statutory privilege. And in *State v Ross*,[139] the court explained that the physician-patient privilege had been extended to criminal cases pursuant to RCW 10.58.010 which applies the civil rules of evidence to criminal prosecutions as far as practicable.

The privilege belongs to the patient, not the physician, and the patient can accordingly waive the protection thus awarded. It has been explained above that the practice differs between the States as to whether or not privilege statutes only protect oral communications between physician and patient, or whether all observations made by the physician during the course of the professional relationship are also protected,[140] and in some States, only potentially embarrassing medical information is protected.[141]

2.2.2. Reasons behind the recognition of privilege

In States which do not recognise medical privilege, the situation seems to be clear: by not enacting a privilege statute the State legislature has expressed the view that in the case of conflict between the interests behind medical confidentiality and the countervailing interests in the context of criminal proceedings, the latter will always prevail, and confidentiality is only protected outside the courtroom. The considerations weighing against a recognition of medical privilege were, for example, explained in *Hague v Williams*,[142] where the court argued that the policy to expose confidential medical information to view when it is relevant to the resolution of litigation is in accord with the general theory that society has a right to every citizen's testimony and that privileges of exemption from this duty can only exceptionally be granted. However, given the importance of privacy protection, it is surprising that the precedence of the interests of justice over medical confidentiality absent a privilege statute seems to be universally accepted.

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[138] S. 13-90-107(1)(d), C.R.S. 1973 (1976 Supp.).
[139] 947 P.2d 1290 (Wash.App.Div.1 1997), at 1292 per Coleman J.
[140] See pp. 215-218.
[141] See pp. 218-219.
[142] 181 A.2d 345 (Sup. Ct. N.J. 1962), at 348 per Haneman, J.

In States with privilege statutes the situation is far more complicated. There, conflicts may arise, as privilege statutes are normally not regarded as formulating an absolute ban on disclosure under all circumstances.[143] It is possible, for example, that the disclosure of confidential medical information is relevant for the defence of an accused. A balancing approach may then be necessary in order to decide which interest should prevail in a given case. It is therefore essential to look at the reasons behind the recognition of medical privilege to determine which weight should be accorded to this interest in case of a conflict. Furthermore, without an analysis of the interests to be protected by privilege, the construction of privilege statutes by the courts cannot properly be understood. Freeman, Chief Justice explained the problems created by the recognition of a privilege in *D.C. v S.A.*:[144]

> 'Privileges which protect certain matters from disclosure are not designed to promote the truth-seeking process, but rather to protect some outside interest other than the ascertainment of truth at trial. ... Thus, privileges are an exception to the general rule that the public has a right to every person's evidence. Privileges are not to be lightly created or expansively construed, for they are in derogation of the search for the truth.'

As privileges thus constitute a deviation from the normal principles underlying court proceedings, their recognition can only be justified if some other, more important interest is thereby enhanced. In *US v Nixon*,[145] the Supreme Court held that the generalised interest in confidentiality cannot prevail over the fundamental demands of due process of law in the fair administration of criminal justice. Therefore, in addition to general confidentiality considerations there must be more specific reasons to justify medical privilege.

Many different arguments have been advanced in favour of protecting medical privilege. There is widespread agreement that medical privilege aims to encourage the patient to feel free to disclose openly to the physician all facts which may have a bearing upon diagnosis and treatment.[146] It is felt that the patient may be inhibited to do so unless it is guaranteed that his/her medical secrets are safe with the physician and will not be disclosed to third parties. Therefore, it seems

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[143] But see *People v Tauer* 847 P.2d 259 (Colo.App. 1993), per Plank, Judge, where it is indicated that the privilege is absolute, subject to a waiver by the patient.
[144] 687 N.E.2d 1032 (Ill. 1997), at 1038.
[145] 418 U.S. 683 (1974), at 713.
[146] *Berry v Moench* 331 P.2d 814 (Sup. Ct. of Utah 1958) at 817 per Crockett, Justice; *People v Harrison* 626 N.Y.S.2d 747 (Ct.App. 1995) per Bellacosa, Judge; *Steinberg v Jensen* 534 N.W.2d 361 (Wis. 1995), at 368 per Steinmetz, Justice.

necessary to respect the trust existing in the physician-patient relationship.[147] Only if such confidence is inspired in the patient, will the physician be able to provide effective medical treatment.[148] In the words of Hamilton, Judge in *State v Boehme:*[149]

> 'The judicially proclaimed purpose of statutes such as ours, establishing the privilege, is to surround communications between patient and physician with the cloak of confidence, and thus allow complete freedom in the exchange of information between them to the end that the patient's ailments may be properly treated.'

Another consideration is that the privilege helps physicians to avoid a 'Hobson's choice ... : choosing between honouring their professional obligation with respect to their patients' confidences or their legal duty to testify truthfully.'[150] Some courts refer to the constitutional privacy arguments explained above and argue that the patient's privacy rights not only mandate the protection of medical confidentiality in general, but also the recognition of a medical privilege. In *Mann v University of Cincinnati*[151] for example, it was stressed that:

> 'There can be no question that information such as a person's medical history is of such a private nature that a constitutional right to privacy exists. ... At least two privacy interests regarding medical care are implicated. The first, of course, is the right to non-disclosure of private information. ... The second is the right to health care. If patients have a genuine concern that their private medical information will become publicly known and may adversely affect their reputations or embarrass them, they will be reluctant to seek medical assistance. Thus, patient's interest in making decisions vital to their health care may be impaired by unwarranted disclosures. ... These same reasons support a doctor-patient privilege.'

The court thus recognised that without a physician-patient privilege, the patient's privacy and health interests cannot receive adequate protection. In *Division of Medical Quality v Gherardini,*[152] the court equally emphasised that:

> 'A person's medical profile is an area of privacy infinitely more intimate, more personal in quality and nature than many areas already judicially recognised and protected. ... The patient-physician privilege ... creates a zone of privacy whose purposes are (1) to preclude the humiliation of the patient that might follow disclosure of his ailments ... and (2) to encourage the patient's full disclosure to the physician of all information necessary for effective diagnosis

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[147] *U.S. v Bein* 728 F.2d 107 (2nd Cir. 1984), at 113.
[148] *State v Beatty* 770 S.W.2d 387 (Mo.App. 1989), at 392 per Greene, Judge.
[149] 430 P.2d 527 (Wash. 1967), at 533.
[150] *People v Harrison* 626 N.Y.S.2d 747 (Ct.App. 1995), per Bellacosa, Judge.
[151] 824 F.Supp. 1190 (S.D. Ohio 1993), at 1199 per Steinberg, U.S. Magistrates Judge.
[152] 156 Cal. Rptr. 55 (1979), at 60-61 per Staniforth, Acting Presiding Judge.

and treatment of the patient. ... The matters disclosed to the physician arise in most sensitive areas often difficult to reveal even to the doctor. Their unauthorised disclosure can provoke more than just simple humiliation in a fragile personality. The reasonable expectation that such personal matters will remain with the physician are no less in a patient and physician relationship than between the patient and psychotherapist. The individual's right to privacy encompasses not only the state of his mind, but also his viscera, detailed complaints of physical ills, and their emotional overtones.'

While this court thus held the privacy concerns of the general physician-patient relationship to be of equal value to those of the psychotherapist-patient relationship, this view is far from being predominant. It has been established that at the federal level, only a psychotherapist-patient privilege, but no medical privilege is recognised. Similarly, all States have recognised the former, but only 41 states have also implemented a medical privilege. The reasons brought forward for this difference in protection are mainly based on the assumption that the psychotherapist-patient relationship concerns a more intimate area of the patient's life then the physician-patient relationship. As Justice Stevens argued for the Supreme Court in *Jaffee v Redmont:*[153]

'Treatment by a physician for physical ailments can often proceed successfully on the basis of a physical examination, objective information supplied by the patient, and the results of diagnostic tests. Effective psychotherapy, by contrast, depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of confidential facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counselling sessions may cause embarrassment or disgrace.'

According to the majority of the Supreme Court, the psychotherapist-patient privilege is thus rooted in the imperative need for confidence and trust, and even the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment. The Court then emphasised that the psychotherapist-patient privilege serves the public interest in the mental health of the citizens by facilitating the provision of appropriate treatment for individuals suffering the effects of a mental or emotional problem. Given that the federal psychotherapist-patient privilege does not have a statutory basis, the decision is also interesting in that the Court had to perform a thorough balancing of the

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[153] 518 U.S. 1 (1996) at 10; see also *In re August, 1993 Regular Grand Jury* 854 F.Supp. 1392 (S.D.Ind. 1993) at 1397 per Tinder, District Judge; *Ceasar v Mountanos* 542 F.2d 1064 (9th Cir. 1976), at 1167 per Jameson, District Judge ('Psychotherapy is perhaps more dependent on absolute confidentiality than other medical disciplines.').

interests promoted by the privilege and those that might be adversely affected thereby:

> 'In contrast to the significant public and private interests supporting recognition of the privilege, the likely evidentiary benefit that would result from the denial of the privilege is modest. If the privilege were rejected, confidential conversations between psychotherapists and their patients would surely be chilled, particularly when it is obvious that the circumstances that give rise to the need for treatment will probably result in litigation. Without the privilege, much of the desirable evidence to which litigants ... seek access ... is unlikely to come into being. This unspoken "evidence" will therefore serve no greater truth-seeking function than if it had been spoken and privileged. In addition, given the importance of the patient's understanding that her communications will not be publicly disclosed, any State's promise of confidentiality would have little value if the patient were aware that the privilege would not be honoured in a federal court.'[154]

This is a very interesting argument. An important criticism of any evidentiary privilege is that it inhibits the truth-finding function of judicial proceedings in making unavailable information that might be relevant and material. The Supreme Court countered that argument by questioning that without privilege, the information would be available. Obviously, if privilege is seen to be necessary in order to encourage the patient frankly to disclose information to the psychotherapist, it can at least be argued that without such privilege, the patient will not disclose this information to the psychotherapist, so that even without a privilege the psychotherapist would not be available to testify in court about the patient's mental condition and intimate thoughts. If this is accepted, the costs of recognising a privilege are relatively low and it is very unlikely that much evidence will be lost. This is a utilitarian argument that focuses on the costs and benefits of privilege and it can only be sustained if there is some proof that without psychotherapist-patient privilege, patients would in fact be deterred from sharing their intimate thoughts with their psychotherapists. The rejection of a physician-patient privilege based on these considerations could equally only be justified if it could be shown that the absence of such privilege would not deter patients from seeking medical treatment.

Other courts have argued that even if some relevant information is lost to the courts, a patient in psychotherapy who in order to receive help must lay bare his/her entire self has a right to expect that such revelations will remain

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[154] 518 U.S. 1 (1996), at 11-13.

confidential,[155] an argument which rests on deontological thought. Thus, in case of a conflict between the interests in the confidentiality of the psychotherapist-patient relationship and the interests of justice, the individual's right of privacy will be given priority.[156] In *Re Zuniga*,[157] the court summarised different arguments in favour of the recognition of a psychotherapist-patient privilege:

> 'The inability to obtain effective psychiatric treatment may preclude the enjoyment and exercise of many fundamental freedoms, particularly those protected by the First Amendment. ... The interest of the patient in exercising his rights is also society's interest, for society benefits from its members' active enjoyment of their freedom. Moreover, society has an interest in successful treatment of mental illness because of the possibility that a mentally ill person will pose a danger to the community. The court ... finds that these interests, in general, outweigh the need for evidence in the administration of criminal justice.'

And *In re Grand Jury Subpoena*[158] the court similarly stressed that:

> 'Society has a discernible interest in fostering the therapeutic treatment of those of its members experiencing emotional turbulence. This interest consists not only in our altruistic concern for our neighbour's well-being, but in our more selfish interest in the effective treatment of those who may pose a threat because of mental illness or drug addiction. The absence of a privilege seems to have at least some deterrent effect on those seeking treatment. Equally important are the privacy rights of psychotherapy patients.'

The public interest in the protection of the confidentiality of the psychotherapist-patient relationship is thus twofold: society has an interest in encouraging mentally ill or unstable persons to seek and receive effective psychiatric treatment so that they will not pose a danger to society. At the same time, society also has an interest in the protection of individual rights and freedoms, such as the privacy right and the right to health. It has been argued that the absence of a psychotherapist-patient privilege would harm both the constitutionally protected interest in avoiding disclosure of personal matters, and the interest in making certain kinds of important decisions autonomously.[159] With regard to the privacy

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[155] See *In re Lifschutz* 85 Cal. Rptr. 829 (Sup. 1970), at 831-832 per Tobriner, Justice; *U.S. v Doyle* 1 F.Supp.2d 1187, (D.Or. 1998), at 1191 per Coffin, U.S. Magistrates Judge.
[156] In *Re B* 394 A.2d 419 (Pa. Sup. Ct. 1978).
[157] 714 F.2d 632 (6th Cir.), at 639.
[158] 710 F.Supp. 999 (D.N.J. 1989), at 1009-1010; see also *U.S. v D.F.* 857 F.Supp. 1311 (E.D. Wis. 1994), at 1320-1322 per Stadtmueller, District Judge.
[159] *In re Grand Jury Subpoena* 710 F.Supp. 999 (D.N.J. 1989), at 1010.

right of the patient, in *Hawaii Psychiatric Soc. Dist. Branch v Ariyoshi,*[160] Byrne, District Judge held:

> 'Constitutionally protected privacy must, at a minimum, include the freedom of an individual to choose the circumstances under which, and to whom certain of his thoughts and feelings will be disclosed. ... This right to choose confidentiality is particularly crucial in the context of communications between patient and psychotherapist.[161] ... The court holds that the constitutionally protected right of privacy extends to an individual's liberty to make decisions regarding psychiatric care without unjustified governmental interference.'[162]

It can be seen that the recognition of a psychotherapist-patient privilege is based on a mixture of deontological and utilitarian considerations. While there are many critics of the physician-patient privilege, all legislators as well as most courts agree on the overriding importance of the psychotherapist-patient privilege. However, there are also critical voices with regard to the recognition of a psychotherapist-patient privilege. Justice Scalia, for example, in a dissent to the Supreme Court's decision in *Jaffee v Redmont,*[163] questioned the likelihood that the absence of a psychotherapist-patient privilege might deter a patient from seeking psychological assistance, and he argued furthermore that even if it were certain that the absence of the psychotherapist privilege would inhibit disclosure of information to the psychotherapist, there was no good reason to protect the interest in confidentiality as it seems 'entirely fair to say that if she wishes the benefits of telling the truth she must also accept the adverse consequences.'

It can be seen that the approach towards the recognition of a medical and/or psychotherapist privilege largely depends on the attitude with regard to the purposes that are thereby served. In principle, the arguments in favour of a psychotherapist-patient privilege are very similar to the arguments brought forward in favour of a physician-patient privilege. In both cases, the privacy and health interests of the patient, as well as society's interest in the health of the citizens are important considerations, and the dividing line between the two approaches is mainly the distinction between physical and mental health, a distinction that is not always easy to make, as the growing significance of

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[160] 481 F.Supp. 1028 (D. Hawaii 1979).
[161] Ibid., at 1038.
[162] Ibid., at 1041.
[163] 518 U.S. 1 (1996), at 22-23.

psychosomatic illnesses shows. But even in cases in which the distinction can be made, it can be questioned whether a different legal approach towards the two situations is desirable and sound. The main reason for a distinction seems to rest on the assumption that the psychotherapist-patient relationship concerns more intimate matters than the ordinary physician-patient relationship, but it should not be forgotten that if confidentiality is guaranteed to protect the patient's interests in making autonomous health care decisions and in controlling the dissemination of confidential information, it is difficult to decide on behalf of the patient which information deserves the strongest protection. Part of the patient's autonomy interest is surely that it should be the patient who decides which information is regarded as particularly sensitive. The fact that most patients will attach more weight to the confidentiality of information imparted in the psychotherapist should not make any difference, as any objective standard regarding the assessment of what information is sensitive impairs the patient's autonomy. Thus, from a deontological perspective, the distinction between psychotherapist-patient privilege and physician-patient privilege seems hardly justified. With regard to the Supreme Court's consequentialist argument in *Jaffee* that not much, if any evidence will be lost by introducing a psychotherapist-patient privilege, proof would be needed to decide whether this is true and whether the same does not apply to the physician-patient relationship, particularly in respect of certain sensitive areas such as venereal diseases, HIV infection etc. Only if there is a provable difference between the two situations can this argument be used as a reason for different legal treatment. If the stronger protection of the psychotherapist-patient privilege is based on society's interest in preserving the mental health of the population, this argument also needs some evidence to demonstrate that the absence of a physician-patient privilege would then not equally endanger society's interest in preserving the physical health of the population.

2.2.3. Limitations to medical privilege

(1) General considerations

A general decision in favour of medical and/or psychotherapist-patient privilege does not necessarily include the decision that the privilege should be absolute, trumping other interests under all circumstances. Most privilege statutes provide for exceptions. While the more specific limitations will be examined at a later stage, it should be noted that some privilege statutes provide for rather general and broad exceptions. In North Carolina, for example, G.S. §8-53 provides that notwithstanding a claim of privilege on the part of the patient, the presiding judge of the superior court may compel the physician or surgeon to disclose communications and information obtained by him 'if in his opinion the same is necessary to a proper administration of justice'. Also, some laws require exceptions to the privilege in areas in which the legislature has found certain social interests sufficiently important to override the State's general interest in protecting confidential patient information from being disclosed to third parties. In many States, for example, physicians must report to the police gunshot and knife wounds which may have resulted from illegal activity. Contagious or infectious diseases must be disclosed to the health department. Even if no statutory exception applies, courts have still argued that privilege cannot be absolute. In *Berry v Moench*,[164] for example, the court held that the responsibility of the doctor to keep confidences may be outweighed by a higher duty to give out information if there is a sufficiently important interest to protect. Even where it is argued that the recognition of medical privilege is based on the patient's constitutional right to privacy, this does not mean that no exceptions to medical privilege will be made. Rather, courts have repeatedly decided that:

> 'However broad the patients' constitutional privacy interest may be, that interest constitutes at most a qualified rather than an absolute privilege. ... We need not here decide the precise reach of the patients' constitutional privacy right. Whatever that reach, the privacy interest must be balanced against society's interest in securing information vital to the fair and effective administration of criminal justice.'[165]

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[164] 331 P.2d 814 (Sup. Ct. of Utah 1958), at 817 per Crockett, Justice.
[165] *Chidester v Needles* 353 N.W.2d (Iowa 1984), at 854 per Wolle, Justice; see also *In re Lifschutz* 85 Cal. Rptr. 829 (Sup. 1970), at 432 and 438 per Tobriner, Justice; *Division of Medical Quality v Gherardini* 156 Cal. Rptr. 55 (1979), at 61 per Staniforth, Acting Presiding Judge.

With regard to the non-statutory federal psychotherapist-patient privilege, courts that came to the conclusion that policy reasons mandated the recognition of such privilege mostly nevertheless argued that it should be recognised only as long as it did not entail undue frustration of other societal interests.[166] They claimed that the recognition of the privilege must be undertaken on a case-by-case basis, as the propriety of the privilege as such as well as its scope must be determined by balancing the interests protected by the privilege with those advanced by disclosure.[167] In *Re Doe*,[168] Winter, Circuit Judge even held that the privilege amounts only to a requirement that a court give consideration to a witness' privacy interests as an important factor to be weighed in the balance when assessing the admissibility of psychiatric histories or diagnoses. Important for the outcome of the balancing test was the sensitivity of the personal information disclosed, and hence the intrusion on the right to confidentiality. The more sensitive the information, the higher the burden on the state to justify disclosure.[169] However, the Supreme Court's decision in *Jaffee v Redmont*[170] may change the case-law in this area. Justice Stevens stressed that:

> 'We reject the balancing component of the privilege implemented by ... a small number of States ... . Making the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege. ... If the purpose of the privilege is to be served, the participants in the confidential conversation must be able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.'[171]

While this very general statement seems to suggest that qualifications to a privilege are unacceptable because they undermine its very purpose, it must be borne in mind that the argument was advanced in the narrow context of whether or not it was appropriate to make the protection of the patient's interests in non-disclosure subject to the relevance of the information in the course of judicial proceedings. It remains to be seen whether this case-law will in the future be interpreted as a strict ban on any exceptions to the psychotherapist-patient

[166] *In re Grand Jury Subpoena* 710 F.Supp. 999 (D.N.J. 1989), at 1007-1008.
[167] *Re Zuniga* 714 F.2d 632 (6th Cir.), at 639-640.
[168] 964 F.2d 1325 (2nd Cir.. 1992), at 1328-1329.
[169] *Hawaii Psychiatric Soc. Dist. Branch v Ariyoshi* 481 F.Supp. 1028 (D. Hawaii 1979), at 1043 per Byrne, District Judge.
[170] 518 U.S. 1 (1996).
[171] Ibid., at 17-18.

privilege, or whether it will be restricted to its narrow meaning of stating that the psychotherapist-patient privilege must not yield merely because the information the disclosure of which is sought would be relevant in court.

(2) Interests in criminal prosecution

In the context of a privilege in criminal proceedings, the patient's interest in non-disclosure will regularly conflict with the state interest in the prosecution of crime and of criminals. To understand the balancing of these interests, it is important to be clear about the content and the significance of the interests with which the interest in medical confidentiality competes. The discussion of the interests involved differs with regard to the different stages of criminal prosecution. Confidential medical information protected by medical privilege may be relevant in the course of police investigations, in the course of grand jury proceedings in which the grand jury decides on the indictment of a suspect, and, finally, in criminal court. As privilege is mainly discussed in the context of criminal trials, this is where the analysis will start.

(a) criminal trials

The interest in unlimited disclosure of information in the course of judicial proceedings was best explained by the Supreme Court in *US v Nixon.*[172] There, the Court had to decide whether or not certain presidential communications were protected from disclosure in court by the presidential privilege. In that case, the Supreme Court delineated the interests in favour of disclosure as follows:

> '"The twofold aim of criminal justice is that guilt shall not escape or innocence suffer." ... We have elected to employ an adversary system of criminal justice in which the parties contest all issues before a court of law. The need to develop all relevant facts in the adversary system is both fundamental and comprehensive. The ends of justice would be defeated if judgements were to be founded on a partial or speculative presentation of the facts. The very integrity of the judicial system and public confidence in it depend on full disclosure of all the facts within the framework of the rules of evidence. To ensure that justice is done, it is imperative to the function of the courts that compulsory process be available for the production of evidence needed either by the prosecution or by the defence.'[173]

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[172] 418 U.S. 683 (1974).
[173] Ibid., at 709 per Chief Justice Burger.

It can thus be seen that evidentiary privileges are regarded as diametrically opposed to the interests of justice which require unlimited disclosure of all evidence that may be relevant to the case, either from the point of view of the defence, or from the point of view of the prosecution. Sissela Bok suggested that in addition to the interests outlined in *Nixon*, the interests in social justice and restitution also have a role to play in the context of prosecuting past crimes.[174]

In the course of criminal proceedings, potential conflicts between the interest in medical confidentiality, on the one hand, and the state interest in criminal prosecution, on the other hand, is regulated generally by either the existence or the absence of privilege statutes. Where no privilege statutes exist, the courts assume that the legislator did not want to make an exception to the principle of the overriding importance of the state interest in the administration of justice, including the interest in criminal prosecution, so that the physician will have to testify about confidential patient information or submit the patient's medical records where this is relevant to the proceedings. Where a privilege statute exists, on the other hand, the legislator decided the conflict in favour of non-disclosure. Therefore, not many cases occupied the courts in which either the patient contested disclosure even in the absence of a privilege statute, or in which disclosure was sought despite the existence of a privilege statute on the grounds that the general interest in criminal prosecution should in the particular case outweigh the interest protected by the statutory privilege. However, *State v Boehme*[175] seems to suggest that even where a statutory privilege is in existence, there is still some room to balance the interests behind the privilege against the interest in criminal prosecution, as:

> 'The privilege, however, should be fairly limited to its purpose. Absent the most cogent of reasons, it should not, by unrealistic or impractical application, become a means whereby criminal activities of third persons may be shielded from detection, prosecution, and punishment. ... To allow the privilege to thus become a device by which the victim of an attempted crime could, without a civically paramount reason, thwart the course of a criminal proceeding against the perpetrator might well promote greater evils than the privilege was designed to avoid. The maintenance of an orderly society, and the circumvention of criminal activities, are functions of government which should not be subject to casual suppression by the operation of a procedural rule primarily designed for the purpose of aiding the healing of physical ailments.'

[174] *Secrets*, at 131.
[175] 430 P.2d 527 (Wash. 1967), at 536 per Hamilton, Judge; see also *Bryson v State* 711 P.2d 932 (Okl.Cr. 1985).

This decision suggests that some courts do not subscribe to the view that the existence of a privilege statute demonstrates that the general conflict between medical confidentiality and the interests of justice was decided in favour of medical confidentiality so that medical confidentiality can then not be outweighed by the interests of justice. The court obviously thought that the results of such an interpretation of the privilege statute would be too abhorrent to be acceptable. It was also argued that 'where confidentiality and privilege are concerned, the rule is that a potential wrongdoer will not be able to hide his deeds behind a physician-patient privilege: crime investigation trumps privilege and confidentiality.'[176] This construction, however, undermines the legislative intention behind privilege statutes. It is thus submitted that in States where privilege statutes are applicable in criminal proceedings, no balancing of the confidentiality interests with the interests in criminal prosecution should be permissible.

The situation is different in cases which rely on the non-statutory federal psychotherapist-patient privilege, as this privilege is a creature of common law which was, until the Supreme Court's decision in *Jaffee v Redmont*,[177] said to apply only subject to the outcome of a balancing exercise in each individual case. *U.S. v D.F*[178] gives some insight into how the courts performed the balancing test in cases in which the interest behind the privilege was in conflict with the interests of justice in criminal proceedings:

> 'Consistent with the case-by-case approach mandated by Rule 501, the court must now consider whether, in the instant case, the privilege should apply to D.F.'s statements. ... Several aspects of this case suggest that the utilitarian gains from the privilege would be minimal. First, the interest in effective therapy will only be served to the extent that D.F., a fourteen year-old girl, understood the implications of disclosure. ... Second, ... there is evidence in the regard to suggest that she believed that the staff at the Centre was required to disclose her statements. ... To the extent that that is the case, the privilege would have been irrelevant. Third, to the extent that D.F.'s "therapy" at the Centre was compelled or coerced ... the existence of the privilege likely provided only marginal utilitarian gains. Application of the privilege in this case would do little to promote privacy interests. The facts of this case suggest that regardless of whether the court finds that D.F.'s statements were privileged, her privacy has already been seriously compromised. The statements have already been widely disseminated amongst both governmental officials and other patients. ... . On the other hand, the interests weighing against the privilege in this case are considerable. The Government believes

[176] Oppenheim, *The Medical Record as Evidence*, at 696.
[177] 518 U.S. 1 (1996).
[178] 857 F.Supp. 1311 (E.D. Wis. 1994).

> that the two infants involved were murdered. D.F.'s statements are clearly relevant to that charge. In fact, the Government has suggested that that charge cannot be sustained without that evidence. Thus, nondisclosure would significantly impair both law enforcement interests and a general interest in the truth-seeking process.'[179]

According to the court, the application of the privilege in this case thus depended on whether and to what extent the privilege would promote the interests behind its recognition. The first consideration seems to suggest that children or other people who may not be aware of the privilege will not be protected, as without such awareness, privilege will do nothing to enhance the willingness to receive therapy and to be frank to one's psychotherapist. Secondly, the psychotherapist's mistaken belief that he/she is under an obligation to disclose confidential information seems to negate the privilege according to this holding. What is even more worrying is the court's remark that the fact that the patient's privacy ha already been widely infringed can justify further invasions. The case shows that the case-by-case approach adopted in cases of federal psychotherapist-patient privilege gives the courts a lot of leeway to do away with the privilege where they think that in the specific case disclosure is a better result than non-disclosure. If a court adopts a utilitarian approach towards medical confidentiality as did the court in *U.S. v D.F,* the balancing test can concentrate on costs and benefits for society, while neglecting the privacy and autonomy interests of the individual patient. As was mentioned above in a different context, it remains to be seen whether or not the Supreme Court's holding in *Jaffee v Redmont*[180] that the psychotherapist-patient privilege is absolute and not subject to any exceptions will be interpreted to mean that a balancing of interests is neither required nor permitted when conflicts between the psychotherapist-patient privilege and the interests in criminal prosecution have to be decided.

(b) Grand jury proceedings or Attorney General investigations

Given the special character of grand jury proceedings and of investigations by the Attorney General, the question arises whether or not privilege is applicable in such proceedings. In *Branzburg v Hayes,*[181] the Supreme Court explained the

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[179] Ibid., at 1320-1322 per Stadtmueller, District Judge.
[180] 518 U.S. 1 (1996).
[181] 408 U.S. 665 (1972).

function of the grand jury in federal proceedings and the consequences for the application of privileges:

> 'The grand jury ... has the dual function of determining if there is probable cause to believe that a crime has been committed and of protecting citizens against unfounded criminal prosecutions. Grand jury proceedings are constitutionally mandated for the institution of federal prosecutions for capital and other serious crimes (fifth amendment), and its constitutional prerogatives are rooted in long centuries of Anglo-American history. The adoption of the grand jury in the Constitution as the sole method for preferring charges in serious criminal cases shows the high place it held as an instrument of justice. Because its task is to inquire into the existence of possible criminal conduct and to return only well-founded indictments, its investigative powers are necessarily broad. Although the grand jury's powers are not unlimited and are subject to the supervision of a judge, the long-standing principle that the public has a right to every man's evidence except for those persons protected by a constitutional, common-law or statutory privilege is particularly applicable to grand jury proceedings.'[182]

Thus, it seems that the interests in disclosure of all relevant information in grand jury proceedings is comparable to the interest in disclosure of all relevant information during a criminal trial. There are, however, differences between grand jury investigations and criminal trials, an important distinction being that information disclosed to the grand jury maintains its confidential status and will not be further disclosed. It cannot, for example, be used in criminal court.

In *Chidester v Needles*,[183] the court held that a subpoena *duces tecum,* with which the attorney general demanded access to patients' records, did not violate medical privilege by forcing the physician 'indirectly' to testify, the reasons being that a subpoena *duces tecum* formed part of the county attorney general's investigatory power for use in lieu of a grand jury proceeding, that information thereby obtained may not be used to perpetuate testimony for trial, and that documents produced in response to a county attorney general's subpoena remain confidential unless and until a criminal charge is filed.[184] The court then performed a balancing exercise and came to the conclusion that:

> 'In weighing the patients' privacy interest against the State's interest in obtaining a thorough investigation, we are also mindful that the privacy interest is partially protected by Iowa Rule of Criminal Procedure 5(6). The records obtained pursuant to a county attorney's subpoena have a confidential status before any criminal charge is filed and may thereafter be kept confidential by

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[182] Ibid., at 686-688.
[183] 353 N.W.2d 849 (Iowa 1984).
[184] Ibid., at 852 per Wolle, Justice.

> court order. ... We conclude that the privacy interest of the clinic's patients must yield to the State's interest in well-founded criminal charges and the fair administration of criminal justice.'[185]

The outcome in the specific case, that is that privilege was outweighed by the interest in disclosure, seems at least partly to rest on the assumption that the disclosure does not lead to the use of the information in court, and that the confidential character of the information would be upheld. As was explained in *United States v Bein,*[186]

> 'The danger in the use of privileged material is not that a tribunal may be misled or a party's litigation position unfairly prejudiced, since the reliability of the evidence is not in question. The fear is rather that valued relationships may be disrupted by an apprehension that confidential communications may be disclosed. Given the fact that grand jury proceedings are normally secret, that an authoritative adjudication as to whether material is privileged may have to await subsequent proceedings and that dismissal of an indictment is a most serious step, courts have declined to dismiss indictments because of the use of privileged matter before the grand jury. Such testimony of course is not permitted at trial.'

The courts' attitude that privileged information should be available to the grand jury, given the confidentiality of the proceedings and the special role of the grand jury is problematic, as the privileged information is then nevertheless disclosed to the investigating authority. Contrast the decision in *Re Grand Jury Subpoena,*[187] where the court held that:

> 'There is something undoubtedly unseeming about requiring psychotherapists to disclose the most intimate of their patient's thoughts and emotions, when such communications merely meet the broad relevancy requirements applicable to grand jury investigations.'[188]

While most courts seem to favour unlimited disclosure of confidential patient information in the course of grand jury investigations, some courts thus seem to promote a different approach when suggesting a more stringent test as to whether or not the confidential information is in fact relevant to the proceedings, an approach which seems more in line with the predominant attitude toward disclosure in the context of judicial proceedings.

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[185] Ibid., at 853-854.
[186] 728 F.2d 107 (2nd Cir. 1984), at 113.
[187] 710 F.Supp. 999 (D.N.J. 1989).
[188] Ibid., at 1010-1011.

(c) Search for and seizure of medical records

When, in the course of criminal investigations, there is a suspicion that a patient's medical records may contain some relevant evidence, it must be determined to what extent the police, the attorney general or the grand jury may obtain access to these records, and to what extent they are protected by medical privilege. In principle, medical privilege not only excludes the physician as a witness in judicial proceedings, but also prevents the state from gaining access to medical records.[189] Thus, in States with privilege statute medical records are exempt from state access. In addition, search and seizure of patient records can raise constitutional issues, particularly Fourth and Fifth Amendment considerations.

A first question, then, is whether and to what extent medical records are protected from search and seizure through the provisions of the Fourth Amendment. It has been explained above that the Fourth Amendment, rather than protecting the privacy interests of the individual as such, only protects individual privacy against certain kinds of governmental intrusion.[190] In the words of Lucas, Chief Justice, in *Hill v National Collegiate Athletic*:[191]

> 'The Fourth Amendment does not proscribe all searches and seizures, but only those that are unreasonable. ... Under the Fourth Amendment ... the reasonableness of particular searches and seizures is determined by a general balancing test "weighing the gravity of the governmental interest or public concern served and the degree to which the [challenged government conduct] advances that concern against the intrusiveness of the interference with individual liberty."'

Case-law that has developed mainly in the area of the attorney-client relationship, the confidentiality of which is regarded as even more worthy of protection than that of the physician-patient privilege, suggests that searches of law offices, and therefore probably also searches of surgeries or hospitals as such are not unreasonable under Fourth Amendment standards.[192] In *U.S. v Burzynski Cancer*

[189] See, for example, Art.4495b Public Health Act Texas; *Behringer Estate v Princeton Medical Centre* 592 A.2d 1251 (N.J.Super.L. 1991) per Crachman, J.S.C.; *Comonwealth v Kobrin* 479 N.E.2d 674 (Mass. 1986), per Abrams, Judge; *In Re Search Warrant* 810 F.2d 65 (3rd Cir. 1987), per Becker, Circuit Judge.
[190] *Katz v U.S.* 389 U.S. 347 (1967) at 350 per Steward, Justice.
[191] 865 P.2d 633 (Cal. 1994), at 650.
[192] *Deukmejian v Superior Court for the County of LA* 162 Cal Rptr. 857 (1980), at 862; *Klitzman, Klitzman and Gallagher v Krut* 744 F.2d 955 (U.S. App. 3rd Cir. 1984), at 959; *In Re Impounded Case (Law Firm)*, 840 F.2d 196 (3rd Cir. 1988) at 202.

Research Institute,[193] an action was brought against a physician and a research centre seeking to enjoin them from violating Federal Food and Drug Regulations, and a criminal search warrant was executed. Some patients whose treatment records had been seized, alleged a breach of their Fourth Amendment rights, claiming that the seizure had invaded their right to privacy. The court rejected this view on the grounds that a seizure of documents that was authorised by a warrant can never amount to an unconstitutional invasion of privacy, since a warrant issued upon prior review by a neutral and detached magistrate was the time-tested means of effectuating Fourth Amendment rights. And in *Re search warrant B-21778*,[194] a case of a law office search, the court held that there are no privileged isles beyond the reaches of a properly predicated search warrant, and that anywhere and everywhere within the limits of a court's jurisdiction may be searched, so that the fact that the warrant was directed at a law office did not make the search unreasonable. However, those courts that have allowed the search of law offices or surgeries have argued that while the Fourth Amendment does not prohibit searches of such places, privileged information is exempt from seizure.[195] Other courts have argued that privilege is sufficiently protected by the procedure requiring that the government obtain leave of the court before examining any seized items, which gives the parties the possibility to assert privilege.[196] Some courts and legal writers argue that rather than issuing a search warrant to search law firms or surgeries, a less intrusive means to obtain the material sought would be the issuance of a subpoena *duces tecum*. As the argument goes, even the most particular warrant cannot adequately safeguard client confidentiality. In *O'Connor v Johnson*,[197] the court came to the conclusion that:

> 'Though this may be seen as limiting the ability of the police to obtain information in the early stage of the investigation, we find this measure necessary to protect the overriding interest of our society in preserving the attorney-client privilege. ... Moreover, our decision rests not only on the fourth amendment, but also on Art. I S.10 of the Minn Constitution. We hold that a warrant authorising the search of an attorney's office is unreasonable and, therefore, invalid when the attorney is not suspected of criminal wrongdoing and there is no threat that the documents sought will be destroyed.'

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[193] 819 F.2d 1301 (5th Cir. 1987), at 1310 per Rubin, Circuit Judge.
[194] 513 Pa 429 (1987), at 439-440.
[195] Ibid., at 440; see also Cissell, *Federal Criminal Trials*, at 476.
[196] *In Re Impounded Case (Law Firm)* 840 F.2d 196 (3rd Cir. 1988) at 202.
[197] 287 N.W.2d 400 (Minn. 1979) at 405.

The subpoena is less intrusive than a search warrant and a means to protect privileged information, as it enables the physician to gather and produce requested documents, thereby eliminating the threat that law enforcement officials will examine and possibly seize privileged and irrelevant documents in the course of a search authorised by a warrant.[198] Moreover, before producing the evidence the physician may obtain a judicial ruling on the applicability of any relevant privilege by filing a motion to quash.[199] The subpoena preference rule is therefore seen by some as the best practicable accommodation of the legitimate needs of law enforcement, on the one hand, and the important values of privileged relationships, on the other hand.[200]

It can be seen that the Fourth Amendment as interpreted by most courts does not award much protection against state access to privileged records. Indeed, medical records receive additional protection only where the Fourth Amendment is interpreted as requiring the subpoena preference rule. However, the true protection of privileged material in the course of searches of surgeries seems to stem from privilege statutes, so that in States without a privilege statute, medical records are less protected than in States in which privilege statutes apply.

It remains to examine whether the Fifth Amendment adds anything to the protection of medical records from search and seizure. The protection of confidential medical information under the Fifth Amendment is rather limited, as the Fifth Amendment protects against self-incrimination by having to produce evidence against oneself, rather than protecting the content of documents as such.[201] Thus, as the Supreme Court made clear in *Andresen v Maryland*,[202] information is not exempt from seizure in the hands of the patient simply because the contents are private and confidential. Therefore, confidential medical documents will only be protected from search and seizure where, in addition to

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[198] Bloom, (1980) 69 Georgetown Law Journal, at 26.

[199] *Matter of Witnesses before Sp. March 1980 Gr. Jury* 729 F.2d 489 (7th Cir. 1984), at 495.

[200] Bloom, (1980) 69 Georgetown Law J, at 54; Mogill, (1988-1989) 21 Connecticut Law Rev., at 354; but see *Zurcher v Stanford Daily* 436 U.S. 547 (1978) where the Supreme Court declined to hold that the Fourth Amendment imposed a general constitutional barrier against warrants to search newspaper premises, to require resort to subpoenas as a general rule, or to demand prior notice and hearing in connection with the issuance of search warrants.

[201] See *Fisher v U.S* 425 U.S. 391 (1976); *U.S. v Doe* 465 U.S. 605 (1983), at 612 per Powell, Justice; *In re: Grand Jury Subpoenas* 144 F.3d 653 (10th Cir. 1998) at 663 per Stephen H. Anderson, Circuit Judge.

[202] 427 U.S. 463 (1976), at 473-476 per Blackmun, Justice; see also *Fisher v U.S.*, 425 U.S. 391 (1976), at 402-404.

their confidential content, they will incriminate the patient, and even then only if they were not voluntarily created. In the hand of the physician, patient records are only protected insofar as they would have been protected by the Fifth Amendment while in the hand of the patient.[203] Given the very narrow scope of Fifth Amendment protection, it is therefore unlikely that the seizure of medical records will violate the patient's Fifth Amendment rights, and the Fifth Amendment does not seem to add much to the protection of medical records under privilege statutes.

(3) A special problem: child abuse

All States have some form of exception from medical and/or psychotherapist-patient privilege with regard to child abuse.[204] Some have argued that these exceptions show the willingness of legislatures to sacrifice confidentiality for the administration of justice where the crime is outrageous to society,[205] an opinion which seems to suggest that in the particular situation of child abuse the state interest in the prosecution of the offender outweighs the interest in medical confidentiality. Some courts, however, argued differently. In *State v Sypult*,[206] for example, the court argued that 'the central purpose of the child abuse reporting statutes is the protection of children, not the punishment of those who mistreat them' and concluded that child abuse exceptions to a privilege statute must be narrowly construed so that the purpose of the reporting statute may be achieved, while the benefits resulting when those who maltreat children seek confidential therapy programs are maintained. According to this view, the protection of children from abuse, rather than the prosecution of the offender seems to be the main consideration behind such an exception to medical privilege. In *Pesce v J. Sterling Morton High Sch. Dist. 201*,[207] a case in which a school psychologist was punished for not reporting suspected child abuse of which he learned in the course

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[203] *In re: Grand Jury Subpoenas* 144 F.3d 653 (10th Cir. 1998) at 663 per Stephen H. Anderson, Circuit Judge; Camp, Levey, 'The Privilege against Self-Incrimination', in: Stone, Taylor, *Testimonial Privilege*, vol. 2, at 4-10 to 4-11.
[204] See, for example, Neb. Rev. State. §27-504 (1984) ('there is no privilege ... in any judicial proceedings ... regarding injuries to children, incompetents, or disabled persons or in any criminal prosecution involving injury to any such person or the wilful failure to report any such injuries.').
[205] Domb, 5 Journal of Law and Health 1990-1991, at 236.
[206] 304 Ark. 5 (1990).
[207] 830 F.2d (7th Cir. 1987), at 797-798 per Cudahy, Circuit Judge.

of confidential communication with a pupil, the court also focused on the element of protection when arguing that:

> 'Even if there is here a federal right to confidentiality that can be infringed only to further a compelling state interest, we conclude that such an interest is present in the present circumstances. Of critical importance here is the fact that the state is acting to protect one of the most pitiable and helpless classes in society - abused children. The Supreme Court has recognised the substantial interest of a state in protecting all children.'

In this case, it is obviously the protection of the child at risk of further abuse that is the main reason behind the exception from the obligation to maintain confidentiality, not the interest in prosecuting the offender. The difference in opinion as to the purpose behind the child abuse exceptions is significant, as it may be decisive when courts have to determine whether or not disclosure will be ordered in a given case. If the purpose behind the exception is the interest in protecting the child, then disclosure will be limited to those persons and institutions that will help to prevent further abuse, but disclosure will then normally not be justified in the course of criminal investigations or proceedings against the offender.

(4) A special problem: drunk driving

In some states, there is no privilege in drunk-driving cases. This is partly due to statutory exceptions to privilege,[208] partly a creation of case-law. In *State v Dyal,*[209] for example, the court held that in a matter so deeply imbued with the public interest as a case involving a suspected drunken driver, the investigating police should not be deprived of blood test results merely because they had been made for treatment purposes and were thus privileged. As those results were not only relevant, but highly persuasive in determining whether the driver was drunk, and as the patient's interest in the confidentiality of hospital records can be protected adequately by requiring the investigating police to establish a reasonable basis to believe that the operator was intoxicated, medical confidentiality was said to be outweighed by the public interest. Similarly, in *State v Dress,*[210] the court recognised that the privilege was premised on the calculation that the benefits to

[208] See, for example, California, Montana, Oregan, Utah.
[209] 97 N.J. 229, at 238-239.
[210] 461 N.E.2d 1312, (Ohio App 1982) at 1316-1317.

the protected relationship outweigh burdens thereby imposed and that the privilege must yield when the public interest outweighs the policy supporting the privilege. This, according to the court, was the case in the context of a prosecution for the offence of driving while intoxicated. As the physician attending a defendant is frequently the sole or most competent source of very relevant evidence, to allow the privilege in such cases would be against the public interest, given that the offence of driving while intoxicated has a great potential for serious injury or death, so that the public interest in prosecuting such offenders is regarded as compelling. This argument is very interesting, as in many States, not even the prosecution of serious crimes such as murder gives rise to an exception to the privilege. The exception seems to be justified by the specific difficulties in prosecuting drunk-driving offences without resort to medical evidence, rather than by the seriousness of the offence. However, the same would apply to other offences such as sexual offences. The danger to society as a whole by drunk-driving which is thought to surpass the danger of other, more serious offences which mainly affect certain individuals, seems another important consideration behind this exception. The drunk-driving exception to medical privilege seems to rest mainly on utilitarian considerations, taking account of the particularly high costs of a privilege in this context.

(5) Investigations against the physician

Another group of cases in which confidentiality problems frequently arise is that of criminal investigations against a physician or proceedings in which a physician is accused of having committed criminal offences in the context of his/her work. This often concerns cases of fraud against health insurance companies, for example where a physician is accused of having claimed fees for treatment he/she did not administer, or cases in which the physician is accused of prescribing controlled substances for improper and illegal purposes. Different courts have adopted different approaches to tackle this problem. Several courts have made an exception to the application of medical privilege in such cases. The special dilemma the prosecution is facing in these cases was, for example, explained in *State v McGriff*:[211]

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[211] 672 N.E.2d 1074 (Ohio App. 3 Dist. 1996), at 1075 per Evans Judge.

> 'The defendant doctor should not be permitted to invoke his patient's privilege in order to shield himself from prosecution. ... Since the defendant has been accused of prescribing controlled substances for improper and illegal purposes and of committing fraud against various health insurance companies, if there is evidence of wrongdoing it will be contained in notations to his patients' medical records. Without these records, the state will be unable to prosecute its case.'

Given the difficulties in investigating and prosecuting such offences, in *Re Search Warrant*,[212] Becker, Circuit Judge held that in the case of the investigation of a physician for fraud the legitimate interests of the state in securing information contained in patient records outweighed the patient's privacy rights, as only the patient's medical records could reveal whether the physician had performed the specified services at the specified time and whether the services were medically necessary. The court thus seemed driven by consequentialist arguments, as it was felt that without this exception to medical privilege, the physician could safely commit criminal offences under the veil of his/her patient's confidentiality rights. It has further been argued that the patient's privacy interests can widely be respected in the course of such investigations, as the relevant and incriminating information, if any, contained in the patient records would be disclosed only to the extent needed to prosecute the defendant. Redaction of the records through erasure or concealment of patients' names and addresses and other information inapplicable to the prosecution of the charged crimes would ensure that each patient's interest in confidentiality and privacy was protected without frustrating the state's interest in prosecuting illegal drug activity.[213] In *Commonwealth v Kobrin*,[214] the court also argued that patient confidentiality should be upheld as much as possible and thus distinguished between those portions of a psychiatrist's records that recite 'the patient's most intimate thoughts and emotions, as well as descriptions of conduct that may be embarrassing or illegal' as it was difficult to see how this could be helpful to a determination of whether the psychiatrist had in fact furnished a reimbursable service, while the State could properly request that a psychiatrist submit those portions of his/her records documenting the times and lengths of patient appointments, fees, patient diagnoses, treatment plans and

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[212] 810 F.2d 65, (3rd Cir. 1987), at 72-73.
[213] *State v McGriff* 672 N.E.2d 1074 (Ohio App. 3 Dist. 1996), at 1075 per Evans Judge; *Schachter v Whalen* 581 F.2d 35 (2nd Cir. 1978), per Oakes, Blumenfeld, and Mehrtens.
[214] 479 N.E.2d 674 (Mass. 1986).

recommendations, and somatic therapies. The court summarised its views as follows:

> 'Those portions of the records, however, which reflect patient's thoughts, feelings, and impressions, or contain the substance of the psychotherapeutic dialogue are protected and need not be produced. ... In sum, a judge confronting the competing demands of the right to privacy ... and the need to supervise the disbursement of Medicaid payments for psychiatric services shall review the psychiatrist's records. Excerpts of those records which reveal that a patient with a given diagnosis saw the psychiatrist on a certain date for a certain length shall be released. The psychiatrist's observations of objective induce of emotional disturbance may be released. Notations of patient prescriptions, blood tests and their results (e.g. lithium carbonate levels), or the administration of electroconvulsive treatment shall be released. Indications of treatment plans (e.g. a recommendation of continuing psychotherapy or of medication) shall be released. The psychiatrist's records of patient conversations shall be withheld.'[215]

This distinction seems problematic, as only the patient's expressed thoughts and feelings are protected, but neither the diagnosis nor any other facts related to the treatment which may be highly confidential and which are protected under most privilege statutes, receive protection. In *Hawaii Psychiatric Soc. Dist. Branch v Ariyoshi,*[216] the court tried a different approach by stating that the mere existence of a valid 'public interest' would not be sufficient to justify an intrusion on the patient's privacy for the purpose of a fraud investigation against the physician. Instead, the court required some showing of an 'individualised, articulable suspicion' before access to a psychiatrist's confidential medical records could be had. And in *State v McGriff,*[217] Thomas F. Bryant, Judge, criticised the approach of placing the state interest in prosecuting the physician above the interest in patient confidentiality. In his view:

> 'If a patient does not waive the physician-patient privilege, his or her physician may not disclose any privileged communications made during that relationship, subject of course to any statutory exceptions. ... The state suggests that the purpose of the physician-patient privilege statute can be achieved by redacting the patient's medical records to delete information that might identify the patients. I deem this suggestion unworkable and an invasion of the privilege as well as a blatant attempt to circumvent the application of the statute. To allow the state to delete any identifying information contained in these patients' medical records would necessarily breach the physician-patient privilege without authority to do so. At least one person ... and more likely three persons

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[215] Ibid., at 681-682 per Abrams, Justice.

[216] 481 F.Supp. 1028 (D. Hawaii 1979), at 1047 and 1050 per Byrne, District Judge.

[217] 672 N.E.2d 1074 (Ohio App. 3 Dist. 1996), at 1078-1081; see also Mogill, (1988-1989) 21 Connecticut Law Rev., at 351 for the case of the attorney-client privilege.

> ..., if not more, would have to examine the contents of each patient's medical record to determine what is to be deleted and what is to be shown as evidence. Further, any information not deleted and subsequently used at trial by the state is still information protected by the privilege. ... It is my view that current Ohio law requires that if the state seeks to use the medical records of a non-party patient in order to prosecute that patient's physician, the state must first obtain a waiver of the privilege by that patient.'

This approach seems more in line with the purpose behind privilege statutes. While it is conceded that without access to patient records, it will often be impossible to investigate any fraud allegations against the physician, it must nevertheless be respected that in States with privilege statutes that do not contain any exception for such a situation, the legislator seems to have been of the opinion that the privilege should prevail over the state interest in the prosecution of crime. The patient's interests in the confidentiality of his/her medical records is not diminished by the fact that the physician abused the professional relationship. In case of conflict, therefore, the patient's interests should prevail and access to patient records only be allowed with the patient's consent.

(6) Conflicting defence rights

Another conflict frequently arising is that between medical confidentiality, on the one hand, and defence rights of an accused, on the other. Different scenarios are possible for this conflict to occur. It is possible that the prosecution is based on privileged evidence which it may want to withhold from the defendant on the grounds of privilege. If that is the case, the defence is obviously affected, as the accused then does not know against what evidence he/she has to defend him/herself. It is also possible that the defence wants to resort to privileged evidence either to cast some doubt on the credibility of a prosecution witness, or to prove his/her innocence.

Certain rights of a criminal defendant are guaranteed by the U.S. Constitution. The main constitutional principles discussed in this context are the Confrontation Clause and the Compulsory Process Clause, both contained in the Sixth Amendment to the U.S. Constitution, and the due process clause.

(a) Confrontation

The Confrontation Clause of the Sixth Amendment guarantees every criminal defendant the right physically to face those who testify against him/her, and the right to conduct cross-examination. A violation of these rights is often alleged in cases in which privilege is asserted. *Pennsylvania v Ritchie*,[218] though not dealing with the specific problem of medical confidentiality, but with that of privilege in child abuse cases, provides a good example of the conflict that frequently materialises. The respondent in that case was charged with various sexual offences against his minor daughter. During pre-trial discovery, the respondent served the CYS (Children and Youth Services) that had investigated the allegations and had conducted interviews with the victim, with a subpoena, seeking access to the records related to the immediate charges, as well as to certain earlier records compiled when CYS had investigated a separate report that the respondent's children were being abused. CYS refused to comply with the subpoena, claiming that the records were privileged under a Pennsylvania statute providing that all CYS records must be kept confidential, subject to specified exceptions, and the trial court confirmed this view. The respondent claimed that by denying him access to the information necessary to prepare his defence, the trial court had interfered with his right of cross-examination and thereby violated his rights under the Confrontation Clause. It was thus not alleged that a witness was not available because of a privilege, but rather that pre-trial access to certain information was barred, information which the defence thought might have been useful for cross-examination purposes. The Pennsylvania Supreme Court reversed the trial court's decision based on the U.S. Supreme Court's holding in *Davis v Alaska.*[219] In that case, the Supreme Court had had to decide whether or not the confidentiality of juvenile records had the effect that a defendant could not cross-examine a prosecution witness as to the fact that he had such a record. The Supreme Court had argued that:

> 'Serious damage to the strength of the State's case would have been a real possibility had petitioner been allowed to pursue this inquiry. In this setting we conclude that the right of confrontation is paramount to the State's policy of protecting a juvenile offender. Whatever temporary embarrassment might result to Green or his family by disclosure of his juvenile record - if the

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[218] 480 U.S. 39 (1987).
[219] 415 U.S. 308 (1974).

> prosecution insisted on using him to make its case - is outweighed by petitioner's right to probe into the influence of possible bias in the testimony of a crucial identification witness. ... The State's policy interest in protecting the confidentiality of a juvenile offender's record cannot require yielding of so vital a constitutional right as the effective cross-examination for bias of an adverse witness.'[220]

According to the Pennsylvania Supreme Court, it followed from *Davis* that a statutory privilege cannot be maintained when a defendant asserts a need, prior to trial, for the protected information to be used at trial to impeach or otherwise undermine a witness' testimony. The U.S. Supreme Court rejected this interpretation of its decision in *Davis* by arguing that:

> 'Ritchie argues that the failure to disclose information that might have made cross-examination more effective undermines the accuracy of the truth-finding process at trial. ... If we were to accept this broad interpretation of *Davis*, the effect would be to transform the Confrontation Clause into a constitutionally compelled rule of pre-trial discovery.'[221]

While the Court confirmed that the right to cross-examine includes the opportunity to show that a witness is biased, or that the testimony is exaggerated or unbelievable, the Court nevertheless argued that:

> 'The right to confrontation is a trial right, designed to prevent improper restrictions on the types of questions that defence counsel may ask during cross-examination. ... The ability to question adverse witnesses, however, does not include the power to require the pre-trial disclosure of any and all information that might be useful in contradicting unfavourable testimony.'[222]

It followed, therefore, that the Confrontation Clause was not violated by the withholding of the CYS file, and that it would only have been impermissible for the judge to have prevented Ritchie's lawyer from cross-examining the witness. In *US v Haworth*,[223] a case in which the defendants sought discovery of records of the psychotherapist who had examined the witness, the court similarly argued that defendants who equate their confrontation rights with a right to discover information that is clearly privileged are mistaken, as their confrontation rights permit them to cross-examine the witness fully regarding his/her treatment by the psychotherapist, but will not guarantee access to the psychotherapist's records. The court distinguished the case in which discovery was sought from that in

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[220] Ibid., at 319-320 per Justice Burger.
[221] *Pennsylvania v Ritchie* 480 U.S. 39, (1987) at 52 per Justice Powell.
[222] Ibid., at 52-53.
[223] 168 F.R.D. 660 (D.N.M. 1996), at 661-662 per Hansen, District Judge.

which defence counsel already had the evidence with which to impeach the witness, and held that in the latter case, the defendant's confrontation rights require that defence counsel may use that evidence. It can thus be seen that the Confrontation Clause does not help the defendant who is seeking access to privileged information by the means of pre-trial discovery, not even where the defendant alleges that the disclosure may be necessary for an effective cross-examination at a later trial.

Even where the defendant contends a violation of the Confrontation Clause because the right to cross-examination is restricted at trial, it is not at all clear that the courts will find a violation of the Sixth Amendment. In *Mills v Singletary*,[224] for example, a case in which a violation of confrontation rights under the Sixth Amendment was contended, as the trial court had allowed Ashley, a witness, to invoke the attorney-client privilege and had accordingly curtailed Ashley's cross-examination, the court rejected this allegation based on the following considerations:

> 'During cross-examination of Ashley, Mills' lawyer induced Ashley to admit that: (1) he changed his story of the events surrounding the murder, thereby implicating Mills, after Florida offered him a deal and deciding that "there was a chance of me getting out and starting a new life"; and (2) the deal that Florida offered Ashley gave him complete immunity from prosecution in the burglary and murder charges in exchange for his testimony against Mills. We hold that this cross-examination exposed Ashley's prior inconsistent statements and bargain with Florida to the extent that the jury could judge his credibility and Mills could argue effectively that Ashley's testimony was not credible. Mills' lawyer engaged in sufficient cross-examination, and the trial judge neither abused his discretion nor violated the Confrontation Clause in limiting the cross-examination to that which the attorney-client privilege did not protect.'[225]

The court's approach mainly seems to depend on the question of whether or not *effective* cross-examination will be possible without touching upon privileged information. Where, as in *Mills v Singletary,* effective cross-examination is not excluded by the restriction of cross-examination to unprivileged information, the defendant's confrontation rights are not violated. Other courts confirmed the view that the mere fact that access to a witness' medical records was denied does not impair a defendant's ability to cross-examine as long as the defendant was not restricted in cross-examination and was able to put before the jury the

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[224] 161 F.3d 1273 (11th Cir. 1998).
[225] Ibid., at 1288-1289 per Hatchett, Chief Judge, Edmondson and Black, Circuit Judges, Per Curiam.

psychological and behaviour problems, drug and alcohol abuse, and hospitalisation of the witness.[226] And in *State v Hanninen*,[227] the court emphasised that although a defendant has the right to present evidence in his own defence, he does not have a right to introduce evidence that is privileged, irrelevant or otherwise inadmissible. If, however, effective cross-examination depends on access to privileged information, then the rights under the Confrontation Clause seem to prevail. Thus, in *People v Adamski*,[228] where the defendant was convicted for sexual intercourse with his daughter and where the defendant's claim for privileged statements the victim had made to her counsellor had been denied, the court held that the complainant's prior inconsistent statements to her counsellor were admissible for impeachment despite the bar of the statutory privilege and that the failure of the trial court to allow the defendant to cross-examine the complainant with regard to her statement that the defendant had not acted inappropriately with her, denied the defendant his Sixth Amendment right of confrontation by limiting cross-examination. With regard to the apparent conflict between the right to privilege and the right of cross-examination, the court held that:

> 'It appears well settled as a matter of constitutional law that common-law or statutory privileges, even if purportedly absolute, may give way when in conflict with the constitutional right of cross-examination. ... The right of cross-examination is not without limit; neither the Confrontation Clause nor due process confers an unlimited right to admit all relevant evidence or cross-examine on any subject. ... Privileges impede the defendant's ability to present a defence by limiting the evidence available. Both this Court and our Supreme Court have not been hesitant to hold that confidential or privileged information must be disclosed where a defendant's right to effective cross-examination would otherwise be denied. ... In the present case, we recognise the important policy underlying the statutory psychologist-patient privilege ... . Weighing against this policy is defendant's interests in his liberty and receiving a fair trial. On its face, the privilege poses an absolute bar to the use of the complainant's statements for impeachment. ... We believe that the statute must yield to defendant's constitutional right of confrontation.'[229]

In *Re Doe*,[230] the court equally held that:

> 'Although appellant's psychiatric files contain material that squarely implicates his privacy interests, the balance in this case weighs overwhelmingly in favour

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[226] *U.S. v Skorniak* 59 F.3d 750 (8th Cir. 1995), at 756 per Hansen, Circuit Judge.
[227] 533 N.W. 2d 660 (Minn.App. 1995), at 661-662 per Amundson, Judge.
[228] 497 N.W.2d 546 (Mich.App. 1993).
[229] Ibid., at 549-550 per Wahls, Presiding Judge.
[230] 964 F.2d 1325 (2nd Cir. 1992).

> of allowing an inquiry into his history of mental illness. Appellant is not only the person who initiated the criminal investigation against Diamond, but also a witness whose credibility will be the central issue at trial. ... We agree ... that a preclusion of any inquiry into appellant's psychiatric history would violate the Confrontation Clause and vitiate any resulting conviction of Diamond.'[231]

Thus, while the Confrontation Clause does not guarantee unlimited access to privileged information merely because this information may be relevant, the interest in medical confidentiality is outweighed where without this information, effective cross-examination is not possible, the reason being that the defendant's interests at stake, i.e. the interest in liberty and in receiving a fair trial, are regarded as more important than the interest in medical confidentiality. This view was also confirmed in *United States v Lindstrom*,[232] where the court held that the interests behind the protection of medical confidentiality could not outweigh the defendant's right to examine and use the psychiatric information contained in the witness' medical files to attack the credibility of a key government witness. The court argued that the desire to spare a witness embarrassment which disclosure of medical records might entail was insufficient justification for withholding such records from criminal defendants on trial for their liberty. Thus, the defendant's right to present evidence and to cross-examine witnesses may in some cases outweigh a privilege, but only where the probative value of the privileged evidence was considered and found sufficient,[233] and where without disclosure, important interests of the defendant would be impaired.

(b) Compulsory Process

Another allegation frequently made by defendants if denied access to privileged information is that the Compulsory Process Clause of the Sixth Amendment was violated thereby. Under the Compulsory Process Clause, criminal defendants have the right to the government's assistance in compelling the attendance of favourable witnesses at trial and the right to put before a jury evidence that might influence the determination of guilt. Thus, the information here is sought either for the purpose of identifying potential witnesses, or for the purpose of its

[231] Ibid., at 1329 per Winter, Circuit Judge.
[232] 698 F.2d 1154 (11th Cir. 1983), at 1167.
[233] See, for example, *People v Foggy* 521 N.E.2d 86 (Ill. 1988), at 92 per Miller, Justice.

presentation to the jury as part of the defence. In *Pennsylvania v Ritchie*,[234] the Supreme Court analysed this problem in some detail. The Pennsylvania Supreme Court had concluded that the right of compulsory process includes the right to have the state's assistance in uncovering arguably useful information, without regard to the existence of a state-created restriction – in that case the confidentiality of the files. The Court argued that while it had never squarely held that the Compulsory Process Clause guaranteed the right to discover the identity of witnesses, or to require the government to produce exculpatory evidence, it was well settled that the government has the obligation to turn over evidence in its possession that is both favourable to the accused and material to guilt or punishment. The Court then balanced the competing interests and held:

> 'Although we recognise that the public interest in protecting this type of sensitive information is strong, we do not agree that this interest necessarily prevents disclosure in all circumstances. This is not a case where a state statute grants CYS the absolute authority to shield its files from all eyes. ... Rather, the Pennsylvania law provides that the information shall be disclosed in certain circumstances including when CYS is directed to do so by court order. ... Given that the Pennsylvania Legislature contemplated *some* use of CYS records in judicial proceedings, we cannot conclude that the statute prevents all disclosure in criminal prosecutions. In the absence of any apparent state policy to the contrary, we therefore have no reason to believe that relevant information would not be disclosed when a court of competent jurisdiction determines that the information is "material" to the defence of the accused. ... Ritchie is entitled to have the CYS file reviewed by the trial court to determine whether it contains information that probably would have changed the outcome of his trial.'[235]

However, the Court rejected the defendant's claim that his attorney should be given access to the files to search for exculpatory evidence. Rather:

> 'We find that Ritchie's interest (as well as that of the Commonwealth) in ensuring a fair trial can be protected fully by requiring that the CYS files be submitted only to the trial court for *in camera* review. ... To allow full disclosure to defence counsel in this type of case would sacrifice unnecessarily the Commonwealth's compelling interest in protecting its child-abuse information. If the CYS records were made available to defendants, even through counsel, it could have seriously adverse effects on Pennsylvania's efforts to uncover and treat abuse. Child abuse is one of the most difficult crimes to detect and prosecute, in large part because there often are no witnesses except the victim. A child's feelings of vulnerability and guilt and his or her unwillingness to come forward are particularly acute when the abuser is a parent. It therefore is essential that the child have a state-designated person

[234] 480 U.S. 39 (1987).
[235] Ibid., at 57-58 per Justice Powell.

> to whom he may turn, and to do so with the assurance of confidentiality. Relatives and neighbours who suspect abuse also will be more willing to come forward if they know that their identities will be protected. Recognising this, the Commonwealth - like all other States - has made a commendable effort to assure victims and witnesses that they may speak to the CYS counsellors without fear of general disclosure. The Commonwealth's purpose would be frustrated if this confidential material had to be disclosed upon demand to a defendant charged with criminal child abuse, simply because a trial court may not recognise exculpatory evidence. ... An *in camera* review by the trial court will serve Ritchie's interest without destroying the Commonwealth's need to protect the confidentiality of those involved in child-abuse investigations.'[236]

In *Ritchie*, the Supreme Court was thus of the opinion that the Compulsory Process Clause of the Sixth Amendment requires that all information, even if privileged, must be made available to the defendant if it is material to the defence, and that the interest in confidentiality is sufficiently protected if the confidential information is inspected by the trial court *in camera*. The materiality standard developed in *Ritchie* has since been adopted by other courts as providing a workable balance between the state's interest in the confidentiality of certain information and a defendant's potential need for such information. In *State v Speese*,[237] for example, the court adopted the approach outlined in *Ritchie* and held that a defendant who is aware of specific information in a confidential file 'is free to request it directly from the court, and to argue in favour of its materiality.' It should be noted, however, that the courts did not provide detailed reasons for the decision that the defendant's compulsory process rights outweigh medical confidentiality as soon as it can be demonstrated that the information is material to the defence. However, this test only seems to apply to privileged information that is already in the hands of the prosecution.

In *U.S. v Doyle*,[238] where the court had to weigh the defendant's needs for disclosure against the victim's psychotherapist-patient privilege, the court disagreed with the defendant's view that his Sixth Amendment right to compulsory process outweighed the victim's right to confidentiality:

> 'If such were the law, what privilege could survive a defendant's assertion of evidentiary needs? Lawyers, spouses, even priests, presumably, could be ordered to cough up their notes or memories about the most private and

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[236] Ibid., at 60-61.

[237] *State v Speese* 528 N.W.2d 63 (Wis.App. 1995), at 69 per Gartzke, Presiding Judge.

[238] 1 F.Supp.2d 1187 (D. Or. 1998).

> confidential communications in the face of a subpoena from a defendant in a criminal case.'[239]

It must be noted, however, that the court relied on the Supreme Courts decision in *Jaffee v Redmont*[240] where the Court had rejected a balancing test based on the relative importance of the patient's interest in privacy and the evidentiary need for disclosure in a given case. This seems to suggest that the holding in *U.S. v Doyle* is limited to cases of psychotherapist-patient privilege and that the materiality test developed in *Ritchie* will only be applied to the conflict between defence rights and medical privilege, but not where the defendant's compulsory process rights clash with privileged information stemming from a psychotherapist-patient relationship.

(c) Due process

Some courts took the stance that the conflict between medical or psychotherapist-patient privilege, on the one hand, and the defendant's evidentiary needs, on the other hand, rather than requiring a Sixth Amendment analysis, was more appropriately dealt with by constitutional due process considerations. In *State v Knutson*,[241] for example, the court argued that the analysis of a discovery issue should start from the premise that due process affords a criminal defendant a right of access to evidence that is both favourable to the accused and material to guilt and punishment, if there is a reasonable probability that, had the evidence been disclosed to the defence, the result of the proceeding would have been different. And in *State Ex Rel. Romley v Superior Court*,[242] the court held that as due process of law was the primary and indispensable foundation of individual freedom, in case of conflict between due process rights of the accused and the rights of the victim due process was the superior right. Therefore, when the court is of the opinion that a victim's medical records are exculpatory and are essential to the presentation of the defendant's theory of the case, or necessary for impeachment of the victim, then the defendant's due process right to a fundamentally fair trial overcomes the statutory physician-patient privilege.

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[239] Ibid., at 1191 per Coffin, U.S. Magistrates Judge.
[240] 518 U.S. 1 (1996).
[241] 854 P.2d 617 (Wash.1993), at 620-622 per Brachtenbach, Justice.
[242] 836 P.2d 445 (Ariz. App. Div.1 1992), at 452-453 per Grant, Presiding Judge.

(d) *In camera* review

It can thus be seen that some defence rights of the accused are protected under the Confrontation and Compulsory Process Clauses of the Sixth Amendment and that, in addition, defence rights are more generally protected by the constitutional principle of due process of law. Whatever the constitutional principle on which the resolution of the conflict between defence rights, on the one hand, and medical privilege, on the other hand, is based, most courts decided that while defence rights principally outweigh the interests protected by medical privilege, as the defendant's liberty may be at stake, it did not necessarily follow that a defendant should therefore be given access to all confidential medical and/or psychological files of the witness. Rather, most courts argued that a balancing test must be performed in each case to decide how the conflicting interests can best be protected. While the sensitivity of the information seems to weigh in the balance, on the part of the defendant it must be shown that the information sought is relevant and material for the defence. This, of course, raises the question of how the defendant can be able to meet this requirement before he/she is given access to the information. The solution favoured by most courts is that of an *in camera* inspection of the confidential records by the trial court in order to determine whether or not the files contain information that meets the materiality and relevancy test. However, does this mean that upon the request of the defendant, a court will rummage through all confidential files of a witness to see whether there is anything of interest to the defence to be found therein? Some courts seem to have adopted such a broad approach to *in camera* inspections of confidential and privileged documents. In *Gale v State*,[243] for example, a case in which a defendant had issued subpoenas for various records in which the state asserted a privilege, it was held that the court would have to review the records *in camera* for material evidence, focusing on the defendant's ability to gather such evidence from other sources, and on how the privileged evidence may relate to the defendant's theory of the case. Other courts have rejected such a wide review of privileged files by the courts and rather required the defendant to make some preliminary showing that the information contained in those documents is material to his/her

[243] 792 P.2d 570 (Wyo. 1990), at 581 per Golden, Justice.

defence.[244] According to the court in *State v Shiffra,*[245] this requirement would be met under the following circumstances:

> 'We conclude that Shiffra has met the burden of making a preliminary showing of materiality. He presented ample evidence during the hearing on his discovery motion that Pamela's psychiatric difficulties might affect both her ability to accurately perceive events and her ability to relate the truth. These difficulties are relevant because they directly affect Pamela's credibility. They also bear directly on Shiffra's defence of consent. Shiffra is entitled to an *in camera* inspection of the records.'[246]

In *Com. v Fuller,*[247] the court stressed that it did not intend to establish a standard and protocol that would result in virtually automatic *in camera* inspection for an entire class of extremely private and sensitive privileged material, as to do so would make the privilege no privilege at all, and would substitute an unwarranted judicial abridgement of a clearly stated legislative goal. In the court's opinion, *in camera* review, while less intrusive than public disclosure or disclosure to a defendant's attorney, is nonetheless a substantial invasion of the privacy of the witness concerned. A judge should therefore undertake an *in camera* review of privileged records only when a defendant's motion for production of the records has demonstrated a good faith, specific, and reasonable basis for believing that the records will contain exculpatory evidence which is relevant and material to the issue of the defendant's guilt. Thus, a privilege should be abrogated only in cases in which there is a reasonable risk that non-disclosure may result in an erroneous conviction. Consequently, even an *in camera* inspection of privileged records may be denied by the courts without violating the Confrontation Clause if the defendant does not specify what information relevant for impeachment purposes the privileged records are thought to contain. In *US v Doyle*[248] the court denied the defendant's request that the court examine the contents of the confidential files *in camera* in order to determine if there was anything therein that could possibly be of assistance to the defendant regardless of any materiality showing, as the court took the stance that the privilege was absolute and that the court's review of the files would itself be a breach of the privilege.

Some courts only perform an *in camera* review of confidential files of a witness if

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[244] *State v Speese* 528 N.W.2d 63 (Wis.App. 1995), at 69 per Gartzke, Presiding Judge.
[245] 499 N.W.2d 719 (Wis.App. 1993).
[246] Ibid., at 724 per Brown, Judge.
[247] 667 N.E.2d 847 (Mass. 1996), at 853-855 per Greaney, Judge.
[248] 1 F.Supp.2d 1187, (D. Or. 1998), per Coffin, U.S. Magistrates Judge.

the witness has consented to this inspection.[249] In *State v Grant*,[250] the court summarised its position as follows:

> 'In some instances, a patient's psychiatric privilege must give way to a criminal defendant's constitutional right to reveal to the jury facts about a witness' mental condition that may reasonably affect that witness' credibility. ... We have therefore directed trial courts to engage in a specific procedure designed to accommodate this inherent tension. "If, for the purposes of cross-examination, a defendant believes that certain privileged records would disclose information especially probative of a witness' ability to comprehend, know, or correctly relate the truth, he may ... make a preliminary showing that 'there is reasonable ground to believe' that the failure to produce the records would likely impair his right to impeach the witness." ... If in the trial court's judgment the defendant successfully makes this showing, the state must then obtain the witness' permission for the court to inspect the records *in camera*.'[251]

It can thus be seen that the courts adopt different approaches with regard to the question of an *in camera* inspection of privileged records. While some courts will examine such records upon the request of the defence without imposing any further conditions, other courts require materiality showings before reviewing such files. The approach largely seems to depend on the court's attitude towards confidentiality. If a court thinks that confidentiality is not affected by *in camera* review, it will be more willing to inspect confidential files than a court that is of the opinion that even an *in camera* review affects the patient's privacy concerns.

The question remains of what should be the consequence if upon an *in camera* inspection the trial court finds that the confidential records do in fact contain evidence material to the defence. Some courts take the stance that in such a case, the defence must be given access to that information, as defence rights will then prevail over any confidentiality interests.[252] Other courts, however, have argued differently and held that in such a situation, the trial court must seek the witness' consent for a disclosure of the relevant parts of the files to the defence. If he/she refuses to do so, his/her testimony shall be stricken and the trial court is ordered to make a redetermination of the respondents adjudications and dispositions based upon the remaining evidence at the original hearing.[253] The courts are thus of the

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[249] See, for example, *Re Robert H* 509 A.2d 475 (Conn. 1986), at 482- 485 per Arthur H. Healey, Judge.

[250] 637 A.2d 1116 (Conn. App. 1994).

[251] Ibid., at 1121-1122 per Frederick A. Freedman, Judge.

[252] *State Ex Rel. Romley v Superior Court* 836 P.2d 445 (Ariz. App. Div.1 1992), at 452-453 per Grant, Presiding Judge.

[253] *Re Robert H* 509 A.2d 475 (Conn. 1986), at 482- 485 per Arthur H. Healey, Judge; *State v*

opinion that the privilege bars them from ordering the release of confidential records without the patient's consent. In such a situation, the only method of protecting the defendant's right to a fair trial is to suppress the witness' testimony.[254] In *State v Speese*,[255] where the disclosure of the witness' psychiatric records for impeachment purposes was denied and where the witness had already testified, the court ordered a new trial without the testimony of that witness, as otherwise the constitutional defence rights would be undermined.

The witness whose confidential records are at stake thus has different possibilities to influence the disclosure of his/her medical records. First, in some States it is up to the patient to decide whether or not the court can inspect the confidential records *in camera*. Secondly, where the patient has given such consent and the court has found relevant passages in those records, the patient's consent is needed for a further disclosure of the confidential material to the defence. It is submitted that this approach provides a good balance of the interests involved. The best possibility to protect the patient's confidentiality interests is to give the patient the choice as to whether or not the information is disclosed to the defence. Even where the defence is thus denied access to relevant confidential records, however, defence rights are not seriously affected if the prosecution can then also not rely on that evidence. While this approach affects the public interest in criminal prosecution, this is the price the legislators that introduced medical privilege were willing to pay.

(e) Evidence favourable to the defence

The situation may be different, though, where the defendant wants to present privileged evidence to prove his/her innocence or to demonstrate mitigating factors. Such cases which would fall under the Compulsory Process Clause of the Sixth Amendment as well as under the constitutional principle of due process, cannot be resolved according to the principles discussed above, as for example striking out the witness' testimony if he/she refuses to give consent to the disclosure of confidential information would not help the defendant. It has been

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Grant 637 A.2d 1116 (Conn. App. 1994), at 1121-1122 per Frederick A. Freedman, Judge; *State v Solberg* 553 N.W.2d 842 (Wis. App. 1996), at 844 per Dykman, Judge.

[254] *State v Shiffra* 499 N.W.2d 719 (Wis. App. 1993), at 721 and 724 per Brown, Judge.

[255] 528 N.W.2d 63 (Wis. App. 1995), at 71 per Gartzke, Presiding Judge.

argued that a criminal defendant should be permitted access to medical records when he/she needs the information contained therein to mount his/her direct defence.[256] This seems particularly important where the privileged evidence could demonstrate the accused's innocence. Even where the witness is a physician who gained his/her knowledge of the accused's innocence through a patient, the accused's fundamental right to present his/her defence and to prove his/her innocence is considered as more important than the patient's right to preserve his/her medical secrets, the physician's concern for his/her professional responsibility, or evidentiary rules designed to encourage the seeking of medical advice and treatment.[257] It can thus be seen that in cases in which the defendant would need access to privileged information to present his/her defence or to prove his/her innocence, the defence rights are regarded as overriding the interest in confidentiality.

An alternative approach would be in such a case to dismiss the charge if the accused is inhibited by a privilege from adducing favourable evidence.[258] As the argument goes, even though the legislator and not the prosecution is responsible for the existence of the privilege, they are both representatives of the same state and it is therefore fair to shift the burden of a state created privilege on the prosecution rather than on the defence. However, it was suggested that this remedy should only be available to the defendant who meets a high standard of evidentiary need and can demonstrate a probability that the evidence would be exculpatory.[259] This raises the problem of where to draw the line. In the words of Hill:

> 'Shall the defendant go free because the person he accuses of being the true criminal has a priest or spouse who is *likely* to know something that may be exculpatory, but who cannot be questioned because of a testimonial privilege?'[260]

Another possibility would be to reduce the remedy to situations in which the witness can demonstrate a likelihood of serious injury resulting from the disclosure of privileged information.

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[256] Oppenheim, *The Medical Record as Evidence*, at 705.
[257] See Thomas-Fishburn, (1990) 61 University of Colorado Law Review, at 201-202, for the comparable situation of the attorney-client privilege.
[258] Weisberg, (1978) 30 Stanford Law Review, at 982-984.
[259] See for a detailed discussion Hill, (1980) 80 Columbia Law Rev., at 1189.
[260] Ibid.

With regard to the question of whether or not the physician should be allowed to disclose confidential patient information if he/she is accused in criminal proceedings and that information could assist his/her defence, it has been argued that any professional who is bound by confidentiality has the right of 'self defence' and that a patient who makes allegations against the physician impliedly waives the privilege thereby.[261]

(7) Crime prevention

The conflict between medical confidentiality and crime prevention has not received much attention by American courts. Those cases that touch upon the issue usually do not directly focus on considerations of crime prevention, but rather on considerations of how to avert risks from third parties. The underlying problem is the same, as in most cases the infliction of harm to third parties will amount to a criminal offence. This conflict is normally discussed in the context of tort law rather than criminal law, and the debate is not so much concerned with the question of whether or not the physician is justified when disclosing confidential patient information to avert a risk from a third party. Instead, the conflict is mostly discussed as a conflict between competing duties, i.e. the duty to maintain medical confidentiality and the duty to warn the potential victim. As this work concentrates on the question of exceptions to the obligation to maintain medical confidentiality, the analysis will not concentrate on the particular problems raised by an obligation to disclose as opposed to an authorisation to disclose, but will instead focus on the reasons why confidentiality is overridden.

In the leading case of *Tarasoff v Regents of the University of California*,[262] a patient had told his psychotherapist that he intended to kill Tatiana Tarasoff. Upon the psychotherapist's request, the campus police briefly detained the patient but released him when he appeared rational, without further action being taken. Two months later, the patient killed Tatiana Tarasoff and her parents brought an action in tort against the psychotherapist. The court decided that when a psychotherapist determines or should determine that a patient poses a serious danger of violence to another, the psychotherapist is under an obligation to use reasonable care to

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[261] Slovenko, *Psychotherapy and Confidentiality*, at 252.
[262] 17 C.3d 425 (Cal. Sup. Ct. 1976).

protect the intended victim against such danger, either by warning the intended victim, by informing the police or by taking other steps that are reasonably necessary to avert the risk. The court recognised the interest in the confidentiality of the psychotherapist-patient relationship that might be affected by such a disclosure, but argued that:

> 'Against this interest, however, we must weigh the public interest in safety from violent assault. ... We realise that the open and confidential character of psychotherapeutic dialogue encourages patients to express threats of violence, few of which are ever executed. Certainly a therapist should not be encouraged routinely to reveal such threats; such disclosures could seriously disrupt the patient's relationship with his therapist and with the persons threatened. To the contrary, the therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger. ... The revelation of communication under the above circumstances is not a breach of trust ... . We conclude that the public policy favouring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins. ... If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify concealment.'[263]

With regard to the question of whether or not the physician is justified when disclosing confidential patient information for the purpose of crime prevention, it can thus be concluded that the interest in medical confidentiality is outweighed where disclosure is necessary to avert a risk from another. This holding raises several problems. First, the decision does not specify the type of risk that justifies or even mandates disclosure. In the *Tarasoff* case, there was a risk to the life of the victim, but it is unclear whether or not other risks, for example the risk of a minor physical injury, or a risk to property interests would equally justify disclosure. Another problem is that of risk assessment. At what point will the physician's obligation shift from an obligation of confidentiality to an obligation to warn? Billings, Chief Justice, argued in a dissent to *Peck v Counseling Service of Addison County*,[264] that it is impossible to predict future violent behaviour and accordingly rejected a duty to warn. Others argue that while the assessment of dangerousness is difficult, it is not impossible, given that psychiatrists have to do

[263] Ibid., at 440-442, per Tobriner, Justice.
[264] 499 A.2d 422 (Vt. 1985), at 427-428.

just that when certifying individuals for commitment to a hospital because of a danger to themselves or to others.[265] Another question is whether or not the risk has to be imminent. Given that in *Tarasoff*, the threat was only carried out two months after the counselling session, the court seems to have rejected this requirement. However, without such a requirement it is difficult to narrow down the cases in which disclosure is justified or even mandated, as it could then be argued that the mere threat that a patient might one day be violent towards a third party would be sufficient to justify disclosure. If that were the case, how can the danger be averted by disclosure? It is submitted that had Tatiana Tarasoff been told that the patient uttered the threat to kill her, the protective effect of the physician's disclosure would have been rather limited. In the recent case of *US v Glass*,[266] it has been held that disclosure could only be required if the threat was serious when it was uttered, and if disclosure was the only means to avert the danger. Can it really be said that those requirements were met in the *Tarasoff* case?

However, the holding in *Tarasoff* was since accepted by many courts,[267] and the main problem discussed in the aftermath of *Tarasoff* was whether or not the duty to warn was only triggered if the third party at risk was identifiable. In *Gammill v United States*,[268] the court stressed that for a duty to warn to apply the physician must be aware of the specific risks to specific persons. And in *Thompson v County of Alameda*,[269] the court held that no duty to warn arises where the patient is potentially dangerous to a whole community, but where no identifiable victims exist.

The reaction of commentators to this case-law was far from unanimous. While it was welcomed by some, at least in cases of a danger to the life of others, as life is regarded as more important than the interests of the patient that might be affected by disclosure,[270] others voiced concern. It was feared, for example, that in the light of such a duty psychotherapists and physicians might be reluctant to explore

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[265] Bok, *Secrets*, at 128; Slovenko, *Psychotherapy and Confidentiality*, at 300-301.
[266] 133 F.3d 1356 (10th Cir. 1998), at 1359-1360 per Porfilio, Circuit Judge.
[267] See, for example, *McIntosh v Milano* 168 N.J.Super. 466 (1979), at 489-490; *Peck v Counseling Service of Addison County* 499 A.2d 422 (Vt. 1985), at 426; *Petersen v State* 671 P.2d 230 (Wash. 1983), at 237; but see, on the other hand, *Hasenai v U.S.* 541 F.Supp. 999 (D. Md. 1982), in which the court rejected the *Tarasoff* doctrine.
[268] 727 F.2d 950 (10th Cir. 1984), at 954.
[269] 614 P.2d 728 (Cal. Sup. Ct. 1980), at 734.
[270] Watson, (1992) 71 Nebraska Law Review, at 1133-1144.

the possibility of dangers to others if a duty to warn is the consequence. If this were the case, then a duty to warn might increase rather than reduce the danger to society. It has been suggested that the potential harm such a duty would inflict upon the physician-patient or psychotherapist-patient relationship might be averted if the doctor informed the patient at the outset that such a duty to warn third parties exists. It is argued that patient autonomy could thus be protected, as the patient will then know that the physician or psychotherapist will disclose this information, and, if he/she still reveals such information, this is interpreted as informed consent to the physician's disclosure.[271] This argument, however, is not very convincing. First of all, patient and therapist may have different perceptions of what constitutes a real risk to a third party and what, on the other hand, is just an expression of aggressive tendencies that will never be translated into action. Also, medical confidentiality is protected to spare the patient the choice between seeking health care at the risk of potential disclosure of confidential information, or preserving his/her secrets by not seeking medical treatment, as both alternatives undermine the patient's autonomy. The patient's autonomy can only be protected if the patient's consent is sought in every situation in which the physician wants to disclose confidential patient information. A different question is whether patient autonomy deserves protection where it conflicts with important interests of third parties, particularly where these interests are endangered by the patient him/herself, and many would argue that in such a case, the patient's autonomy must yield.[272]

In some States, a statutory duty to warn was introduced. In Louisiana, for example, psychiatrists have a duty to warn when a patient has communicated an immediate threat of physical violence against a clearly identified victim.[273]

2.3. Summary and conclusion

Given the difference in approach to almost all questions raised in this chapter throughout the U.S., to present a conclusion is not an easy task. First, it is important to stress that while medical confidentiality is protected by the U.S. Constitution, this protection is not extended to medical privilege, i.e. the

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[271] Hermann, Gagliano, (1989) 48 Maryland Law Review, at 75.
[272] See, for example, Bok, *Secrets*, at 128.
[273] La. Rev. Stat. Ann. 9:2800.2(A) (West Supp. 1990).

protection of medical confidentiality in judicial proceedings is not mandatory under the tenets of the Constitution. It is rather left to the States whether and to what extent to recognise medical privilege.

At federal level, no statutory medical privilege exists, and the relevant provision of FRE 501 was interpreted so as not to grant a medical privilege in federal proceedings. A statutory federal psychotherapist-patient privilege does not exist, either, but some federal courts as well as recently the U.S. Supreme Court decided that such a privilege should be recognised in federal courts, given the particular sensitivity of the psychotherapist-patient privilege. This approach partly rests on utilitarian considerations. It has been argued that the benefits of that privilege for society are great, as without its recognition, the mental health of the population could not be preserved. At the same time, the loss of information was said to be negligible, as without privilege, no sensitive information would be imparted in the psychotherapist and such information would consequently not be available through the psychotherapist's testimony.

At State level, the main distinction is that between States with and States without privilege statutes. In States without privilege statutes, the interests of justice are regarded as more important than the interests in medical confidentiality, so that in case of a conflict, medical confidentiality must yield to the interests of justice. In States with privilege statutes, the situation is more complex. Privilege statutes are not regarded as absolute, but are rather subject to statutory and common law exceptions. While some privilege statutes are not applicable to criminal proceedings, others contain exceptions for certain criminal offences. Surprisingly, some courts have restricted privilege statutes that do not contain any such exceptions so as to be applicable in criminal proceedings only subject to a balancing exercise, an opinion which circumvents the intention behind privilege statutes.

With regard to the conflict between medical confidentiality and the interest in criminal prosecution, in States without privilege statutes, the interest in criminal prosecution prevails, while in States with privilege statutes, the legislator decided the conflict in favour of medical confidentiality. With regard to the search for and seizure of confidential patient records, the most far-reaching protection is provided by privilege statutes which mostly protect medical records from

disclosure. In addition, some limited protection is available under the Fourth Amendment to the U.S. Constitution, but courts normally do not find searches that are based on search warrants unreasonable. In States without privilege statutes, therefore, patient records can be seized without a violation of the Constitution as long as a search warrant was first obtained.

In some specific cases, even in States with privilege statutes the conflict between medical confidentiality, on the one hand, and the interest in criminal prosecution, on the other hand, has been decided in favour of the latter. For child abuse cases, it should be noted, however, that while all States have exceptions to their privilege statutes for this particular situation, many courts have argued that the exception exists not in the interest of criminal prosecution, but rather in the interest of protecting children from further abuse. Another situation in which exceptions often apply is that of prosecuting drunk-driving offences. This exception, which is recognised in some States with privilege statutes, is aimed at the prosecution of offences that are regarded as dangerous for society as a whole and the prosecution of which largely depends on medical evidence. The exception for investigations against and the prosecution of physicians is partly based on similar considerations, as particularly fraud regarding the fees for medical treatment can only rarely be detected without resort to confidential medical records. However, as the investigations are here not directed against the patient, some courts try to optimise the interests at stake by restricting disclosure to those parts of medical records that are relevant for the investigation, or by requiring the patient's consent before the records can be used for that purpose. It is interesting to state that in the case of drunk-driving offences and of investigations against physicians, the exceptions seems to be based mainly on pragmatic reasons, as they are not justified by the overriding importance of the competing interests, but rather by the difficulties in prosecuting certain offences without access to medical evidence.

The conflict that has received most attention in the academic and judicial discussion is that between medical confidentiality and defence rights. Defence rights are guaranteed by the Confrontation and the Compulsory Process Clauses of the Sixth Amendment as well as by due process considerations. It can be seen that, in principle, defence rights seem to outweigh confidentiality, as the individual's liberty is at stake. However, this does not mean that otherwise privileged information is automatically available for defence purposes. Rather,

access to privileged information is limited to situations in which effective cross-examination would otherwise be impossible, or cases in which the information is material to the defence. Where the defence meets the materiality requirements, this will only lead to an *in camera* inspection of the relevant material by the court, and some courts decline even *in camera* review without the patient's consent. If the court, upon *in camera* inspection, finds that the material is in fact relevant for defence purposes, some courts make the material available to the defence. Other courts, however, will do so only with the patient's consent. If the patient refuses to consent, the interests of the defence are safeguarded by striking the evidence altogether or, where this is impossible, by ordering a re-trial. No case-law exists with regard to the question of whether or not the same principles should be applied to the situation that the defendant seeks access to the information in order to demonstrate his/her innocence or to present favourable evidence. Some commentators suggest that in such a case, defence rights outweigh confidentiality interests, while others argue that the charges against the defendant should be dropped if the patient refuses to give consent to the disclosure of confidential medical information.

With regard to crime prevention, American courts focus on the aversion of a risk to third parties and hold that a physician is not only authorised to disclose information, but is even under a duty to do so, where the disclosure is necessary to avert a risk from an identifiable third party. This approach raises many problems, the most significant of which is that of risk assessment.

The situation in the U.S. gives a good indication that even in the light of a constitutional guarantee of privacy interests, the state has broad leeway in shaping the scope and limits of the protection of medical confidentiality, and is, in particular, not prevented from giving important state interests precedence over the privacy rights of the individual.

Chapter 8 - Medical confidentiality and medical privilege from a comparative perspective

The results presented in the preceding chapters show that in all of the legal systems that have been examined, the protection of medical confidentiality raises problems which are sometimes difficult to resolve. The potential conflicts between medical confidentiality, on the one hand, and the interests in criminal prosecution, defence rights and crime prevention, on the other, cause particularly difficult problems shared by all legal systems. The resolution of conflicts arising in this context requires value judgments to be made and must, therefore, be approached with caution, as convincing criteria to decide difficult cases are frequently lacking. As the constraints and conditions existing in each legal system will necessarily narrow down domestic perceptions of the problems and possible solutions, a comparative study may help to broaden the perspective by demonstrating different ways of identifying and resolving problems. A comparative analysis will be used as a tool to extract general principles from the different approaches in order to develop workable, consistent and morally justified criteria for the resolution of these conflicts. The attitudes of different legal systems towards medical confidentiality will also be compared at a general level to see which factors might influence the different approaches and whether and how fundamental differences between the legal systems will limit the transferability of principles and solutions from one legal system to another. Of course, a comparative analysis can only be of limited practical value. Its purpose is not to propose one universally valid solution to a given problem which should then be adopted by all other systems. After all, different legal systems start from completely different premises, and have considerably different legal as well as the cultural traditions. Accordingly, a solution which may be totally compelling for one legal system may be unsuitable for adoption by another legal system.

1. General reflections

This detailed examination of four different systems has brought to light many similarities as well as many differences. It is common ground in all legal systems that medical confidentiality is a principle worth protecting. However, every legal system has developed its own ways of guaranteeing such protection. While

constitutional protection of medical confidentiality plays an important role both in Germany and the U.S., it is of only minor significance in France, and does not exist in the UK. Neither the German,[1] nor the U.S.[2] Constitution require a decision in favour of medical confidentiality in case of a conflict, and many States in the U.S. do not recognise medical privilege. Moreover, in the U.S. with its constitutional protection of privacy as a fundamental right, courts only protect medical confidentiality when in conflict with important public interests where this protection is required by statute. In *Z v Finland,*[3] the European Court of Human Rights similarly decided that despite the protection of the individual's private life under Art.8 ECHR, States are free to accord overriding importance to competing state interests. In France, on the other hand, medical confidentiality and medical privilege receive extensive protection which is mainly achieved by means of ordinary law. It follows that the existence of a constitutional guarantee of medical confidentiality is not decisive for the scope of protection accorded to medical confidentiality, and that the protection of privacy by ordinary statutes is more important than constitutional protection.

Constitutional protection of an interest indicates its fundamental significance. However, this is only one way of expressing a principle, and not the only way to do so. Particularly where the interests conflicting with a constitutional principle are of equal constitutional rank, as in the case of conflicts between medical confidentiality and the interests behind criminal prosecution, defence rights and crime prevention, constitutional protection would not automatically afford medical confidentiality overriding status. In the U.S. as well as in Germany, constitutional protection nevertheless plays an important role. Reference to constitutional principles is made both by the legislators and the courts when guaranteeing or even extending the protection of medical confidentiality, particularly where other interests are thereby impaired. However, while constitutional principles can thus deliver valid arguments supporting a protection of medical confidentiality and facilitating the introduction of medical privilege, the protection through ordinary law is far more influential in the context of

[1] See BVerfGE 33, 367, 383 (1972) regarding a social worker privilege.
[2] See, for example, *Felber v Foote* 321 F.Supp. 85 (D. Conn. 1970), at 87; *Pagano v Oroville Hosp.* 145 F.R.D. 683 (E.D.Cal. 1993), per Hollows, U.S. Magistrate Judge; *State v Beatty* 770 S.W.2d 387 (Mo.App. 1989), at 391 per Greene J; *State v Boehme* 430 P.2d 527 (Wash. 1967), per Hamilton, Judge.
[3] (1998) 25 E.H.R.R. 371.

specific conflict resolution, as ordinary legislation provides the main point of reference for the courts. With regard to the potential effect of the Human Rights Act 1998 on the protection of medical confidentiality in the UK, it follows that even though the Act for the first time recognises a general right to privacy, it will not in itself lead to dramatic changes in the legal protection of medical confidentiality, and will not require a recognition of medical privilege.

All four legal systems have in common that medical confidentiality is, in principle, protected by ordinary law, and that private law remedies are available for a breach of medical confidentiality. In none of the systems is this protection expressly guaranteed by statute. Rather, courts in all systems have to apply general legal principles to the specific situation of a breach of medical confidentiality by the physician. In Germany, France, and partly also in the U.S., the physician-patient relationship is based on a contract so that a breach of medical confidentiality would amount to a breach of contract, giving rise to a claim for compensation. Where no such contract exists between patient and physician, courts in all jurisdictions have not hesitated to provide other remedies. Thus, in Germany, a breach of medical confidentiality is actionable as a tort under s.823(1) Civil Code, and in France, the same result is reached pursuant to Art.1382 Civil Code. In the U.S., courts have awarded compensation under tort law[4] or for breach of a fiduciary duty.[5] English courts, absent a general action for a breach of privacy, have developed a common law duty to maintain confidentiality, the contravention of which gives rise to a claim for compensation.[6] It can thus be seen that regardless of conceptual differences, in all legal systems the courts have recognised the need to protect medical confidentiality under private law. The existence or rejection of general privacy protection does not affect this outcome.

With regard to the scope of protection medical confidentiality enjoys, France, Germany, the UK and some U.S. States have adopted widely similar approaches, even though the means of protection differ. Medical confidentiality covers not only what the patient expressly confides in the physician, but also all observations

[4] See, for, example, *McCormick v England* 494 S.E.2d 431 (S.C.App. 1997), at 432-438 per Anderson, Judge.
[5] *Petrillo v Syntex Laboratories, Inc* 499 N.E.2d 952 (Ill.App.1 Dist. 1986), at 961 per Linn, Presiding Justice; *Brandt v Medical Defence Associates* 856 S.W.2d 667 (Mo.banc 1993), at 470 per Thomas, Judge.
[6] *Attorney General v Guardian Newspapers Ltd and others* (2) [1988] 3 All ER 545.

the physician makes in connection with the physician-patient relationship. While in Germany, this result is reached by the express wording of s.203 Criminal Code, and some U.S. privilege statutes contain express provisions to this effect, the same result has been reached in France, the UK and some U.S. States, either by judicial interpretation of statutes (France and the U.S.), or by interpreting the scope of the common law duty to maintain medical confidentiality (UK). However, some U.S. courts have given their privilege statutes a very narrow meaning when holding that communication protected by a privilege statute is limited to oral communication.[7] The similarities of the outcome in Germany, France, the UK and some U.S. States confirm the view that differences in legal method and the question of whether medical confidentiality is mainly protected by constitutional law, criminal law, or private law do not have a great impact on the scope of protection of medical confidentiality.

It nevertheless makes a difference whether medical confidentiality is mainly protected under private law or under criminal law. Criminal law protection is usually stricter, and the possibilities to justify a breach are far more limited. Furthermore, as the discussion of private law remedies for a breach of medical confidentiality in the U.S. and the UK has shown, criminal law provides stronger protection, as there is no need to establish and quantify the damage caused by disclosure. Instead, unauthorised disclosure is regarded as harmful, regardless of its consequences. The very limited number of criminal cases in this area, both in France and Germany, may indicate, however, that breaches of medical confidentiality are rarely prosecuted, and hardly ever lead to a criminal conviction.

It is surprising that courts in all legal systems have held that the protection of medical confidentiality lies in the public interest, and not solely in the private interest of the individual. In France and Germany, the existence of the criminal offences of breach of professional confidences sends a clear statement that medical confidentiality is protected not merely in the private interest of the patient, but also lies in the public interest. Where medical confidentiality is protected as part of the constitutional right to privacy, this constitutional guarantee

[7] See, for example, *Re The June 1979 Allegheny County Investigating Grand Jury* 415 A.2d 73 (Sup. Ct. Pa 1980), at 76-77 per Eagen, Chief Justice.

implies that privacy protection lies in the public interest, as the state has an interest in protecting the fundamental liberties of the citizens. However, the same result has been achieved by English case-law,[8] even though medical confidentiality is only protected by private law provisions and remedies, and even though privacy as such is not protected.

Important differences in approach can nevertheless be observed. In France and Germany, the restriction of the criminal offence of breach of confidence to members of certain professions emphasises that the respective legal systems accord special protection to the confidentiality of relationships between the individual and necessary confidants.[9] U.S. privilege statutes are based on similar considerations.[10] The protection of medical confidentiality by English courts, in contrast, does not focus on this concept of the necessary confidant, but emphasises instead the general desirability of protecting information that was imparted in confidence, no matter what the relationship between the parties might be.[11] This difference in perspective may be more important for the approach towards the conflict between medical confidentiality and the interests of justice than the recognition or rejection of a general right to privacy. If the relationship between physician and patient is not protected because of the particular needs of the patient to entrust him/herself in the physician, but rather because confidences between private parties in general deserve the protection of the law, on the balance, those aspects of medical confidentiality that justify its special treatment, such as the close link to autonomy and to bodily integrity, are lost. Given its broad nature, the general interest in the protection of information imparted in confidence is less likely to prevail over the interests of justice.

An interesting question is whether or not it is possible to identify fundamental differences in approach between common law and civil law countries. It is submitted that with regard to the protection of medical confidentiality and medical privilege, the differences in style are not insignificant, but should at the same time not be over-emphasised, as the results achieved in the various systems are not

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[8] *X v Y and others* [1988] 2 All ER 648 (QBD), at 656 per Rose J; *W v Egdell* [1990] 1 All ER 835 (CA), at 846 per Stephen Brown P.
[9] See *supra*, at 55 and 108.
[10] See *supra*, at 236.
[11] See *supra*, at 155, 156.

necessarily affected thereby. It was already mentioned that both common law and civil law countries broadly achieve the same results when it comes to the protection of medical confidentiality as such. With regard to the specific problem of medical privilege, common law courts, in the absence of a privilege statute, tend to accord overriding importance to the interests of justice and are not willing to recognise medical privilege based solely on case-law authority. The adoption of privilege statutes by many U.S. States, and their rejection by other U.S. States, as well as by the UK, highlights fundamental differences between different common law countries.

There are also differences between common law and civil law countries. Where a common law system recognises medical privilege, this is achieved by the means of privilege statutes specifically drafted for the situation of the physician's testimony in judicial proceedings, providing detailed regulations regarding the scope and limits of medical privilege. Accordingly, these statutes give the physician, as well as the courts, comprehensive guidance for their decisions. Because of this statutory foundation, courts are rarely willing to allow for exceptions to medical privilege that are not outlined in the statute. The main advantage of these statutes is that they are especially formulated to deal with the specific conflicts surrounding medical privilege, and it is usually unnecessary to refer to other provisions or general legal principles when interpreting the statute. Here, U.S. type privilege statutes differ considerably from the relevant statutory provisions in France and Germany.

In France and Germany, the starting point for a legal discussion of medical privilege is that any breach of medical confidentiality by the physician amounts to a criminal offence. Consequently, in the context of medical privilege the main question must be whether the obligation extends to the physician's testimony in criminal court. To decide whether or not an exception from the obligation to maintain medical confidentiality applies, reference must be made to general legal justifications, such as the necessity defence, which are not specifically drafted to deal with the situation of medical privilege. This means that the situation is governed by an interplay of different provisions to be found in different codes. Courts are then faced with the problem of how to apply these different provisions coherently. Although the starting point is the same in France and Germany, the conflict resolution nevertheless differs quite considerably. In Germany, conflicts

will always be resolved by a strict application of the relevant legal justification, which poses difficulties, as the situations in which breaches of medical confidentiality most frequently occur might not fit neatly into the framework of existing legal justifications, and the German system thus considerably limits the availability of defences for a breach of medical confidentiality. Also, even though legal justifications provide broad criteria for the resolution of a given conflict, their application still requires extensive interpretation and often a balancing of interests. French courts seem to overcome the problem of the narrow scope of application of legal justifications by referring to general thoughts and interests, rather than to legal justifications when resolving cases of conflict in the area of medical confidentiality. The French approach is thus far more pragmatic than the German approach, and it can be seen that the similarities in written law may be qualified by different ways of applying the law. Accordingly, the impact of differences in legal style between the two civil law countries should not be underestimated.

It should be added that privilege statutes are normally restricted to regulating the physician's testimony in court, and will therefore not provide regulations with regard to questions of disclosure in favour of crime prevention. Even the most precise U.S. style privilege statute will thus leave some problems unanswered, and will make a balancing exercise in individual cases necessary. Outside of the realm of the specific problem of the physician's testimony in criminal court, the differences between the U.S. approach and the French and the German approaches are thus less dramatic.

2. Conflict between medical confidentiality and the interests of justice in criminal proceedings

2.1. Medical privilege in criminal courts

With regard to the conflict between medical confidentiality, on the one hand, and the interests of justice in the context of criminal prosecution, on the other, all legal systems under examination have found a clear approach at least in respect of the basic issues involved. In France and Germany, under the provisions of the respective Codes of Criminal Procedure, the physician is exempt from the obligation to give testimony in court. Medical confidentiality is thus valued more

highly than the interest in criminal prosecution. In the U.S., the situation depends on whether or not a privilege statute exists in the State in which the case has to be decided. In States where privilege statutes apply to criminal proceedings, the physician does not have to give testimony, while in States without such a statutory privilege, it is generally felt that the interest in criminal prosecution outweighs the interest in medical confidentiality,[12] so that the physician has to testify. Equally, in England there is no physician-patient privilege in judicial proceedings, so that the physician has to testify, unless the testimony is not relevant and material to the proceedings. In that case, English courts have a discretion to exclude evidence to uphold the confidentiality of the physician-patient relationship.[13]

It is interesting to note that all legal systems that recognise medical privilege in judicial proceedings introduce the privilege on a statutory basis. As far as the Continental legal systems, France and Germany, are concerned, this is hardly surprising, as a privilege introduced by the judiciary would be alien to the legal culture, at least as long as the general obligation to give testimony is regulated by statute. With regard to the common law systems, however, it is more note-worthy that where a statutory privilege is missing, the judiciary does not seem willing to introduce medical privilege by case-law. This suggests that the interest in criminal prosecution is, in principle, seen by the judiciary as more important than the interest in medical confidentiality. This result is reached by courts in the UK as well as in the U.S., even though in the U.S., medical confidentiality is protected as part of the constitutional privacy protection,[14] while the UK at present does not recognise any general right to privacy.[15] This supports the conclusion presented above that the existence of a constitutional right to privacy does not necessarily influence the approach to medical privilege. In common law systems, the reluctance to recognise medical privilege is frequently explained by reference to the adversarial system governing criminal proceedings. It is often argued that an adversarial system is particularly dependent upon all evidence being made available to the court.[16] But is this really a distinctive feature of the adversarial

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[12] See Peiris, (1984) 33 ICQL 301-330, at 326-327.
[13] *Hunter v Mann* [1974] 2 All ER 414 (QBD), at 420 per Widgery, LJ.
[14] See, for example, *U.S. v Westinghouse Electric Corporation* 638 F.2d 570 (3rd Cir. 1980); *Whalen v Roe* 429 U.S. 589 (1977).
[15] See, for example, *Kaye v Robertson* [1991] FSR 62 (CA).
[16] See, for example, *U.S. v Nixon* 418 U.S. 683 (1974), at 709 per Chief Justice Burger; Hogan, (1989) 30 Boston College Law Review 411-476, at 418.

system? A detailed analysis of the differences between the adversarial and the inquisitorial systems is beyond the scope of this dissertation. However, it is submitted that an inquisitorial system pursues the same purpose as an adversarial system, that is to establish the truth in the course of judicial proceedings in order to come to a fair and just solution of the case before the court.[17] As can be seen from the example of the U.S., where States with and without medical privilege function side-by-side, in the setting of the same adversarial system, medical privilege is not alien to an adversarial system and does not undermine its functioning. This seems to suggest that the difference between an adversarial and an inquisitorial system cannot be seen as the decisive factor influencing the recognition or rejection of medical privilege.

Any privilege is based on the value judgment that the interests behind the privilege are regarded as more important than the interests of criminal justice. It is submitted that the judiciary, as it is mainly concerned with ensuring the purposes of judicial proceedings, is unlikely to make a value decision to the detriment of the interests behind criminal prosecution. The judiciary is more likely to attempt to maximise the interest in an unhindered administration of justice. This view is supported by the courts' attitude towards legal professional privilege, which is, at least in England, not recognised to protect the privacy interests of the patient, but rather serves the interests of justice which, according to the courts, would suffer if clients did not feel confident to seek comprehensive legal advice and assistance.[18] This is also in line with the discretionary approach adopted by English courts which are willing to consider the exclusion of confidential medical information from judicial proceedings as long as this information is not relevant and material for a just decision of the cases at hand. Confidential information will thus only be protected if its costs for an effective administration of justice are relatively low. This shows that the courts, absent a legislative decision in favour of medical privilege, take a consequentialist approach and give the interests in criminal prosecution precedence over the interests in medical confidentiality. It follows that it is unlikely that a comprehensive medical privilege will be introduced by case-law.

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[17] Shuman, (1985) 39 Southwestern Law Journal 661-687, at 686.
[18] *Reg. v Derby Magistrates' Court, ex parte B* [1996] AC 487 (HL), at 507 per Taylor, LJ.

It is understandable that courts are reluctant to introduce medical privilege where this would lead to the exclusion of relevant and material evidence. In such a situation, the recognition of a privilege would constitute an interference with the smooth functioning of the very system that the judiciary is there to represent. However, it is interesting to note that some federal courts in the U.S. have recognised a psychotherapist-patient privilege, even though such a privilege is not based on a privilege statute.[19] The Advisory Committee on the Federal Rules of Evidence had explicitly recommended the introduction of such a privilege which is recognised by all U.S. States.[20] In some U.S. States in which a privilege statute exists but is ambiguous as to its applicability in criminal proceedings, courts have adopted a broad approach and extended the privilege statute to criminal proceedings.[21] This shows that once a legislative statement, or at least a recommendation in favour of a privilege exists, courts appear to be more willing to accept its underlying value and to protect it even by means of a broad interpretation. However, there are also examples to the contrary, again from the U.S., where the courts' mistrust of privilege statutes has been such that on occasion they have given them as narrow an interpretation as possible.[22]

Given the differences in approach, it is useful to assess which approach is more convincing. Two main questions arise when assessing different approaches to medical privilege. First, is medical privilege desirable as such, that is, is medical confidentiality, in principle, important enough to outweigh the interests behind criminal prosecution? Secondly, if the first question is answered in the affirmative, how can medical confidentiality best be protected in the context of criminal proceedings?

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[19] *Covell v CNG Transmission Corp.* 863 F.Supp. 202 (M.D. Pa. 1994), per McClure, District Judge; *Cunningham v Southlake Ctr for Mental Health, Inc* 125 F.R.D. 474 (N.D. Ind. 1989), at 477; *In Re Doe* 964 F.2d 1325 (2nd Cir. 1992), per Winter, Circuit Judge; *In re Grand Jury Subpoena* 710 F.Supp. 999 (D.N.J. 1989), at 1012-1013; *In re Zuniga* 714 F.2d 632 (6th Cir.), at 639; *U.S. v D.F.* 857 F.Supp. 1311 (E.D. Wis. 1994), per Stadtmueller, District Judge.

[20] 'Advisory Committees notes on the proposed Federal Rules of Evidence', 56 F.R.D. 183, at 242.

[21] See, for example, *Clark v District Court* 668 P.2d 3 (Colo. 1983); *In the Matter of a Grand Jury Investigation of Onondaga County* 59 N.Y.2d 130 (1983); *People v Murphy* 101 N.Y. 126; *People v Decina* 2 N.Y.2d 133; *People v Reynolds* 195 Colo. 386 (1978); *State v Boehme* 430 P.2d 527 (Wash. 1967) at 533 per Hamilton J; *State v Ross* 947 P.2d 1290 (Wash.App.Div.1 1997).

[22] See, for example, *People v Doe* 107 Misc.2d 605 (Sup Ct 1981); *People v Lowe* 96 Misc.2d 33 (1978).

With regard to the first question of whether or not medical privilege should, in principle, be recognised, the answer depends on the outcome of a value judgment as to the significance of medical confidentiality, on the one hand, and the interests of justice in the context of criminal prosecution, on the other. It was seen in the second chapter that neither the utilitarian nor the deontological approach to medical privilege were entirely convincing, so that the question cannot be answered simply by referring to the solutions offered by philosophers or medical ethicists. Given the practical problems of a utilitarian cost-benefit analysis, particularly in the light of the ambiguity of the notion of utility, the utilitarian approach is unhelpful when it comes to deciding the principal conflict of interests. It may only be of use as a corrective once a decision has been made, to assist with an evaluation of the consequences of the promoted value judgment.

The main problem of the deontological approach is the difficulty of establishing a ranking of the competing interests. As was seen, most deontologists seem to favour medical confidentiality over the interests of justice.[23] The outcome of the balancing test in favour of medical confidentiality seems so obvious that no need is perceived to justify this result by reference to ethical arguments. However, although the philosophical as well as the legal studies have demonstrated the close link between medical confidentiality, privacy and autonomy, interests of a very high rank, it should not be forgotten that the public interest in the administration of criminal justice which involves such important issues as the trust in the criminal justice system, and the investigation of past crimes and the punishment of criminal offenders, is also of great importance. While both of the competing interests are of high value, none of them is regarded as absolute. Rather, they can both be outweighed by interests of overriding importance. Consequently, it does not seem sufficient simply to state that one of them prevails over the other, as it does not seem obvious at first sight which of the two interests outweighs the other. However, this seems to be the approach most of the promoters and opponents of medical privilege are satisfied with.

To interpret the approach of a given legal system once a privilege statute has been enacted is not too difficult a task, as the value judgment of the legislature is then clear. It is immeasurably more difficult to assess whether or not medical privilege

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[23] Krattenmaker, (1973) 62 Georgetown Law Journal, at 90; Louisell, Crippin, (1956) 40 Minnesota Law Review, at 414.

should be introduced, given the differences in approach to be found among different legal systems as well as among different philosophical schools. Most legislators seem to agree that the interest in medical confidentiality can be outweighed by a public interest, for example the interest in preserving public health, as they impose on physicians obligations to disclose information about patients infected with certain contagious diseases.[24] Equally, most legislators seem to agree that the interests of justice can sometimes be outweighed by the rights of individuals. Thus, while the truth-finding function of criminal proceedings is highly valued, certain ways of establishing the truth are nevertheless prohibited, such as the extraction of a confession by means of torture, or forced self-incrimination of the accused. It could be argued that the two examples given cannot be compared to the situation of medical privilege. Both prohibitions could be said to promote the interests of justice, rather than undermining them. Evidence resulting from torture bears a very high risk of unreliability, as does evidence which emerges owing to a disregard for the privilege against self-incrimination. It could thus be argued that both prohibitions are necessary in order to avoid miscarriages of justice. However, it is submitted that both prohibitions at the same time serve other purposes. Thus, confessions induced by torture, or forced self-incrimination would seem unacceptable, regardless of whether or not the reliability of the evidence thus obtained could be established in the individual case. Even if it could be demonstrated with certainty that the confession made under torture was in fact correct, its admissibility would nevertheless be unacceptable, as the use of torture constitutes a blatant disregard for human dignity as well as autonomy and bodily integrity.[25] To force a person to incriminate him/herself in the course of criminal proceedings against him/her similarly violates human dignity as well as personal autonomy. It can therefore be seen that evidence or certain means of collecting evidence are not merely excluded on the grounds that they may harm the interests of justice, but that they are also excluded for extra-judicial goals such as the protection of basic human rights. At the same time, it could be argued that it is not in the interest of justice

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[24] For France, see Le Roy, D.1963.280; Pradel, JCP.1969.I.2234; for Germany, see ss.3-5 Bundes-Seuchengesetz (Federal Epidemic Act); for the UK, see s.2 NHS (Venereal Diseases) Regulations 1974; for the U.S., see, for example, A.R.S: §36-621 (Arizona); *Simonsen v Swenson* 104 Nebr. 224 (1920), at 228; Ensor, (1988) 47 Maryland Law Review, at 682-683.

[25] Kleinknecht/Meyer-Goßner, 3 to s.136(a); Stefani, Levasseur, Bouloc, *Procédure Pénale*, at 34; *Rogers v Richmond* 365 U.S. 534 (1961) for confessions obtained through police trickery.

that truth be established at all costs. Rather, while truth-finding is one important goal, the criminal justice system also strives to guarantee a fair trial and achieve just results. These latter concepts may sometimes conflict with and outweigh the truth-finding function of judicial proceedings.

It could then also be argued that if the interests of justice require that adequate consideration be given to the rights and interests of individuals,[26] medical privilege, like legal professional privilege, though for different reasons, could be regarded as serving the interests of justice rather than undermining them. This approach might be tempting as it seems at first sight as if a conflict of interests can be avoided and a balancing exercise be made unnecessary by specifying the interests of justice so as to include the interest in medical confidentiality. However, it is submitted that this approach does not present a way to circumvent the problem of effectively weighing these two competing interests against each other. It merely shifts the focus from a conflict between the interest in medical confidentiality and the interests of justice to a conflict between two competing aspects of the interests of justice. Therefore, no matter how one looks at it, the problem comes down to a judgment as to which of the two interests should prevail in case of a conflict.

If it is so difficult to reach a final decision on which of the two conflicting interests deserves to override the other, does it follow that a generalised approach, deciding the conflict in a general and abstract way for all actual and potential cases is indefensible, and that the outcome of the balancing test should instead be left to an assessment of the particular circumstances of each individual case?

All legal systems under examination have opted for the first approach and decided the conflict of interests in a general and abstract way. Where a privilege statute exists, it reflects the legislative decision that medical confidentiality is generally more important than the interests in criminal prosecution and will therefore prevail in every case in which the two interests are in conflict with each other. Where no such statute exists and the question had to be decided by the courts, they equally decided the conflict in an abstract way by principally rejecting medical privilege, thus expressing the judgment that the interests behind criminal prosecution generally outweigh the interests in medical confidentiality. Room for

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[26] Karlsruher Komentar-Boujong, 1 to s.136(a); Stefani, Levasseur, Bouloc, *Procédure Pénale*, at 34.

discretion is left only where the confidential information is not relevant and material to the proceedings, and the interests of justice are therefore not seriously affected. Peiris, calls the English approach discretionary and argues that this approach has the benefit of according 'equal recognition both to the privacy of professional relationships and the public interest in maintaining that privacy, and to the countervailing issue in respect of reception of the fullest evidential material facilitating the administration of justice.'[27] Yet this analysis is not entirely accurate. As has already been demonstrated, the English approach very clearly favours the interests in an effective administration of justice over the interest in medical confidentiality.[28] The discretionary approach as applied by English courts does no more than respect medical confidentiality once it has been established that the loss of information is comparatively small. In contrast, a case-by-case approach would start from the assumption that the interests are, in principle, of equal weight, and would look at the particularities of each case to decide whether factors are present in the light of which the balance should shift to one side or the other.

What, then, are the benefits and disadvantages of a generalised approach, on the one hand, and of a case-by-case approach, on the other? The main advantage of a case-by-case approach could be flexibility. None of the competing interests would have to be given a principal precedence over the other, and an attempt could be made to optimise both interests as far as possible in any given case. For example, it would be possible to develop criteria, such as the relevancy and materiality of the evidence, the unavailability of alternative evidence to establish the same facts, the seriousness of the criminal offence at issue, to operate in favour of the interest in criminal prosecution, and the sensitivity of the information, the degree of trust that was placed in the physician, the harm to ensue from disclosure, to operate in favour of a preservation of medical confidentiality. This approach to some extent resembles the case-by-case approach suggested by some utilitarians.[29]

It must be noted that such flexibility is achieved at the cost of uncertainty and of unpredictability of results. None of the purposes behind the protection of medical confidentiality can properly be accomplished this way. Insofar as medical

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[27] Peiris, (1984) 33 ICQL, at 309.
[28] See *supra*, at 170-171.
[29] See chapter 2, 3.1.1.

confidentiality serves the purpose of encouraging the patient to seek medical advice and treatment and to disclose all relevant information to the physician, this purpose can hardly be achieved if the patient cannot be certain whether in his/her individual case the balance will come down in favour of or against disclosure.[30] If medical confidentiality is protected to guarantee the patient's autonomy and privacy, this goal will equally not be achieved. A patient who cannot be sure that the information confided in the physician will be protected in the context of judicial proceedings is hardly in a position to make an autonomous decision when deciding whether or not to seek medical advice and treatment and what information to disclose to the physician. This shows that the interest in medical confidentiality is not only adversely affected by forced disclosure,[31] but that the mere possibility that disclosure may be required is sufficient to undermine the purpose behind medical confidentiality.

It should now be evident that the interests at stake are of a very different quality. The interest in criminal prosecution is not equally endangered by a case-by-case approach, but is amenable to a balancing of the interests at stake in every individual case. The completely different impact of the case-by-case approach on the two interests to be balanced can also be explained by a rather practical observation. The interests of justice are directly related to judicial proceedings, so that their determination by the judiciary would be relatively easy and straightforward. The interests behind medical confidentiality, on the other hand, are far more complex, as they do not stand in a direct relationship to judicial proceedings, but have many different facets which lie outside of the scope of a trial. Their exact determination in an individual case will thus be considerably more difficult than the definition of the interests of justice. More importantly, to determine the value of medical confidentiality in an individual case would require some knowledge of the content of the information in order to assess its sensitivity, the particular features of the physician-patient relationship etc. To obtain such knowledge, medical confidentiality would have to be impaired to some extent. At least where the interests to be balanced against the interest in medical confidentiality are as broad as the interests in the administration of criminal

[30] Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges*, vol. 2, at 7-10; Thomas-Fishburn, (1990) 61 University of Colorado Law Review, at 194 regarding the attorney-client privilege; Gurfein, (1981) 49 Fordham Law Rev., at 733 also regarding the attorney-client privilege.
[31] See also Weisberg, (1978) 30 Stanford Law Review, at 979-980.

justice, and the criteria as broad as relevancy of information to a criminal trial, medical confidentiality can hardly be promoted by a case-by-case approach.

This leads neatly on to an assessment of the suitability of the generalised approach. When it is argued that such an approach is too inflexible to accommodate unforeseen circumstances or nuances of a given case,[32] this disadvantage may be outweighed by the benefits deriving from predictability. If the interests in medical confidentiality cannot easily be determined in every individual case, and if the case-by-case determination presupposes a breach of medical confidentiality, the interest in medical confidentiality is much better served by a generalised judgment of its value. Furthermore, given the bias of the judiciary towards the interests of justice, a generalised approach seems the only meaningful way to protect medical confidentiality. At the same time, the interests of justice can easily be determined in a generalised way, as they are of a general and abstract nature and largely independent from the individual case. To adopt a generalised approach does not necessarily mean that no room is left for discretion. Rather, as the English example shows, a generalised approach rejecting medical privilege leaves some discretion for the protection of medical confidentiality where this only marginally affects the interests of justice. Equally, a generalised approach favouring medical privilege does not exclude exceptions to the general rule in certain cases in which factors are present that might shift the balance towards disclosure.[33]

Of course, a generalised approach rejecting medical privilege harms the patient's interest in medical confidentiality more than a case-by-case approach. However, several factors might mitigate this judgment. First, if the materiality and relevance of the information is a decisive factor to be weighed on the balance when a case-by-case approach is adopted, medical confidentiality does not receive much additional protection by such an approach as contrasted with a generalised approach which allows for judicial discretion to exclude confidential evidence where it is neither relevant nor material. And with a generalised approach, the patient knows where he/she stands and that, in principle, medical confidences will not be protected from disclosure in court. The patient can then decide whether or

[32] Peiris, (1984) 33 ICQL, at 328.
[33] 'Developments in privileged communications, (1985) 98 Harvard Law Review, at 1548 and 1553.

not to disclose confidential information under such circumstances. A generalised approach in favour of medical privilege, on the other hand, obviously provides for much stronger protection of medical confidentiality than a case-by-case approach.

It seems that better arguments point towards the introduction of medical privilege. Where the state infringes the fundamental rights or interests of an individual, or, to put it differently, violates its *prima facie* obligation to respect these interests, such an intrusion or violation requires a thorough justification. Usually, an interest can only be outweighed by another if it can be demonstrated that the prevailing interest is of overriding importance, and the violation of the overridden interest is the best and least intrusive course of action in the light of such a conflict.[34] This means that the state would have the burden of showing that the interests of justice override the fundamental interest in medical confidentiality, privacy and autonomy. This also means that there is a presumption in favour of a protection of individual freedom, absent a showing that these interests have to yield to overriding interests. When looking at the nature of the different interests that are at stake, it is obvious that the interest in medical confidentiality directly affects individual freedom and only indirectly affects the public interest in preserving such freedom, while the interest in criminal prosecution directly affects the public interest and only indirectly affects the interest of individuals. This means that a predominantly public interest conflicts with an interest that is primarily granted to protect the freedom of the individual. As such interests are of a fundamentally different nature, their value cannot easily be compared.

To resolve such a conflict, much depends on the view of the relationship between the rights and interests of the individual and the public interest. Dworkin's argument that individual rights only make sense if they cannot be routinely outweighed by public interest considerations, but rather, in principle, only where they conflict with overriding third party interests,[35] seems compelling. If fundamental rights, such as the right to autonomy and privacy, could be overridden whenever they affect a public interest, they would be at the disposition of the state and would only have to be granted as long as their protection does not cause any inconvenience. Such an approach would undermine the very idea of

[34] See, for example, Beauchamp, Childress, *Principles of Biomedical Ethics*, at 34.
[35] Dworkin, *Taking Rights Seriously*, at 194-200.

fundamental rights. Coming back to the problem of medical privilege, this means that medical confidentiality as a fundamental right cannot be routinely outweighed by the interests of justice. Only if medical privilege is recognised can the patient's privacy interests as well as the patient's autonomy in the health care setting be adequately safeguarded. No case was made by the opponents of medical privilege to demonstrate that medical privilege results in costs that go beyond the costs that always arise where fundamental individual rights must be respected. The experience of France, Germany, and the U.S. with privilege statutes shows that the administration of criminal justice is not markedly impaired by a generalised medical privilege.

It is thus submitted that if one accepts that medical confidentiality is closely linked to privacy and autonomy, medical privilege should be recognised, as the individual right then outweighs the state interest in criminal prosecution. However, it was seen above that an opposite approach is adopted by the English and American judiciary who, in the absence of privilege statutes, seem to find it self-evident that the public interest in the administration of justice outweighs the privacy interests of the individual.

2.2. Psychotherapist-patient privilege

Would it make a difference if a psychotherapist, rather than a physician, were called as a witness in criminal proceedings? In France, Germany and England, the legal situation would be the same as in the case of a physician's testimony in criminal court. In France and Germany, the provisions governing medical confidentiality and medical privilege include both physicians and psychotherapists,[36] so that both professional groups have similar rights and obligations. As medical privilege is comprehensively recognised, there is no need to award any additional protection to the psychotherapist-patient relationship. In England, while some commentators argue that there is a much stronger case for an introduction of a psychotherapist-patient privilege than for the recognition of a general physician-patient privilege,[37] a psychotherapist-patient privilege is no more recognised than medical privilege in general. This demonstrates that the

[36] In Germany, s.53 Code of Criminal Procedure only applies to psychological psychotherapists. Psychological psychotherapists are psychologists with a specific degree in psychotherapy.
[37] See, for example, McHale, *Medical Confidentiality and Medical Privilege*, at 133.

interests of justice are regarded even as overriding the confidentiality of the psychotherapist-patient relationship. While the three European systems for different reasons thus treat the psychotherapist-patient relationship similar to the physician-patient relationship, this is not the approach adopted by all American States. In the U.S., all States recognise a psychotherapist-patient privilege, while only 41 States provide for a physician-patient privilege. And at federal level, no physician-patient privilege exists, but a psychotherapist-patient privilege has nevertheless been recognised.[38] What, then are the reasons behind the preferential treatment of the psychotherapist-patient relationship in parts of the U.S.? From a utilitarian standpoint, the main argument would be that psychotherapy depends even more on patient frankness than the ordinary physician-patient relationship, and that a psychotherapist-patient privilege is consequently even more important than a physician-patient privilege to guarantee that professional advice is sought and effective treatment given.[39] In addition, it is sometimes argued that patients in need of psychotherapy have less incentive to seek treatment, so that an active encouragement by the way of guaranteeing absolute confidentiality is particularly important in this area of medical practice.[40] Deontological arguments mainly focus on the particularly private, intimate and sensitive nature of psychological information which is said to increase the patient's privacy interest.[41]

It is submitted that any distinction between the physician-patient and the psychotherapist-patient relationship is problematic.[42] First, from a practical perspective, the distinction will often be very difficult to make. Psycho-somatic illnesses, which demonstrate the close link between the body and the psyche, are on the increase. For the distinction to be workable it would have to be determined whether the psychotherapist-patient privilege should be tied to the qualification of

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[38] *Jaffee v Redmont* 518 U.S. 1 (1996); *Covell v CNG Transmission Corp.* 863 F.Supp. 202 (M.D. Pa. 1994), per McClure, District Judge; *Cunningham v Southlake Ctr for Mental Health, Inc* 125 F.R.D. 474, 477(N.D. Ind. 1989); *In Re Doe* 964 F.2d 1325 (2nd Cir. 1992), per Winter, Circuit Judge: *In re Grand Jury Subpoena* 710 F.Supp. 999 (D.N.J. 1989), at 1012-1013; *In re Zuniga* 714 F.2d 632 (6th Cir.), at 639; *U.S. v D.F.* 857 F.Supp. 1311 (E.D. Wis. 1994), per Stadtmueller, District Judge.

[39] Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges,* vol. 2, at 7-9 to 7-10.

[40] Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges,* vol. 2, at 7-10; Kottow, 'Stringent and predictable medical confidentiality', in: Gillon, *Principles of Health Care Ethics,* at 478.

[41] Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges,* vol. 2, at 7-9 to 7-10; Slovenko, *Psychotherapy and Confidentiality,* at 49.

[42] See, for example, Saltzburg, (1980) 66 Virginia Law Review, at 621.

the professional as a psychotherapist, or whether it should attach to the content of the information revealed. If a patient seeks medical treatment for a psycho-somatic illness, would all psychological information the patient may reveal to the physician be protected under a psychotherapist-patient privilege? Equally, if a patient in the course of psychotherapy revealed physical problems, would the psychotherapist-patient privilege apply?

In addition to such practical problems, the distinction seems unconvincing for other reasons. The utilitarian gains of a psychotherapist-patient privilege cannot be specified, and therefore cannot be compared to the similarly uncertain gains of a physician-patient privilege. From a deontological view, which values confidentiality highly because of its close link to privacy and autonomy, it seems inconsistent to make an objective assessment as to the degree of privacy attached to certain information. Rather, a patient's privacy and autonomy can only be safeguarded if this judgment is left to the patient, and is not made on the patient's behalf. For all these reasons, it seems undesirable to treat the physician-patient and the psychotherapist-patient relationships differently. McHale's suggestion for the UK to introduce a psychotherapist-patient privilege, but to leave questions of medical privilege to the discretion of the courts[43] is thus not convincing.

2.3. Medical privilege at the discretion of the physician?

What is the status of privilege should the physician wish to give testimony in a criminal court, for example because he/she feels that his/her duties as a citizen demand that he/she assist the court with the proceedings? In the U.S., the situation is clear. The privilege is that of the patient,[44] so that without the patient's consent, the physician is not allowed to give testimony in court, at least not for the purposes of criminal prosecution. Thus, the physician's attitude towards giving testimony is irrelevant. If the physician testifies in court despite the existence of a privilege statute, the physician will thereby breach the obligation to medical confidentiality and be subjected to private law and disciplinary sanctions. In France, the situation appears, at first sight, to be equally clear. As art.226-13 Criminal Code imposes upon the physician the obligation to maintain medical

[43] McHale, *Medical Confidentiality and Medical Privilege*, at 133.
[44] Gellman, (1984) 62 North Carolina Law Review, at 272.

confidentiality, and art. 109 Code of Criminal Procedure exempts the physician from the obligation to give testimony in criminal court, it seems as if the legislator has made a clear decision in favour of medical confidentiality.[45] However, some legal writers argue that the physician should be given the choice between the two conflicting obligations.[46] In Germany, s.53 of the Code of Criminal Procedure is interpreted by the courts as well as by the pre-dominant opinion among legal writers so as to give the physician the right to refuse to testify, without imposing upon him/her an obligation to that effect.[47] However, when choosing to give testimony, the physician will commit the criminal offence of a breach of professional confidentiality under s.203 of the Criminal Code, and no legal justification will apply in cases in which the testimony merely serves the purposes of criminal prosecution.[48]

What, then, is the more convincing approach? Should a physician, where a privilege statute applies, nevertheless be allowed to give testimony in criminal court? The answer to these questions seems to rest entirely upon the purpose to be served by the existence of the privilege statute. If a decision in favour of the overriding importance of medical confidentiality in the context of criminal prosecution is taken, it is difficult to conceive of any reasons which may justify giving the physician the choice between respecting or disregarding this decision.

On the other hand, there is a possibility that the privilege statute could be primarily aimed at protecting the physician against a potential ethical dilemma. If so, it would make sense to give the physician the choice between an obligation to maintain medical confidentiality and a civic duty to give testimony in a criminal court, and to accept whichever choice the physician makes in the individual case. There are, however, no convincing arguments in support of the view that medical privilege exists mainly to protect the interests of the physician. While the physician may indirectly benefit from medical privilege, in that it facilitates the

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[45] Mazen, *Le Secret Professionnel des Practiciens de la Santé*, at 130; Vouin, *Droit Pénal Spécial*, at 367.

[46] Chomienne, Guéry, ALD.1995.comm.85; Rassat, *Droit Pénal Spécial*, at 381.

[47] See, for example, BGHSt 9, 59, 61 (1956); 15, 200, 202 (1960); 42, 73, 76 (1996); Karlsruher Kommentar-Senge, 7 to s.53 with further references; Kleinknecht/Meyer-Goßner, 6 to s.53; Laufs/Uhlenbruck-Ulsenheimer, at 511.

[48] Baier, *Strafprozessuale Zeugnisverweigerungsrechte außerhalb der Strafprozeßordnung als Ergänzung der §§ 52 ff StPO*, at 117; Haffke, GA 1973, at 69; Kramer, NJW 1990, at 1763; Ostendorf, DRiZ 1981, at 11; Schilling, JZ 1976, at 620; Steinberg-Copek, *Berufsgeheimnis und Aufzeichnungen des Arztes im Strafverfahren*, at 60; Sydow, *Kritik der Lehre von den "Beweisverboten"*, at 115.

exercise of his/her profession, medical privilege is nevertheless mainly aimed at the protection of the patient's privacy and autonomy in the health care setting. The patient's interests are of a very high rank, whereas the physician's interests in medical confidentiality do not touch upon any fundamental values, and can therefore not be regarded as interests that outweigh the public interest in criminal prosecution. Consequently, if medical privilege aims mainly at protecting the patient's interests, it is difficult to conceive of convincing reason to give a physician the right to disregard medical confidentiality without the patient's consent.

While the French, German and American approaches, despite their apparent differences, will in most cases lead to similar results, the American and the French approaches are much more convincing than the solution favoured in Germany. In U.S. States with privilege statutes, the physician is under a clear and unequivocal obligation to maintain medical confidentiality even in the course of criminal proceedings. The same is true in France, where the law unmistakably states what the physician's obligations are. In Germany, on the other hand, the physician is given a choice between testifying and refusing to testify, and evidence thus obtained is admissible in criminal proceedings, even though the physician's testimony will almost certainly amount to a criminal offence.[49] Given that medical privilege is mainly aimed at protecting the interests of the patient, this purpose can only fully be achieved if the physician is not allowed to testify in court about confidential medical information. Furthermore, it is submitted that a physician is in a much better position if the law clearly states his/her obligations.[50] To let the physician choose between keeping the patient's confidences and testifying in criminal court in the presence of a privilege statute is inconsistent, as the physician is then under a legal obligation to maintain medical confidentiality in criminal court, and it does not seem desirable to provide him/her with the choice of orientating his/her behaviour at an ethical, rather than a legal obligation. In addition, it should be borne in mind that the interests behind criminal prosecution are public interests the protection of which lies in the exclusive responsibility of the state. Therefore, if the state has waived this interest for the physician's

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[49] BGHSt 9, 59, 62 (1956); 18, 146, 147 (1962); BGHR-Schweigepflicht I zu StPO §53 (1995); Karlsruher Kommentar-Senge, 9 to s.53; Löwe/Rosenberg-Hans Dahs, 11-14 to s.53; for a further discussion see Alternativkommentar-Kühne, 3-6 to s.53.
[50] Gellman, (1984) 62 North Carolina Law Review, at 272.

testimony in criminal court by the means of medical privilege, it would not be appropriate to give the physician any discretion to question this judgment.

The differences between the three approaches rest, at least partly, on the different ways of implementing medical privilege. In the U.S., privilege statutes are specifically drafted for the situation of the physician's testimony in judicial proceedings, and they clearly state the physician's obligation not to testify in criminal court without the patient's consent. France and Germany, on the other hand, guarantee medical confidentiality by criminal law provisions. Accordingly, the main function of medical privilege is to clarify that the obligation of medical confidentiality equally applies to criminal proceedings. It then seems sufficient to formulate medical privilege as an exemption from the obligation to give testimony, rather than as an additional obligation of the physician. It was already discussed in great detail that, properly interpreted, the interplay of all relevant provisions of the French and German codes, respectively, leads to the same unequivocal result as the application of a U.S. privilege statute. However, the practice has shown that the Continental solution leaves considerable scope for confusion and inconsistencies. Therefore, while a U.S. style privilege statute would not fit into the French and German systems, the French and German approaches are not exemplary and a look to the U.S. may help avoid problems of interpretation. An interesting solution that may be feasible for all legal systems is that to be found in the Arizona privilege statute, providing in A.R.S. section 13-4062(4) that:

> A person shall not be examined as a witness in the following cases: ... 4. A physician or surgeon without consent of his patient, as to any information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient.

Here, the privilege statute is addressed to the court, prescribing a prohibition to examine the physician as to confidential patient information. This may be a better way to protect the patient's privacy interests in court than imposing an obligation upon the physician not to testify, as the court will then have to ensure that the physician does not violate his/her obligation, and as the physician's testimony in violation of the privilege statute is then clearly inadmissible.

2.4. Voluntary disclosure of information to the police

In none of the legal systems under examination is the physician under a general obligation to report to the police confidential information that may assist with the prosecution of a criminal offence. Given that, where a privilege statute exists, the disclosure of confidential patient information for the purposes of criminal prosecution is not at the discretion of the physician, it follows that the physician should not be justified when disclosing confidential patient information to the police. Even in England, where no medical privilege is recognised, the organisations of the medical profession advise their members only to disclose confidential patient information to the police if directed to do so by a judge.[51] This seems justified, given that the conflict between medical confidentiality and the interest in criminal prosecution is not the same in the context of police investigations as in the context of criminal proceedings. In the context of police investigations, the interest in guaranteeing the truth-finding function of the courts, in upholding the trust in the effective functioning of the judicial system and in avoiding miscarriages of justice is not affected, so that there is less reason for a breach of medical confidentiality than in the course of a criminal trial.

2.5. Medical privilege only for minor offences?

Should it make a difference whether the physician's testimony is sought in a case of murder, rather than in a case of minor assault? In the U.S., much depends on the privilege statute that is in operation in a given State, and also on the courts' interpretation of the relevant privilege statutes. In some States, privilege statutes contain express exceptions for cases of serious crime.[52] Other States do not make such a distinction, and it is neither made in France nor in Germany. In both France and Germany, it is generally accepted that the introduction of medical privilege contains a decision of the legislator in favour of medical privilege, regardless of the seriousness of the crime. Even if the physician wanted to testify in the course of a murder trial, this would only be lawful if a legal justification applied, but no such justification exists for the purposes of criminal prosecution, not even if the

[51] BMA, 'Interim guidelines on confidentiality for police surgeons', no.8.
[52] See, for example, D.C. Code Ann. §14-307; Ill. Comp. State. Ch. 735 5/8-802; Kan. State. Ann. §60-427(b).

trial concerns the most serious criminal offences.[53] In the UK, on the other hand, medical privilege is not even recognised for the prosecution of minor offences. What, then, is the better and more convincing approach? Does the seriousness or the nature of the criminal offence shift the balance in favour of the interest in criminal prosecution?

In some U.S. States, this question is obviously answered in the affirmative. Exceptions to privilege statutes regarding the prosecution of serious criminal offences seem to suggest that the costs of the privilege are deemed higher where it could obstruct the prosecution of a more serious criminal offence, and that a decision in favour of medical confidentiality is regarded as less acceptable if it stands in the way of convicting a person who committed a serious crime.[54] From a utilitarian standpoint, this argument may have some force. However, it is submitted that if there is a danger that the offender may commit future crimes, this would have to be considered in the context of crime prevention. If there is no such danger, the state interest in criminal prosecution does not change sufficiently where a serious, rather than a less significant offence is concerned, so as to shift the balance from a decision in favour of medical confidentiality to a decision in favour of the interests of justice. To make a generalised judgment that some offences are so serious that their prosecution deserves special treatment in the context of evidentiary privileges and outweighs fundamental individual rights and interests, would require a careful justification. However, no such justification has yet been presented by the promoters of such an exception to medical privilege. When balancing the competing interests, it must be borne in mind that the interest in truth-finding in criminal proceedings, and the interest in the effective administration of criminal justice are not affected by the seriousness of the crime at trial. While other interests behind criminal prosecution, such as the interest in retribution, may be altered by the seriousness of the offence, it is questionable whether those interests are important enough so as to override the interests behind medical confidentiality. However, it must again be stressed that all depends on a complex value judgment, and that it seems impossible to achieve a general consensus on this question. Consequently, if one disagrees with the approach promoted here, one will have to perform the difficult task of delineating which

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[53] See chapter 4, 2.2., and chapter 5, 2.1.3, respectively.

[54] See, for example, Kendrick, Tsakonas, Smith, 'The physician-patient, psychotherapist-patient, and related privileges', in: Stone, Taylor (eds.), *Testimonial Privileges*, vol. 2, at 7-35.

crimes are serious enough to justify an exception from an otherwise existing privilege statute.

In some countries, two types of criminal offences have received special attention: child abuse and drunk driving offences. All American States make exceptions from their privilege statutes for cases of child abuse, and in France, child abuse has also received special legislative treatment. In France, art.434-3 Criminal Code makes it a criminal offence not to inform the relevant authorities of cases of child abuse, but physicians are exempted from this obligation. However, art.226-14 Criminal Code contains an exception from the criminal offence of breach of confidence for cases of child abuse. Thus, in France the physician is not under any obligation to inform the authorities if he/she comes across a case of child abuse in the course of his/her profession, but neither is the physician under an obligation to maintain medical confidentiality in such a situation. In the U.S., on the other hand, the situation is mostly regulated by enacting an exception to the privilege statute for cases of child abuse, so that the physician is not given a choice, but he/she rather has to testify or otherwise to disclose the information, depending on the text of the statute. In Germany, no exception exists for cases of child abuse, which demonstrates that in the realm of criminal prosecution, child abuse is not given any special attention. A physician would accordingly commit the offence under s.203 of the Criminal Code when disclosing information on child abuse for the purposes of criminal prosecution.

An evaluation of the different approaches seems to depend to a large extent on the purpose to be served by the child abuse exception. In some U.S. States, it is clear that the child abuse exception serves at least partly the purpose of criminal prosecution. The Nebraska privilege statute,[55] for example, clearly states that:

> There is no privilege ... in any judicial proceedings ... regarding injuries to children, incompetents, or disabled persons or in any criminal prosecution involving injury to any such person or the wilful failure to report any such injuries.

However, in other States the emphasis very clearly lies on the prevention of further abuse.[56] In France, the place of the provision in the context of provisions on the prevention of crimes and of harm to individuals seems to suggest that the

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[55] Neb. Rev. State. §27-504 (1984).
[56] See, for example, *State v Sypult* 304 Ark. 5 (1990).

provision primarily aims at the protection of the child from further abuse, rather than at the prosecution of the offender. As questions of crime prevention will be discussed below, it suffices here to state that a child abuse exception for the purpose of criminal prosecution seems undesirable. Though regarded as a particularly abhorrent offence, child abuse nevertheless covers a wide range of cases and does not necessarily refer to serious offences. From a utilitarian standpoint, it must be taken into account that the treatment of the offender as well as the situation of the victims may be adversely affected if confidential information received by the physician can be used for the purposes of criminal prosecution. The offender might then be reluctant to undergo therapy, and may be equally hesitant to seek medical treatment for the abused child. The child, too, may be reluctant frankly to reveal abuse if it cannot be guaranteed that the information will not be used to prosecute the abuser.[57] On the other hand, it is sometimes argued that the child abuse exception is necessary, as medical evidence is particularly essential for the prosecution of the offender, given that other evidence will often not exist, or not be sufficient for a successful prosecution.[58] Again, therefore, the utilitarian analysis does not lead to a conclusive result regarding the problem of whether or not to recognise a child abuse exception for the purposes of criminal prosecution. From a deontological perspective, all seems to depend on the attitude towards the problem discussed above of whether or not the seriousness of the offence affects the outcome of the balancing test, and if so, whether or not child abuse offences are serious enough so as to participate in the exception to medical privilege.

With regard to drunk driving cases, it seems as if only some U.S. States provide for an exception,[59] while this is neither recognised in France nor in Germany. Looking at the reasons given for the drunk-driving exception in some U.S. States, it mainly seems to be based on practical considerations. Thus, it is argued that the prosecution of drunk-driving offences without medical evidence will frequently not be possible and that this should be reason enough to justify an exception to medical privilege. Another argument relates to the particular dangerousness of such offences to the public.[60] However, it is submitted that these arguments are

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[57] *Pennsylvania v Ritchie* 480 U.S. 39 (1987), at 60 per Justice Powell.
[58] *U.S. v Burtrum* 17 F.3d 1299 (10th Cir. 1994), at 1302 per Kelly, Circuit Judge.
[59] See, for example, California, Montana, Oregan, Utah.
[60] *State v Dyal* 97 N.J. 229, at 238-239; *State v Dress* 461 N.E.2d 1312, (Ohio App 1982) at 1316-

unconvincing. If a blood test was made by a physician for the purpose of determining the blood alcohol level of a driver, an obligation to maintain medical confidentiality does not arise, as there is then no confidential relationship between the patient and the physician. The drunk-driving exception would thus only apply to cases in which a blood test was made for treatment or diagnostic purposes, for example after a road accident, and an increased blood alcohol level was detected.[61] It is difficult to see why in a case in which the evidence clearly derives from a confidential physician-patient relationship, the practical difficulties encountered when prosecuting drunk-driving offences should weigh in favour of the interests in criminal prosecution. The only consistent justification for a drunk-driving exception would therefore be, for those who allow for exceptions to medical privilege for the prosecution of serious crimes, to include these offences in the list of exceptionally serious offences. However, it is submitted that similar to the case of child abuse, to classify all drunk-driving offences as particularly serious would stretch the notion of seriousness.

2.6. Effect of the patient's consent

Should the physician be allowed to maintain medical confidentiality where the patient has consented to the physician's testimony in criminal court? In such a case, both in the U.S. and in Germany, the physician would have to give testimony. In the U.S., this purpose is partly achieved by express regulation in the privilege statute,[62] partly by judicial interpretation. As the privilege belongs to the patient, the patient can waive it and the physician will then be under an obligation to give testimony. Thus, the physician can invoke the privilege only in the interests of the patient, and loses this prerogative once the patient has made it clear that he/she is in fact interested in disclosure. In Germany, the same result is achieved by s.53(2) Code of Criminal Procedure. However, the French approach differs dramatically, as the patient's consent does not have the effect of relieving the physician from the obligation to maintain medical confidentiality. The fact that the patient has consented to the disclosure would thus neither lead to an obligation of the physician to give testimony, nor would it justify a breach of

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[61] *Collins v Howard* 156 F.Supp 322 (1957), *State v Erickson* 241 N.W.2d 854 (N.D. 1976), per Sand, Judge.

[62] See, for example, D.C. Code Ann. §14-307(a) (1981).

medical confidentiality. The French approach not only leads to inconsistencies within the French legal system,[63] but is also undesirable. As the reasons for a rejection of the French approach were already discussed in some detail above,[64] they need not here be repeated. It should be sufficient to state that there is no need to protect confidential patient information where the patient has waived such protection. A protection of a patient's confidence against the patient's wishes can neither be in the patient's, nor in the public interest, as the patient's privacy is not violated if the patient opted for disclosure, and the public interest to protect the trust in the confidentiality of the physician-patient relationship is equally not affected if the physician discloses a patient's confidence with the patient's consent.

2.7. Medical records

With regard to the problem of state access to medical records for the purposes of criminal prosecution, should the rules governing the physician's testimony in criminal court apply, or should this specific question be treated differently? In the U.S., medical records and the physician's testimony are, to a large extent, governed by the same rules. Thus, where a privilege statute exists, it usually not only excludes the physician's testimony in criminal court, but also bars state access to medical records.[65] In Germany, the prohibition to seize medical records of the accused is seen as a necessary supplement to the physician's right to refuse to give testimony in criminal court, which could otherwise be circumvented by introducing the patient's medical records where the physician's testimony is not available.[66] A distinction is made between medical records of a person who is accused in criminal proceedings which are exempt from search and seizure, and those of all other patients to which the prohibition of s.97(1) Code of Criminal

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[63] Mazen, *Le Secret Professionnel des Practiciens de la Santé*, at 90; Waremberg-Auque, Revue de science criminelle et de droit pénal comparé 1978, at 246; Légal, JCP.1948.II.4141; Savatier, Auby, Savatier, Péquignot, *Traité de Droit Médical*, at 303; Savatier, JCP.II.15126; Fénaux, D.1988.106; Honnorat, Melennec, JCP.1979.I.2936; Pradel, JCP.1969.I.2234; Merle, Vitu, *Traité de Droit Criminel*, at 183.

[64] Chapter 4, 2.4.

[65] See, for example, Art.4495b Public Health Act Texas; *Behringer Estate v Princeton Medical Centre* 592 A.2d 1251 (N.J.Super.L. 1991), per Crachman, J.S.C.; *Comonwealth v Kobrin* 479 N.E.2d 674 (Mass. 1986), per Abrams, Judge; *In Re Search Warrant* 810 F.2d 65 (3rd Cir. 1987), per Becker, Circuit Judge.

[66] BVerfGE 32, 373, 385 (1972); BVerfGE 44, 353, 373 (1977); BGHSt 38, 144, 145 (1991); OLG Frankfurt StV 1982, 64, 65; Karlsruher Kommentar-Nack, 1 to s.97

Procedure does not apply. However, it has already been discussed earlier that the German approach is unsatisfactory and inconsistent,[67] and that the courts have developed ways to protect medical records of non-accused patients by reference to constitutional principles.[68] In France, medical records can be seized by the examining magistrate, and medical privilege only requires that certain protective procedures are adhered to, but does not restrict access to confidential medical records as such.[69] In England, access to medical records can be had in the course of criminal proceedings. However, in the course of police investigations, medical records receive far-reaching protection from search and seizure by the provisions of the Police and Criminal Evidence Act 1984.[70] It is nevertheless almost unanimously accepted that the physician will be justified when voluntarily submitting confidential patient material to the police for the purpose of criminal prosecution.

It can thus be seen that the situation varies from systems in which medical records and the physician's testimony are treated similarly (U.S. and partly Germany), and a system where the police or the examining magistrate can have access to medical records, while the physician cannot be forced to testify in court about the same facts (France), to a system in which access to medical records in the course of police proceedings is almost completely excluded, yet the physician would have to give testimony about the same fact when called as a witness in criminal court (England).

How can these differences be explained, and which system seems most appropriate? The French approach seems to be based on the thought that the examining magistrate can only adequately perform his/her tasks of investigating criminal offences and deciding whether or not criminal proceedings should be initiated against a suspect if given full access to all evidence. However, the decision that the physician does not have to give testimony in criminal court is based on a legislative assessment that medical confidentiality is more important than the interests in criminal prosecution. This decision is circumvented if access

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[67] Chapter 5, 2.2.1.; see also Krekeler, NStZ 1987, at 201; Muschallik, *Die Befreiung von der ärztlichen Schweigepflicht und vom Zeugnisverweigerungsrecht im Strafprozeß*, at 138; Schmitt, *Die Berücksichtigung der Zeugnisverweigerungsrechte nach §§ 52, 53 StPO bei den auf Beweisgewinnung gerichteten Zwangsmaßnahmen*, at 128.
[68] BGH NStZ 1997, 562; LG Hamburg NJW 1990, 780, 781.
[69] 24 April 1969, JCP 1970.II.16306; see also Chappart, D.1969.637.
[70] See chapter 6, 2.2.1.

to medical records is possible in the course of investigations into a criminal offence, or can be introduced as evidence in criminal court. If the differential treatment is based on the thought that the interest in medical confidentiality is more seriously affected when the physician is forced to testify in court, as this involves the physician's active participation in the disclosure, whereas in the case of a seizure of medical records, the state obtains access to pre-existing records by the use of compulsion, this argument is not very convincing. Medical privilege primarily aims at protecting the patient's private sphere which is no less violated where the physician discloses confidential facts in the course of oral testimony, than where confidential medical records come to the knowledge of persons who stand outside of the physician-patient relationship, with or without the physician's active participation. The French approach accordingly protects the physician rather than the patient, as the physician does not actively have to breach the medical secret, while the patient's medical information is not given comprehensive protection from state access. The decision of the English legal system to protect information more comprehensively in the course of police investigations than in the course of judicial proceedings can be more easily explained. Once a case must be decided by a court, the interests to be balanced against medical confidentiality are not reduced to the interest in criminal prosecution; the interests of justice as such are equally affected. If those interests are regarded as more important than medical confidentiality, it is consistent to deny medical privilege in court while protecting medical confidentiality outside of judicial proceedings. If, on the other hand, medical confidentiality is regarded as outweighing the interests of justice in the context of criminal proceedings, the best approach would be to exclude state access to confidential medical information altogether, be it in the form of the physician's oral testimony or in the form of medical records.

With regard to the question of whether or not the physician can be justified in voluntarily handing over confidential patient records to the police or the court, it is submitted that the principles outlined in the context of the general conflict between medical confidentiality and the interests behind criminal prosecution apply, as medical records and the physician's oral testimony should receive the same legal treatment. Therefore, where a medical privilege exists and the physician is not allowed to testify in court for the purposes of criminal

prosecution, he/she would equally not be justified in voluntarily handing over confidential patient records to the police or the court.

2.8. Prosecution of the physician

A last point to be discussed in the context of criminal prosecution is that of whether it makes a difference if the investigation or the prosecution is directed against the physician. The problem is mainly discussed in the context of the search of surgeries and the seizure of medical records in the course of investigations against the physician for fraud. In Germany, s.97 Code of Criminal Procedure does not apply to records of persons who are not accused in criminal proceedings, so that no provision stands in the way of a seizure of confidential patient records. In the U.S., the opinions among different courts are split. While some courts argue in favour of disclosure in such a case,[71] some try to find a compromise by allowing for disclosure, but accepting that individualised patient data can be anonymised as far as practicable.[72] This seems to be in line with the approach suggested in France, where the courts came to the conclusion that confidential patient records could be seized, particularly where a physician had unnecessarily included identifiable and confidential patient information into his book-keeping records and then argued that they could not be submitted without a breach of medical confidentiality.[73] In England, the specific problem did not find any attention of the courts or of legal writers.

How can the different approaches be assessed? The arguments brought forward in favour of and against disclosure of confidential patient records in this context are very similar in the different legal systems. In favour of disclosure, it is argued that the physician-patient relationship does not deserve protection if the physician abuses it to cover criminal activity.[74] However, the practical difficulties in prosecuting the physician without access to patient records would seem to be the decisive argument. It is feared that without the power to seize those documents, physicians could use the patient's privilege as a cover for the commission of

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[71] *In Re Search Warrant* 810 F.2d 65, (3rd Cir. 1987), at 72-73 per Becker, Circuit Judge.
[72] *State v McGriff* 672 N.E.2d 1074 (Ohio App. 3 Dist. 1996), at 1075 per Evans Judge; *Schachter v Whalen* 581 F.2d 35 (2nd Cir. 1978), per Oakes, Blumenfeld, and Mehrtens.
[73] 11 February 1960, JCP.1960.II.11604.
[74] Melennec, Gaz. Pal.1980.doct.145; Schlüchter, *Das Strafverfahren*, at 289.

criminal offences without having to fear discovery.[75] However, none of these reasons are convincing. The physician's abuse of the confidential professional relationship can hardly negate the protection owed to the patient's medical confidences, as only the patient, but not the physician has the right to waive medical confidentiality.[76] And practical difficulties alone cannot justify a disregard for the patient's fundamental privacy interests.[77] At least where an anonymisation of patient records is not a feasible option or will, in the individual case, not lead to an adequate protection of medical confidentiality, the only appropriate solution will be to seek the patient's consent to the seizure of his/her medical records,[78] which will in many cases probably be forthcoming, particularly if a considerate use of these data were guaranteed.

3. Defence rights

A problem for which no legal system seems to have found a consistent and convincing solution is that of the conflict between the interest in medical confidentiality, on the one hand, and defence rights, on the other. Different problems have to be distinguished. It is possible that the patient is accused in criminal proceedings and that the physician's testimony or records may be favourable to the defence. In that case, the problem of the effect of the patient's consent to disclosure becomes relevant. In Germany, the U.S. and the UK, no problem arises, as the physician has to testify once the patient consented to disclosure in court. In that case, no conflict between medical confidentiality and defence rights would ensue. The situation is different in France where the patient's consent does not have the effect of obliging the physician to testify where the patient wants to rely on this testimony for his/her defence.[79] It has already been discussed that the French approach is not convincing, as it is inconsistent with the goals behind the protection of patient confidences to deny

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[75] *In Re Search Warrant* 810 F.2d 65 (3rd Cir. 1987), at 72-73 per Becker, Circuit Judge; *State v McGriff* 672 N.E.2d 1074 (Ohio App. 3 Dist. 1996), at 1075 per Evans Judge; Weyand, wistra 1990, at 6.

[76] Lorenz, MDR 1992, at 316; Savatier, Commentary to 11 February 1960, JCP.1960.II.11604.

[77] *Hawaii Psychiatric Soc. Dist. Branch v Ariyoshi* 481 F.Supp. 1028 (D. Hawaii 1979), at 1047 and 1050 per Byrne, District Judge.

[78] *State v McGriff* 672 N.E.2d 1074 (Ohio App. 3 Dist. 1996), at 1078-1081 per Thomas F. Bryant, Judge, dissenting.

[79] See, for example, Cour de Cassation 22 December 1966, D.1967.122; 5 June 1985, Bull n° 218.

the patient the possibility to waive medical confidentiality, particularly where this conflicts with the patient's defence rights.[80]

In addition, it is possible that the patient the disclosure of whose medical information is sought in a criminal court is not the accused, but the victim or a witness. In such a case, a conflict may arise between the patient's interest in medical confidentiality, on the one hand, and the defence rights of the accused, on the other. Defence rights mainly involve the interest of the accused to present a defence against the case of the prosecution, for example by impeaching prosecution witnesses, or by presenting evidence that is favourable to the defence. This interest is protected regardless of the accused's guilt or innocence, as no one should be convicted in criminal proceedings unless he/she was given the possibility adequately to present his/her version of the event. Defence rights serve the private interests of the accused, but their protection lies also in the public interest. In all legal systems under examination, defence rights are regarded as interests of very high rank. The U.S. Constitution protects certain specific defence rights, the right to compulsory process and the right to confront witnesses, by the Sixth Amendment, and defence rights in general are also protected by the due process clause. The German Constitution equally protects certain defence rights, such as the right to be heard in judicial proceedings (Art.103(1) Basic Law), and the fair trial principle which follows from the principle of the rule of law.[81] In France, defence rights are also regarded as fundamental rights.[82] The European Convention on Human Rights which, to varying degrees, influences the law in France,[83] Germany and the UK guarantees certain aspects of fair trial and defence rights in Art.6. To understand the significance of defence rights, it is important to realise that for a person who is accused in criminal proceedings, important individual rights and interests, such as personal freedom, financial interests, but also his/her reputation, are at stake. In a criminal trial, the accused is faced with the superior power of the state. Defence rights therefore serve the purpose of mitigating the inequalities inherent to the situation, and it should not be left to the state to abrogate them easily.

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[80] Chapter 4, 2.4.
[81] Karlsruher Kommentar-Pfeiffer, 27 to Introduction.
[82] Champeil-Desplats, D.1995.chron.323.
[83] For a discussion of the influence of the ECHR on the French approach toward defence rights see Stefani, Levasseur, Bouloc, *Procédure Pénale*, at 86-87.

However, defence rights are nevertheless far from absolute. They are, for example, restricted by exclusionary rules and privileges, such as the privilege against self-incrimination, and testimonial privileges. Every decision to limit the access to or admissibility of certain evidence in a criminal trial may adversely affect defence rights, and the very existence of medical privilege in criminal proceedings expresses the view that medical confidentiality is, in principle, more important than the defence rights of the accused. Defence rights are guaranteed only within the framework of a given legal system, that is they are subject to certain restrictions, and do not go as far as awarding a right of access to evidence regardless of its content or the methods through which it came about. The principal guarantees of defence rights or of a fair trial thus do not give the accused the right to demand that all evidence must be produced in criminal court, even if a privilege applies. Given the fundamental importance of defence rights, the legislators are, however, not entirely free in restricting defence rights, but rather have to pay respect at least to the fundamental guarantees contained in the respective Constitutions, or in international documents such as the European Convention on Human Rights.

Does it follow from the widespread agreement that defence rights can be restricted by privileges, that the recognition of medical privilege is morally justified even if it conflicts with defence rights? Different answers to this question seem possible. It could be argued that, as long as confidential evidence the disclosure of which is sought, is neither available to the prosecution nor the defence, the defence rights of the accused are not unduly prejudiced. There is no inequality of arms, as the prosecution does not deny the defence access to evidence in its possession. However, the validity of this argument is no longer obvious where the defence seeks access to privileged evidence in order either to impeach a prosecution witness, or to present a favourable defence. If, for example, the prosecution presents a key witness, and confidential medical information may cast some doubt on the reliability of the witness, it can no longer be said that the defence is not prejudiced merely because this information is equally unavailable to the prosecution.

It is interesting to note that the general conflict between medical confidentiality and defence rights has only been discussed in the U.S., but not in the other two systems with privilege statutes. In France and Germany, it seems to be accepted

that defence rights are restricted by medical privilege. Even if the defence rights of an accused person appear to be adversely affected by medical privilege in an individual case, the court does not have the discretion to order the physician's testimony, which is barred by privilege. The German Federal Supreme Court recently rejected to order disclosure of a witness' psychological records for impeachment purposes, even though s.97 Code of Criminal Procedure does not protect the medical or psychological records of witnesses from seizure and from use in criminal court, as this measure was regarded as an unconstitutional intrusion upon the witness' private sphere, at least absent a sufficient showing of materiality.[84] The Court thus protected medical confidentiality even beyond the scope of the privilege statute. When access to medical records is sought in France, the procedure sometimes followed by the courts is that of appointing an expert to make a report of the witness' psychological condition, and to grant this expert access to the confidential medical records of the treating physician.[85] However, the relevant French case-law is not concerned with the conflict between medical confidentiality and defence rights and is therefore, in this context, of only very limited value.

In the U.S., the rights of the accused under the Confrontation Clause of the Sixth Amendment to the U.S. Constitution are not violated by medical privilege as long as the accused or his/her defence lawyer are given the opportunity to cross-examine the witness effectively. If the credibility of a key witness is at stake and the defence wants access to the files of the witness' psychotherapist in order to use them for impeachment purposes, this is not mandated by the accused's confrontation rights, as long as the witness can be cross-examined about the psychotherapeutic treatment, and the witness' psychological problems may thus be introduced and put before the jury.[86] However, if effective cross-examination is not possible without access to confidential and privileged information, access to this information is required by the Confrontation Clause.[87] Compulsory process rights are violated if a defendant is denied access to favourable information in the possession of the prosecution, even where the information is privileged, as long as

[84] BGH NStZ 1997, 562.
[85] 20 January 1976, Bull n° 23; 16 November 1976, Bull n° 327.
[86] See, for example, *U.S. v Haworth* 168 F.R.D. 660 (D.N.M. 1996), at 661-662 per Hansen, District Judge; *U.S. v Skorniak* 59 F.3d 750 (8th Cir. 1995), at 756 per Hansen, Circuit Judge.
[87] *People v Adamski* 497 N.W.2d 546 (Mich.App. 1993); *In Re Doe* 964 F.2d 1325 (2nd Cir. 1992).

the materiality of the information can be demonstrated.[88] Thus, in the U.S., constitutional principles are infringed if access to confidential medical information which is material either for impeachment purposes or for its assistance with the direct defence is denied, and without it, an effective cross-examination, or the effective presentation of a direct defence is not possible.

However, it does not necessarily follow that the physician or psychotherapist is required to hand over material but privileged information to the defence. Many U.S. courts instead resort to the method of *in camera* review of confidential files. This is based on the assumption that while the defence should not be denied access to potentially favourable information because of medical privilege, medical privilege should not be completely abrogated by the evidentiary needs of the defence. As a compromise, once an initial materiality showing has been made, the court will review the confidential files *in camera*, and they will only be handed over to the defence if they contain information that is material for defence purposes.[89] This procedure raises several problems. First, it can be argued that the court may not be in the best position to assess the materiality of information for the defence, so that defence rights are not adequately protected by *in camera* review. At the same time, *in camera* review of confidential files in itself constitutes a breach of confidentiality, so that the interest in medical confidentiality is adversely affected by *in camera* review.[90] Thus, while this procedure gives more weight to both interests than an all-or-nothing approach which, in favour of one of the interests, would completely disregard the other, it is nevertheless harmful to both interests involved, so that it must be asked whether a more convincing approach is available.

An approach adopted by some U.S. courts is that of resorting to *in camera* review only where the consent of the patient to this procedure was first obtained.[91] Once the court's *in camera* review establishes that the files would, in fact, be favourable to the defence, some courts decided that defence rights will then override medical

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[88] *Pennsylvania v Ritchie* 480 U.S. 39 (1987), at 57-58 per Justice Powell.

[89] *State v Speese* 528 N.W.2d 63 (Wis.App. 1995), at 69 per Gartzke, Presiding Judge; *State v Shiffra* 499 N.W.2d 719 (Wis.App. 1993), at 724 per Brown, Judge.

[90] See *U.S. v Doyle* F.Supp.2d 1187, (D. Or. 1998), per Coffin, U.S. Magistrates Judge, where *in camera* review of confidential psychological files was rejected.

[91] See, for example, *Re Robert H* 509 A.2d 475 (Conn. 1986), at 482- 485 per Arthur H. Healey, Judge; *State v Grant* 637 A.2d 1116 (Conn. App. 1994), at 1121-1122 per Frederick A. Freedman, Judge.

confidentiality,[92] while others argued that even under such circumstances, the files can only be passed on to the defence with the patient's consent.[93] The consequence would be that the testimony of the witness concerned must either be stricken, or a new trial directed.[94] The same applies where the patient refuses to consent to *in camera* review as such.

Looking at the situation in the three different jurisdictions, it is striking that in all three countries, confidential medical records of a witness cannot routinely be used in criminal court at the request of the defence, not even in Germany, where the witness' records are not protected by ordinary statutes. However, while in the U.S., the inadmissibility of such records has far-reaching consequences and can even result in striking the witness' testimony or ordering a re-trial, no such consequences are envisaged in France or Germany. How can this difference in approach be explained, given that in France and Germany, defence rights are also protected as fundamental rights? First, the protection of defence rights as fundamental individual rights in France and Germany is less specific and less comprehensive than the protection afforded by the Sixth Amendment to the U.S. Constitution. Moreover, the differences in criminal procedure may have a significant impact on the solution favoured in each legal system. *In camera* review is alien to the French and German legal systems. One reason for this may be the fact that the decision about the guilt or innocence of the accused is made by the court. If, in such a system, the court could scrutinise confidential material and then deny the defence access to it, either on the grounds that the information was not favourable to the defence, or on the grounds that the patient did not consent to the disclosure, the court would have obtained knowledge of evidence which might influence its later decision, but which is unknown to the defence and to which the defence can therefore not respond. In Germany, such a procedure would violate the constitutional principle that the accused must have the opportunity to be heard before a judicial decision is made. This principle, which aims to prevent that the court can make use of facts that are unknown to the accused to his/her

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[92] *State Ex Rel. Romley v Superior Court* 836 P.2d 445 (Ariz. App. Div.1 1992), at 452-453 per Grant, Presiding Judge.

[93] *Re Robert H* 509 A.2d 475 (Conn. 1986), at 482- 485 per Arthur H. Healey, Judge; *State v Grant* 637 A.2d 1116 (Conn. .App. 1994) at 1121-1122 per Frederick A. Freedman, Judge; *State v Solberg* 553 N.W.2d 842 (Wis. .App. 1996), at 844 per Dykman, Judge.

[94] *State v Shiffra* 499 N.W.2d 719 (Wis. App. 1993), at 721 and 724 per Brown, Judge; *State v Speese* 528 N.W.2d 63 (Wis. .App. 1995), at 71 per Gartzke, Presiding Judge.

disadvantage,[95] applies to all decisions of the court and would therefore include a decision about disclosure after *in camera* review of information. While, from the point of view of the defence, *in camera* review is always problematic, it is far more dangerous to the defence where the reviewer is the final decision-maker over guilt and innocence.

In the U.S., all of the different approaches used by the courts point towards a precedence of defence rights whenever it can be established that the confidential information the disclosure of which was sought might be relevant and material. In that case, courts either come to the conclusion that, after *in camera* review, the information should be disclosed to the defence, despite the existence of medical privilege, or they uphold confidentiality, but seek to protect defence rights by ordering that the testimony of the witness, who cannot be impeached because of medical privilege, be disregarded. In France and Germany, on the other hand, none of these drastic measures is taken, Rather, the only consequence of an impairment of defence rights by medical privilege is that the court, when making its decision on the guilt or innocence of the accused, will have to consider the fact that the defence has been denied access to certain potentially favourable evidence because of medical privilege. This difference in approach may be explained by the thought that courts are in a better position to take account of the fact that certain evidence was not available for impeachment purposes than is a jury. This would even apply to the French 'Cour d'Assize' in which nine jurors deliberate and decide together with three professional judges. Therefore, Continental legal systems may not perceive the same need for strict evidentiary rules as common law systems with jury trials.

While this analysis shows that it would be difficult to transfer solutions from Continental to common law systems, and *vice versa*, it nevertheless seems appropriate to assess whether it is, in principle, more justifiable to resolve the conflict between medical confidentiality and defence rights by deciding in favour of disclosure,[96] by refusing disclosure and making allowances for the impairment of the defence when reaching the final decision, or by respecting medical confidentiality and striking the evidence affected by medical privilege. Disclosure against the patient's wishes does not seem an adequate solution to the problem.

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[95] Karlsruher Kommentar-Pfeiffer, 26 to Introduction.
[96] See Allan, [1988] NLJ 668-669 for cases of legal-professional privilege.

Where a privilege statute exists, a legislative decision was made in favour of medical confidentiality in the context of judicial proceedings, leaving no room for an abrogation of the privilege where it conflicts with defence rights, absent a statutory exception to the privilege statute for that purpose.[97] Such an exception leading to disclosure without the patient's consent does not seem to be a satisfactory solution, even where the defence could establish that the privileged evidence was material and relevant. Given that medical confidentiality, similar to defence rights, serves the protection of fundamental individual rights and interests, medical confidentiality should only have to yield to defence rights if no less intrusive means are available for a satisfactory resolution of the conflict.

What, then, could be a less intrusive alternative to disclosure, given that the compromise of *in camera* review without the patient's consent has already been dismissed as inadequate, and also as untenable for Continental legal systems? Where the patient refuses to consent to disclosure of information sought for impeachment purposes, to strike the testimony of the witness concerned would protect the interests of the accused as effectively as disclosure. At the same time, this would protect the interests of the patient comprehensively. To strike the witness' testimony is thus a less drastic means to protect the interests of the accused than an exception to the privilege statute. The objection that such a result would unduly undermine the case of the prosecution is not convincing. The existence of the privilege statute is attributable to the state, and the prosecution is the representative of the state in criminal proceedings. Therefore, if defence rights are guaranteed in order to ensure a fair trial, and if the state impairs the defence by implementing a privilege that hinders defence access to potentially favourable evidence, it seems only fair that the state rather than the accused will have to suffer the adverse consequences of a privilege statute.[98]

Given that the striking of a witness' testimony, though the best available option in cases of a conflict between medical confidentiality and defence rights, nevertheless considerably affects the state interest in criminal prosecution, particular attention must be given to the determination of the circumstances under which such a remedy should be made available to the defence. It is submitted that the defence should have the burden of demonstrating that the privileged evidence,

[97] Hill, (1980) 80 Columbia Law Review, at 1180.
[98] Ibid., at 1184-1185; Weisberg, (1978) 30 Stanford Law Review, at 983.

if admissible, would have cast some doubt on the credibility of the prosecution witness. This requires some showing that there is at least a probability that the evidence the disclosure of which was sought contains favourable information, and that the defence has some idea of the content of the information sought. To trigger such a drastic remedy, it would not be sufficient to base a request for a witness' psychotherapeutic records on the knowledge or the assumption that the witness received psychotherapy and that there is the remote possibility that these records contain evidence that might be useful for defence purposes. In such a case, it can hardly be said that the defence is disadvantaged by medical privilege, as this is not different from other cases of 'fishing expeditions' in which access to evidence will also be denied.

It could be argued that defence rights are sufficiently protected if the assessment of the potentially adverse effects of medical privilege is left to the court or the jury, respectively, based on the showing of the probable content of the evidence and of its materiality. While this may be a possibility in Continental legal systems, it is not equally tenable for jury trials.[99] However, even where the court and not the jury decides on the question of guilt or innocence, the accused will be better protected where the evidence is disregarded altogether.

To strike evidence only constitutes a useful remedy for an interference with defence rights where the defence was denied access to information to be used to refute the case of the prosecution. In that case, the loss of this evidence by the prosecution would provide effective protection of the accused. However, the same would not be true where the evidence was sought as part of the direct defence of the accused. In that case, the only effective remedy apart from disclosure would be either to infer that the evidence, if admissible, would have been favourable to the defence,[100] or to drop the charges altogether.[101] It is submitted that in such a case, an inference is the less drastic measure, and would protect the interests of the accused as effectively as a dismissal of the case. Such an inference is also less intrusive than disclosure, as the interests of the accused and of the patient can both be protected this way. With regard to the interests of the prosecution, the same argument advanced in the context of evidence sought for impeachment purposes

[99] Hill, (1980) 80 Columbia Law Review, at 1182.
[100] Ibid., at 1184-1185.
[101] Weisberg, (1978) 30 Stanford Law Review, at 982-984.

applies, as it seems the best possible solution that the state will have to suffer the adverse consequences of a privilege statute.

The discussion takes a slightly different turn if the focus no longer lies on the general conflict between medical confidentiality and defence rights, but the emphasis rather shifts to the conflict between medical confidentiality and the interests of a person who is wrongly accused. Would disclosure be justified if the physician were in possession of information that would clearly establish the innocence of the accused? It could be thought that the conflict of interests emerging in such a situation differs from the general conflict analysed thus far, in that account not only has to be taken of the interests of an accused in having a fair trial. Instead, the interests of a citizen not to be wrongly convicted, thus the interests in liberty, financial interests in cases of an impending fine, or the loss of reputation, also need to be considered. However, it is submitted that all of these interests are integral parts of the interest in presenting an effective defence. Defence rights not only aim at the protection of the rights of the guilty to be convicted only after a fair trial that was conducted in accordance with procedural safeguards, but they also aim at protecting the interests of the innocent not to be convicted at all. Given the presumption of innocence, any distinction between the interests of the guilty and of the innocent seems artificial and unacceptable, as prior to the verdict, every accused person must be regarded as innocent. The rights of the accused to demand access to confidential material are thus the same, be he/she guilty or innocent.

However, the question of guilt or innocence nevertheless had some impact on the legal debate regarding the question of whether or not a physician's voluntary disclosure of information would be justified. In France, art.434-11 Criminal Code makes it a criminal offence not to disclose information establishing the innocence of a person who has either wrongly been convicted for a criminal offence, or is wrongly under arrest for investigation. However, physicians are exempt from this obligation and can therefore only lawfully disclose such information where a legal justification applies.[102] While no provision comparable to art.434-11 French Criminal Code exists in any of the other countries, the problem has nevertheless

[102] Rassat, *Droit Pénal Spécial*, at 381.

been discussed, and many seem to agree that where the innocence of a person who is wrongly charged with a criminal offence can be established, the physician's disclosure will be justified. A similar suggestion has been made in the U.S.[103] In Germany, these cases are resolved by an application of the necessity defence. This raises several problems. First, it must be decided at what point in time a present danger to the interests of the wrongly accused person materialises. Such an assessment is difficult to make, particularly for a physician who may not be familiar with all the details of criminal procedure and may therefore not be in the best position to evaluate at what moment disclosure would be adequate. Another problem is that of a balancing of interests, as it is controversial whether medical confidentiality is outweighed by the interest in personal freedom, by financial interests, and by interests in a good reputation.[104] In the UK, defence rights are usually given precedence over other interests.[105] However, a different decision has been taken in respect of the conflict between defence rights and legal professional privilege, the only professional privilege recognised in the UK.[106]

Given the importance of the interests behind medical confidentiality, it does not seem to be sufficient simply to state that the interests of an accused person not to be convicted for an offence he/she did not commit have to prevail over the interests in medical confidentiality. The criteria advanced in Germany in the context of the necessity defence similarly do not provide an acceptable and workable solution. In France, an alternative way is suggested. Where the physician holds evidence regarding the innocence of a person who is accused in criminal proceedings, he/she should forward this evidence without exposing the identity of the real perpetrator.[107] While this way, the competing interests could widely be reconciled, the decision on guilt or innocence would then exclusively rely on the physician's averment which may frequently not be amenable to any proof, unless corroborative evidence exists in the individual case. However, it is submitted that this would be a less intrusive way to resolve the problem than a full disclosure by the physician. This solution is also in line with that proposed for the

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[103] See Thomas-Fishburn, 61 University of Colorado Law Review 1990, at 201-202, for the comparable situation of the attorney-client privilege.
[104] See *supra*, at 125.
[105] See, for example, *Taylor v Serious Fraud Office* (HL (E)) [1998] 3 WLR 1040, at 1049 per Hoffmann LJ
[106] *R v Derby Magistrates' Court, ex parte B* [1996] AC 487 (HL).
[107] Anzalec, Gaz. Pal. 1971.113.

general conflict between medical confidentiality and defence rights. Where the physician has declared to be in the possession of evidence that may exculpate the accused, he/she should therefore merely be allowed to reveal this fact, without at the same time disclosing any confidential patient information. It could then either be inferred that the physician's testimony, if not barred by privilege, would have been favourable to the accused, or the revelation of the physician could be assessed by the court when deciding on the guilt or innocence of the accused.

Should it make a difference whether the real offender is the patient or a third party? A distinction between the two situations is sometimes promoted, as it is felt that a stronger case for medical confidentiality exists where the physician would have to inform on the patient, rather than a party not protected by the physician-patient relationship.[108] However, this distinction is not convincing. First, the patient's privacy interests are not diminished by the fact that the confidential medical information the physician is going to disclose does not incriminate him/her, but rather a third party. Furthermore, the patient may be as interested in protecting a close friend or relative from criminal prosecution as in his/her own protection, so that the harm to the physician-patient relationship ensuing from disclosure may be the same regardless of whether the disclosure refers to the patient or a to a third party.

Finally, where the criminal proceedings or investigations are directed against the physician, and the physician could exonerate him/herself by revealing confidential medical information, the conflict is, in principle, similar to the general conflict between medical confidentiality and defence rights and should be dealt with accordingly. However, courts and legal writers mostly promote the idea that in such a case, the physician's violation of medical confidentiality should be justified.[109] This may be based on the view that the physician is in a different position than other persons who are accused in criminal proceedings. If the physician could exonerate him/herself with confidential patient information, this means that the physician has favourable information in his/her possession.

[108] Pradel, JCP.1969.I.2234.
[109] See, for example, Cour de Cassation 20 December 1967, D.1969.309; Damien, *Le Secret Nécessaire*, at 36; Décheix, D.1983.chron.133; Mazen, *Le Secret Professionnel des Practiciens de la Santé*, at 147; Pradel, JCP.1969.I.2234; Rassat, D.1989.chron.107; Reboul, JCP.1979.I.825; Thouvenin, *Le Secret Médical et l'Information du Malade*, at 99-100; BGHSt 1, 366, 368 (1951); KG JR 1985, 161, 162; Tröndle/Fischer-Tröndle, 31 to s.203; Leipziger Kommentar-Jähnke, 83 to s.203; Schönke/Schröder-Lenckner, 33 to s.203.

Accordingly, medical privilege would not bar access to privileged material that is not already in the possession of the defence, but would rather bar the admissibility of evidence the physician could easily produce. It is nevertheless submitted that accused physicians should not be treated different from other accused persons. The production of confidential medical information for defence purposes would violate the procedural prohibition of introducing privileged material as evidence. Therefore, to deny the physician the possibility to introduce such evidence is not different from generally denying the admissibility of evidence that was created in ways that violate procedural provisions, such as the introduction of conversations that were recorded without the consent of the person concerned.[110] An exception only seems mandated in cases in which the patient accuses the physician of criminal conduct in the course of the physician-patient relationship, as in such a case, no meaningful defence would otherwise be possible, and it can be argued that the patient in that case waived medical privilege by making a public accusation against the physician.[111]

The preceding discussion has demonstrated that defence rights will not necessarily be adversely affected by a recognition of medical privilege, as the two competing interests can widely be reconciled in the case of a conflict. Consequently, the conclusion of the British Criminal Law Revision Committee[112] that medical privilege should not be introduced in the light of the importance of the rights of the defence is not compelling.

4. Crime prevention

A breach of medical confidentiality for the purposes of crime prevention raises particularly difficult problems. While all legal systems as well as the different philosophical approaches seem to agree that in some circumstances, medical confidentiality may be outweighed by the interest in crime prevention, it is not at all clear how to delineate these cases and which criteria to apply when balancing the conflicting interests in an individual case. This is a problem shared by all legal systems. Even the English system which does not recognise medical privilege has

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[110] For the inadmissibility of such evidence in Germany see Kleinknecht/Meyer-Goßner, 43 to s.163.
[111] Slovenko, *Psychotherapy and Confidentiality*, at 252.
[112] Eleventh Report, Cmnd 4991, para.272-276.

to find a solution to the problem, as medical confidentiality is protected outside the courtroom, and the physician who breaches medical confidentiality to prevent a criminal offence may be held liable for compensation, unless the disclosure is justified. None of the legal systems have succeeded in presenting a coherent approach to this problem, and the same must be said about the philosophical discussions of the problem. A thorough analysis of the different approaches and the results thereby achieved is thus necessary to see whether a convincing approach can, in fact, be developed.

A first problem consists of defining the dividing line between crime prevention and criminal prosecution. While Continental legal systems usually sharply distinguish between the two situations, the same is not true for common law systems. There, both problems are often discussed together, apparently because it is felt that the prosecution of a criminal or a crime will at the same time prevent future crimes. However, it is submitted that such a view is not entirely convincing. It is, of course, possible that a person who has committed a crime in the past may continue to do so in the future. In that case, investigations aimed at prosecuting the perpetrator may at the same time serve the purpose of preventing future crimes. But this is not necessarily the case. Frequently, criminals will not commit more than one crime, and their prosecution can then not be said to be motivated by purposes of crime prevention, apart from the general idea that the prosecution of crime will deter the public from committing criminal offences, an interest that is one feature of the interest in criminal prosecution.

Crime prevention pursues the purpose of preventing harm to potential victims of potential criminal offences. Many uncertainties are involved, as frequently neither the potential victim nor the potential criminal offence are amenable to further specification. This lack of clarity complicates any assessment of the weight to be given to the interests in crime prevention in the course of a balancing exercise. Is it necessary that the potential victim can be identified, or is at least identifiable, in order for the interest in medical confidentiality to be outweighed? Furthermore, to what extent does the plan to commit a criminal offence need to be specified? Is it sufficient that a person has dangerous, aggressive or violent tendencies which may, at an indeterminate time, turn into criminal activity? What possible crimes may justify a breach of medical confidentiality? The balancing exercise involves so many indeterminable factors that it seems very difficult to develop workable

criteria. Should it follow that the interests in crime prevention can never justify a breach of medical confidentiality, as hypothetical dangers cannot be weighed against a real breach of medical confidentiality?[113]

This is certainly not the solution promoted by any of the legal systems under investigation. In France, art.434-1 Criminal Code imposes an obligation on every individual to inform the relevant authorities of criminal offences the commission of which can be prevented or the effects of which can be limited, regardless of the seriousness of the offence. However, physicians are exempted from this obligation. This means that a physician who learns, in the course of his/her profession, that a criminal offence will be committed, is not faced with conflicting legal obligations. He/she is under an obligation to maintain medical confidentiality, from which he/she is not exempted even if disclosure would help to prevent a criminal offence, while there is no obligation for the physician to disclose confidential information for the purpose of crime prevention.

In Germany, s.138 Criminal Code imposes an obligation on every individual to disclose information about the criminal offences listed in that provision if their commission or consequences can still be averted. S.139(3) Criminal Code somewhat mitigates this obligation for physicians. Physicians are only under the obligation to report those offences that are listed in s.139(3) Criminal Code, and are, with regard to the offences listed in s.138 Criminal Code, exempted from the obligation to disclose if they made a serious effort either to prevent the commission of the offence or to avert its consequences.

Both France and Germany thus introduced an obligation to disclose criminal offences if their commission or their consequences can be averted, and both legal systems provide for exceptions to this obligation where physicians would otherwise have to disclose confidential patient information. However, there are also some important differences between the two approaches. In France, the general obligation to disclose refers to all criminal offences, regardless of their seriousness, while the German legislator has opted for an obligation that is limited to certain offences regarded as particularly dangerous. In France, the physician is completely exempted from the general obligation to disclose and is therefore under no obligation even to report the most serious criminal offences in order to

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[113] This solution is promoted by Kottow, 'Stringent and predictable medical confidentiality', in: Gillon, *Principles of Health Care Ethics*, at 477.

prevent their commission. The French system thus makes a general statement that medical confidentiality is regarded as more important than the prevention of criminal offences. The German legislator, on the other hand, adopted a more differentiated view in distinguishing between different criminal offences. The exception for physicians only applies where the physician has tried to avert the danger, but is not at all applicable to the offences listed in s.139(3) Criminal Code. This shows that the exception is based on the view that medical confidentiality has to yield where the prevention of the most serious criminal offences could be achieved by a breach of confidence. At the same time, it is clear that medical confidentiality is valued so highly that apart from the most serious crimes, the legislator protects medical confidentiality by allowing the physician to resort to less intrusive means of trying to prevent the criminal offence without breaking his/her obligation to medical confidentiality. Here, to achieve the protection of medical confidentiality, the legislator is even willing to take the risk that these less intrusive measures might fail, as it requires no more than that the physician seriously tries to avert the risk, but does not impose an obligation to disclose where such an attempt remained unsuccessful.

So far, it has only been explained whether and under what circumstances physicians may be under an obligation to disclose confidential patient information in order to prevent a criminal offence. However, this does not necessarily answer the question under what circumstances the physician may be justified to breach a patient's confidence for the purposes of crime prevention. It is interesting to note that in both Germany and France, this problem has not occupied the courts and has received only little attention from legal writers. In France, the discussion mainly focuses around the question of whether or not the legislative provisions in this area leave the physician a choice between maintaining confidentiality and disclosure for the purposes of crime prevention.[114] For a Continental legal system, the French discussion is surprisingly unsystematic. Given that the physician is under an obligation to maintain medical confidentiality, but under no obligation to disclose information for the purpose of crime prevention, it is inconsistent to argue that the physician can be justified when committing a criminal offence merely on the grounds that he/she has chosen to do so. This certainly contravenes the principles of criminal law, as a criminal offence can only be exceptionally

[114] See chapter 3, 2.5.1.

justified where the state has decided that the obligation to follow the criminal law is outweighed by overriding considerations. In that respect, it seems more consistent to follow the German example which allows for a justification of the offence of breach of confidence only where the physician is either under an obligation to disclose the information, or where a legal justification applies. However, the German approach, while formally in line with legal principles, also encounters many problems. As the question of whether or not the physician can be justified when disclosing confidential patient information in order to prevent the commission of a criminal offence is governed by the principles of the necessity defence pursuant to s.34 German Criminal Code, it must be established whether there is a present and imminent danger to another which cannot be averted without disclosure, and whether the impaired interest is significantly outweighed by the interest protected through disclosure. If these requirements are fulfilled, the justification will depend on the showing that disclosure was an appropriate means to avert the danger.

In the U.S., the problem is mainly discussed in the context of whether or not the physician is under an obligation to disclose information necessary for the purpose of crime prevention. Since the influential *Tarasoff*[115] decision, many States have adopted the approach that a physician is under a duty to disclose confidential patient information where this would help avert the risk of harm to another.[116] With regard to the specification of criteria which might help to decide whether or not a disclosure may be justified for the purpose of crime prevention, the holding in *Tarasoff* is rather vague, as it does not define what kind of danger is required, and how specific the threat must be. In Louisiana, where the *Tarasoff* duty has been enacted by statute,[117] an imminent danger of violence to a specified person is required. Other States reject an obligation to disclose altogether,[118] but they are then still faced with the problem of whether, absent such an obligation, disclosure for the purpose of crime prevention can be justified, and if so, under which circumstances. In England, the Court of Appeal's decision in *W v Egdell*[119]

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[115] *Tarasoff v Regents of the University of California* 31 Cal. Rptr. 14 (Cal. Sup. Ct. 1976).
[116] See, for example, *McIntosh v Milano* 168 N.J.Super. 466 (1979), at 489-490; *Peck v Counseling Service of Addison County* 499 A.2d 422 (Vt. 1985), at 426; *Petersen v State* 671 P.2d 230 (Wash. 1983), at 237.
[117] La. Rev. Stat. Ann. 9:2800.2(A) (West Supp. 1990).
[118] See, for example, *Hasenai v U.S.* 541 F.Supp. 999 (D. Md. 1982).
[119] [1990] 1 All ER 835.

suggests that disclosure for the purpose of crime prevention is justified where there is a real risk of danger to the public.

While in France, no criteria for a justification of a disclosure of confidential medical information for the purpose of crime prevention are discussed, the criteria suggested in Germany, the U.S. and England are rather ill-defined and need further specification, before their workability can be assessed and a critical evaluation be made. Given that the disclosure of confidential medical information by the physician violates the patient's privacy rights, and constitutes a breach of a professional obligation to medical confidentiality as well as, depending on the legal system concerned, a criminal offence, a tort, a breach of contract or a breach of a fiduciary duty, it seems fair to limit instances of justified disclosure to situations in which a compelling case for disclosure can be made.

The three systems seem to agree that there must be some risk of danger to another. This raises several questions. It must, for example, be decided what kind of danger should be required in order to justify disclosure. Does a danger to any interest of a third party provide sufficient justification for disclosure? Given the high value of medical confidentiality as promoting privacy and autonomy, it is submitted that disclosure can be justified only in order to avert a danger to an interest that is of even higher value than medical confidentiality. This, of course, immediately raises the problem of how to rank the competing interests. The German discussion suggests an orientation at the list of offences contained in ss.138, 139 Criminal Code, which are all offences that are either directed against weighty public interests, or offences involving some serious form of violence against third parties.[120] In the U.S., it is sometimes required that the danger must involve a threat of physical violence against another.[121] While English and American courts did not expressly specify this requirement, all case-law existing in this area involves either a threat to the life of third parties, or at least a threat of physical violence or abuse. A requirement of a danger of physical violence is also promoted by legal writers.[122] It seems fair to conclude that there is wide-spread agreement that in cases of a danger to the life or physical integrity of a third party, medical confidentiality may sometimes be outweighed.

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[120] Schönke/Schröder-Lenckner, 31 to s.203; Maurach/Schroeder/Maiwald, *Besonderer Teil 1*, at 293.

[121] See La. Rev. Stat. Ann. 9:2800.2(A) (West Supp. 1990).

[122] See, for example, Kennedy, Grubb, *Medical Law*, at 657.

Is this agreement based on morally justifiable considerations? Most utilitarians seem to agree that the preservation of medical confidentiality in cases of a danger of violence would be more costly than disclosure. However, others disagree and argue that it is difficult to assess how many lives might be saved in the long run by maintaining medical confidentiality.[123] Again, therefore, the utilitarian analysis is not helpful for the development of consistent criteria. From a deontological perspective, there seems almost universal agreement that the interest in privacy and personal autonomy is outweighed by the interest in life and physical integrity.[124] However, it should be borne in mind that there may be many cases in which the risk is slim, or in which the injury to be feared might be so minor that it cannot be said to outweigh disclosure. Also, it does not seem right to reduce the balancing exercise to weighing the potential victim's interests in physical integrity against the patient's interests in autonomy and privacy, as on the patient's side, decisional autonomy indirectly serves the patient's health interests and therefore the patient's interests in bodily integrity.

It has been argued that where the risk to a third party emanates from the patient, the patient's interests do not deserve protection, as the patient's autonomy finds its limits where its exercise interferes with the autonomy of a third party.[125] However, it should not be overlooked that this argument, if at all valid, only holds for the patient, but fails where the risk emanates from a person who is not party to the physician-patient relationship. It could be argued to the contrary that medical confidentiality weighs more heavily where the threat emanates from the patient, as in such a case the breach of the confidential relationship may be regarded as more serious.[126]

Given the variety of factors influencing the balancing process in the context of crime prevention, it is difficult to agree on a general ranking of the interests involved, apart perhaps from cases in which the life of a third party is at risk, or where there is a threat of serious violence. This difficulty is reflected in the approaches adopted by the different legal systems. Different from the conflict of interests to be resolved in the context of criminal prosecution, none of the legal systems under examination opts for a generalised way of resolving the conflict

[123] Moore, (1985-86) 36 Case Western Reserve Law Review, at 193.
[124] Ibid., at 194-195; Beauchamp, Childress, *Principles of Biomedical Ethics*, at 426.
[125] See, for example, Jones, [1990] 6 PN, at 22.
[126] Pradel, JCP.1969.I.2234.

between medical confidentiality and crime prevention, apart from a few exceptional situations. Rather, all systems adopt a case-by-case approach and make the resolution of the conflict dependent upon the facts of the individual case. How can such a difference in approach be explained? In most cases of crime prevention, there will be a danger to a third party, while in the case of criminal prosecution, there is a danger to a public interest. Furthermore, the interests behind crime prevention vary from case to case, as crime prevention relates to many completely different potential offences which can have manifold consequences. This means that in every individual case, the outcome of the balancing test will vary, depending on the specific features of the case. This is different from the situation of criminal prosecution where the interests to be weighed against medical confidentiality are the interests of justice, interests of a general and abstract nature, the content of which is largely independent from the individual case. Given the imponderabilities of cases of crime prevention, it seems adequate to regulate the conflict by giving some leeway to the physician's judgment, as the prevention of harm to third parties involves a situation in which the risks in a given case must be assessed and balanced against competing interests. While criteria for the balancing of interests in the individual case are necessary, it is thus not appropriate that the conflict between the interest in medical confidentiality and the interest in crime prevention is resolved on a generalised basis.

Does it make a difference whether or not the danger is present or imminent, and whether there is a danger to the public at large, as opposed to a danger to a specific person? If information can be disclosed whenever there is a risk of danger to another, regardless of whether there is any probability that the risk might materialise in the foreseeable future and whether or not the potential victim is identifiable, this arguably leads to the possibility of disclosure in a large number of cases. Whenever a person shows aggressive or violent tendencies, this could then lead to disclosure, as with such persons there is always at least a slight possibility that the tendencies may one day turn into actual violence. Should it really be said that this in itself can give rise to a justification of a breach of medical confidentiality? Given the lack of thoroughly defined legal criteria, the situation is not at all clear. In Germany, the predominant opinion interprets the 'present danger' requirement of the necessity defence to demand a risk that the

danger might materialise at any time, and that immediate action is therefore required in order to avert the danger.[127] The application of this criterion is problematic, as a prediction of the time at which the patient might commit a criminal offence is difficult, if not impossible. The German discussion, for example, raises the problem of whether there is a present danger merely because the permanent dangerousness of a person could at any time lead to the commission of a criminal offence.[128] It is submitted that the determination of the presence of the danger as an isolated criterion is not very helpful, and that it can achieve no more than exclude disclosure in cases in which no immediate action is, in fact, required. This would, for example, apply to the British case of *W v Egdell,*[129] where the Court of Appeal came to the conclusion that the dangerous disposition of a patient as such can be sufficient to justify disclosure under the public interest defence. The result in *Egdell* was reached even though the patient's release from a secure unit was far from imminent. While the Court of Appeal argued that the disclosure was necessary as otherwise the patient's release may have progressed without adequate information being available to the relevant authorities, this seems to be a clear case in which there was no present danger, and in which disclosure should already have been excluded on those grounds.

Is it more meaningful to focus on the question of a specific threat exceeding the general risks of life?[130] This consideration can be found in the American decision of *Thompson v County of Alameda,*[131] and the British decisions in *Re V (Sexual Abuse: Disclosure); Re L (Sexual Abuse: Disclosure).*[132] In the American case, the court held that no duty to warn arises where the patient is potentially dangerous to a whole community, but where no identifiable victims exist. In the British case, the Court of Appeal was not prepared to hold that a risk the existence of which was mainly inferred from the past behaviour of the person concerned, and the potential victims of which were not specified, was sufficient to justify the disclosure of confidential information. Is the identifiability of the victim a sustainable criterion for the disclosure of confidential medical information? Imagine the case of a physician who is told by a patient that (1) he will go to a

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[127] Tröndle/Fischer-Tröndle, 4 to s.34.
[128] Schönke/Schröder-Lenckner, 17 to s.34.
[129] [1990] 1 All ER 835.
[130] For Germany, see Jakobs, *Allgemeiner Teil*, at 415.
[131] 614 P.2d 728 (Cal. Sup. Ct. 1980), at 734.
[132] [1999] 1 FLR 267 (CA), per Butler-Sloss, LJ.

club that evening to shoot a friend (a clearly identified person), (2) that he intends to shoot the first person to enter the club (an identifiable person), or (3) that he intends to shoot one person in the club which he will select at the spur of the moment. While it may be argued that the degree of risk is different for the clearly identified or the identifiable person, the significance of the interest to be protected by disclosure is exactly the same in all three cases. Even if one were prepared to agree that in the third case, the victim will only have to tolerate a general risk of life, this would then equally apply to the second case.

The main problem may be described as a problem of the avoidability of the risk, or the suitability of disclosure as a means to avert the danger, a criterion which can be found in the German necessity defence, and which was similarly promoted in the recent decision of *US v Glass*.[133] Seen this way, the three scenarios look slightly different, as disclosure to the potential victim may be a possibility to avert the risk in the first two cases, but to avert the risk is more difficult in the third case, as it will not be possible to warn a non-identifiable victim. The possibilities to avert the danger through a disclosure to the police are also uncertain, as the police does not have many preventive measures at its disposal to avert an unspecified risk. All would depend on the enormously difficult problem of risk assessment. In the American case of *Peck v Counseling Service of Addison County*,[134] Billings, Chief Justice, for example, argued in his dissent that it is impossible to predict future violent behaviour. Others argue that while the assessment of dangerousness is difficult, it is not impossible, given that it is the normal job of psychiatrists who certify individuals for commitment to a hospital if it is felt that they cause a danger to themselves or to others.[135] This introduces an interesting thought. Cases of potentially dangerous patients who do not pose a danger to another that is specific enough to be averted by disclosure either to the potential victim or the police, may more appropriately be dealt with by the respective regulations regarding the commitment to psychiatric hospitals. This solution would be consistent with the fact that a preventive arrest by the police is usually neither legitimate, nor acceptable.[136] If, in the individual case, disclosure

[133] 133 F.3d 1356 (10th Cir. 1998), at 1359-1360 per Porfilio, Circuit Judge.
[134] 499 A.2d 422 (Vt. 1985), at 427-428.
[135] Bok, *Secrets*, at 128; Slovenko, *Psychotherapy and Confidentiality*, at 300-301; Emson, (1988) JME, at 90.
[136] Kottow, 'Stringent and predictable medical confidentiality', in: Gillon, *Principles of Health Care Ethics*, at 477.

would not help to avert the danger, as no protective measures could be taken, or the potential protective measures are disproportionate to the danger, such as preventive arrest of all persons with aggressive tendencies, or the disclosure of such tendencies to the world at large, then disclosure cannot be justified, regardless of the weight of the interests stake.

Assessing case-law according to the criteria thus developed shows that disclosure would not have been justified in the *Tarasoff* case. The victim was killed two months after the threat had been uttered in a therapeutic session. It is submitted that it is very doubtful whether disclosure to the victim would have averted the danger, and the campus police had been informed but had to release the patient! Coming back to the cases of *Re V (Sexual Abuse: Disclosure); Re L (Sexual Abuse: Disclosure)*,[137] the decisions against disclosure seem correct. In both cases, the risk was so vague that disclosure would only have had a chance of preventing a potential danger if drastic measures would have been adopted, to which the degree of risk did not give rise, and which, therefore, would have been disproportionate.

It can thus be seen that in cases of a disclosure of confidential medical information for the purposes of crime prevention, a comprehensive analysis of all the factors involved is necessary in order to come to a well-reasoned decision as to whether or not disclosure can be justified. The outcome of the balancing test does not depend on an abstract evaluation of the interests at stake, but instead on a detailed analysis of the value of the competing interests, the degree of danger, and, most importantly, the suitability of the disclosure for the prevention of harm. It is submitted that disclosure to the potential victim or the police cannot be an appropriate means of crime prevention, unless the risk is specific enough to give preventive measures at least a chance of success, which would exclude all cases in which the threat merely emanates from potentially dangerous characteristics of an individual.

This leaves, as a last problem, the case of a patient who has committed past crimes, perhaps of a very serious nature, but, though eventually likely to commit future crimes, does not at present have any specified plans to commit criminal

[137] [1999] 1 FLR 267 (CA), per Butler-Sloss, LJ.

offences. In Germany, disclosure in such a case would not be justified, as there is then no 'present' danger to another. If, however, the main focus of the debate lies on the question of avoidability of harm and the suitability of preventive measures, this case must be distinguished from the above examples, as the patient's arrest in such a case would clearly be an option, awaiting further investigations and a possible trial. The measures to be taken to avoid further danger are means of criminal prosecution, rather than methods of crime prevention, which suggests that disclosure, though potentially, but uncertainly, also preventing the commission of future crimes, mainly serves the purposes of criminal prosecution of the offender. Disclosure for this purpose, however, is not justified where a privilege statute exists. Even if the physician's disclosure were justified, and the patient could be arrested, the physician's evidence would not be available in criminal court, so that the patient's conviction would be far from certain. The case is thus not different from that of a patient who is on trial for a criminal offence, and in the proceedings against whom medical privilege bars certain evidence. This is the price to be paid if one values medical confidentiality enough to protect it even in the context of criminal prosecution.

5. Conclusion

Given the complexity of the subject matter and of the methodology used, it is fair to say that the thesis mainly demonstrates that there are no easy answers to the problems raised. It has been established that there is surprising unanimity regarding the significance of medical confidentiality among all legal systems as well as the different philosophical schools. While every legal system has its own ways of guaranteeing the protection of medical confidentiality, the scope of protection does not differ significantly, regardless of whether the protection is awarded by the Constitution, by criminal law or by private law. The existence of a fundamental right to privacy thus does not necessarily influence the protection of medical confidentiality.

However, this unanimity evaporates as soon as medical confidentiality conflicts with the interests in criminal prosecution, crime prevention or with defence rights. In this area of law, all comes down to value judgments, and the ethical analysis indicates that there are no universally valid principles at which such judgments

could be orientated. This result was confirmed by the comparative legal study which demonstrates that, apart from a few similarities, different legal systems not only differ in style and legal method, but also in the value judgments promoted and in the results achieved. The approach towards the resolution of conflicts between medical confidentiality and the competing interests depends to a large extent on the value accorded to medical confidentiality, and on the interests medical confidentiality is aimed to protect.

With regard to the interests behind medical confidentiality, it has been shown that the two main ethical approaches to medical confidentiality, that is utilitarian and deontological approaches, are also reflected in the value judgments made by different legal systems. Thus, medical confidentiality is regarded in all legal systems as important to promote the patient's privacy and autonomy. All legal systems also accept to different degrees the consequentialist argument that medical confidentiality is important in order to enhance patient frankness in the context of the physician-patient relationship, which is considered to be important for the preservation of individual and public health. The German and the French system also take account of the physician's interests behind medical confidentiality.

Courts and legislators in all systems seem to combine different justifications behind the principle of medical confidentiality intuitively, but mostly, one approach will be given precedence over the other. Thus, the German debate, while occasionally referring to utilitarian ideas, is primarily influenced by deontological thought, while the debate in the UK is predominantly based on utilitarian theory, and deontological justifications are only of secondary importance. The comparative study leads to the conclusion that where medical confidentiality is primarily based on consequentialist thought, it will, in case of conflict, often have to yield to other interests. Particularly with regard to the conflicts examined in this thesis, the consequences of decisions to the detriment of the interests in criminal prosecution, defence rights and crime prevention will frequently be more obvious and graphic than the consequences of decisions to the detriment of the interests behind medical confidentiality. Where medical confidentiality is protected as promoting privacy and autonomy, the protection will be far more comprehensive, as there is then an increased willingness to accept that such protection may sometimes result in harm to other important interests. As soon as conflicts

between medical confidentiality and other interests have to be decided, the significance attached to privacy thus gains importance.

The comparative analysis confirms that values are relative, and that alternative ways of approaching a problem are not only possible, but also practised. It can be seen that different systems function quite well even though taking diametrically opposed approaches to the same problem. This helps to put domestic attitudes into perspective. Thus, the English debate which fears the recognition of medical privilege because of its possibly adverse consequences for an effective administration of justice can draw from a comparative study that other legal systems have made a fundamentally different value decision, and that the administration of justice has nevertheless not ceased to be efficient. While the comparative analysis shows that difficulties in balancing competing interests, another reason why medical privilege is rejected in the UK, do, in fact, arise, it nevertheless demonstrates that other legal systems have developed ways to address this problem. Consequently, the rejection of medical privilege no longer appears to be the only logical response to this dilemma. On the other hand, the German debate which is imbued with the overriding importance of privacy protection, can infer from the comparative analysis that without medical privilege, patients will not necessarily feel that their privacy and autonomy is fundamentally impaired, as neither the British example nor the example of American States without privilege protection give any indication for such an assumption.

It has been demonstrated that each legal system has to face inherent inadequacies and inconsistencies. From a German perspective, for example, the regulation of medical privilege through different provisions of different codes, and the solution of conflicts by the means of general legal justifications seems inevitable, even though many difficulties are thereby created. Looking at other approaches, such as the fundamentally different U.S. style privilege statutes, or the French approach which is closely related to the German approach, but more pragmatic, indicates that the specific problems encountered in Germany are caused by the particularities of the German system, rather than by the complexity of the subject matter as such. In areas in which the solutions adopted by different legal systems are not too far apart, but where consistent criteria for an adequate conflict resolution are lacking, the comparison helped to develop more stringent criteria by learning from the strengths and weaknesses of other approaches, and by

combining elements of different approaches to a more coherent system. This was demonstrated in the context of the conflict between medical confidentiality and crime prevention, where an analysis of the different legal systems led to an identification of criteria that can be used by all legal systems.

Some gripping issues necessarily remain unmentioned, as they lie beyond the scope of this thesis. It may, for example, be interesting to examine whether it is compatible with the rationale behind medical confidentiality and medical privilege that the patient can be examined about confidential medical facts, where the physician's testimony about the same information is barred by privilege. Indeed, Shuman's observation made in 1985, that with regard to medical privilege, much work remains to be done,[138] is still valid.

[138] Shuman, (1985) 39 Southwestern Law Journal, at 687.

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Abbreviations

A.2d	Atlantic Reporter, Second Series
AC	Appeal Cases
AJDA	Actualité Juridique Droit Administratif
ALD	Actualité Législative Dalloz
All ER	All England Law Reports
Ariz.	Arizona; Arizona Supreme Court Reports
Ariz.App.Div.	Arizona Appellate Division
Ark.	Arkansas; Arkansas Supreme Court Reports
Ark.App.	Arkansas Court of Appeal
Ark.R.Evid.	Arkansas Rules of Evidence
ARS	Arizona Revised Statutes
Art.	Article
Arts	Articles
Bay ObLG	Bayerisches Oberstes Landesgericht
BGH	Bundesgerichtshof
BGHR	Bundesgerichtshof Rechtsprechung Strafsachen
BGHZ	Entscheidungen des Bundesgerichtshofs in Zivilsachen
BL	Basic Law
BMA	British Medical Association
BMJ	British Medical Journal
BMLR	Butterworths Medical Law Reports
BT	Deutscher Bundestag
Bull.	Bulletin
BVerfGE	Entscheidungen des Bundesverfassungsgerichts
C3d	California Reports, Third Series
CA	Cour d'Appel
CA	Court of Appeal
Cal. Rptr.	California Reporter
Cass. Civ.	Arrêt de la Chambre Civile de la Cour de Cassation
Ch	Law Reports, Chancery Division

Ch. civ.	Chambre Civile
Ch. corr.	Chambre correctionnelle
Ch. Crim.	Chambre Criminelle
Ch D	Chancery Division
Cir.	U.S. Court of Appeal ... Circuit
CJ	Chief Justice
C.L.R.	Commonwealth Law Reports
Cmnd.	Command Papers
Colo.	Colorado; Colorado Reports
Comm.	Commentaire
Conn.	Connecticut
Conn. Gen. State.	Connecticut General Statutes
Cr App R	Criminal Appeal Reports
Crim LR	Criminal Law Review
C.R.S.	Colorado Revised Statutes
CYS	Children and Youth Services
D.	District Court (Federal)
D.	Recueil Dalloz Sirey
DC	District of Columbia; District Council; District Court
D.C. Code Ann.	District of Columbia Code Annotated
D.chron.	Dalloz chronique
D.D.C.	District Court District of Columbia
Dist.	District
D.Md.	United States District Court for the District of Maryland
D.N.J.	United States District Court for the District of New Jersey
D.N.M.	United States District Court for the District of New Mexico
DNotZ	Deutsche Notarzeitschrift
D.P.	Recueil Dalloz Périodique et Critique
DRiZ	Deutsche Richterzeitung
ECHR	European Convention on Human Rights
ECJ	European Court of Justice
ECR	European Court of Justice, Reports of Cases (European Court Reports)

Ed.	Edition; editor
E.D.	Eastern District
E.D.N.Y.	United States District Court for the Eastern District of New York
EHRR	European Human Rights Reports
EJHL	European Journal of Health Law
F.2d	Federal Reporter, Second Series
F.3d	Federal Reporter, Third Series
Fam	Law Reports, Family Division
Fam Law	Family Law
FCR	Family Court Reporter
FD	Family Division
FLR	Family Law Reports
FRD	Federal Rules Decisions
FRE	Federal Rules of Evidence
FSR	Fleet Street Reports of Patent Cases (England)
F.Supp.	Federal Supplement
F.Supp.2d	Federal Supplement, Second Series
GA	Goltdammer's Archiv für Strafrecht
Ga App	Georgia Court of Appeal
Gaz.Pal.	Gazette du Palais
Gaz.Pal.doct.	Gazette du Palais doctrine
Gaz.Pal.somm.	Gazette du Palais sommaire
GMC	General Medical Council
G.S.	General Statutes
HL	House of Lords
ICLQ	International and Comparative Law Quarterly
Ill. App.	Illinois Court of Appeal
Ill. Comp. State	Illinois Compiled Statutes
Ind.	Indiana
J	Justice
JA	Juristische Arbeitsblätter
J.C.P.	Juri-classeur périodique (Semaine juridique)
JMBlNW	Justizministerialblatt für das Land Nordrhein-Westfalen

JME	Journal of Medical Ethics
JOAN	Journal Officiel de l'Assemblée Nationale
JR	Juristische Rundschau
JZ	Juristenzeitung
Kan.	Kansas
Kan. State. Ann.	Kansas Statutes Annotated
KG	Kammergericht
La. App.	Lousiana Court of Appeal
La. Rev. Stat. Ann.	Lousiana Revised Statutes Annotated
LG	Landgericht
LJ	Lord Justice
LSA-C.E.	Lousiana Statutes Annotated – Code of Evidence
Ltd	Limited
Mass.	Massachusetts
Md. Code Ann. Cts. & Judic. Proc.	Annotated Code of Maryland, Courts and Judicial Proceedings
M.D.Pa	United States District Court for the Middle District of Pennsylvania
MDR	Monatschrift für Deutsches Recht
Med L Rev	Medical Law Review
Med. Sci. Law	Medicine, Science and the Law
Mich. Comp. Laws Ann.	Michigan Compiled Laws Annotated
Mich.App.	Michigan Court of Appeals
Minn.App.	Minnesota Court of Appeal
Misc.2d	New York Miscellaneous Reports, Second Series
MLR	Modern Law Review
Mo.	Missouri
Mo. Ann. State.	Vernon's Annotated Missouri Statutes
Mo Ct App.	Missouri Court of Appeal
MR	Master of the Rolls
N.C.	North Carolina
N.D.	Northern District; North Dakota
N.D.R.Evid.	North Dakota Rules of Evidence

N.E.2d	North Eastern Reporter, Second Series
Neb. Rev. State.	Revised Statutes of Nebraska
N.H.	New Hampshire; New Hampshire Supreme Court Reports
NHS	National Health Service
N.J. Super.	New Jersey Superior Court; New Jersey Superior Court Reports
NJW	Neue Juristische Wochenschrift
NLJ	New Law Journal
n°	number
NStZ	Neue Zeitschrift für Strafrecht
N.W.2d	North Western Reporter, Second Series
N.Y.	New York; New York Reports
N.Y.2d	New York Court of Appeals Reports, Second Series
N.Y.S.2d	New York Supplement, Second Series
Ohio St.	Ohio State Reports
Okl.	Oklahoma
OLG	Oberlandesgericht
P	President of the Family Division
P.2d	Pacific Reporter, Second Series
Pa.	Pennsylvania
PACE	Police and Criminal Evidence Act
Pa. State. Ann.	Pennsylvania Statutes Annotated
PN	Professional Negligence
QB	Law Reports, Queen's Bench Division
QBD	Queen's Bench Division
R	Rule
R.	Receuil des Décisions du Conseil d'Etat
R.	Regina, Rex
RCW	Revised Code of Washington
Rec.	Recueil des Décisions du Conseil Constitutionnel
RGSt	Entscheidungen des Reichsgerichts in Strafsachen
RPC	Reports of Patent Cases
RSA	Revised Statutes Annotated

RSC Ord	Rules of the Supreme Court Ordinance
S	Scotland
S.	Recueil Sirey
s.	section
S.C.	South Carolina
S.C.App.	South Carolina Court of Appeal
S.D.	Southern District; South Dakota
S.D.N.Y.	United States District Court for the Southern District of New York
S.E.2d	South Eastern Reporter, Second Series
Sec.	Section
S.W.2d	South Western Reporter, Second Series
So.2d	Southern Reporter, Second Series
Sol J	Solicitors Journal
ss.	sections
StPO	Strafprozeßordnung
StV	Strafverteidiger
Sup.	superior, supreme
Sup. Ct. of Utah	Supreme Court of Utah
Sup. Ct. Or.	Supreme Court of Oregon
Sup. Ct. Pa	Supreme Court of Pennsylvania
Sup. Ct. S.D.	Supreme Court of South Dakota
Supp.	Supplement
Trib. Corr.	Tribunal Correctionnel
U.S.	United States Supreme Court Reports
Va.	Virginia
V-C	Vice-Chancellor
Vol.	volume
Vt.	Vermont; Vermont Reports
Wash	Washington
Wash. App. Div.	Washington Appellate Division
W.D.	Western District
Wis.	Wisconsin
Wis.Stat.Ann.	Wisconsin Statutes Annotated
wistra	Zeitschrift für Wirtschaft, Steuer, Strafrecht
WLR	Weekly Law Reports

Wyo.	Wyoming
ZStW	Zeitschrift für die gesamte Strafrechtswissenschaft