COMMONWEALTH LAW CONFERENCE

MOOTING FINAL

AUCKLAND NEW ZEALAND

AIDS AND CONFIDENTIALITY

BRADLEY V JONES

IN THE COMMONWEALTH MOOT COURT)

COURT OF APPEAL)

HOLDEN AT AUCKLAND, NEW ZEALAND)

CORAM: KIRBY P
KENNEDY J
MANOHAR J

WEDNESDAY 18 APRIL 1990

BRADLEY v JONES
BRADLEY v ADAMS

MEDICAL NEGLIGENCE - duty to disclose HIV status of one patient to another - held: No such duty in the circumstances.

BREACH OF CONFIDENCE - whether disclosure of HIV status of dentist patient to Dental Association within public interest exception to duty of confidence - held: In the circumstances, it was.

ORDERS

1. In Bradley v Jones appeal allowed with costs. Set aside judgment of Waka J. In lieu thereof, enter judgment in favour of the defendant with costs; and

2. In Bradley v Adams appeal allowed with costs. Set aside judgment of Waka J. In lieu thereof, enter judgment in favour of the defendant with costs.

1990 COMMONWEALTH MOOTING COMPETITION WINNERS

UNITED KINGDOM.

COUNSEL

Mr Simon Mitchell and Mr Robert Hucker of the New Zealand Moot Bar for the Appellant, Dr Susan Bradley.

Mr David Cavender of the United Kingdom Moot Bar for the Respondent, Dr Thomas Adams.

Mr Ivan Hare of the United Kingdom Moot Bar for the Respondent, Mr Benjamin Jones.

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JUDGMENT

KIRBY P: Like most matters coming to a final appellate court this appeal raises questions of some difficulty. In issue is the duty of a medical practitioner to safeguard the confidences of the patient and the limits upon that duty where it is thought to clash with duties to other identifiable persons or to society in general.

Two patients undergo tests for HIV and AIDS

The appeal is yet another instance of the growing body of law resulting from the spread of the human immuno deficiency virus (HIV) which in many if not all cases, once acquired, causes the usually fatal acquired immuno deficiency syndrome (AIDS). It is not necessary for the Court to describe the features of this very serious infection. All parties agreed that it was adequately described in a paper delivered at the recent Auckland Commonwealth Law

Conference. See M D Kirby, "Will law fail the AIDS test?", in Ninth Commonwealth Law Conference, Conference Papers, CCH New Zealand Limited, 1990, 479, 480 ff.

In normal circumstances the Court would have taken steps to protect the identity of the patients involved. But as these have been disclosed in earlier proceedings below no point is served by doing so now. Cf X v Sattler, (unreported, Supreme Court of Western Australia, Kennedy J, 1989) and see Scott v Scott [1913] AC 417, 433 (HL).

Dr Adams is an oral surgeon. He is homosexual. His lover was Mr Jones. They consulted Dr Bradley, their local physician to have the test to disclose whether they, or either of them, had been exposed to HIV. In addition to the usual duties of confidence which attach to the medical relationship with patients (whether as a result of contract or the equitable duty of confidence) the two patients were were specifically assured by Dr Bradley that their test results would be, and remain, "strictly confidential". In the result Dr Adams' test was positive. Mr Jones' test was negative.

Dr Bradley counselled her patients separately. She urged Dr Adams to disclose his status to Mr Jones. She counselled Mr Jones not to have unprotected sex. She had reason to believe that Dr Adams would not tell Mr Jones of his HIV status. She did not breach the confidence of her patient in this regard. Mr Jones was tested six months later and then found to be positive. It was found as a fact that

this change of status resulted from unprotected sex with Dr Adams. Mr Jones claims that Dr Bradley owed him a duty to warn him of the particular danger which he faced from having sexual relations with Dr Adams. Mr Jones sued her and succeeded at first instance before Waka J. Dr Bradley appeals to this Court against that judgment.

Heard with the proceedings just described was a separate action brought against Dr Bradley by Dr Adams. It arose in this way. Dr Adams was counselled by Dr Bradley that he should not perform dental operations except with the use of protective gloves in case he should accidentally infect a patient of his with HIV. Dr Adams told Dr Bradley to mind her own business. She then informed the Dental Council who, as a result, restricted Dr Adams' licence to practise his profession. Dr Adams sued Dr Bradley for damages for breach of confidence. This action was consolidated with the earlier action. In those proceedings Waka J found in favour of Dr Adams. Dr Bradley has appealed. The appeals have, by consent, been heard together.

Principles governing disclosure of the results by a physician

It is agreed that there is no constitutional or statutory law, whether directly or by analogous reasoning, affecting the problems before the Court. No binding authority resolves these questions. The Court was not referred to international instruments expressing relevant basic human rights. Such instruments, and the jurisprudence

which develops around them may be used today in developing the gaps in the common law. See R Lallah, "The domestic application of international human rights norms" in Conference Papers, op cit at 391. Obviously, the right to privacy which sustains the patient's right to medical confidentiality is one such right in point. No claim was made in argument to a legal right to privacy so that we can pass that question by. The claims made in this Court are grounded in tort and contract and in the equitable duty of confidence.

Nor has any decision of high authority been cited which is directly in point to the issues argued in the appeal although many which have been cited have provided useful guidance to the Court. It is therefore necessary for the Court to go back to basic principles.

I take these to be the principles involved:

1. A medical practitioner owes his or her patient a duty of strict confidentiality in relation to the confidences which that patient discloses in the course of seeking professional advice and treatment. Such information has all of the qualities to attract the duty of confidence. Coco v AN Clark (Engines) (1969) RPC 41, per Megarry J. See also W v Edgell [1990] 2 WLR 471, 477 (CA);
2. The duty is owed to the patient both in contract - by an express or implied term - and by the equitable duty to safeguard confidences. The confidence belongs to

the patient, not the medical practitioner. Duchess of Argyl v Duke of Argyl [1967] Ch 302; Moorgate Tobacco Co Ltd v Phillip MorrisLimited [1984] 145 CLR 457. Statute apart, it is therefore normally for the patient alone authorize disclosure of the confidences to third parties;

3. The duty goes back to the earliest days of the practice of medicine. It is mentioned in the Hippocratic Oath as Mr Cavender pointed out and in Biblical text. It is thus fundamental to the medical relationship. It supports not only the patient's individual interests but the public interest in sick and infected people coming forward to medical practitioners in the confidence that their personal lives and secrets will not ordinarily be disclosed to others;

4. In the case of HIV/AIDS there are particular reasons for safeguarding confidences. See discussion in X v Y & Ors [1988] 2 All ER 648. There is great public alarm about these conditions. Many of the people most at risk already feel alienated. Stigma, discrimination, loss of livelihood and other untowards results can be attached to disclosure of a person's HIV status or even test. Yet seeking the test can be an important step on the road to self protection and the protection of others. It is in my view in the public interest to encourage people voluntarily to take the test so long as the results are protected by strict

confidentiality. The law should support and facilitate this end for it advances the interests of society and of the individuals who make it up;

5. The duty of medical confidence is not, however, an absolute one. There are exceptions by statute. There are exceptions on a need to know basis within a hospital or medical practice. There are exceptions as where a court requires disclosure in evidence or where a subpoena requires the production of medical records to a court or tribunal. This by no means exhausts the list of exceptions. See eg W v Edgell & Ors [1989] 1 All ER 1089; and

6. There is also an exception where a disclosure is required in the "public interest" or for "the safety of the public". The very width of these expressions - upon which (in particular cases) minds may differ - requires a court to balance carefully the competing public interests which support adherence to the confidence and exceptional permission to breach it. In Frazer v Evans (1969) 1 QB 349 at 362 Lord Denning said: "There are some things which may be required to be disclosed in the public interest, in which event no confidence can be prayed in aid to keep these secret."

No duty to disclose one patient's results to another

Turning then, first, to the appeal against the judgment recovered by Mr Jones, the following considerations, amongst others, support the primary judge's findings:

1. The fact that Mr Jones was the patient of Dr Bradley. He was readily identifiable as being at risk. He was not an unidentifiable person whose identity would require enquiry on her part. Clearly Dr Bradley owed Mr Jones a duty of reasonable care as his physician. That is not in doubt. What is in question is the scope of the duty and whether Dr Bradley was in breach of it, as properly defined;

2. The fact that Mr Jones was her patient in the context of a revealed concern about HIV. There was a special relationship and in that sense the duty was, as Mr Hare pointed out, stronger than that found in Tarasoff v Regents of the University of California [No 2] (1976) 551 Pacific Reporter (2d) 334.

3. The fact that the medical Association acknowledges the possibility of breaching the confidence when the patient at risk has "no other reasonable means of knowing";

4. The fact that the acquisition of HIV is a very serious health risk indeed with grave consequences which cannot be set aside as trivial or relatively insignificant. This too made the case stronger than Tarasoff No 2 (above); and

5. The fact that Dr Adams indicated to Dr Bradley

his unwillingness to disclose his HIV status to Mr Jones for fear of losing his affection.

However, in balancing the public interests involved I would conclude that, at least in the circumstances of this case as found by Waka J, there was no duty in Dr Bradley to disclose Dr Adams' status to Mr Jones:

1. First, the information was that of Dr Adams and he specifically forbade its disclosure;
2. The fact that Mr Jones was also a patient was coincidental. It no more authorized disclosure to him of Dr Adams' confidences than to any other patient or a stranger without consent or authority of law;
3. Dr Bradley specifically instructed Mr Jones on the high importance of safe sexual practices with any sexual partner. That advice was applicable to all of his sexual activity, including with Dr Adams. It went as far as Dr Bradley was required by law to do. Cf Kirkham v Chief Constable [1989] 3 All ER 882, 887. Although disclosure of Dr Adams' condition to Mr Jones might have saved Mr Jones from infection with HIV and its terrible consequences this Court must consider what such an expansion of the common law would involve. It would effectively destroy the duty of

physician-patient confidence. It would establish by the common law (without adequate safeguards, procedures or protections) a duty in every case to disclose to interested third parties the risk of infection. And it could not, as a principle, be held to stop with HIV/AIDS. Necessarily, it would have to extend to every contagious condition of which AIDS is, on the evidence, one of the least infectious. It would mean, in effect, that every physician would have to disclose every case of herpes, of venereal disease, of Hepatitis B to any person known or reasonably discoverable as being at risk of infection. And it might even result in medical practitioners having to seek out possible sources of risk in order to avoid liability in negligence. It is necessary to draw the line somewhere. Medical confidentiality is vitally important. We should not turn doctors into a profession of informers and tell-tales;

5. Medical practitioners receive a great deal of information in confidence. Those to whom they may pass it on would not necessarily or ordinarily be so bound. The information, once haemorrhaged, could not be retrieved. It could do great harm to the patient, especially in a

condition with the emotive connotations of HIV/AIDS. I could not put the position I hold more succinctly than did Rose J in X v Y [1988] 2 All ER 648, 653:

> "In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients 'will not come forward if doctors are going to squeal on them' Consequently confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care ..."

6. In short, if a duty is to be imposed by law it should not be imposed by processes of the common law in a hard case such as the present. It should refined by Parliament preferably with the aid of the Law Reform Commission. Only then could the right procedures - of counselling, peer review, appeal and prior notification to the patient affected be established. I have been greatly helped in coming to my conclusion by the article by Donald Cassell "Disclosure by a physician of AIDS related patient information: an ethical and legal dilemma" (1989) 68 Canadian Bar Rev 225. To the extent that Tarasoff v Regents of University of California (above) decides otherwise I would not follow it, preferring as I do the dissenting

The subsidiary questions as to extent of the breach alleged and causation of the loss suffered by Mr Jones do not arise in view of the decision which I have reached about the limits of the scope of the duty which Dr Bradley owed him in negligence when that duty conflicted with her duty of confidence to Dr Adams.

I would allow the appeal by Dr Bradley and set aside the judgment against her in favour of Mr Jones. In lieu thereof judgment should be entered in her favour in the action brought by Mr Jones. He should pay her costs at first instance and on the appeal.

Disclosure to Dental Association was premature and unlawful

Many of the considerations just elaborated apply in the case of the action by Dr Adams. Indeed, as was observed during argument, there is an inherent inconsistency in the findings of Waka J that there was a duty in Dr Bradley to tell Mr Jones but a duty not to tell the Dental Council. Can the breach of the duty of confidence to the Dental Council be excused as a well-meaning endeavour by Dr Bradley to protect the public from what has been found to be a small but appreciable risk of infection of Dr Adams' dental patients?

I draw a distinction between imposing a positive duty to disclose a medical confidence and excusing the well meaning disclosure where the latter is shown to be a genuine exercise of the exception to the duty of confidentiality,

exercised in a sincere belief about countervailing obligations of the public interest. See W v Edgell [1970] 1 WLR 471. Cf Jeffries J in Duncan v Medical Practitioners Disciplinary Committee [1986] 1 NZLR 513. To impose a duty to breach medical confidences goes far beyond excusing an exceptional departure from the accepted general rule of guarding the patient's confidence. In this regard I am therefore sympathetic to the action which Dr Bradley took. I would strive to uphold it, being satisfied that it was motivated by her perception of the public interest and of her duty in that regard. After all, Dr Adams proved recalcitrant to her advice. She is herself concerned in one of the caring professions. She obviously felt a duty to patients generally. She left it to the Dental Council to do whatever was required. She did not exceed the proper bounds of disclosure, eg by going to the media or irrelevant third parties.

However, in my opinion Dr Bradley acted precipitately in disclosing her patient's confidence in the way she did. In the shock of discovering his HIV status (as Dr Bradley would have known), Dr Adams' behaviour might not have been entirely normal. She should have called him back and sought to persuade him again. If he would not come to see her she should have written to him alerting him of her proposed course of action. She should at the very least have warned him specifically that she was contemplating notification to the Dental Association, just as she did of her original plan

to tell Mr Jones. She should have given him the first opportunity to inform the Association.

It is to be noted as Kennedy J pointed out during argument, that in Edgell, the Home Office first informed the lawyers of the patient before his medical secrets were sent on to the Home Office. Instead, using Dr Adams' confidences which came to her in her relationship as his physician, and whilst he was still in a state of shock, she disclosed his secrets to third parties who were not bound by the duty of confidentiality which governed her. Although her disclosure was limited, it was of great consequence to Dr Adams, as Mr Cavender pointed out. Few disclosures could have had a more telling consequence, as she must have known and intended. I would have upheld her action, had she taken more care and given more notice. However, in the circumstances, I believe it cannot be said that her disclosure was made in the "public interest" at the time and in the way in which she acted. In the words of Mr Cavender for the respondent, Dr Adams, there was not in the circumstances such an urgent, immediate and serious risk to the public as would warrant the course adopted by Dr Bradley. Accordingly, I believe Waka J was right in those proceedings to find in favour of Dr Adams in his claim. The judgment in that action is sustained.

Orders

The result is that the orders which I would propose are:

1. In the appeal Bradley v Jones appeal allowed with costs. Set aside judgment of Waka J and enter judgment for the defendant with costs.

2. In Bradley v Adams - appeal dismissed with costs.

KENNEDY J: I adopt the statement of the facts given by the presiding judge. In my opinion it is necessary to recognise an area of discretion in a medical practitioner to disclose facts to a person such as Mr Jones and to the Dental Association in the circumstances shown by the evidence. I would dismiss the appeal by Dr Bradley against the judgment entered by Waka J in favour of Mr Jones. In my view Waka J was right to hold that in the circumstances Dr Bradley was under a duty to disclose to Mr Jones the great risk he was facing. In the appeal concerning the claim by Dr Adams. I am likewise of the view that Dr Bradley was authorized by law in the circumstances to disclose the facts of Dr Adams' HIV status to the Dental Association. In those proceedings, I would allow the appeal with costs and set aside the judgment of Waka J in favour of Dr Adams. In lieu thereof, I would enter judgment for the defendant with costs in those proceedings.

MANOHAR J: In the appeal Bradley v Jones, I agree with what Kirby P has said and with the orders which he proposes. In the appeal Bradley v Adams I find myself in agreement with Kennedy J and I agree with the orders which he has proposed.

KIRBY P: The orders of the Court are, accordingly, by majority in each appeal:

1. In Bradley v Jones, appeal allowed with costs. Set aside the judgment of Waka J. In lieu thereof enter judgment in favour of the defendant with costs; and

2. In Bradley v Adams, appeal allowed with costs. Set aside the judgment of Waka J. In lieu thereof, enter judgment in favour of the defendant with costs.