Singapore Med J 1999; Vol 40(12):726-732

Confidence and Confidentiality – Aspects of the Law

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Introduction

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The growth of information technology and the increasing hunger for medical information has brought the doctor's duty of confidentiality into sharp focus. It is a difficult area where the ground has been soggy because no broad principles have been clearly defined to accommodate modern developments which threaten the old order that doctors and their patients have generally regarded as resting on a sacrosanct duty; the only exceptions to which are instances founded on either implied or express consent and so these do not impinge on the absolute nature of the duty. It is not possible to provide any definitive answer to the myriad issues concerning this subject, but I hope to provide some stimulus to a deeper consideration of the opposing duties of confidentiality and disclosure. I hope to do so by first reviewing the position in law over the recent past before moving to the developments in medical science, practice and administration in the new age and the nature of the challenges stemming from these developments. Finally, I will attempt to provide a different perspective by examining some aspects of the philosophical basis of rights and duties. I begin with the humble reflection that although lawyers tend to regard cases in the 18th and 19th centuries as the foundation of the law concerning breaches of confidentiality, doctors have a claim that goes much further back in time. In the 3rd or 4th century before Christ, a professional physician crystallised his thoughts on this subject, and it is to him that this portion of that well-known oath is attributed:

"Whatever in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge as reckoning that all should be kept secret."

Is the duty of confidentiality so envisaged above an absolute one? Written in his day, the above injunction does not appear to admit of any exception, but its passage through time has seen great changes in the development of medicine and law, with the inevitable dilution of the notion of absolutism that was born with the origin of that duty. As we hurtle through the Information Age, the tussle between individual rights and public rights will continue to test the legitimacy of the absolute nature of that duty.

Confidentiality and Confidential Information

The concept of confidentiality as reckoned by Hippocrates was principally in respect of a patient's rights, but I should point out that the duty of confidentiality and confidential information are by no means homogeneous. The former generally pertains to matters that arise out of a fiduciary relationship such as that which exists between a priest and his congregation, a husband and wife, a lawyer and his client, and a doctor and his patient. Confidential information, on the other hand, may arise in relationships that are no more ordinary than the plain relationship of businessmen. This distinction is significant because the two lean on different branches of the law. A fiduciary relationship is founded on trust and reposed in confidence. Information passing between persons in such relationships is thus marked by having a higher moral and ethical content. When a party in such a relationship profits from a breach of confidence, the essence of the resulting grievance is not merely a commercial one, and is therefore, more difficult to ascertain the appropriate redress for the wrong done. On the other hand, confidential information arising from a purely commercial relationship is a commodity capable of economic appraisement and the remedy for a breach in those cases is usually a matter of finding the appropriate monetary compensation.

I will take a moment or two, however, to examine the nature of some of the various fiduciary relationships. Once the law recognises a relationship as a fiduciary one, it will recognise also that information passing within that relationship has to be protected from disclosure to a third party, and makes available to the innocent party various remedies in the event of a breach or threatened breach; the usual remedies being an award of damages and an injunction against threatened or further disclosures. However, the nature and extent of protection and remedies available in the case of a breach will naturally vary from one case to the other. The law also has prescriptions as to what confidential information may be adduced in evidence in court. Section 124 of the Evidence Act provides that:

"No person who is or has been married shall be

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compelled to disclose any communication made to him during marriage by any person to whom he is or has been married; nor shall he be permitted to be disclose any such communication unless the person who made it or his representative in interest consents, except in suits between married persons or in any proceedings in which one married person is prosecuted for any crime committed against the other."

Section 134 of the same Act provides that a witness may not decline to answer a question on account that in so doing he or she may expose the spouse to criminal proceedings. In contrast, there are no similar provisions relating to evidence by a doctor against his patient. There is, naturally, room for out-of-court debate as to which of the two relationships is more sacred. For completeness, it is necessary for me to refer to the provision in the same Act which deals with communication between a solicitor and his client. Section 128(1) provides that:

"No advocate or solicitor shall at any time be permitted, unless with his client's express consent, to disclose any communication made to him in the course and for the purpose of his employment as such advocate or solicitor by or on behalf of his client, or to state the contents or condition of any document with which he has become acquainted in the course and for the purpose of his professional employment, or to disclose any advice given by him to his client in the course and for the purpose of such employment."

The exceptions to this rule are provided in subsection 2 in which the information is not protected if it was communicated to the solicitor for the furtherance of an illegal act; or if the information was discovered by the solicitor as showing that a fraud or crime had been committed after he had been employed as such solicitor. In comparison, therefore, it will be seen that when a doctor is testifying in court, there is no statutory provision which may justify a refusal to answer any question on account that in so doing he will be in breach of his professional duty to his patient. The only exclusionary rule in his favour lay in the general rule governing the admissibility of evidence, namely that evidence is admissible only if it is relevant.

Duty of Confidentiality Owed by a Doctor

The duty of confidentiality owed by a doctor to his patient is both contractual and professional. It is contractual in that the law will readily imply that duty as a term of the contract for his services. It is a professional duty precisely because it is regarded by the general body of medical practitioners as a cornerstone of the doctor-patient relationship. From the point of view of the law, this duty is founded in contract and in equity. In neither case, it seems, is there an absolute duty of silence, or conversely an express duty of disclosure. Two English cases, therefore, invite close study. The first is the case of *W v Egdell [1989] 1 All ER 1089*. The background facts of this case are straightforward. *W* shot five of his neighbours and two other persons on a day of rampage in which he also threw home-made bombs from his car. Five of his victims died and the other two were injured. He was found to be suffering from paranoid schizophrenia and ordered to be detained in a secure hospital indefinitely. Some ten years later, he instructed his solicitors to help him obtain a transfer to another institution with a view to eventual discharge and release. In order to support the case for him, his solicitors arranged for him to be examined by a psychiatrist named Dr Egdell so that a report may be furnished for use before a mental health review tribunal known as the Medical Review Board ("the tribunal"). *W* had already received a report from one Dr Ghosh who was the medical officer responsible for him in his detention. Dr Ghosh's report was a positive one and supports *W*'s intended application. However, Dr Egdell formed the view that *W* suffered from a psychopathic deviant personality, and his report was so grimly negative that after receiving it, *W* and his solicitors decided not to use it. In fact, *W* consequently withdrew his application for transfer. Dr Egdell appeared astonished that neither the tribunal in charge of recommending the transfer of patients such as *W*, nor the hospital in charge of him had received a copy of his report. The doctor then talked to the director of the hospital who agreed to have a copy of that report in the interests of *W*'s further treatment. Dr Egdell then sent a copy of his report to the Home Secretary (who has the discretionary power to grant the transfers recommended by the tribunal). The Home Secretary, in turn, sent a copy of the report to the tribunal. When *W* discovered what had happened he issued a writ against the various parties to restrain them from using Dr Egdell's report, and also claimed damages against the Home Secretary and Dr Egdell for breach of confidence.

This is a landmark case for some very interesting and important points. The claim against each of the defendants was based on the confidential character of the communication between *W* and Dr Egdell. This is a classic breach of confidence case between a patient and his doctor. The claims however were also made against the Home Secretary and the Hospital who, in the context, were really third parties in the chain. The ethical code binding the doctor did not apply to these defendants and therefore, the court approved the stand taken in earlier authorities that each defendant must be assessed separately.

The claim against Dr Egdell was made on two basis. First, in contract for breach of an implied term of confidentiality. Secondly, in equity, which is that body of law which the courts apply to ensure that the strict application of rules and contract terms do not result in a miscarriage of justice. So, for example, if a man kills his wife he will not be permitted by a court of equity to claim the benefits of any insurance policy taken out by him on his wife even though the insurance contract may not have this incorporated as an express term of the contract.

So far as the claim in equity was concerned, Justice Scott held that he had no difficulty in coming to the conclusion that there was a duty of confidence in such circumstances. He cited no authority, obviously taking the view that no contrary approach can be supported. He remarked that if Dr Egdell had sold the contents

of his report to a newspaper the courts would have no hesitation in stopping him. The big question for the court concerned the breadth of the duty of confidence. The learned judge noted the observation of Lord Goff in the *AG v Guardian Newspapers (N0.2) [1988] 3 All ER 545*, a case better known as the *Spycatcher* case, in which the Law Lord stated that the duty of confidence is not an absolute duty, but one subject to various limiting principles, the most important of which, in the medical context, is the necessity of "balancing the public interest of maintaining confidence and the countervailing public interest favouring disclosure".

Justice Scott then held that Dr Egdell was not liable to *W* for breach of confidence. The basis for his decision is of some interest. He said:

"Did these circumstances impose on Dr Egdell a duty not to disclose his opinions and his report to Dr Hunter, the medical director at the hospital? In my judgment they did not. Dr Egdell was expressing opinions which were relevant to the nature of the treatment and care to be accorded to *W* at the hospital. Dr Egdell was, in effect, recommending a change from the approach to treatment and care that Dr Ghosh was following. He was expressing reservations about Dr Ghosh's diagnosis. The case seems to me to fall squarely within para (b) of r 81.

But I would base my conclusion on broader considerations than that. I decline to overlook the background to Dr Egdell's examination of *W*. True it is that Dr Egdell was engaged by *W*. He was the doctor of *W*'s choice. Nonetheless, in my opinion, the duty he owed to *W* was not his only duty. *W* was not an ordinary member of the public. He was, consequent on the killings he had perpetrated, held in a secure hospital subject to a regime whereby decisions concerning his future were to be taken by public authorities, the Home Secretary or the tribunal. *W*'s own interest would not be the only nor the main criterion in the taking of those decisions. The safety of the public would be the main criterion. In my view, a doctor called on, as Dr Edgell was, to examine a patient such as *W* owes a duty not only to his patient but also a duty to the public. His duty to the public would require him, in my opinion, to place before the proper authorities the result of his examination if, in his opinion, the public interest so required. This would be so, in my opinion, whether or not the patient instructed him not to do so."

Rule 81(b) referred to comes from the British Medical Council's "Advice on Standards of Professional Conduct and of Medical Ethics". It reads as follows:

"Confidential information may be shared with other registered medical practitioners who participate in or assume responsibility for clinical management of the patient."

Public Interest

The fascinating impact of this judgment is not that under certain circumstances a breach of confidence may be excused, but that there is an express duty of disclosure where the public interest so requires. This may pose a strain on those who are charged with the task of balancing the individual's rights to confidentiality and the public duty of disclosure. The dilemma is amply illustrated in the case of *X v Y [1988] 2 All ER 648*. This is a case in which a health authority applied to the High Court for an injunction against a newspaper company from publishing the names of two doctors who had been contaminated with the AIDS virus but were allowed to continue their practice. The two doctors had sought medical advice from the health authority and had received counselling, which in the view of the health authority was a sufficient safeguard. The court accepted the expert opinion that there was a small theoretical risk that these two doctors might infect their patients, but that risk had been removed by counselling. No detailed reasoning on this aspect can be gleaned from the judgment, and it is arguable as to whether that represents the universal medical opinion, but the matters of direct concern here relate only to the duty of confidentiality and disclosure. That is, therefore, the aspect of the case on which I will focus my comments. Justice Rose in this case, ruled that "the public interest in preserving the confidentiality of hospital records identifying actual or potential AIDS sufferers outweighed the public interest in the freedom of the press to publish such information, because victims of the disease ought not to be deterred by fear of discovery from going to hospital for treatment, and free and informed public debate about AIDS could take place without publication of the confidential information acquired by the defendants". This case is easily reconciled with that of Dr Egdell's on the basis that the respective courts came to their conclusions by striking a balance between competing public interests. In the *X v Y* case, Justice Rose considered the freedom of the press to be one of the important public interest factors to be weighed. He did not consider the right of the public to be informed as a relevant factor. The "freedom of the press" factor was probably considered more significant than the public's need to be informed (of the circumstances prevailing in the medical industry) because it was found as a fact in that case that there was no danger to the public to allow the two doctors to carry on their practice. I think that the court might have come to a different conclusion if the evidence had indicated some danger to the public on account of the doctors' condition.

Once it is established that the greater public interest lay in disclosure, the duty of keeping confidence gives way to a duty of disclosure. In the case of *Gartside v Outram (1856) 26 LJ Ch 113* Wood V-C declares that "there is no confidence as to the disclosure of iniquity", to which Lord Denning added in *Fraser v Evans [1969] 1 All ER 8,11*, that "There are some things which may be required to be disclosed in the public interest, in which event no confidence can be prayed in aid to keep them secret".

What constitutes a "public interest" and how are competing public interests evaluated? These are perplexing questions that admit of no easy answer. In Dr Egdell's case, the duty of confidentiality of a

doctor was regarded as a matter of public interest. However, the court perceived the need to inform the relevant authority that a specific person might be a danger to the public, as serving an even greater public interest. In *X v Y*, on the other hand, the public interest in preserving the confidentiality of hospital records prevailed over the public interest of the freedom of the press. As a matter for further consideration, if the duty of disclosure is regarded as a matter of public interest, then it is not only a duty which binds the doctor, but the patient as well. That was perhaps the underlying principle in the *X v Y* case.

It has been a decade since Dr Egdell's case came before the courts. The legal issues concerning the duty of confidentiality remain substantially the same but the stage has been enlarged. Artificial intelligence (in the form of computer programmes) feeds on data. It has a seemingly insatiable appetite. This in turn, spawns massive infrastructures for the purposes of data collection and dissemination. Personally, identifiable private information may readily find its way into data banks and be available in electronic forms not only to doctors but also to researchers, health administrators and even employers and insurance companies. Two principal concerns need to be addressed. The first is the need for the retention of privacy and confidentiality of the individual's personal information ("the private interest" factor). The second is the obligation to provide the necessary data for medical research and facilitating the administration of health services (the "public interest" factor). They are, indeed, the same old issues.

The approach taken by the courts in the *Egdell* and *X v Y* cases point to the striking of a balance between the two competing interests. Private interests are perhaps more readily identifiable by reason of the inherently attractive idea of the individual's personal right to confidentiality based on contract and the fiduciary relationship existing between him and his doctor. The question of what constitutes public interests, however, needs elaboration. It can scarcely be disputed that in a democratic society such as ours, the interests of the public is best gauged through parliamentary pulse, which is then carried into effect by the executive arm of the government. Thus, plainly, public interests so declared in this way cannot be challenged as a principle of law. The function of the courts is to ensure that the letter and spirit of the law are fulfilled. This is the broad picture. The details are not so easily etched. The difficulty lies partly on the fact that from time to time, the doctor or hospital administrator at the frontline may be placed in a position where a critical decision has to be made. In those circumstances, that person has to determine what he thinks the public interest is before he can begin the task of striking the balance. In short, there are situations in which one can scarcely wait for legislative directions.

While there can be little doubt that the doctor is the most appropriate person to determine what is in the best interests of the patient; it does not follow that he would be the most appropriate person to ascertain what is in the public interest. Indeed, the two interests may be so polarised as to be irreconcilable. In such circumstances, the doctor will probably be ill-placed to draw the distinction. Take, for instance, a situation in which a psychotic child-abuser was coaxed into accepting psychiatric therapy. He agrees only on the express promise by the doctor that he will make no disclosure whatsoever of information obtained in the course of treatment. It then transpires that the patient was carrying on a sexual relationship with a 10-year-old child. Two issues which I have alluded to earlier surface to vex the doctor. First, in the absence of guidance from the legislature or the courts, how would the public interest to be defined, and in which order of precedence should they take? In other words, would the need to protect the child be seen as an overriding public interest, or the need to maintain the duty of confidentiality so that persons with such disorders would not shrink away from treatment for fear of exposure? Wider interests beyond the doctor-patient relationship come into play. Secondly, it leads us to the secondary question as to what safeguards there are should a doctor feel himself bound to and do disclose confidential information about his patient to the authorities. In the case of *D v National Society For The Prevention Of Cruelty To Children[1978] AC 171*, the House of Lords in England ruled that a similar immunity from disclosure of identity should be extended to those who gave information about the neglect or ill-treatment of children to the authority or the NSPCC to that which the law allows to police informers. The NSPCC case concerned an action by a parent against the NSPCC for negligence. The NSPCC applied in the course of the proceedings for an order that there be no discovery of documents as to reveal the identity of the informer. Lord Diplock said that the "public interests served by preserving the anonymity of both classes of informants are analogous; they are of no less weight in the case of the former than in that of the latter class". This statement was made, however, outside the context of the balancing of a private right and a public right in the example that I have just enunciated, but it would appear from the reasoning of Lord Diplock that the psychiatrist who breaches his psychotic patient's confidence (by revealing his on-going affair) may receive the protection of the law from any disclosure of his identity. That, however, does not mean that he would be immune to a private suit by the patient should he learn of the informer's identity independently. The wheel thus turns round once again to the issue of the degree of absolutism in the duty of confidentiality. Questions such as those that I have raised above escort us into deep areas of jurisprudence and medical and social philosophy but pondering over them will, I am sure, be a happy and healthy pursuit, and a source of enrichment of the mind.

I revert to the important cases of Dr Egdell and *X v Y*. These two cases implicitly oppose any notion of an absolute duty to keep medical information confidential. They recognise and endorse the principle of the overriding public interest for disclosure in

certain situations. Since doctors and hospital administrators are at frontline duty the initial decision will often, if not invariably, lie with them as was demonstrated in the two cases themselves. Dr Egdell felt that it was his duty to make disclosure of his own report. Although he did not articulate the full grounds of his own reasoning, it is obvious from the facts that he had carried out his own balancing of the competing interests. Decisions like his may have to be made from time to time, and the circumstances will of course differ. Another hypothetical example may be useful to emphasise the complexity of the problem. Bearing in mind that the basic duty of confidentiality is owed by the doctor to his patient and the patient alone, how ought a doctor to respond in the following situation? A husband and wife each suffering from a different terminal illness consults a doctor. Neither knows about the terminal nature of the other's condition because they had each given the doctor instructions not to make any disclosure to the other. The husband then tells the doctor that he will be signing his will disposing of all his property to his wife in the expectation that she will recover from her illness and because he does not wish to leave his assets to their prodigal son. He made it clear that if not for the wife he would have willed his assets to charity as they have no other relatives apart from the son. In these circumstances, is the doctor bound to disclose the wife's terminal condition to the husband, and if so, would he be excused both professionally and at law should he be sued by the son on account of the fact that had the doctor kept his mouth shut the family fortune would have been his? It must be pointed out that in respect of the question of breach of confidence, only the wife would have the standing to sue in this case. The question really, is whether there is any other ground for the son to sue the doctor whose disclosure cost the son a fortune. There are many other situations similar to this. The most notorious one concerns the almost daily occurrence in which doctors freely respond to questions from well meaning friends and relatives of patients under their care. If the duty of confidentiality is owed to the patient (which it is), what justification is there for the doctor to discuss his patient's condition and treatment with anyone else – especially when consent for the nature and extent of treatment can only come from the patient himself? There are no easy answers, partly because of the inherent difficulty of the problem, and partly because the facts are likely to be so varied that precedents may not be called in aid. Since I can offer no solution presently, I must declare that I am not raising these questions merely to tease the medical profession, but to set it thinking; that even in some of their mundane or unremarkable cases, doctors may be faced with difficult decision-making challenges. The vital first step, as always, is to recognise such a situation when it occurs. This may not be as simple as it sounds because a doctor may be oblivious of the consequences of his decision and overlook the potential danger. But, the next step, after recognising the danger, is even more herculean. The rest of this lecture will indicate why this is so.

Competing and Corresponding Duty of Disclosure

I have till this point focused on the passing of a patient's confidential information by a doctor (or health administrator) to a third party. In so doing, I have broached the notion of a competing and corresponding duty of disclosure. In the complex web that forms a doctor-patient relationship, it may be necessary to recognise a duty by the doctor to disclose to his patient confidential information received by the doctor from a third party, such as a drug company. This is a particularly troublesome area because in part, it trespasses into the realm of informed consent. It is precisely because the critical issue often disguises itself or is camouflaged by the question of informed consent, that a doctor may fail to make the appropriate disclosure to his patient. He might regard the information sufficient to extract a patient's consent does not include the particular confidential information passed to him by a third party concerning the drug or treatment, or any other matter. That is perhaps, the real hazard in this aspect of the doctor's duty.

In the face of such daunting issues, it will not be altogether unreasonable, therefore, to seek relief in the conventional response of laying down even more detailed and specific rules and codes of conduct. This will, however, remain an imperfect solution. The first problem is that codes of conduct, especially professional codes, may not appropriately be used to regulate the conduct of non-medical professionals, such as health administrators or data control officers. Secondly, if a rule is too broad, it tends to overreach. If it is too specific it tends to suffer from inadequacy when a problem extends beyond the stricture of its defined scope. Furthermore, a code of conduct governing the medical practitioner may be inconsistent with a health institution's (such as a hospital) corporate regulations. It may also fall short of the standard required at law; of course, it may also over-regulate by being excessively stringent. But these are mere practical difficulties. The actual prescription of codes and regulations presents a lesser challenge than the greater one of ascribing the philosophical basis for the rules and the object of the rules.

The search for a philosophical basis must necessarily begin by questioning the very assertion that a patient's personal medical information is clothed in the armoured suit of a "right". If it is a right, where does it stand in relation to other claimed rights such as the right of free speech, the right to life or the right to the equal treatment before the law? At the base level of abstraction, it does not matter that the other rights so called are entrenched in primary legal documents such as the Constitution of the land. The exercise may first be conducted on the basis that all these rights have the same quality and moral authority and then, alternatively, on the basis that there are significant value differences. Moral and natural law jurists steadfastly embrace the notion that such "right" is essential because it is immoral for a person in a fiduciary position to breach his duty of confidentiality. Therefore, they argue, that there must be laws to

safeguard the sacredness of that duty. For the purposes of argument, they take the position that the duty of confidentiality is more than just an expectation but a right. Nihilistic and anarchist theorists on the other hand, will readily argue that there is no moral content in the expectation of confidentiality, and therefore, any exercise designed to create such a right is pretentious and false. Somewhere in between is the utilitarian who asserts that even if such right exists it is a subordinate right because the doctrine of the greater good of mankind devours the lesser need of man whenever necessary. Therefore, the collective strength of the public's expectation to know about *W*'s condition in the case of *W v Egdell*, over-powers the lesser "right" to confidentiality because that right has been isolated, and consequently weakened by that isolation, to resist the demands of the greater public interest. In this regard, the Machiavellian doctrine of "the end justifies the means" sometimes creep into the argument, disguised in the form of utilitarianism. In truth, that doctrine's pedigree might well have come from the same root stock. The doctrine, however, will be met (as it always has) by the standard opposition of the moralists and natural law jurists for its questionable amoral approach. The more neutral objection, however, lies in the criticism that in difficult cases, one can hardly differentiate the means from the end. A doctor making a decision to abort a child faces the prospect of killing its mother in the process. Is saving the mother the end and aborting the child the means, or is saving the child the end and killing the mother the means?

Reverting to the utilitarian basis, it might be asked, why should not the individual right be greater? There can be little justification if the answer lies merely in the refuge of numbers because the argument that quantity is never a match for quality is difficult to rebut. Those yoked to the pure absolutism principle that nestles in the Hippocratic Oath may further argue that the interests of the public embrace the need for a duty of confidentiality at the highest level; and that any breach in the dyke will soon break the entire dam. That is the classic floodgates theory which has only a meagre space in the great halls of philosophy. I shall, for the time being, leave aside the contention that any pure theory of law and morals should withstand the test of time and changing civilizations, a point which requires a separate debate and concentrate on the utilitarian view and that of its opponents.

Any evaluation of the greater good of the majority inexorably draws one to consider the question from the perspective of the social contract which binds the society as a whole. The process of comparing the good and detriment that may be derived from a dilution of the duty of confidentiality is a qualitative evaluation, not a quantitative one. The incidents in its favour or against it may be counted, but it is the abstract value that has to be attached to each of these factors that is intrinsically uncountable. Take for instance, the subsidiary argument that every individual is a unit of the whole; that any improvement in medical science and the public administration of health services benefits the community and ultimately, indirectly as well as directly, the individual; that the moment a person becomes a patient he invokes the assistance, directly or indirectly, of the entire health care system of his society. The quid pro quo, or the price he pays is the consent that he must give to consign his confidential patient information to the public data-pool. The evaluation of values is further complicated by sharp and intractable disagreements between the different schools of philosophy to which different interest groups may subscribe. The premium placed on the right of confidentiality by the absolutist school, clashes with the emphasis on the duty of disclosure by rival schools. The classic debate concerning the correspondence of right and duty never ends, but the arguments of the proponents of a wider duty of disclosure are compelling. Why should a person infected with the AIDS virus enjoy anonymity, privacy and confidentiality when unsuspecting people all around risk being infected through him? Furthermore, should the management of public health services, as well as medical research be hindered in the process of shielding the infected man?

A frontal assault against the absolutist school of thought traditionally employs either John Locke's basic principle of exclusive right or Ronald Dworkin's priority of individual rights theory. John Locke's basic principle is that everyone has an exclusive right to his own person and to his own labour. The inclusion in the second part of his principle to include the exclusive right to common property if a man mixes it with his own labour has rendered his principle virtually indefensible. Arguments by modern philosophers such as Robert Nozick have convincingly rebutted that aspect; but the first part of his principle is still subject of a live debate and some of its proponents include Ronald Dworkin. Dworkin holds the view that rights trump policies and rules. In order to resolve conflicts between rights he assigns a different weight to each right. But it is precisely this need to assign a different weight to each recognised right that weakens the force of his otherwise determined attack against the iron doctrine of the universal good. Dworkinism is a practical solution in so far as one may assign a greater weight to the right of confidentiality against the right of disclosure, or vice versa, but it offers little assistance as to how the weightage system works except to suggest that the values or weights may be imposed by what Dworkin himself calls "market forces".

The assignment of weightage to different rights is subject to the same criticism Dworkin himself levied against utilitarianism because the latter is often a rule of the majority; and the majority operates by voting on what Dworkin refers to as "external preferences", a notion he utterly eschews in favour of what he calls "personal preferences". If I want a garden for myself that is my personal preference; but if I want a garden for my neighbour, that is an external preference. When a majority decides what is good, it often leaves the minority no chance to determine what is good for themselves. But life (and philosophy) is really not as simple as that. It is not a case of a straightforward exchange of the oppression by the majority for the tyranny of the minority. I had alluded earlier that the

duty of disclosure may not only bind the doctor, but also one that enshrouds the patient as well. If this proposition is accepted, then it is an important concession because a large part of the aura of a supreme right of confidentiality arises from the fact that information is passed from patient to doctor in the course of communication in a special fiduciary relationship. But once that channel is no longer considered relevant by virtue of the fact that the primary source of the information is himself bound to make the disclosure in the public interests the force of the argument is spent. There can be little resistance to the assertion that the status of a person's health is a matter of private domain. We register our marriages in a public register; we register the birth of our children in a similar register; when we die our deaths are also registered. Why then, should a man whose death is a matter of public interest, be permitted to keep the process of dying a private matter? It can be said that it is in the public interest to record the living and the dead just as records are necessary for marriages and births only because the status of each entitles or disentitles the person concerned to public amenities and benefits. This very same argument, however, applies to the duty of disclosure. Every patient utilises directly or indirectly public resources; it is only a question of remoteness and extent. Thus, once reduced to such a calculation and comparison, the objection in principle is greatly undermined. So it will be seen, that each school of philosophy has its strengths and weaknesses. Therefore, to each his own.

At this point, I anticipate that one might well ask whether the solution lies in strict controls, censorship and selective disclosure. These suggestions are certainly relevant at ground level but not at an inquiry into the philosophical basis of duty and right. The obvious reason is that any discussion concerning controls and censorship presupposes the predominance of one duty over the other. And so, the search for a philosophical basis to rationalise the conflicting duties may be long and difficult; but as those from the school of the X-Files will say: "The truth is out there ... somewhere".

I hope that the matters that I have raised are sufficient to lead you to a deeper and greater enquiry into this fascinating and important topic. Those of you who might have the opportunity of helping to craft the ground rules may find it useful to consider the higher abstract basis of the diverse schools of philosophy because a solid foundation will be beneficial to the structure of rules governing the concept of confidentiality and the duty of disclosure.

Conclusion

In conclusion, I think that it is a fair statement to say that we can expect medical and computer science to continue to make quantum advances and affect immensely the way medicine is practised. From the practical point of view, the duty of confidentiality may become an enigma in the age of information technology, but so long as law and morals are still central to the application of science and medicine, and are justly and morally administered, the computer will not take over, but function only to serve our needs and enhance the quality of our lives. I will leave you to ponder over the principle of "double effect". A man who saves his own life from an attacker may do so by taking the life of his attacker. The natural law philosophers will argue that if his motive was to save his own life, his action is right; but if his motive was to end his attacker's life then his action is wrong. Such distinctions are necessary where absolutism prevails. The classic example is that of the doctor who has to choose between saving the life of the unborn child at the expense of its mother, or the life of the mother at the expense of the child. No matter what he does he ends the life an innocent, and unless the principle of double effect is prayed in aid, we may have to say that he is morally responsible for having taken an innocent life.

It is my great privilege and honour to have delivered the 1999 SMA Lecture.

The 1999 SMA Lecture was delivered on 28 November 1999 at the COMB Auditorium.
The citation of Mr Choo can be found in this issue of the SMA News on page N7.