

ASPECTS OF CONFIDENTIALITY

IN

MEDICAL LAW

by

JEAN LILIAN NELL

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Promotor: Prof Dr PA Carstens

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SUMMARY

The aim of this study was an examination of the patient's right to privacy and confidentiality in medical law, the causes of actions under which the medical practitioner can be found liable and the grounds of justification or defences and exceptions that the medical practitioner can rely on to rebut the unlawfulness of his or her conduct. The examination was conducted within the framework of the South African, Canadian and American legal systems and particular attention was paid to privacy in the mental health care setting.

This analysis necessitated the need to start with an examination of the definitions and concepts of privacy and confidentiality and a discussion of the need and importance thereof in the doctor-patient relationship. This included a discussion of the ethical issues involved. The physician-patient privilege is also examined. In particular the development and protection of the concept of privacy through legislation and constitutional protection is analysed and examined.

What is clear is that the right to privacy and confidentiality can never be absolute. The rights of others in society always need to be considered and therefore certain exceptions to maintain confidentiality are allowed, such as the duty to warn an endangered person, and legislation that requires the reporting of notifiable diseases. Likewise, in the modern health care there are many other people, that have a legitimate claim to information, be it for billing purposes, managed care, research purposes, quality assurance or workplace or fraud investigations to name but a few. What is important is that the minimum required information necessary for the purpose for which it is needed, must be given, and that the patient must be informed and give consent to the release of such information. There are also operational difficulties in the modern health care setting that make it difficult to maintain privacy, such as semiprivate rooms and caregiver stations within earshot of waiting rooms.

The most important findings are that South Africa is actually in a better position to that of the USA and Canada, in the sense that there is no patchwork of law that protect the right to privacy. We have similar legislation either in place or in the pipeline and not such a confusing array of provincial and national legislation. What still needs to be put

into place and what is suggested in the *Protection of Personal Information Draft Bill*, published by the SALRC, is the office of Information Protection Commissioner. What is also needed is a code of conduct for the health care professional, giving practical guidelines on how to protect health information.

Common law privacy jurisprudence will continue to have application in the resolution of privacy disputes. However, in accordance with the principle of constitutional supremacy, a court must test a challenged conduct against all possible relevant provisions of the Bill of Rights, whether the applicant relies on them or not. Any conduct or law that is inconsistent with the Bill of Rights is invalid and the obligations proposed by it must be fulfilled.

1. Preface

1.1 Purpose of study

The purpose of this study is a comparative analysis of confidentiality and privacy in medical law. Valuable insights can be gained by comparing how the USA and Canada approach medical confidentiality matters.¹ When interpreting the Bill of Rights our Courts may consider foreign law² and therefore any insights gained can be applied to our situation in South Africa, and recommendations and conclusions can be drawn. Because of the vast scope of this subject, one problem area³ have been identified and is concentrated on in detail, namely mental health, in the context of maintaining confidentiality. Due to the highly personal nature of the information about a patient's mental state and the stigma attached to mental illness, the patient may for instance not get promoted or be denied an insurance policy if such information should be disclosed. The patient also needs to trust the doctor in order to open up and talk and this is only possible if the patient knows that everything discussed will not be disclosed.

1.2 Outline of study

The first chapter serves as an introduction to the topic. The terms "confidentiality" and "privacy" are defined and the need for confidentiality is examined. This is followed a discussion on the ethical aspects relating to medical confidentiality, and the physician-patient privilege. The conflicting rights of privacy versus the right to information by third party players such as medical aid schemes and managed care organisations is looked at, and mention is made of other problem areas that are not covered in depth in this dissertation, due to space restrictions.

¹ See the reason under 1.3 Methodology.

² *Constitution of the Republic of South Africa, 2006*; s. 39(1)(c).

³ Other problem areas include privacy issues in telemedicine, information about patients receiving treatment for drug and alcohol abuse, and the ability to predict according to one's genes which serious illnesses a person is most likely to manifest with in the future.

The concept of privacy, its development and protection is discussed in the second chapter. The causes of action and defences are discussed in the third chapter, while the fourth chapter describes the exceptions that allow breach of confidentiality outside a court of law. All three chapters are discussed from a comparative perspective. This is followed by an in depth comparative study of one problem area, namely confidentiality relating to mental health and the psychologist / psychiatrist-patient relationship in chapter five. Chapter six contains the final observations and conclusions that can be drawn from this study.

1.3 Methodology

A comparative study was undertaken, due to the valuable insights that could be gained from the vast amount of information written on this topic. The landmark case in the USA of *Tarasoff*⁴ and the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* and Department of Health and Human Services (HHS) Privacy Rules are very relevant to the topic. A great deal has been written in the USA about privacy, data protection and doctor-patient confidentiality. Canada was also chosen due to the similarities between their constitution and bill of rights and ours, and also because of the whole doctor-patient privilege debate that has been written about extensively in the Canadian literature.⁵ Section 39(1)(c) of our *Constitution*⁶ states that when interpreting the Bill of Rights a court, tribunal or forum may consider foreign law and therefore it is important to study how other countries such as Canada and the USA handle the same privacy issues.

South Africa has a hybrid system of law where Roman law developed into Roman-Dutch law and later interacted and intermixed with English Common law. Whenever Roman-Dutch law seemed unclear, inadequate, or obsolete, the courts had a tendency to rely on English case law.⁷

Canada, excluding Quebec, follows the common law tradition. The law in Canada apart from Quebec⁸ was unmistakably modelled on the law in England until recently. The tradition of English Common law has been one of gradual development from decision to

⁴ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553.

⁵ See more about this under on p27, heading 4.3.

⁶ *Constitution of the Republic of South Africa, 2006*.

⁷ Zweigert and Kötz (1998) 232-235.

⁸ Quebec which is predominately French speaking follows the civil law tradition.

decision and therefore one could say it is historically speaking case law, not enacted law. It comes from the Court and therefore legal practitioners predict how the judge will deal with a problem, taking into consideration existing decisions.⁹ Canadian Courts regard decisions of the House of Lords and the Privy Council as binding and treat decisions of the other English courts as having persuasive authority. Since the end of the Second World War and more so since the abolition of appeals to the Privy Council in 1949, there appears to be an increasing independence in Canadian legal thought and more attention is being paid to promptings from the USA.¹⁰

The USA follows the common law tradition and is said to possess “perhaps the most complicated legal structure that has ever been devised and made effective in man’s effort to govern himself.” This has arisen from the complexities of the concurrence of federal and state law, and from the fact that both the United States and the several states possess fully equipped court systems. The legislatures of each of the fifty states can pass their own statutes in an area of law and the judges in these areas are free to develop the law of their state in different directions, as they often do. There is often a confusing hodgepodge of federal and state law.¹¹

⁹ Zweigert and Kötz (1998) *Introduction to comparative law* 69, 224.

¹⁰ Zweigert and Kötz (1998) 224.

¹¹ Zweigert and Kötz (1998) 249-253.

Chapter 1

Conceptualisation of matters related to confidentiality and privacy

1. *Introduction and definitions*

1.1 Introduction

A brief discussion of the main concepts and terminology relevant to this topic follows in Sections 1.2 and 1.3 below.

According to Neethling, the identification and delimitation of protected interests such as privacy are of utmost importance for *inter alia*, the law of delict, since it increases the courts' or the legislature's ability to articulate, develop and apply principles of legal protection. Conceptual clarity will render privacy dogmatically and practically more manageable and in this way promote legal certainty.¹²

This section is not dealt with comparatively, since the meanings of these concepts do not differ, from country to country. There is also a definite need for confidentiality in the physician-patient relationship, and the reasons for this need are discussed in Section 2 of Chapter 1 below. Ethical considerations are intrinsically linked to the concepts of privacy and confidentiality and are discussed in Section 3 of Chapter 1 below. The physician-patient privilege has especially in Canada been discussed in great detail and is looked at from a comparative perspective in Section 4 of Chapter 1 below. The many legitimate interests that parties have in medical records today, in the modern medical care setting, are discussed from a general point of view in Section 5 of Chapter 1 and in Section 6 of Chapter 1, attention is given to specialized areas in medicine that require a heightened degree of confidentiality.¹³

¹² Neethling (2005) *The concept of privacy in South African law SALJ* 18,28.

¹³ Confidentiality relating to Mental Health also requires a heightened degree of confidentiality and this issue is concentrated on in detail in Chapter 5 below; due to space restrictions other important aspects are just touched on.

1.2 The concept of confidentiality in general

There is a difference in saying someone's privacy has been infringed versus saying someone's right to confidentiality has been infringed. An infringement of a patient's right to confidentiality only occurs if the person, to whom the patient disclosed the information in confidence, deliberately discloses the information without the patient's consent, or fails to adequately protect it. The information must be given in a confidential relationship, before the person or institution can be charged with breaching confidentiality.¹⁴ Confidentiality is characterised by a relationship between two or more people, of which one or more has agreed either explicitly or implicitly not to reveal to third parties any information revealed during the course of the relationship.¹⁵

Schneider defines confidentiality as "the ethical, professional and legal obligation of a physician not to disclose what is communicated to him or her in the physician-patient relationship."¹⁶ A "breach of confidentiality" means the release of medical information without the patient's consent and without legal necessity or legal authorisation for the release.¹⁷ Taitz on the other hand defines confidentiality as the,

"duty cast upon a medical practitioner, by reason of his calling and his special relationship with his patient, to keep secret and confidential all, and any, information, whether relating to a patient's ailment or otherwise, which information was obtained directly or indirectly by the practitioner as a result of the doctor-patient relationship,"¹⁸

while Giesen states that the concept of medical confidentiality arises from the patient-physician relationship and is therefore almost as old as medicine itself, and older than the Common Law and the Civil Law.¹⁹

¹⁴ Beauchamp & Childress *Principles of biomedical ethics* (1994) 418; see also Austin *Confronting malpractice: legal and ethical dilemmas in psychotherapy* (1990) 45.

¹⁵ Laurie "Challenging medical-legal norms: the role of autonomy, confidentiality, and privacy in protecting individual and familial group rights in genetic information" (2001) 22 *Journal of legal medicine* 15a.

¹⁶ Bloom & Bay eds *A practical guide to mental health, capacity, and consent law of Ontario* (1996) 379.

¹⁷ Turkington "Medical record confidentiality: law, scientific research, and data collection in the information age" (1997) *Journal of law, medicine and ethics* 114.

¹⁸ Taitz "The rule of medical confidentiality v the moral duty to warn an endangered third party" (1990) 78 *SAMJ* 29.

¹⁹ Giesen *International medical malpractice law* (1988) 406.

1.3 The concept of privacy in general

Ackermann J in *Bernstein ao v Bester ao NNO*²⁰ states that “the concept of privacy is an amorphous and elusive one which has been the subject of much scholarly debate.”

The following definition as proposed by Neethling was accepted in *National Media Ltd ao v Jooste*²¹:

“Privacy is an individual condition of life characterised by exclusion from the public and publicity. This condition embraces all those personal facts which the person concerned has determined himself to be excluded from the knowledge of outsiders and in respect of which he has the will that they be kept private.”²²

In 1890 Warren and Brandeis accepted Judge Cooley’s definition of privacy as the as the “right to be let alone.”²³ On a basic level, privacy means that no one is obliged to tell anything about himself or herself to any person.²⁴ Alderman states that “privacy allows us to keep certain facts to ourselves if we so choose. The right to privacy, it seems, is what makes us civilized.”²⁵

2. Need for confidentiality

2.1 Need for confidentiality in general

The concept of medical confidentiality is very old, and arises from the doctor-patient relationship.²⁶ Due to the content of several professional ethical codes, it is generally assumed that health care workers have a duty to respect the confidentiality of medical information. If the person whom it concerns consents to the release of the information or requests that the information be released to third parties, the confidentiality may be breached.²⁷

²⁰ *Bernstein and others v Bester and others NNO* 1996 (2) SA 751 (CC) at 787-8.

²¹ *National Media Ltd ao v Jooste* 1996 (3) 262 (A) at 271; Harms JA states that a footnote in Neethling’s *Deliktereg* 3rd ed at 344 n 239 puts the ‘privaathoudingswil’ in true perspective; “absent a will to keep a fact private, absent an interest (or a right) that can be protected. The boundary of a right or its infringement remains an objective question.”

²² Translated from Afrikaans and quoted from the South African Law Reform Commission Project 124 “Privacy and data protection” Issue paper 24 December 2003, 48.

²³ Warren & Brandeis “The right to privacy” (1890) *Harvard law review* 193.

²⁴ Bennett & Erin eds *Hiv and Aids: testing, screening and confidentiality* (1999) 210.

²⁵ Eddy “A critical analysis of Health and Human Services proposed health privacy regulations in light of the Health Insurance Privacy and Accountability Act of 1996” (2000) 9 *Annals of health law* 1; He is referring to the book *The Right to Privacy* by Ellen Alderman and Caroline Kennedy. Giesen *International medical malpractice law* (1988) 407.

²⁶ Giesen *International medical malpractice law* (1988) 407.

²⁷ Bennett & Erin (1999) 140.

Information concerning one's health is often of a very sensitive or delicate nature. If the information is released without the consent of the person concerned, it may give rise to serious emotional and material harm. This is especially so, where for instance the material is released to third parties such as insurers, bankers, or employers who may discriminate against the applicant by refusing an applicant on the basis of their medical health. Information concerning certain intimate parts of the body or certain medical conditions may harm the person it may concern and cause them both embarrassment and ridicule²⁸. Release of certain medical data, for example genetic data, can lead to patients being discriminated against. Many kinds of discrimination are difficult to detect and prove and therefore laws against discriminatory practices provide only limited remedies. Harm may also be difficult to prove.²⁹

Respecting individual autonomy is another reason for confidentiality. This question of autonomy is two-sided. Firstly it has to do with considering people to be the master of their own well-being.³⁰ The person to which the information pertains, is in the best position to decide whether or not revealing certain information to certain people may benefit or harm them. The kind of information that a person will pass on to relatives would normally differ from the kind of information passed on to others. The kind of information passed on to others is indicative of the relationship they share. By controlling the kind of information that is passed on, one can in turn control the kind of relationship one has with others.³¹ Secondly, respecting autonomy is an expression of respect for the dignity of individual people. This leaves people free to make choices and act morally right or morally wrong.³²

Turkington also states recognising a patient's right to privacy is a form of respect, which in turn promotes communication and enhances treatment. Privacy and confidentiality are however never absolute.³³ Laurie states that central to the principle of respect for autonomy is firstly, the idea of having one's choices respected, and secondly non-

²⁸ Bennett & Erin (1999) 144; Picard & Robertson *Legal liability of doctors and hospitals in Canada* (1996) 14.

²⁹ Woodward "Medical record confidentiality and data collection: current dilemmas" (1997) 2-3 *Journal of law, medicine & ethics: a journal of the American Society of Law, Medicine and Ethics* 90.

³⁰ Bennett & Erin (1999) 143.

³¹ Bennett & Erin (1999) 144.

³² Bennett & Erin (1999) 145.

³³ Turkington (1997) 25 *Journal of law, medicine and ethics* 113.

interference or the ability to make choices without interference by others. There needs finally to be the capacity to make one's own choices.³⁴

For the patient to maintain trust in the doctor, the doctor has to respect the patients' confidentiality. The main ground for honouring medical confidentiality is utilitarian. It encourages people to seek treatment who might otherwise avoid doing so out of shame or embarrassment³⁵. If the doctor breaches the patients trust it could lead to situations where patients avoid going to the doctor for fear of their condition being reported. This in the long run could endanger public health.³⁶

2.2 What South African commentators state about the need for confidentiality

The commentators from the three countries studied all accept that confidentiality is essential to the doctor-patient relationship, but they vary in their reasoning, as to why it is essential.

Van Oosten states that the purpose and function of confidentiality in medical law, is to protect the patient's privacy and to protect public health.³⁷ Confidentiality should continue even after death. Dhai observes that families of HIV/Aids sufferers often face ostracism and discrimination when the death certificate of loved one state that they died from an Aids related illness. Some families are unable to bury their loved ones in traditional burial grounds once the cause of death becomes known. Insurance benefits are also not always paid out once it becomes known the person died from HIV / Aids.³⁸

2.3 What American commentators state about the need for confidentiality

The American Medical Association (AMA) acknowledges that the basis for maintaining confidentiality is to ensure a trusting, honest and open therapeutic relationship in which the patient feels secure in revealing their private concerns.³⁹

³⁴ Laurie (2001) 22 *Journal of legal medicine* 19.

³⁵ Hall *Health care law and ethics in a nutshell* (1999) 118.

³⁶ Bennett & Erin (1999) 146.

³⁷ Van Oosten *International encyclopaedia of law : Medical law* (1996) 90.

³⁸ Dhai "Confidentiality – a dying wish?" (2001) 91 *South African Medical Journal* 123.

³⁹ Spielberg "Online without a net: physician-patient communication by electronic mail" (1999) 25 *American Journal of law and medicine* 284.

Curran states that the doctor-patient relationship, is a fiduciary relationship of the highest degree.⁴⁰ This in turn involves every element of trust, confidence and good faith.⁴¹“Fiduciary duties arise as heightened aspects of general tort and contract law rather than through a separate branch of legal doctrine.”⁴² The doctor is there to protect the patient’s best interests and this involves a duty to protect the confidentiality of patient information.⁴³ However, a doctor-patient relationship must be established, before such a duty arises.

According to Veatch confidentiality is central to respecting the patient’s human dignity. If someone reveals private information about us without our consent, that person effectively takes control of our lives and has takes our identities away from us, which is disrespectful. This shows why human dignity hinges on confidentiality.⁴⁴

2.4 What Canadian commentators state about the need for confidentiality

The legal duty of confidentiality was recognised by the Supreme Court of Canada in *McInerney v MacDonald*⁴⁵ as being grounded in the fiduciary nature of the doctor-patient relationship.⁴⁶ Picard says that not every doctor-patient relationship is fiduciary and that exceptions do exist. An example would be were a doctor at the request of the defendant examines a plaintiff in a personal injury case. No real doctor-patient relationship is established. Neither is the nature or extent of the fiduciary obligations the same in every case.⁴⁷ The fiduciary duty exists for the protection of the patient.

⁴⁰ Curran says, “fiduciary law can be thought of not so much as a separate source of distinct legal duties, but instead as a legal status that heighten or alters ordinary contract or tort law.”

⁴¹ See more on the fiduciary nature of the relationship, in Picard (1996) 5.

⁴² Curran *Health care law and ethics* (1998) 187.

⁴³ Hall (1999) 116.

⁴⁴ Curran (1998) 189.

⁴⁵ Veatch *Medical ethics* (1997) 90.

⁴⁶ *McInerney v MacDonald* (1992) 93 DLR (4th) 415 (SCC).

⁴⁷ Picard (1996) 15.

⁴⁷ Picard (1996) 6.

3. ***Ethical aspects relating to medical confidentiality***

3.1 **Ethical aspects of confidentiality in general**

Medical ethics⁴⁸ does not stand separate from the law. It is interwoven with and has a constant influence on the doctor-patient relationship. Medical ethics can be defined as an analysis of choices in medicine.⁴⁹ Ethical considerations are inextricably linked with considerations of a legal nature, and what the rules of medical ethics demand of a doctor, will to a large extent also be the legal obligations that have to be fulfilled.⁵⁰

The different codes of medical ethics have commonly contained rules of confidentiality.⁵¹ The original source of a physician's duty to maintain confidentiality is the Hippocratic Oath. This provides in part that

“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 such should be kept secret.”⁵²

The World Medical Association also supports rules of confidentiality, and its Declaration of Geneva, asserts an obligation of “absolute secrecy” and includes the pledge that the patient's secrets will be protected even after death.⁵³

One moral base for the obligation that medical professionals maintain confidentiality is an implied promise to do so, for which the basic moral principle is fidelity or promise keeping.⁵⁴ The principle of fidelity possibly provides the best foundation for the duty not to disclose information learned in personal relations.⁵⁵ There are however, certain limits

⁴⁸ Veatch (1997) 5 gives a definition of ethics. It is the “enterprise of disciplined reflection on the moral intuitions and moral choices that people make, and often begins with our intuitions and long-held convictions.”

⁴⁹ Veatch (1997) 1.

⁵⁰ Giesen *International medical malpractice law* (1988) 669.

⁵¹ See also: Moodie, P & Wright, M “Confidentiality, codes and courts: an examination of the significance of professional guidelines on medical ethics in determining the legal limits of confidentiality” (2000) 29 *Anglo-American law review* 39-66.

⁵² Giesen *International medical malpractice law* (1988) 670.

⁵³ Beauchamp & Childress (1994) 419.

⁵⁴ Veatch *Case studies in allied health ethics* (1997b) 202.

⁵⁵ Veatch (1997b) 105.

on the promise of confidentiality. Confidentiality can be breached to benefit the patient or to benefit others.⁵⁶

Four principles of ethics, developed by Beauchamp have notably influenced much of Western thinking and action, especially in the medical-legal world. These four principles are autonomy, beneficence⁵⁷, non-maleficence⁵⁸, and justice⁵⁹.⁶⁰ Beauchamp states it is not “inherently or intrinsically wrong for one person to disclose information received from another in a special relationship,”⁶¹ and he believes there are three types of arguments to support the need for confidentiality namely:

- 1) consequentialist-based arguments
- 2) rights-based autonomy and privacy arguments, and
- 3) fidelity-based arguments

Consequentialists establish a need for confidentiality, but disagree about which rule of confidentiality should be adopted, and about the rule’s scope and weight.⁶² In *Tarasoff*⁶³ both the majority and dissenting opinions used consequentialist arguments to justify their interpretation of the rule of confidentiality and its exceptions. Consequentialist arguments rest on the principle that the lack of confidentiality will prevent a person who needs medical or psychiatric treatment from seeking it. However, these claims have not been adequately tested.⁶⁴ The few studies that are available seem to support a strong duty of confidentiality, however they do not support an absolute rule of nondisclosure. Legal exceptions to confidentiality, such as reporting child abuse or contagious diseases are allowed.

The second argument supporting confidentiality looks to moral principles or rules such as respect for privacy and autonomy. Breaches of confidentiality have often been seen

⁵⁶ Veatch (1997b) 106.

⁵⁷ Beneficence means that one should strive to bring benefit to people wherever possible.

⁵⁸ Non-maleficence means one should try at all times to minimize harm to others.

⁵⁹ Justice requires that similar cases be treated alike and that no person or group be unjustifiably prejudiced on irrelevant or unjustified grounds.

⁶⁰ Laurie (2001) 22 *Journal of legal medicine* 15.

⁶¹ Beauchamp & Childress (1994) 421.

⁶² Beauchamp & Childress (1994) 422.

⁶³ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553.

⁶⁴ Beauchamp & Childress (1994) 422.

as violations of privacy and personal autonomy⁶⁵, which can result in the loss of support from friends and family, the loss of a job, emotional distress and discrimination.⁶⁶This argument is chiefly a moral rather than a legal argument. However the common law, statutory law and constitutional law recognition of protected privacy rights support it.⁶⁷

Beauchamp's third fidelity based argument, supporting confidentiality, looks to a doctor's duty to live up to the patient's reasonable expectation of privacy and to the trust that confidentiality will be maintained. The disclosure of private and sensitive information often occurs in medical practices, and therefore a breakdown in fidelity can seriously cause damage to the doctor-patient relationship. Due to the ethical codes, such as the Hippocratic Oath that all doctors swear to, the patient has a right to expect privacy, except if the doctor expressly disavows confidentiality.⁶⁸

There has been a gradual trend away from the absolute rules of confidentiality imposed by the Hippocratic Oath.⁶⁹ None of the above three arguments support absolute rules of confidentiality. Jointly these three arguments provide a convincing explanation for a strict rule of medical confidentiality, and they also help to explain why medical oaths have typically expressed obligations of confidentiality in absolutist terms.⁷⁰

Tur also argues that the duty of confidentiality is not absolute but relative, and that it depends on the professional judgement of the health professionals to determine whether the public interest or any other compelling reason should take precedence over that duty.⁷¹This duty will be dependant on the facts of each case. An absolute duty is easier to understand and state but it can have some shocking consequences in extreme cases. A relative duty is more difficult to state and teach and is likely to generate uncertainty and place an unwelcome moral burden on health care professionals. "Thou shalt

⁶⁵ Bennett (1999) 208, gives a definition of autonomy presented by Gerald Dworkin, namely: "autonomy is a second-order capacity to reflect critically upon one's first-order preferences and desires, and the ability to identify with these or to change them in light of higher-order preferences and values Liberty, power, and privacy are not equivalent to autonomy."

⁶⁶ *Ibid.*

⁶⁷ Beauchamp (1994) 424.

⁶⁸ *Ibid.*

⁶⁹ Friedland "Physician-patient confidentiality: time to re-examine a venerable concept in light of contemporary society and advances in medicine" (1994) 15 *Journal of legal medicine* 259.

⁷⁰ *Ibid.*

⁷¹ Tur "Medical confidentiality and disclosure: moral conscience and legal constraints" (1998) 15 *Jnl of Applied Philosophy* 26.

not breach confidence” is more readily understood than “thou shalt not breach confidence unless there is a reason that most of us would consider valid in your particular circumstances.” Anglo-American common law upholds a relative duty of confidentiality and therefore compelling reasons are necessary to justify disclosure of such information. However health professionals encounter moral dilemmas in deciding what is a good reason for breaching confidentiality.⁷²

Beauchamp explains that there are certain times when infringement of confidentiality is justified. This occurs for instance in the case of child abuse or a patient’s serious intent to murder someone, when the person is not entitled to the confidence. This lack of entitlement to a confidence makes disclosure permissible,” but in other cases health care professionals have an obligation to breach confidentiality.⁷³ Beauchamp states that both the probability that harm will materialize and the magnitude of the harm should be balanced against the obligation of confidentiality.

		<u>Magnitude of harm</u>	
		<i>Major</i>	<i>Minor</i>
<i>HIGH</i>	1	2	
<u>Probability</u>			
<i>LOW</i>	3	4	

In the above diagram it can be seen that it is the borderline cases, (2 and 3) where breach of confidentiality is more difficult to justify. Certain particularities of the case can be considered to determine whether one is justified in breaching confidentiality. These particularities include the “foreseeability of a harm, the preventability of the harm through intervention by a health care professional, and the potential impact on policies and laws regarding confidentiality.”⁷⁴

⁷² Tur (1998) *Jnl of Applied Philosophy* 16.

⁷³ See *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553 *Infra* 137.

⁷⁴ Beauchamp & Childress (1994) 425.

One of the most difficult problems in medical ethics is deciding when to breach confidentiality. Three situations can be distinguished, in which the justification for overriding confidentiality becomes progressively stronger. :

1. "Revealing the information would produce some considerable good.
2. Revealing the information would prevent some possible risk of harm to someone, but who that would be is not known for certain.
3. Revealing the information would prevent some very likely harm to specific and identifiable individuals."⁷⁵

There are many grey areas where doctors will be faced with tough decisions in deciding whether to breach patient confidentiality for the sake of a greater public interest. Sometimes the public interest may be so convincing that the doctor is not just justified in breaching confidentiality, but is required to do so, and failure may result in the doctor being held liable in damages if somebody is injured.⁷⁶ *Tarasoff*⁷⁷ serves as a good example of the above, where the court described the duty of confidentiality as ending where the public peril begins.

3.2 Ethical aspects of confidentiality in South Africa

The Health Professions Council of South Africa supports professional confidentiality in the doctor-patient relationship, and imposes a general duty not to divulge any information that ought not to be divulged. Section 14, Rule 12 of the ethical rulings states the following:

"A practitioner may not divulge any information regarding a patient which ought not to be divulged, except with the express consent of the patient or, in the case of a minor under the age of 14 years, with the written consent of his or her parent or guardian or, in the case of a deceased patient, with the written consent of his or her next of kin or the executor of his or her estate."⁷⁸

⁷⁵ Veatch (1997) 92.

⁷⁶ Picard (1996) 32.

⁷⁷ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553; for a discussion on this see p. 139-140.

⁷⁸ Health Professions Council of South Africa *Ethical rulings* (2000) 41.

Rule 13 of the Draft rules of the Health Professions Council of South Africa published in 2004, deals with professional confidentiality. It states the following:

- “(1) A practitioner shall only divulge verbally or in writing information regarding a patient which he or she ought to divulge-
- a) in terms of a statutory provision;
 - b) at the instruction of a court of law; or
 - c) where justified in the public interest
- (2) Any information other than the information referred to in sub-rule (1) shall only be divulged by a practitioner –
- a) with the express consent of the patient;
 - b) in the case of a minor under the age of 14 years, with the written consent of his or her parent or guardian; or
 - c) in the case of a deceased patient, with the written consent of his or her next-of-kin or the executor of such deceased patient’s estate.”⁷⁹

One of the Core Ethical Values and Standards for Good Practice, published in the Professional Guidelines given out by the HPCSA is confidentiality.⁸⁰ The following is taken from section 2.4:

1. Recognise the right of patients to expect that you will not pass on any personal and confidential information you acquire in the course of your professional duties, unless they agree to disclosure, or unless you have good and overriding reason for doing so. (Examples of such reasons may be any probable and serious harm to an identifiable third party, a public health emergency, or any overriding and ethically justified legal requirements.)
2. Do not breach confidentiality without sound reason and without the knowledge of your patient.
3. Ask your patients’ permission before sharing information with their spouses, partners or relatives.

⁷⁹ Health Professions Council of South Africa [Draft] *ethical rules of conduct for practitioners registered under the Health Professions Act (2004) Rule 13.*

⁸⁰ Health Professions Council of South Africa *Professional guidelines* Para. 2.4; these guidelines do not constitute a code, but are merely intended as advice.

The National Patient's Rights Charter states the following on confidentiality and privacy: "Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or any order of court."⁸¹

3.3 Ethical aspects of confidentiality in Canada

The Canadian Medical Association's Code of Medical Ethics requires doctors to keep in confidence information derived from a patient or from a colleague regarding a patient, and divulge it only with the permission of the patient except when otherwise required by law.⁸²

The Canadian Medical Association (CMA) adopted a Health Information Privacy Code⁸³ to protect the privacy of its patients, the confidentiality and security of its health information and the trust and integrity of the doctor-patient relationship. The Code is based on the Canadian Standards Association's Model Code for the Protection of Personal Information (CSA Code) as a sectoral code of the CSA Code. The Code provides instruction and guidance respecting health information collection, use, disclosure and access."⁸⁴

3.4 Ethical aspects of confidentiality in the USA

The 1957 code of the AMA states the following:

"A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community."⁸⁵

The code had a paternalistic quality.⁸⁶ In 1980 the code was revised to state that patients' confidences should be safeguarded within the constraints of the law. This was the first codification written by physicians, that contains an explicit

⁸¹ Health Professions Council of South Africa *National Patients' Rights Charter* (2002) 2.

⁸² Picard (1996) 15; Giesen (1988) 671.

⁸³ <http://www.cma.ca> .

⁸⁴ South African Law Reform Commission, *Privacy and data protection* (2003), Issue Paper 24, Project 124, 139.

⁸⁵ Curran (1998) 189.

⁸⁶ Veatch (1997) 10.

commitment to the rights of the patients. The paternalism⁸⁷ had been dropped.”⁸⁸
In June 1994 the Council on Ethical and Judicial Affairs modified the opinion to restore the paternalistic exception. It now permits “the breaking of confidence if the patient threatens to inflict serious bodily harm to himself or herself or to another person.”⁸⁹

The American Medical Association’s Principles of Medical Ethics elaborates on this duty:

“... the patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services... the physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.”⁹⁰

Allied health professionals such as physiotherapists and occupational therapists have increasingly their own code of ethics. Psychologists in the USA are similarly bound by the ethical codes of the American Psychological Association.⁹¹ This can give rise to problems. Not all allied health professionals are members of their own professional group. The question is whether the code of ethics can be binding on non-members. If a physician and for example a physiotherapist work together, there might be a conflict of ethical codes. Whose ethical code must then be followed?⁹² According to Veatch one possible solution is that whenever there is a conflict between the ethical codes of different professional groups, the physician’s ethical code should be followed.⁹³

Justified breaches of confidentiality are seen by the AMA Principles of Medical Ethics, as breaches of confidentiality that are required by law.⁹⁴

⁸⁷ Veatch (1997) 77 explains paternalism as refusing to submit to the wishes of another person for that person’s own benefit. It is placing the moral principle of benefiting another person, according to our own view, on a higher plane than the moral principle of autonomy.

⁸⁸ Veatch (1997) 10.

⁸⁹ Veatch (1997) 11.

⁹⁰ Furrow (2000) 151.

⁹¹ Hermann *Mental health and disability law in a nutshell* (1997) 114.

⁹² Veatch (1997b) 11.

⁹³ Veatch (1997b) 15.

⁹⁴ Beauchamp & Childress (1994) 425.

According to the South African Law Commission Issue Paper 24,⁹⁵ the American Medical Association keeps to the US Constitution and ethical duties so as to provide guidance to doctors in patient confidentiality.

4. Physician-patient privilege

4.1 Physician-patient privilege in general

The physician-patient privilege is an “evidentiary device that prohibit either the discovery of medical records or their admissibility at trial.” The privilege is a right held by the patient, which can also be waived by the patient. Only medical information is privileged, not other incidental information discussed in the course of a consultation.⁹⁶

Physician-patient privilege exists both inside and outside the courtroom in civil law countries, but the privilege does not exist in this form at common law. A doctor can be held in contempt of court and be fined or even jailed if he refuses to testify about confidential information in a court of law. In this way he can be compelled to testify.⁹⁷ Civil and common law systems approach judicially compelled disclosure of confidential information differently. Civil law has limited judicially compelled disclosure in a variety of different relationships. These include physician-patient, nurse-patient and pharmacist-patient relationships. These differences continue in civil and common law Canada.⁹⁸

Rodgers-Magnet states that ironically the discussion concerning the necessity of granting testimonial privilege most often assumes that beyond the background of in-court disclosure, any unauthorised disclosure would be subject to sanction in private law. It is only as an aid to the judicial search for truth that the value of non-disclosure is potentially outweighed by more important social values. The presence or absence of statutory privilege has often determined the success or failure of a private law remedy.⁹⁹

⁹⁵ South African Law Reform Commission (2003) 139.

⁹⁶ Furrow (2000) 151-152.

⁹⁷ Giesen (1988) 413; Picard (1996) 17.

⁹⁸ Picard & Robertson *Legal liability of doctors and hospitals in Canada* (1996) 17-18.

⁹⁹ Steel (1983) 268.

4.2 Physician-patient privilege in South Africa

According to Strauss in South Africa it is “not only unethical for a doctor to disclose medical facts to a third party without authorisation, but it is illegal in that it amounts to an actionable violation of the patient’s privacy rights.” However an exception to this rule and the one pertaining to physician-patient privilege states that where a doctor is called as a witness in a court action between a patient and another party, and is ordered by the presiding officer to testify on medical facts, the doctor is compelled to testify. Professional secrecy may be breached only under protest after direction from the presiding judicial officer.¹⁰⁰ This condonation only applies to trial proceedings where the doctor would be expected to give oral testimony and not to motion or application proceedings where evidence is led by way of affidavit.¹⁰¹ There is therefore no absolute privilege for communications between a physician and patient in South Africa. Physicians can be held in contempt of court and fined, if they do not comply with a court order to provide the necessary information.¹⁰² However, being ordered to testify in court is seen as an absolute defence to the breach of medical confidentiality.

Van Dokkum argues that our current law fulfils the first three of Wigmore’s requirements, but that the final requirement¹⁰³ can be problematic, because the privilege cannot be supported where its observance would be more harmful than beneficial to the public good. Wigmore’s final query would seem to be answered in the negative by our courts. As a general rule such protection of confidentiality in a court of law is more harmful than beneficial to the interests of justice and therefore our courts will exclude such evidence only if its admission would be unfair¹⁰⁴ or prejudicial.^{105 106}

¹⁰⁰ Strauss *Doctor, patient and the law* (1991) 112, 454.

¹⁰¹ Van Dokkum (1996) “Should Doctor-patient communications be privileged?” *De Rebus* 748

¹⁰² Giesen (1988) 414.

¹⁰³ See p. 28.

¹⁰⁴ *S v Mushimba en Andere* 1977 (2) SA 829 (A) at 840 and *S v Forbes and another* 1970 (2) SA 594 (C).

¹⁰⁵ *S v Roets and another* 1954(3) SA 512 (A).

¹⁰⁶ Van Dokkum (1996) “Should Doctor-patient communications be privileged?” *De Rebus* 749-751;

4.3 Physician-patient privilege in Canada

The traditional rule that communication in a courtroom, between a doctor and a patient, is not privileged was confirmed in the renowned judgement of Lord Mansfield in the bigamy trial of the Duchess of Kingston in 1776.¹⁰⁷ Lord Mansfield stated that

“a surgeon has no privilege, where it is a material question, in a civil or criminal cause ... if a surgeon was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honour, and of great indiscretion; but, to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever.”¹⁰⁸

Two factors need to be noted. Firstly the surgeon himself raised the objection to the disclosure of confidential medical information and secondly it was raised as a question of evidentiary rules, during a criminal trial for bigamy. According to Roders-Magnet the remarks concerning the disclosure of information outside of the context of a criminal or civil cause of action are clearly *obiter*. The recognised value of the protection of confidentiality of the physician-patient relationship must be balanced against the equally important value of access to truth in the judicial process.¹⁰⁹

Even though the traditional common law rule in Canada rejects testimonial privilege for doctors, this can no longer be said to apply in every case. Any communication that is made in a physician-patient relationship is potentially entitled to common law privilege on a case-by-case basis. Each case will be analysed in terms of the four-part Wigmore test.¹¹⁰ The common law recognises a public interest exception to the duty of medical confidentiality even though its exact scope is not clear. The Supreme Court of Canada in *McInerney v MacDonald* acknowledged this.¹¹¹

In 1991 the Supreme Court of Canada in *R v Gruenke*¹¹² emphasised the need for a more flexible approach, and held that privilege should be determined on a case-by-case

¹⁰⁷ *Kingston's (Duchess) Case* (1776), 20 State Tr. 355.

¹⁰⁸ Picard (1996) 17-18.

¹⁰⁹ *Steel Issues in tort law* (1983) 266.

¹¹⁰ Caulfield *International encyclopaedia of law: Medical law* (1999) 74.

¹¹¹ *McInerney v MacDonald* (1992) 93 DLR (4th) 415 (SCC).

¹¹² *R v Gruenke* [1991] 3 SCR 263.

basis. Relying on its previous decision in *Slavutych v Baker*¹¹³, the Supreme Court of Canada approved, as a broad framework, the principles first suggested by Dean Wigmore, an American authority on the law of evidence, who suggested a more broadly based and flexible approach to privilege.¹¹⁴

Wigmore maintains that the following four conditions must be met before communications will be recognised as privileged:

1. “the communication must originate in a confidence that they will not be disclosed.
2. this element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties;
3. the relation must be one which in the opinion of the community ought to be sedulously fostered; and”
4. The interest served by protecting against disclosure outweigh the interests served by pursuit of the truth and the correct disposal of litigation.¹¹⁵

The question is whether the communication between a doctor and patient meets the above four conditions. Picard says no clear answer has emerged. With regards question one, not all communications between patients and doctors arise in a confidence that will not be disclosed. It is common for patients to talk to their friends and family about their ailments. Wigmore himself said that in only a few instances does the communication between a patient and doctor arise in confidence. This is more likely to occur in the fields of psychology and psychiatry. Several Canadian cases have held that the relationship between a psychotherapist and patient satisfies the first of Wigmore’s four conditions.¹¹⁶

With regards Wigmore’s second condition, the question is not so much whether “confidentiality” is essential, but rather whether “privilege” is. The answer is not obvious since the medical profession has carried on without privilege for centuries, and many writers have also argued that patient care is not adversely affected by the lack of privilege. The

¹¹³ *Slavutych v Baker* [1976] 1 SCR 254.

¹¹⁴ Picard (1996) 19,413.

¹¹⁵ Picard (1996) 19.

¹¹⁶ Picard (1996) 20.

lack of privilege also does not seem to deter patients from seeking medical treatment. As with the first condition some Canadian courts have held that certain types of therapeutic relationships, especially those involving psychotherapists, satisfy Wigmore's second condition.¹¹⁷

Thirdly the doctor-patient relationship should definitely be fostered in the community. Therefore the third condition is fulfilled.

With regards the fourth condition Wigmore denied that the injury to the doctor-patient relationship resulting from disclosure was greater than the social benefit. In many instances there would be no injury to the relationship, but when the information is of a particularly sensitive or private nature this might not be the case. Once again the psychotherapist relationship may satisfy Wigmore's fourth condition. It is possibly for this reason that some Canadian courts have refused to compel psychiatrists from giving evidence.¹¹⁸

As a result of this case by case approach adopted by the Supreme Court of Canada, privilege will be held to be justifiable in some situations and not in others even when it concerns a sensitive relationship such as that which exists between a psychotherapist and a patient. Requests for privilege of psychiatric evidence have tended to be denied in criminal proceedings and child protection cases, but have been more successful in civil litigation especially matrimonial cases. Determination of privilege in a doctor-patient relationship must be done on a case-by-case basis. The nature of the particular relationship before the court, the nature of the legal proceedings, and the effect of denying or granting privilege in each particular case must all be taken into account. In the words of the Law Reform Commission the overriding consideration is whether "the public interest in the privacy of the relationship outweighs the public interest in the administration of justice."¹¹⁹

¹¹⁷

Ibid.

¹¹⁸

See *Dembie v Dembie* (1963) 21 RFL 46 (Ont. SC) where the judge stated " I think it rather shocking that one profession should attempt to dictate the ethics of another they are forcing a breach of the [Hippocratic] oath"; Picard (1996) 21.

¹¹⁹

Picard (1996) 22-23.

The common law of Canada recognises only an attorney-client privilege, while the civil law province of Quebec recognises a professional secret for communications between physicians, dentists and their patients.¹²⁰ Professional secret is the civil law's counterpart to the common law's concept of privilege. This was recognised in Quebec in 1909.¹²¹ The professional secret does not apply in criminal cases and within civil cases the privilege is not either absolute. Certain exceptions are recognised, such as "physician discipline, contagious disease, venereal disease, public curatorship, psychiatric detention, child abuse, and medical malpractice actions instituted by the patient."¹²² Privilege can be conferred by statute. In Quebec for example the *Medical Act*¹²³ provides that "no physician may be compelled to declare what has been revealed to him in his professional character."¹²⁴

According to Caulfield, when a party to either criminal or civil proceedings seeks to compel the production of therapeutic records for which a common-law privilege is claimed, the court must undertake a balancing of the various interests at stake. This involves numerous factors such as the plaintiff or alleged victim's privacy rights, society's interest in the fair and proper disposition of litigation and a defendant's right to fundamental justice, which requires knowledge of all information relevant to the case. Current evolving factors such as current social concerns, and the entrenchment of rights under the Canadian Charter of Rights and Freedoms may also influence how the court will weigh competing rights and interests.¹²⁵

Rodgers-Magnet states that in the realm of criminal law, the law across Canada is uniform. "Theoretically, the value or injury inherent in disclosure of medical confidences in the context of criminal prosecution, must be weighed not only against the necessity for ascertaining the truth to the fullest extent possible, but also against the severity of the

¹²⁰ Shuman & Weiner & Pinard "The privilege study (Part III) : psychotherapist-patient communications in Canada" (1986) 9 *International journal of law and psychiatry* 393.

¹²¹ Shuman & Weiner & Pinard (1986) *International journal of law and psychiatry* 401.

¹²² Shuman & Weiner & Pinard (1986) 405.

¹²³ *Medical Act R.S.Q chp M-9; s. 42.*

¹²⁴ Shuman & Weiner & Pinard (1986) *International journal of law and psychiatry* 401.

¹²⁵ Caulfield (2004) [Canada] *International encyclopaedia of law: Medical law* 77.

consequences of a conviction for the accused, recognised in Canadian law primarily by the criminal law doctrine of burden of proof.”¹²⁶

Rodgers-Magnet summarises the situation in Canada with regard to evidentiary privilege as stating that it is in an interesting state of confusion. This confusion is likely due to the fact that belief in the necessity or undesirability of such a privilege reflects a policy determination by the individual being questioned, which results in an element of unpredictability.¹²⁷

4.4 Physician-patient privilege in the USA

Miller describes the physician-patient privilege as a “rule that a physician is not permitted to testify as a witness concerning certain information gained in the physician-patient relationship,” and it applies only when a *bona fide* physician-patient relationship exists.¹²⁸ Roach states that even if a court rules that a medical record is discoverable, the physician-patient privilege may later prohibit admissibility, under the stricter standard for admitting records into evidence.¹²⁹

In the USA¹³⁰ almost every state has either a physician-patient or psychotherapist-patient privilege.¹³¹ Approximately two-thirds of the states have enacted a statutory physician-patient privilege.¹³² The physician-patient privilege plays only a limited role in protecting confidential information. It is only a testimonial privilege, not a general obligation to maintain privilege. It does not require the doctor to keep information from employers, insurers or other physicians. It is a statutory privilege and therefore it does not exist in all the jurisdictions of the USA. Forty-three states have some form of testimonial privilege, but some only apply to psychiatrists. Thirdly, a privilege created by state statute does not apply in non-diversity federal court proceedings. Fourthly, it is also subject to many exceptions, which reduces the effectiveness of the privilege. State statutes often cover only physicians, and not other health care workers. Finally the physician-patient

¹²⁶ Steel (1983) 269.

¹²⁷ Steel (1983) 268.

¹²⁸ Miller *Problems in health care law* (2000) 544.

¹²⁹ Roach *Medical records and the law* (1998) 242.

¹³⁰ For a more detailed explanation of the physician-patient privilege in the United States of America see Roach (1998) 242.

¹³¹ Furrow (2000) 151.

privilege applies only to confidential information disclosed during the course of treatment and the patient can easily waive it. Where patients put their health at issue in a lawsuit, or fail to object to admission of testimony, their waiver of the privilege is implied.¹³³

Insurance applications and policies often include waivers. If a claim is made based on emotional distress or other mental condition, the psychotherapist-patient privilege is usually waived as a result. Waiver of the privilege usually only allows formal discovery and testimony, not informal interviews. Patient consent is needed for that to occur.¹³⁴

Turkington distinguishes between three different types of privileges, namely relationship-based privileges, record-based privileges and therapeutic relationship privileges. These vary considerably from state to state in the USA.

Relationship-based privileges are created largely through legislation that bases the privilege on the relationship between the health professional and the patient. In virtually all states the relationship between physicians' or psychotherapists' and their patients fall within the privilege law. In most states social workers fall within the privilege law and in some states rape counsellors and family counsellors also do.¹³⁵

With record based privileges one looks at the kind of information that is privileged. For instance psychotherapist-patient privileges may protect all information acquired during treatment. Some laws give privileged status to specific kinds of health records, for instance drug and alcohol treatment records.¹³⁶

With regard to therapeutic relationship privileges, "psychotherapists have persuaded courts and legislatures that confidentiality is uniquely important to mental health treatment records, at least with respect to limiting their inclusion in court records." This is because compelled disclosure can cause great harm in a relationship where trust is im-

¹³² Miller (2000) 544.

¹³³ Furrow *et al.* (2005) [United States of America] *International encyclopaedia of law: Medical law* 107.

¹³⁴ Miller (2000) 545.

¹³⁵ Turkington (1997) 25 *Journal of law, medicine and ethics* 117.

¹³⁶ *Ibid.*

perative and talk is the treatment. A majority of the states in the USA now have strong privilege statutes for psychiatrists and psychologists as well as licensed social workers.

In *Jaffee v Redmond*¹³⁷, the US Supreme Court found a psychotherapist-client privilege to be part of federal common law.¹³⁸ According to Gates & Arons, what was striking about this case was the strong endorsement by the Supreme Court for the need for confidentiality in the clinical relationship, even in the face of a plaintiff's claim that the information from that relationship was necessary to pursue a civil damages claim.¹³⁹

5. Privacy v the legitimate right to information

5.1 Privacy v the legitimate right to information in general

This section is discussed from a general point of view, since all of these factors are relevant to a greater or lesser extent in South Africa, Canada and the USA. In the USA these factors are very much at play when discussing confidentiality of medical records, and therefore it is important to take note of them.

According to Furrow most medical records are available to third parties for both questionable and legitimate purposes. Examination of patient records has continued to expand due to the growth of electronic databases, third party utilisation review, managed care organisations and government oversight.¹⁴⁰ Drug companies and managed care organisations¹⁴¹ have a compelling interest in medical data to control costs, increase revenues and improve performance.¹⁴² Other legitimate reasons for which the information is sought include providers providing follow-up care to insure continuity of care, insurance companies with obligations to bill, and law enforcement authorities as well as employers and credit investigators needing information.¹⁴³ The government may also require access to medical records for workplace or fraud investigations.¹⁴⁴ Access is also sought for a variety of medical evaluation and support purposes, such as in-house

¹³⁷ *Jaffee* 116 S Ct 1923.

¹³⁸ Turkington (1997) 25 *Journal of law, medicine and ethics* 117.

¹³⁹ Gates & Arons (2000) *Privacy and confidentiality in mental health care* 109-110.

¹⁴⁰ Furrow (2000) 145.

¹⁴¹ Roach (1998) 154, says that managed care organisations request the information for purposes of utilization review or quality improvement; monitoring discharge planning and case management.

¹⁴² Furrow (2000) 168.

¹⁴³ Furrow (2000) 155.

quality assurance committees, accreditation inspection teams and licensure reviewers. They must all review medical records to assess the quality of hospital care.¹⁴⁵ Medical researchers also frequently use information from medical records.

This has resulted in increasing tension between the need for confidentiality of patient records and the many legitimate claims for access to these records. This conflict is no longer easily resolved by professional ethics and institutional management practices, but, especially in the USA, by increasing lawsuits.¹⁴⁶

Miller also states the need to find a balance between the patient's need for confidentiality and the need for access to such information. The cost of implementing some form of confidentiality protection must also be taken into account.¹⁴⁷ Starr feels the threat to the privacy of health information is not so much a result of technological change, but that it is rather economic in nature. Health care has been transformed into a complex industry representing one-seventh of the economy in the United States. Employers, insurers, pharmacists and many others have a growing interest in data to control their costs and increase their performance.¹⁴⁸

6. Other areas of concern where increased privacy is needed

6.1 Problem areas in general

There are a number of areas in medicine where increased privacy is needed, such as with the results of genetic testing and with the medical records of drug and alcohol abuse patients, where release of information could result in discrimination or embarrassment. The developments that have been happening around information technology and the impact that this has had on the electronic transmission of patient records is also an area of concern. In the USA the recent HIPAA and HHS privacy rules are relevant in this regard.¹⁴⁹

¹⁴⁴ Furrow (2000)156.

¹⁴⁵ *Ibid.*

¹⁴⁶ Furrow (2000) 145.

¹⁴⁷ Miller (2000) 533.

¹⁴⁸ Starr "Health and the right to privacy" (1999) *American journal of law and medicine* 193.

¹⁴⁹ For more details see p. 88.

6.2 The problems associated with genetics

Improved technology has resulted in an increased knowledge and understanding of our genetic makeup, and the genes responsible for certain medical conditions. This promises to expand the duties of physicians to warn and protect not only patients but third parties, such as the patient's nearest relatives, that might also have the gene for certain serious illnesses. The necessary monitoring and certain prophylactic measures can then be taken. If this information should land in the wrong hands, for instance, health insurance companies, it could have serious repercussions for the patient.¹⁵⁰

The children of the affected patients can be susceptible to the same form of discrimination by insurance companies because they too might have inherited the genes.¹⁵¹

6.3 Problems associated with telemedicine

Telemedicine or "remote electronic clinical consultation" is another area of medicine that has a number of unanswered privacy issues. Due to the "easy access, duplication, and linkage capabilities of telemedicine technology, confidential patient data may be intercepted and misused by non-medical insiders, such as billing clerks, insurers, as well as outside hackers."¹⁵² As a result of the electronic transmission of patient data, telemedicine increases the number of people who have, or can obtain access.

6.4. Problems associated with drug and alcohol abuse

Information relating to drug or alcohol abuse is of a very sensitive nature. Great harm can be caused to the patient if their employer for instance were to find out about past or present drug or alcohol abuse. In the USA there is the Drug Abuse and Treatment Acts and the *Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Re-*

¹⁵⁰ Furrow (2000) 162.

¹⁵¹ For more detailed information on the role of autonomy, confidentiality and privacy in protecting genetic information see Laurie (2001) 22 *Journal of legal medicine* 1-54 and Miller (1994) 2 *Health law journal* 141-158. For more information see also Sudell, A "To tell or not to tell: the scope of physician-patient confidentiality when relatives are at risk of genetic disease" (2001) 18 *Journal of contemporary health law & policy* 273.

¹⁵² Rackett "Telemedicine today and tomorrow: why virtual privacy is not enough" (1997) 25. *Fordham Urb L J* 169; see also Daley HA "Telemedicine: the invisible legal barriers to health care of the future" (2000) 9 *Annals of health law* 73-106.

*habilitation Act*¹⁵³ that imposes rigorous requirements on the disclosure of information from alcohol and drug abuse treatment programs.¹⁵⁴

7. Summary

As can be seen from the issues touched on above, the fact that the information given out within the doctor-patient relationship should remain confidential is not disputed. There is a definite need for confidentiality, and ethically this cannot be disputed, but at the same time one can never say confidentiality is absolute. There are times when a physician has a duty to disclose the information for the benefit of a third party or society. The physician can also in certain circumstances be compelled to give evidence in court. There are many legitimate reasons for which people seek medical information in the medical setting of today, which did not exist in the past. More often than not the records are also in an electronic form. What is needed is legislation and / or guidelines to protect patient privacy in this fast changing technological environment. It is clear that there is no easy answer to these complex privacy issues and that everything needs to be examined on a case-by-case basis.

¹⁵³ *Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act* USCA §§290dd-3, 390ee-3.

¹⁵⁴ Furrow *et al.* (2005) [United States of America] *International encyclopaedia of law: Medical law* 107.

CHAPTER 2

The concept of privacy: its development and protection

1. Introduction

Privacy is a relative newcomer to the body of justiciable and fundamental rights.¹⁵⁵ A number of difficulties have been encountered in defining the legal limits of the concept of privacy. This has led some writers to propose that a separate right to privacy is not warranted. ¹⁵⁶Kalven¹⁵⁷ complains that no legal profile exists for the tort of privacy and Stein and Shand argue “if privacy cannot be defined with any precision then it is a right that cannot and should not be upheld by the courts.”¹⁵⁸

McQuoid-Mason feels that such criticism may be true of actions based on Anglo-American common law, but that this does not necessarily apply to actions derived from the civil law.¹⁵⁹

The historical basis of confidentiality can be misleading. According to Veatch the old model for confidentiality assumes there is one physician and one patient. It is also assumed that the information is largely kept in the physician’s memory, and that it is up to the physician to disclose the information or not. The current health care situation is extremely different. Not only are there dozens of physicians and other health care providers involved in care, but there is also a need for written records to which many people must have access. Information needs to be transmitted to insurance companies and others with a financial interest to ensure payment for services.¹⁶⁰

According to the South African Law Reform Commission, Project 124, the right to privacy has become one of the most important rights of the modern age. In many countries

¹⁵⁵ Devenish, GE (2005) *The South African Constitution* 86.

¹⁵⁶ McQuoid-Mason *The law of privacy in South Africa* (1978) 11.

¹⁵⁷ McQuoid-Mason quotes from the article by H Kalven, “Privacy and tort law – were Warren and Brandeis wrong?” (1966) 31 *Law & Contemporary Problems* 326 at 333.

¹⁵⁸ McQuoid-Mason (1978) 11.

¹⁵⁹ *Ibid.*

¹⁶⁰ Veatch (1997) 89.

privacy is now protected by constitutional guarantees or general human rights legislation. For example the Constitution of the Netherlands, the Republic of the Philippines and the Russian Federation all recognise the right to privacy in their constitution. The United Kingdom's *Human Rights Act*, 1988 also protects the right to privacy.¹⁶¹

The modern benchmark for privacy at an international level is found in article 12 of the Universal Declaration of Human Rights, which protects both territorial and communications privacy.¹⁶² Articles 17 and 18 of the Covenant of Civil and Political Rights, and articles 8(1) and 9(2) of the European Convention of Human Rights also protect privacy.¹⁶³

The American Convention on Human Rights (Art 11, 12) and the American Declaration on Rights and Duties of Mankind (Art V, IX, and X) also contain provisions similar to those found in the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights (ICCPR)¹⁶⁴. The African Charter on Human and People's Rights however, does not make any reference to privacy rights.¹⁶⁵ International instruments are important because the Constitution states that when interpreting the bill of rights, courts, tribunal or forums must consider international law.¹⁶⁶ The Constitutional Court stated in *S v Makwanyane*¹⁶⁷ that both binding and non-binding public international law may be used as tools of interpretation. It is also not confined to instruments that are binding on South Africa. "Section 39(1) invokes public international law primarily for the purpose of interpretation of rights and for determining their scope, not for proving their existence."¹⁶⁸

A brief overview follows on the development of the concept of privacy and the relevant statutes relating to privacy in South Africa, Canada and the United States of America.

¹⁶¹ South African Law Reform Commission (2003) 38.

¹⁶² South African Law Reform Commission (2005) 3.

¹⁶³ Devenish, GE *The South African Constitution* (2005) 78.

¹⁶⁴ Article 17 of the ICCPR provides that no one shall be "subjected to arbitrary or unlawful interference with his privacy, family".

¹⁶⁵ South African Law Reform Commission (2005) 16-17.

¹⁶⁶ *Constitution of the Republic of South Africa, 2006*; s. 39(1)(b).

¹⁶⁷ *S v Makwanyane 1995 (3) SA 391 (CC)*; par. 36-7.

¹⁶⁸ Currie and De Waal (2005) *Bill of Rights Handbook* 160.

2. South Africa

2.1 Privacy in general

The right to privacy in South Africa is protected by both the common law and section 14 of the Constitution. The rights of personality under the common law are protected under the *actio injuriarum* and are not absolute but limited by the rights of others and by public interest.¹⁶⁹

Most delicts are actionable under the general principles of either the *Lex Aquilia*, for patrimonial loss or under the *actio injuriarum*, for sentimental damages. The essential elements of the above actions have been clearly defined by the courts.¹⁷⁰ Unlike Anglo-American law, McQuoid-Mason feels that an action for invasion of privacy in South Africa may well have an identifiable profile.¹⁷¹

2.2 Historical development

2.2.1 Historical basis

The Roman or the Roman-Dutch jurist did not specifically mention a right to privacy. However several *injuriae* or affronts to personality that are very similar to the modern right to privacy were recognised. The Roman law *actio injuriarum* forms the basis for the protection of personality rights in South Africa.¹⁷²

There were three main elements in the developed *actio injuriarum* :

- 1) The act had to be done with the intention to injure or intentionally (*animus injuriandi*);
- 2) There had to be an impairment of a person's personality, be it *fama*, *corpus* or *dignitas*;
- 3) The wrong must have been wrongful according to the prevailing *mores* of society (*contra bonos mores*).¹⁷³

¹⁶⁹ South African Law Reform Commission (2005) 4.

¹⁷⁰ McQuoid-Mason (1978) 11.

¹⁷¹ *Ibid.*

¹⁷² McQuoid-Mason (1978) 13.

¹⁷³ McQuoid-Mason (1978) 27.

The concept of *dignitas* was flexible enough to incorporate the right to privacy.¹⁷⁴ “The classical concept of *injuriae* was taken over by the Roman-Dutch law jurists when the Roman laws were received into the Netherlands.”¹⁷⁵

Grotius divided *injuriae* in the wide sense into wrongs against the body, honour (*hoo*n), and reputation (*lastering*), while in the narrow sense he regarded such injuries as ‘wrongs against personal liberty’.¹⁷⁶ Voet followed Ulpian’s classical definition of “a wrongful act committed in contempt of a free person by which his person, dignity, or reputation is intentionally impaired.”¹⁷⁷

The *actio injuriarum* in Roman-Dutch law was in essence the same as that recognised by the Romans, and similarly included a number of *injuriae* comparable to the modern action for invasion of privacy.¹⁷⁸

In order to successfully claim sentimental damages under Roman-Dutch law, using the *actio injuriarum*, the plaintiff would have to prove:

1. that the wrongdoer had the *animus injuriandi*, or intention to injure;
2. “that there had been an impairment of the plaintiff’s person, dignity or reputation, and
3. that the act itself was wrongful or *contra bonos mores*”¹⁷⁹

Intention is concerned with fault, unlike wrongfulness that deals with the invasion of another person’s right. “The test for such intention was subjective, and it was considered to be present:

1. when an act is done by a person with the definite object of hurting another in regard to his person, dignity or reputation;
2. when an unlawful act is done as a means of effecting another object the consequence of which act such a person is aware will be to hurt another in regard to his person, dignity, or reputation.”¹⁸⁰

¹⁷⁴ *Ibid.*
¹⁷⁵ McQuoid-Mason (1978) 28.
¹⁷⁶ *Ibid.*
¹⁷⁷ *Ibid.*
¹⁷⁸ McQuoid-Mason (1978) 33.
¹⁷⁹ *Ibid.*
¹⁸⁰ McQuoid-Mason (1978) 100.

In Roman and Roman-Dutch law *animus injuriandi* therefore required both the intention to injure as well as a consciousness of wrongfulness. If either of these two elements were absent the action would fail. Where the plaintiff recognised that the defendant had committed an *injuria* there was a presumption that the defendant had acted wrongfully and with *animus injuriandi*.¹⁸¹

The third requirement of wrongfulness is to a large extent a question of policy, which, in cases where there is little authority in our law, often may be answered by reference to developments in other legal systems.¹⁸² Problems can arise when the law is required to determine which forms of invasions of privacy should be recognised. The courts must balance the rights of the individual against the rights of society.¹⁸³ A useful guideline for establishing whether the defendant's conduct was wrongful is to determine if the said conduct is offensive to good morals or public morality or public policy or order.¹⁸⁴ As soon as the court is satisfied that the invasion is wrongful, it must consider whether the plaintiff's personality has been or is likely to be impaired.¹⁸⁵ This *contra bonos mores* approach was used in Roman law, and still applies today, since it allows for changes in the current thinking and the values of the community.

2.2.2 Commentators views

According to McQuoid-Mason the modern action for invasion of privacy in South Africa was born,

“unheralded and without the difficulties which attended its nativity in Anglo-American and Continental legal systems. There was no need to discover a new tort or interpret a particular section of a Code. The recognition of the action in South Africa is a logical development under the *actio injuriarum* which affords a general remedy for wrongs to interests of personality.”¹⁸⁶

McQuoid-Mason submits that there is no need to create a new wrong, “because apart from the threat to privacy by data banks, the Roman-Dutch law, as adapted by South

¹⁸¹ McQuoid-Mason (1978) 101.

¹⁸² McQuoid-Mason (1978) 34.

¹⁸³ McQuoid-Mason (1978) 117.

¹⁸⁴ McQuoid-Mason (1978) 118.

¹⁸⁵ McQuoid-Mason (1978) 122.

¹⁸⁶ McQuoid-Mason (1978) 86.

African law, is flexible enough to cope with many modern-day invasions of privacy.”¹⁸⁷In most cases an action for invasion of privacy will be based primarily on the *actio injuriarum*, with an infrequent subsidiary claim under the *lex Aquilia*.¹⁸⁸

South African courts have recognised that an impairment of a person’s privacy *prima facie* constitutes an impairment of his dignity under the *actio injuriarum*.¹⁸⁹Van der Merwe and Olivier and Neethling appear to agree that the action lies under the *actio injuriarum*¹⁹⁰ but maintain that it should be recognised as an independent law of personality. The above writers give no indication as to what its limits should be, but support Joubert’s view that privacy should be separated from the concept of *dignitas*.¹⁹¹

Neethling states, according to McQuoid-Mason, that “because the courts see *dignitas* as a collection of personality rights rather than a separate right, and since such personality rights incorporate the right to privacy, the latter should be regarded as a separate right.”¹⁹²

Neethling maintains that the equation of privacy and dignity should be rejected and that it is not only unacceptable from a theoretical perspective, but is also without doubt contrary to both Roman and Roman-Dutch law. He goes on to say that it can be safely accepted that today the right to privacy is recognised as an independent right of personality.¹⁹³

Prosser’s four categories, namely intrusions, publication of private facts, false light and appropriation can also be accommodated in South African law.¹⁹⁴The category, publication of private facts, is the most appropriate category for breaches of confidentiality regarded medical information. Revealing that a person suffers from a particular physical deformity or disease, for instance being crippled, blind, itchy or mangy fell into the above category. “¹⁹⁵ A doctor unjustifiably telling colleagues that a patient has AIDS

¹⁸⁷ McQuoid-Mason (1978) 257.

¹⁸⁸ *Ibid*.

¹⁸⁹ McQuoid-Mason (1978) 98; as quoted from *S v A* 1971 (2) SA 293 at 297.

¹⁹⁰ *Ibid*; It is necessary to prove intention, wrongfulness and impairment of the plaintiff’s personality under this action.

¹⁹¹ McQuoid-Mason (1978) 98.

¹⁹² McQuoid-Mason (1978) 126.

¹⁹³ Neethling & Potgieter & Visser *Neethling’s law of personality* (1996) 242.

¹⁹⁴ McQuoid-Mason (1978) 86-89.

¹⁹⁵ McQuoid-Mason (1978) 31.

would also fall under this category. Neethling observes that although the information published in such a case is true, unless it can be shown that such publication is also in the public interest, it will amount to the invasion of privacy.¹⁹⁶

When an outsider himself becomes familiar with the individual or his personal affairs, but contrary to the individual's determination or wishes, this may be described as instances of acquaintance or intrusion. When the outsider acquaints third parties with the individual or his personal affairs, which although known to the outsider remain private, this may be described as instances of disclosure or revelation.¹⁹⁷

Neethling distinguishes between two types of intrusion, namely acquaintance with private facts, where such acquaintance is totally excluded or is limited to specific persons and secondly where the acquaintance is permissible to an indeterminate but limited number of persons.¹⁹⁸ He submits that in the former instances almost every acquaintance with private facts may be regarded as an infringement of the right to privacy.¹⁹⁹

The fact that a disclosure made to a small group of people does not constitute a breach of confidence will not in itself deprive the plaintiff of a remedy for invasion of privacy. However, the greater the publicity or the fact that the disclosure is a breach of confidence, the more likely it is that such conduct will be considered wrongful.²⁰⁰ McQuoid-Mason submits that Neethling's argument that normally in the "disclosure" cases the disclosure must be made to a large group of people is not part of our law, in that the degree of publication is one of several factors to be taken into account by the courts when deciding if the act is wrongful.²⁰¹

Certain professional relationships such as that which exists between doctor and patient, gave rise to an obligation of confidentiality in Roman-Dutch law. These principles seem to apply in our law, except where such persons are required to testify in court.²⁰² There

¹⁹⁶ McQuoid-Mason (2000) *Invasion of privacy: common law v constitutional delict – does it make a difference?* AJ 227.

¹⁹⁷ Neethling *The law of delict* (1999) 354; Neethling (1996) 244.

¹⁹⁸ Neethling (1996) 244.

¹⁹⁹ *Ibid* .

²⁰⁰ *Ibid*; McQuoid-Mason (1978) 133-134.

²⁰¹ McQuoid-Mason (1978) 170.

²⁰² McQuoid-Mason (1978) 193.

is no doctor-patient privilege in our law.²⁰³ The confidential nature of the relationship is only one of a number of factors that are taken into account by the courts. The presence of a confidential relationship may, however, make the plaintiff's task easier in convincing the court that he or she has suffered an invasion of his or her privacy (i.e. that the defendant's act was wrongful), and may be an aggravating factor when assessing damages.²⁰⁴

2.2.3 Case law

“The *locus classicus* for the recognition of an independent right to privacy in South African is considered to be *O’Keeffe v Argus Printing and publishing Co Ltd ao*²⁰⁵ In the above case Watermeyer AJ interpreted *dignitas* widely enough so as to include the whole legally protected personality, except bodily integrity and reputation. Although it was not explicitly stated by the court, the judgment leaves one in no doubt that the right to privacy is included as one of those rights relating to dignity.²⁰⁶ Many recent cases have also followed this approach including *Jansen van Vuuren ao NNO v Kruger*²⁰⁷ and *National Media Ltd ao v Jooste*^{208 209}.

Therefore one can conclude that despite the decisions equating privacy with dignity, it can safely be accepted that the right to privacy is recognised by the common law as an independent right of personality and that it has been delimited as such within the *dignitas* concept.²¹⁰

The recognition of the concept of privacy in the Constitution further confirms the independent existence of the right to privacy and the action for invasion of privacy was therefore a logical development under the *actio injuriarum*, and did not require the same development as the concept did in the United States of America. Section 14 of the Con-

²⁰³ See *supra* p 25.

²⁰⁴ McQuoid-Mason (1978) 194.

²⁰⁵ *O’Keeffe v Argus Printing and Publishing Co Ltd ao* 1954 (3) SA 244 (C).

²⁰⁶ South African Law Reform Commission (2003) 44.

²⁰⁷ *Jansen van Vuuren ao NNO v Kruger* 1993 (4) SA 842 at 849; see page 97 for a discussion on this case.

²⁰⁸ *National Media Ltd ao v Jooste* 1996(3) SA 262 (A) at 271-272.

²⁰⁹ South African Law Reform Commission (2003) 46.

²¹⁰ *Ibid.*

stitution²¹¹ further solidifies the protection of the privacy of communications in South Africa, be it in the health care setting or otherwise.

2.3 Constitutional right to privacy

With the enactment of the Constitution of the Republic of South Africa, Act 200 of 1993 came the express recognition of the right to privacy. The first part of section 14 guarantees a general right to privacy while the second part protects against specific infringements of privacy.²¹² It reads as follows:

Everyone has the right to privacy²¹³, which includes the right not to have

- a) their person or home searched;
- b) their property searched
- c) their possessions seized; or
- d) the privacy of their communications infringed.²¹⁴

Neethling observes that it is clear that these instances of protection of the right to privacy above correspond to the concept of privacy as a secluded condition of human life embracing private facts, and do not constitute a *numerus clauses* but may be expanded to any other method of obtaining and disclosing information.²¹⁵ A breach of section 14 will *prima facie*, be regarded as an unlawful invasion of privacy and the onus will be on the person breaching it to establish that such breach was justified in terms of section 36 of the Constitution. Fault is not a requirement and therefore strict liability may be imposed upon a defendant who breaches the constitutional right to privacy. There must be a subjective expectation of privacy that must be objectively reasonable, which means that the definition of the right is delimited by the rights of the community as a whole.²¹⁶

²¹¹ Constitution of the Republic of South Africa, 2006; Section 14 states “everyone has the right to privacy, which includes the right not to have – (d) the privacy of their communications infringed.” Devenish, GE (2005) 79.

²¹² ²¹³ This guarantees a general right to privacy according to the South African Law Reform Commission Project 124, 50-52; the revival of the apology can be supported because it is in conformity with the Bill of Rights.

²¹⁴ *Constitution of the Republic of South Africa Act 200 of 1993*, Section 14.

²¹⁵ Neethling (2005) SALJ 20-21.

²¹⁶ Rautenbach (2001) *The conduct and interests protected by the right to privacy in Section 14 of the Constitution* TSAR 115.

According to De Waal it should be remembered that the rights entrenched in the Bill of Rights are formulated in general and abstract terms. The meaning of these provisions will therefore depend on the context in which they are used and their application to particular situations will necessarily be a matter of argument and controversy.²¹⁷ In giving content to the general substantive right to privacy, common law precedents will in the first place guide the courts and secondly the courts will be influenced by international and foreign jurisprudence.²¹⁸

According to section 36(1) the rights in the bill of rights may be limited only in terms of a law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors including (1) the nature of the right (2) the importance of the purpose of the limitation (3) the nature and extent of the limitation (4) the relation between the limitation and its purpose; and (5) less restrictive means to achieve this purpose. The Constitutional Court has pointed out in *S v Manamela*²¹⁹ that these factors do not constitute an exhaustive list and that the court must engage in a balancing exercise and arrive at a globular judgment on proportionality and not adhere mechanically to a sequential checklist.²²⁰

Devenish observes that there is a considerable amount of overlap between infringements of the right to privacy and the infringement of other rights, such as the right to human dignity. Therefore the manner in which rights operate is not compartmentalised, but they operate holistically.²²¹ O'Regan J said in *Khumalo v Holomisa*²²² that there is a close link between human dignity and privacy in our constitutional order, since the right to privacy, which protects a sphere of intimacy and autonomy serves to foster human dignity. Neethling feels this view can be accepted as long as it does not lead to a complete blurring of the distinction between privacy and dignity as independent interests of personality, thereby creating legal uncertainty.²²³

²¹⁷ South African Law Reform Commission (2003) 50; as quoted from De Waal *et al* at 117.

²¹⁸ South African Law Reform Commission (2005) 49.

²¹⁹ *S v Manamela* 2000 (1) SACR 414 (CC) at 430.

²²⁰ McQuoid-Mason (2000) AJ 246,253.

²²¹ Devenish, GE (2005) 80.

²²² *Khumalo v Holomisa* 2002 (5) SA 401 (CC) para 27.

As stated above the right to privacy in South Africa, is protected by our common law as well as by our Constitution. Currie and De Waal feel the Constitutional Court's treatment of the interim Constitution's right to privacy in *Bernstein ao v Bester ao NNO*²²⁴ remain its richest and most comprehensive interpretation of the right.²²⁵ In this case the Constitutional Court emphasised the interdependency between the common law and the constitutional right to privacy. Ackermann J drew a distinction between the two-stage constitutional inquiry into whether a right has been infringed and whether the infringement is justified, and the single inquiry under the common law, as to whether an unlawful infringement of a right has taken place. The presence of a ground of justification means that an invasion of privacy is not wrongful. He cautioned against attempting to project common-law principles onto the interpretation of fundamental rights and their limitation.

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Ackermann J held that there was a strong family resemblance in the approaches that the USA, Canada and Germany took to privacy. He concluded that 'it seems to be a sensible approach to say that the scope of a person's privacy extends *a fortiori* only to those aspects in regard to which a legitimate expectation of privacy can be harboured.' This expectation has two components namely "a subjective expectation of privacy ... that society has recognised... as objectively reasonable."²²⁷ Currie summarises Ackermann J's reasoning as follows: a) privacy is a subjective expectation of privacy that is reasonable; b) it is reasonable to expect privacy in the 'inner sanctum', in the 'truly personal realm'; c) this is because a protected inner sanctum helps achieve a valuable good – one's own autonomous identity²²⁸ and concludes that perhaps the principle value served by privacy is human dignity.²²⁹

In *Mistry v Interim Medical and Dental Council of South Africa ao 1998 (4) SA 1127(CC)*

223 Neethling (2005) SALJ 23.

224 *Bernstein and others v Bester and others NNO* 1996 (2) SA 751 (CC).

225 Currie and De Waal (2005) 317.

226 South African Law Reform Commission (2003) 43; see also Currie and De Waal (2005) 317.

227 Currie and De Waal (2005) 318.

228 Currie and De Waal (2005) 319.

229 Currie and De Waal (2005) 320-21. In *S v Jordan 2002 (6) SA 642 (CC)* it was made clear that the spatial metaphors encountered in *Bernstein* (inner sanctum, personal space) are misleading to the extent that they suggest that privacy is a space or a place. The fact that conduct takes place outside of the inner sanctum (eg. At work) should not deprive it of protection but what is decisive is whether that conduct is dignity-affirming, and that it therefore conforms to the principal purpose of the privacy right.

the court assumed that even though breach of informational privacy was not expressly mentioned in section 13 of the interim Constitution, it would be covered by the broad protection of the right to privacy guaranteed by section 13.²³⁰ By authorising intrusion on the ‘inner sanctum’ the Medicines Act permitted the violation of privacy.²³¹ The following factors were considered to be important when considering the information aspect of the right to privacy in *Mistry*: 1) whether the information was obtained in an intrusive manner; 2) whether it involved data provided by the applicant for one purpose which was then used for another; 3) whether it was disseminated to the press or the general public or persons from whom the applicant could reasonably expect such private information would be withheld.²³²

The bill of rights is applicable to all law, and it therefore also applies to the common law relating to privacy. It binds not only the state²³³ but also natural and juristic persons if applicable.²³⁴ This vertical and horizontal application of the bill of rights can take place directly or indirectly.²³⁵ When applied indirectly, “the bill of rights respects the rules and remedies of ordinary law, but demands furtherance of its values mediated through the operation of ordinary law.” Rights and duties are instead imposed by the common law or legislation. When applied directly, it overrides ordinary law and any conduct that is inconsistent with it and, to the extent that ordinary legal remedies are inadequate, the bill of rights generates its own remedies.²³⁶

Direct vertical application means that the State may not infringe the right to privacy except in so far as such infringement is reasonable and justifiable in terms of the limitation clause.²³⁷ Direct horizontal application means that the courts must give effect to the right to privacy by applying and developing the common law to the extent that legislation

²³⁰ See *Mistry v Interim Medical and Dental Council of South Africa* 1998 (4) SA 1127 (CC) 1141F-1142 A/B; as quoted by South African Law Reform Commission (2005) 26.

²³¹ Currie and De Waal (2005) 320.

²³² Currie and De Waal (2005) 324.

²³³ *Constitution of the Republic of South Africa Act 200 of 1993*, Section 8(1).

²³⁴ *Constitution of the Republic of South Africa Act 200 of 1993*, Section 8(2).

²³⁵ South African Law Reform Commission (2003) 41.

²³⁶ Currie and De Waal (2005) *The Bill of Rights Handbook* 32-33; 43; the Interim Bill of Rights did not apply directly to horizontal cases but it did have indirect application. This was mainly because of the absence of the word “judiciary” in s.7 (the application section) of the bill of rights.

²³⁷ South African Law Reform Commission (2003) 41; *Constitution of the Republic of South Africa Act 200 of 1993*, Section 36 (1).

fails to do so, except where it is reasonable and justifiable to develop the common law to limit the right to privacy in accordance with Section 36(1) of the constitution.²³⁸

The indirect operation of the right to privacy means that all legal rules, principles or norms relating to the right to privacy are subject to and must be given content in the light of the basic values of the Bill of Rights. The courts have an obligation to develop the common law in accordance with the spirit, objects and purport of the Bill of Rights.²³⁹ According to Neethling this applies in particular to the application of the so-called open ended or flexible delictual principles such as the *boni mores* test for wrongfulness and the reasonable person test for negligence. Policy considerations and factors such as reasonableness, fairness and justice may play an important role in deciding these issues.²⁴⁰ As far as indirect application is concerned, the basic values of the Constitution will always play an important role in determining wrongfulness, causality and negligence in common law disputes.²⁴¹

Neethling argues that in so far as the direct application of the Constitution is concerned, a distinction should be made between a constitutional wrong and a delict.²⁴² The question that McQuoid-Mason asks is if a constitutional right to privacy can give rise to a constitutional delict.²⁴³ A delict can be distinguished from an infringement of the bill of rights in the following ways. A delict arises from the breach of a subjective right or a legal duty unlike a breach of a fundamental right. A subjective right is a private law concept whereas a fundamental right primarily grants public law remedies against the state.²⁴⁴ Damages awarded for the breach of a fundamental right are not aimed at providing compensation but at affirming constitutional values. Constitutional relief²⁴⁵ is also separate from delictual relief and fault is not a requirement for the breach of a funda-

²³⁸ South African Law Reform Commission (2003) 41.

²³⁹ *Ibid*; *Constitution of the Republic of South Africa Act 200 of 1993*, Section 39(2).

²⁴⁰ Neethling (2001) *The law of delict* 23.

²⁴¹ South African Law Reform Commission (2005) 20.

²⁴² Neethling (2001) 22.

²⁴³ McQuoid-Mason (2000) *AJ* 243.

²⁴⁴ McQuoid-Mason “*Invasion of privacy : common law v constitutional delict – does it make a difference?*” (2000) *Acta juridica* 245 ; McQuoid-Mason states that the above statement may be true in countries such as the USA, Canada and Germany, which have Constitutions that operate vertically, but it is not necessarily true for South Africa, where the bill of rights operates vertically and horizontally.

²⁴⁵ It is possible to request a court for a declaration of rights in addition to a delictual claim.

mental right, whereas delict is fault based.²⁴⁶ The two may however overlap. McQuoid-Mason observes that many of the so called distinctions between a private law delict in terms of the common law and a public law delict arising from a breach of a fundamental right are more apparent than real.²⁴⁷

There are basically three broad categories of constitutional remedies available, namely constitutional damages²⁴⁸, interdicts²⁴⁹ and declarations of invalidity²⁵⁰ (to the extent of their inconsistency). The first two are especially relevant to a delictual action for invasion of privacy and the latter may sometimes be relevant. These categories are however not closed and the court has the power to grant any other appropriate remedy such as exclusion of evidence, administrative law remedies or a declaration of rights. McQuoid-Mason states that the remedy of retraction, apology or reply could be reintroduced as an appropriate new constitutional remedy in order to restore the dignity of the plaintiff.²⁵¹

Devenish maintains that the constitutionalisation of the right to privacy endorses and entrenches an existing process of development and in addition creates new rights to privacy. These new rights must in turn give rise to new actions in relation to the interests protected by both the common law and the Constitution as against the state and other individuals.²⁵² The entrenchment of fundamental rights including the right to privacy strengthens the rights protection and gives them a higher status in the sense that they are applicable to all law, and are binding on the executive, the judiciary and state organs as well as on natural and juristic persons. A statutory provision for example that limits the right to privacy in an unreasonable manner may be set aside or interpreted in a restrictive manner.²⁵³ The recognition of the right to privacy as a fundamental human

²⁴⁶ McQuoid-Mason "Invasion of privacy : common law v constitutional delict – does it make a difference?" (2000) *Acta juridica* 243; quoting from JC van der Walt and JR Midgley *Delict : Principles and Cases 2ed* (1997) para 5

²⁴⁷ McQuoid-Mason (2000) *AJ* 246.

²⁴⁸ In *Fose v Minister of Safety and Security* 1997 (3) SA 786 (CC) *para 58 and 98* the Constitutional Court said that in most cases the ordinary common law remedies for delictual damages for infringement of personality rights would be an adequate remedy for a breach of a fundamental right.

²⁴⁹ Interdicts are forward looking and the Constitutional Court has used the remedy of interdict and mandamus to protect fundamental rights. The same principles apply at common law.

²⁵⁰ This remedy does not exist at common law.

²⁵¹ McQuoid-Mason (2000) *AJ* 256-259.

²⁵² Devenish, GE (2005) 82.

²⁵³ Neethling (2001) *The law of delict* 21-22.

right as stated above confirms the importance of privacy. In future settlements of disputes involving the right to privacy, including private law disputes, the courts will have to give careful consideration to the provisions of the Constitution regarding the Bill of Rights.²⁵⁴

Presently there is no legislation dealing specifically with the protection of the right to privacy in South Africa. It is therefore important to evaluate the right to privacy in the light of both the common law and section 39(2)²⁵⁵ of the Constitution.²⁵⁶ Slabbert maintains that the general constitutional provisions relating to privacy and access to information are inadequate in dealing with the specifics of the doctor-patient relationship.²⁵⁷ This is the case but the new *Protection of Personal Information Draft Bill* which is in the pipeline and its recommendations to establish a Information Protection Commission, which will see to it that the provisions of the yet to be Act are complied with, will go a long way in improving the situation.²⁵⁸ Finally a code of conduct relating to privacy between patients and health care practitioners needs to be established.

2.4 Legislation protecting privacy

Except for the Constitution itself, there is no legislation that deals specifically and fully with the right to privacy. South African commentators such as Neethling are unanimous that the creation of such measures through legislation is a matter of great urgency.²⁵⁹ As mentioned above this is presently receiving attention in the form of the *Protection of Personal Information Draft Bill*, which will be discussed below.

There are a number of acts which are relevant and which deal specifically with the protection of health information or information in general.

²⁵⁴ Neethling (1996) 239.

²⁵⁵ This states that “when interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.”

²⁵⁶ South African Law Reform Commission (2005) 18-19.

²⁵⁷ Slabbert (2004) “Parental access to minor’s health records in the South African health care context: concerns and recommendations” *PER* 2.

²⁵⁸ For more on this *Protection of Personal Information Draft Bill 2005* see p. 58 below.

²⁵⁹ South African Law Reform Commission (2005) 9.

2.4.1 National Health Act 61 of 2003

This is a reasonably new piece of legislation that was signed into law on 18 July 2004. However, it only commenced on the 2nd of May 2005 and then not in its entirety. It was enacted, to provide a framework for a structured uniform health system, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local government level, with regard to health services.

Section 14(1) of the *National Health Act 61 of 2003* states that “all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential.”

“User” in this sense means the person receiving treatment in a health establishment.²⁶⁰ If the person receiving treatment or using a health service is below the age contemplated in section 39(4) of the *Child Care Act 74 of 1983* the term “user” then includes the person’s parent or guardian or if the user is incapable of taking decisions, “user” includes the person’s spouse or partner or in the absence of such spouse or partner the person’s parent, grandparent, adult child or brother or sister.

Section 14(2) states that, subject to section 15 of the said Act, no person may disclose any information contemplated in section 14(1) unless the user consents to the disclosure in writing, or unless a court order or any law requires the disclosure or unless the non-disclosure will represent a serious threat to public health.²⁶¹

Section 15 of the *National Health Act*²⁶² regulates the access to health records. Section 15(1) states that:

“a health care worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user.”²⁶³

²⁶⁰ *National Health Act* 61 of 2003; s. 1.

²⁶¹ *National Health Act* 61 of 2003; s. 14.

²⁶² It commenced on the 2nd May 2005.

²⁶³ “Personal information” in this section means personal information as defined in s. 1 of the *Promotion of Access to Information Act*, 2 of 2000.

The access to health records by a health care provider is governed by section 16 of the *Act*. Section 16(1) provides that a health care provider may examine a user's health records for the purpose of treatment with the authorisation of the user. The health care provider may also examine a user's health record for the purpose of study, teaching or research but only with the authorisation of the user, head of the health establishment concerned and the relevant health research ethics committee.²⁶⁴ If however the health record contains no information regarding the identity of the user, the above authorisations need not be obtained.²⁶⁵

Section 17 of the *National Health Act*²⁶⁶ provides for the protection of health records. Any person who fails to set up control measures to prevent unauthorised access to these records commits an offence and is liable on conviction to a fine or to imprisonment for a period not exceeding one year or both a fine and such imprisonment.

"Health care provider" in terms of the definitions in Section 1 of the above act, could mean a doctor, nurse, pharmacist, dental technician, or anyone registered in terms of the *Allied Health Professions Act 63 of 1982*.

2.4.2 Promotion of Access to Information Act, 2 of 2000

The above act (also known as PAIA) was enacted to give effect to the constitutional right of access to any information²⁶⁷ held by the State and any information held by another person and that is required for the exercise or protection of any rights.²⁶⁸ However, this is subject to justifiable limitations, including, but not limited to, limitations aimed at the reasonable protection of privacy and in a manner that balances that right with any other right.²⁶⁹ "Personal information" as defined in section 1 of the above act, means information about an identifiable individual, including but not limited to information relating among other things to sex, pregnancy, physical or mental health, well-being and disability.²⁷⁰

²⁶⁴ *National Health Act 61 of 2003*; s 16 (1).

²⁶⁵ *National Health Act 61 of 2003*; s 16(2).

²⁶⁶ *National Health Act 61 of 2003*; s 17.

²⁶⁷ Section 32 of the *Constitution of the Republic of South Africa, 1996*.

²⁶⁸ *Promotion of Access to Information Act 2 of 2000*; s 9(a)(i) & (ii).

²⁶⁹ *Promotion of Access to Information Act 2 of 2000*; s 9(b)(i) & (ii).

²⁷⁰ *Promotion of Access to Information Act 2 of 2000*; s 1. At the bill stage it was called the Open Democracy Bill.

Chapter 4 of the Act deals with the grounds for refusal of access to records. Section 34 says that “subject to subsection (2), the information officer of a public body must refuse a request for access to a record of the body if its disclosure would involve the unreasonable disclosure of personal information about a third party, including a deceased individual.”²⁷¹

Subsection (2) in turn says, “A record may not be refused in terms of subsection (1) insofar as it consists of information about a individual who has consented in terms of section 48 or otherwise in writing to its disclosure to the requester concerned.”²⁷²

A record may also not be refused in terms of subsection (1) insofar as it consists of information about an individual’s physical or mental health, or well-being who is under the care of the requester and who is (i) under the age of 18 years; or (ii) incapable of understanding the nature of the request, and if giving access would be in the individual’s best interest.²⁷³ This exception can be interpreted to include parental access to an 18 year old and younger child’s file under any circumstances, provided it is not unreasonable and if disclosure would be in the child’s best interests. Slabbert argues that the disclosure of personal information that violates the right to privacy will undoubtedly be unreasonable, but that it is conceivable that some health care providers would not regard the disclosure of a minor’s personal health information to his parents or guardian as “unreasonable”. This would require the balancing of two interests. The interest in the protection of confidential information on the one hand, and the right of parents to access their child’s medical records in order to exercise their parental authority and rights on the other hand. A paternalistic health care culture would probably favour parental authority.²⁷⁴

Likewise a record may not be refused insofar as it consists of information about an individual who is deceased and the requester is (i) the individual’s next of kin or (ii) making the request with the written consent of the individual’s next of kin.²⁷⁵

²⁷¹ *Promotion of Access to Information Act 2 of 2000*; s 34 (1).

²⁷² *Promotion of Access to Information Act 2 of 2000*; s 34(2)(a).

²⁷³ *Promotion of Access to Information Act 2 of 2000*; s 34 (2)(d).

²⁷⁴ Slabbert (2004) *PER* 14.

²⁷⁵ *Promotion of Access to Information Act 2 of 2000*; s 34 (2)(e).

Section 37 deals with the mandatory protection of certain confidential information. Subject to subsection 2, the information officer of a public body must refuse a request for access to a record of the body if the disclosure would constitute an action for breach of a duty of confidence owed to a third party in terms of an agreement.²⁷⁶

The information officer may refuse a request for access to a record of the body if the record consists of information supplied in confidence by a third party and (i) the disclosure of which could reasonably be expected to prejudice the future supply of similar information, and (ii) if it is the public interest that similar information, or information from the same source, should continue to be supplied.²⁷⁷

However, the protection of information is not absolute. Section 46 deals with the mandatory disclosure of information in the public interest. Despite any other provisions of Chapter 4, the information officer of a public body must grant a request for access to a record of the public body as contemplated in sections 34 and 37 if the disclosure of the record would reveal evidence of (i) a substantial contravention of, or failure to comply with the law or (ii) an imminent and serious public safety risk and the public interest in the disclosure of the record clearly outweighs the harm contemplated in the provision in question.²⁷⁸

The information officer of a public body considering a request for access to a record contemplated in terms of section 34 or 37 must take all reasonable steps to inform the third party to whom the request relates, of the request made for information.²⁷⁹

Part 3 of the act deals with the access to records of private bodies. A private body is defined amongst other things as a natural person who carries out a profession, and as such the medical practitioner can be seen in this sense as a private body.²⁸⁰

A requester must be given access to any record of a private body if (a) that record is required for the exercise or protection of any rights and (b) that person complies with the

²⁷⁶ *Promotion of Access to Information Act 2 of 2000*; s 37(1)(a).

²⁷⁷ *Promotion of Access to Information Act 2 of 2000*; s 37(1)(b).

²⁷⁸ *Promotion of Access to Information Act 2 of 2000*; s 46.

²⁷⁹ *Promotion of Access to Information Act 2 of 2000*; s 47(1).

²⁸⁰ *Promotion of Access to Information Act 2 of 2000*; s 1.

procedural requirements of the Act, and (c) access to that record is not refused in terms of any ground for refusal found in Chapter 4 of Part 3 of the act.²⁸¹ The requester must also be acting in the public interest, when requesting the information²⁸².

Chapter 4 of Part 3 deals with the grounds for refusal of access to records. Section 63 is about the mandatory protection of the privacy of a third party who is a natural person. Subject to subsection (2) the head of a private body must refuse a request for access to a record of the private body if its disclosure would involve the unreasonable disclosure of personal information about a third party, including a deceased person.²⁸³

Subsection (2) states that a record may not be refused in terms of subsection (1) insofar as it consists of information about a person who has consented in terms of section 72 or otherwise in writing to its disclosure. The record may not be refused if it is about a person's physical or mental health, or well-being, who is under the care of the requester and who is (i) under the age of 18 years or (ii) incapable of understanding the nature of the request and if giving access would be in the person's best interests.²⁸⁴ The record may also not be refused if it is about a person who is deceased and the requester is (i) the person's next of kin or (ii) making the request with the written consent of the person's next of kin.²⁸⁵

Section 65 deals with the mandatory protection of certain confidential information of third parties. "The head of a private body must refuse a request for access to a record of the body if its disclosure would constitute an action for breach of a duty of confidence owed to a third party in terms of an agreement."²⁸⁶

Just as section 46 deals with the mandatory disclosure in the public interest when dealing with public bodies, section 70 deals with the same topic but relating to private bodies. Despite any other provisions in Chapter 4, the head of a private body must grant a request for access to a record of the body contemplated in sections 63 and 65, if the

²⁸¹ *Promotion of Access to Information Act 2 of 2000*; s 50(1).

²⁸² *Promotion of Access to Information Act 2 of 2000*; s 50 (2).

²⁸³ *Promotion of Access to Information Act 2 of 2000*; s 63 (1).

²⁸⁴ *Promotion of Access to Information Act 2 of 2000*; s 63(2)(a) & (d).

²⁸⁵ *Promotion of Access to Information Act 2 of 2000*; s 63(2)(e).

²⁸⁶ *Promotion of Access to Information Act 2 of 2000*; s 65.

disclosure of the record would reveal evidence of (i) a substantial contravention of, or failure to comply with the law or (ii) imminent and serious public safety risk and the public interest in the disclosure of the record clearly outweighs the harm contemplated in the provision in question.²⁸⁷

The head of a private body considering a request for access to a record that might be record contemplated in section 63 or 65 must take all reasonable steps to inform the party to whom the record relates of the request.²⁸⁸

“No person is criminally or civilly liable for anything done in good faith in the exercise or performance or purported exercise or performance of any power or duty in terms of this Act.”²⁸⁹

It is clear from above that the Act has in most instances provided adequately for the release of sensitive information, such as medical information. The only exception is the release of information for failure to comply with the law, or a serious or imminent public safety risk. The same exceptions are found in the USA and Canada and this emphasises once more that no right is absolute and that the interests of others in society need also to be considered and weighed up against the right to privacy.

I have some misgivings about the release of information about a deceased individual to the next of kin.²⁹⁰ The wording does not specifically mention information relating to the physical or mental health of the deceased, but I think this can be read into the wording. If the deceased had an illness like AIDS, which he or she never revealed to the family while alive, it could be very traumatic for the whole family to hear such news and it would be mean the doctor would be going against the deceased wishes after death which in my mind is not very ethical. If a patient wants their family to know about their illness they should be the one to tell them, unless the patient gives written permission to the doctor to do so after their death.

²⁸⁷ *Promotion of Access to Information Act 2 of 2000*; s 70.

²⁸⁸ *Promotion of Access to Information Act 2 of 2000*; s 71(1).

²⁸⁹ *Promotion of Access to Information Act 2 of 2000*; s 89.

²⁹⁰ *Promotion of Access to Information Act 2 of 2000*. s 63(e).

The parent or guardian of a minor under 18 years can also request the minor's medical records if it is in the minor's best interests. Setting this age at 18 is quite high given the rights accorded to minor's over the age of 14 in the *Child Care Act 74 of 1983*²⁹¹, the *Choice on the Termination of Pregnancy Act 92 of 1996*²⁹² and Ethical rulings²⁹³ of the Health Professions Council.

The SALRC proposes that privacy legislation should deal with the access to the personal information of the requester and that PAIA should deal with the right to access all other information. It is proposed that a single authority will administer both acts.²⁹⁴

2.4.3 Human Tissue Act 65 of 1983²⁹⁵

According to section 33 of the above act no person may publish to any other person any fact whereby the identity of a deceased person whose body or tissue has been donated or of a living person from whose body any tissue, blood or gamete has been removed in terms of section 19, unless consent thereto was granted in writing by the deceased person concerned prior to their death, or after his death by a person referred to in section 2(2)(a) or by a district surgeon referred to in section 2(2)(b) of the said Act.

2.4.4 Protection of Personal Information Draft Bill 2005

The right to privacy as laid out in section 14 of the Constitution, obligates the government to adopt legislation for the adequate protection of data privacy, since the ordinary private law principles provide only partial protection.²⁹⁶

The *Protection of Personal Information Draft Bill* was compiled by the South African Law Reform Commission (SALRC) and appeared in October 2005 and comments could be given until the 28th of February 2006. The Commission has tried to develop and expand on the proposals that were set out in the Issue Paper 24 that was published in 2003.

²⁹¹ The present statutory age for independent consent to medical treatment is 14 years, while a minor who is 18 years or older, may independently consent to a medical operation according to s 39(4)(b) of the *Child Care Act 74 of 1983*;

²⁹² Any female of any age according to s 1(xi) may lawfully have her pregnancy terminated upon request during the first twelve weeks of pregnancy. The medical practitioner is only under an obligation to advise her to consult her parents before the abortion.

²⁹³ See p. 21-22 of thesis.

²⁹⁴ South African Law Reform Commission. (2005) 198.

²⁹⁵ The whole of the *Human Tissue Act 65 of 1983* is to be repealed by the *National Health Act 61 of 2003* but as yet this has not yet been proclaimed by the President in the *Government Gazette*.

The Law Commission does not regard the self-regulatory system of privacy, to be suitable for South Africa, since it results in a patchwork of provisions, and individual's rights are difficult and costly to pursue. Likewise the Commission feels the culture of privacy cannot be securely established without the presence of a supervisory authority. The regulatory and co-regulatory systems both make provision for a comprehensive act and a supervisory authority. It is also envisaged that the single supervisory authority will administer both the information privacy legislation and the access to information legislation.²⁹⁷

The Commission's preliminary proposal is therefore that a comprehensive act should be instituted with or without sectoral legislation and codes of conduct, which will be implemented within a regulatory system and by a statutory regulatory authority working in conjunction with individual sectors.²⁹⁸ It covers both manual and automatic processing of information and will protect identifiable natural and juristic persons.²⁹⁹

The SALRC recommends that privacy and information protection should be regulated by a general information protection statute, with or without sector specific statutes, which will be supplemented by codes of conduct for various sectors and which will be applicable to both the public and private sector. General principles of information³⁰⁰ protection should also be incorporated and developed in the legislation and a statutory regulatory agency known as the Information Protection Commission should³⁰¹ be established. Enforcement of the bill will be through the Commission and a flexible approach should be followed in which industries will develop their own codes of conduct. Finally it is the SALRC's objective to ensure that the legislation provides an adequate level of information protection in terms of the EU Directive.^{302 303}

²⁹⁶ Roos (2003) *The law of data (privacy) protection, a comparative and theoretical study* LLD 716.

²⁹⁷ South African Law Reform Commission (2005) 283.

²⁹⁸ South African Law Reform Commission (2005) 283-284.

²⁹⁹ South African Law Reform Commission (2005) 404.

³⁰⁰ The proposed bill gives effect to eight core information protection principles.

³⁰¹ South African Law Reform Commission (2005) 265. An adequately resourced oversight body like the Commissioner is important to ensure that individuals and companies have recourse to the law without the need for litigation.

³⁰² South African Law Reform Commission (2005) viii-ix.

³⁰³ The 1981 Organisation for Economic Cooperation and Development's Guidelines (OECD) governing the protection of privacy and transborder data flows of personal data; the legislation of non-EU countries must provide an adequate level of data protection, before EU members states would be allowed to transfer data. The inability to transfer data would negatively impact on the business community of South Africa.

The Information Protection Commission will be responsible for the implementation of both the *Protection of Personal Information Act* and the *Promotion of Access to Information Act*. Data subjects are obligated to notify the Commission of any processing of personal information before they³⁰⁴ undertake such processing. Enforcement should also be through the Commission using as a first step a system of notices. Failure to comply with the notices will be a criminal offence. The Commission may also assist data subjects in claiming compensation from a responsible party for damage suffered.³⁰⁵ Codes of conduct for individual sectors may be drawn up, and these codes will have to accurately reflect the information protection principles as set out in the Act. They should also assist in the practical application of the rules in a specific sector.³⁰⁶

The protection of information privacy in South Africa will be brought into line with international requirements and developments should these proposal as set out in the draft bill, be adopted. The OECD guidelines³⁰⁷ have been used to identify the information principles set out below. Apart from the importance of protecting the constitutional right to privacy, another reason stated for introducing these principle into legislation, was that various commercial opportunities exist for information outsourcing, and that if South Africa's national standards do not conform to international requirements, especially the EU's directive, it will prevent such opportunities from taking place.³⁰⁸

The object of the proposed act is to give effect to the constitutional right to privacy by (i) safeguarding a person's personal information when processed by public and private bodies (ii) in a manner which balances that right with any other right (iii) subject to justifiable limitations.³⁰⁹ Furthermore the object is also to establish voluntary and mandatory procedures that will be in harmony with international prescripts, and which while upholding the right to privacy, will contribute to the social and economic development³¹⁰ and generally to promote transparency, accountability and effective governance of all public and private bodies.³¹¹

³⁰⁴ South African Law Reform Commission (2005) 405.

³⁰⁵ *Ibid.*

³⁰⁶ *Ibid.*

³⁰⁷ See heading 3.2 on p. 67 below for a more detailed explanation of these guidelines.

³⁰⁸ South African Law Reform Commission (2005) 114.

³⁰⁹ *Protection of Personal Information Draft Bill 2005*; s. 1 .

³¹⁰ *Protection of Personal Information Draft Bill 2005*; s. 1(b).

³¹¹ *Protection of Personal Information Draft Bill 2005*; s. 1(c).

The definition of “personal information” in this Bill corresponds to the same definition in the *Promotion of Access to Information Act* 2 of 2000 as well as the *National Health Act* 61 of 2003. A “private body” means a natural person who carries or has carried on a profession, but only in such capacity.³¹²

The proposed act does not apply to the processing of information that has been de-identified to the extent that it cannot be re-identified again or that has been exempted in terms of section 33.³¹³

Chapter 3 deals with the conditions for the lawful processing of personal information. Principle 1 deals with processing limitations. Personal information must be processed in accordance with the law and in a proper and careful manner in order not to intrude upon the privacy of the data subject to an unreasonable extent.³¹⁴ Section 8 deals with the minimality principle, namely that personal information may only be processed where, given the purpose for which it is collected or subsequently processed, it is adequate, relevant and not excessive.³¹⁵

Personal information may only be processed where the data subject has given consent for the processing or processing is necessary for the performance of a contract or agreement to which the data subject is party and which are necessary for the conclusion or implementation of a contract.³¹⁶ The information must also be collected directly from the data subject.³¹⁷

Principle 2 deals with the purpose specification. “Personal information must be collected for a specific, explicitly defined and legitimate purpose.”³¹⁸ The data subject must also be made aware of the purpose for which the information is being collected and the intended recipients of the information, according to subsection (1). This must be done before the information is collected or if that is not possible, as soon as reasonably practicable after the information is collected. These steps need only be taken once if it relates

³¹² *Protection of Personal Information Draft Bill 2005*; s. 1 .

³¹³ *Protection of Personal Information Draft Bill 2005*; s. 4.

³¹⁴ *Protection of Personal Information Draft Bill 2005*; s. 7.

³¹⁵ *Protection of Personal Information Draft Bill 2005*; s. 8.

³¹⁶ *Protection of Personal Information Draft Bill 2005*; s. 9(1)(a-b).

³¹⁷ *Protection of Personal Information Draft Bill 2005*; s. 10.

to the same kind of information and the purpose of collection and intended recipients remain unchanged.³¹⁹It is not necessary to comply with subsection (1) if non-compliance is authorised by the data subject or non-compliance will not prejudice the interests of the data subject.³²⁰

Principle 3 deals with the further processing limitation. Personal information must not be further processed in a way incompatible with a purpose for which it has been collected in terms of principle 2.³²¹The further processing of personal information must not be regarded as incompatible as referred to under subsection (1)"where the processing of the information for that other purpose is necessary to prevent or mitigate a serious and imminent threat to (i) public health or public safety; or (ii) the life or health of the data subject or another individual."³²²

Principle 4 deals with the quality of information. Steps must be taken to ensure that the personal information is complete, not misleading, up to date and accurate.³²³Principle 5 deals with openness. Personal information may only be collected by a responsible party that has notified the Commission accordingly in terms of this Act, and which notification has been noted in a register kept by the Commission for this purpose. This need only be done once if the responsible party has previously taken those steps in relation to the collection, from that data subject, of information of the same kind.³²⁴From a practical point of view this might mean that all doctors in private practice might need to notify the Commission that they collect personal information, and that their names be put on a register.

Principle 6 deals with security safeguards. The responsible party must implement appropriate technical and organisational measures to secure (a) the integrity of personal information by safeguarding against the risk of loss of, or damage to, or destruction of personal information and (b) against the unauthorised or unlawful access to or process-

³¹⁸ *Protection of Personal Information Draft Bill 2005*; s. 11.

³¹⁹ *Protection of Personal Information Draft Bill 2005*; s. 12.

³²⁰ *Protection of Personal Information Draft Bill 2005*; s. 12(4).

³²¹ *Protection of Personal Information Draft Bill 2005*; s. 14(1).

³²² *Protection of Personal Information Draft Bill 2005*; s. 14(3)(d).

³²³ *Protection of Personal Information Draft Bill 2005*; s. 15.

³²⁴ *Protection of Personal Information Draft Bill 2005*; s. 16(1) & (4).

ing of personal information.³²⁵This section would pertain to patient files kept by doctors and with regards medical aids, the billing information received from medical practitioners. Likewise the scripts kept by pharmacists would also have to measure up to these safety standards.

Anyone acting under the authority of the responsible party, as well as the processor himself, where they have access to personal information, must only process such information with the knowledge or consent of the responsible party, except where otherwise required by law.³²⁶

The persons referred to under subsection (1), who are not subject to an obligation of confidentiality by virtue of their profession, are required to treat as confidential the personal information that comes to their knowledge, except where the communication of such information is required by law or in the proper performance of their duties.³²⁷This section would apply to medical receptionists and the people that handle the doctor's accounts.

Principle 8 deals with accountability. The responsible person must make sure that the measures set out above are complied with.³²⁸

It is prohibited to process personal information concerning a person's health or sex life, except where the data subject has given his or her explicit consent.³²⁹This prohibition does not apply where the processing is carried out by medical professionals or health-care facilities, provided it is necessary for the proper treatment and care of the data subject, or for the administration of the institution or professional practice concerned.³³⁰Likewise the prohibition does not apply where the processing is carried out by insurance companies, provided it is necessary for assessing the risk to be insured by the insurance company and the data subject has not objected thereto.³³¹Schools may also process such information, provided that it is necessary with a view to providing special sup-

³²⁵ *Protection of Personal Information Draft Bill 2005*; s. 17.

³²⁶ *Protection of Personal Information Draft Bill 2005*; s. 18 (1).

³²⁷ *Protection of Personal Information Draft Bill 2005*; s. 18(2).

³²⁸ *Protection of Personal Information Draft Bill 2005*; s 23.

³²⁹ *Protection of Personal Information Draft Bill 2005*; s 24.

³³⁰ *Protection of Personal Information Draft Bill 2005*; s 29(1)(a).

port for the pupil,³³² as well as institutions for probation, child protection or guardianship where it is necessary for the performance of their legal duties.³³³ The Ministers of Justice and Constitutional development may also process such information provided it is necessary when implementing prison sentences.³³⁴ Administrative bodies, pension funds, employers or institutions working for them may process personal information firstly where it is necessary for the proper implementation of the provisions of the laws, pension regulations or collective agreements,³³⁵ and secondly where it concerns the reintegration of or support for workers entitled to benefit in connection with sickness or work incapacity.³³⁶

In all the above cases under section 29(1), “the information may only be processed by persons subject to an obligation of confidentiality by virtue of office, employment, profession or legal provision, or under a written agreement.”³³⁷ Regulations, containing more detailed rules, may be made concerning the application of subsection 1(b) and (f).³³⁸

The SALRC submits that effective information protection will only be achieved through regulation by legislation. This is due to firstly, the inherent conservatism of our courts, as well as the fact that the protection of privacy is still in its infancy in South African law. It is improbable that the application of the information principles by the courts will occur often or extensively enough in the future to ensure the protection of personal information. Major law reform should be the task of the legislature and not the judiciary, especially when it involves more than a few incremental changes to the common law.³³⁹

The type of legislation being proposed here is long overdue and very necessary in South Africa. It will go a long way in ensuring that the right to privacy is respected and enforced. The Constitution basically obligates the government to ensure that the rights in the Constitution are protected and this draft bill is a result of this. As recommended by

331 *Protection of Personal Information Draft Bill 2005; s 29(1)(b).*
332 *Protection of Personal Information Draft Bill 2005; s 29(1)(c).*
333 *Protection of Personal Information Draft Bill 2005; s 29(1)(d).*
334 *Protection of Personal Information Draft Bill 2005; s 29(1)(e).*
335 *Protection of Personal Information Draft Bill 2005; s 29(1)(f)(i).*
336 *Protection of Personal Information Draft Bill 2005; s 29(1)(f)(ii).*
337 *Protection of Personal Information Draft Bill 2005; s 29(2).*
338 *Protection of Personal Information Draft Bill 2005; s 29(6).*

the SALRC it would be ideal if the health sector could draw up a code of conduct, reflecting the information protection principles found in this Act, to assist the medical community with the practical application of the rules. Both Canada and the USA have similar legislation.

2.4.5 *Electronic Communications and Transactions Act 25 of 2002*

This act provides for the regulation of electronic communications and transactions. Section 51 deals with the principles for electronically collecting personal information. “Personal information” means information about an identifiable individual, including but not limited to information relating to amongst other things sex, pregnancy, sexual orientation, age physical or mental health, well-being and disability.³⁴⁰ It also means information relating to the medical history of the individual³⁴¹ or blood type of the individual.³⁴²

The data controller must have the express written permission of the data subject for the collection, collation, processing or disclosure of any personal information on that data subject unless he or she is permitted or required to do so by law.³⁴³

Only the information necessary for the lawful purpose for which the personal information is required may be collected and stored.³⁴⁴ The data controller must disclose in writing to the data subject the specific purpose for which any personal information is being requested, collected, collated, processed or stored³⁴⁵ and may not use the personal information for any other purpose without the written permission of the data subject.³⁴⁶

Likewise the data controller may not disclose any of the personal information held by it to a third party, unless required or permitted by law or specifically authorised to do so in writing by the data subject.³⁴⁷

All personal information, which is obsolete, must be deleted or destroyed by the data controller.³⁴⁸

³³⁹ South African Law Reform Commission (2005) 53.
³⁴⁰ *Electronic Communications and Transactions Act 25 of 2002*; s.1(a).
³⁴¹ *Electronic Communications and Transactions Act 25 of 2002*; s.1(b).
³⁴² *Electronic Communications and Transactions Act 25 of 2002*; s.1(d).
³⁴³ *Electronic Communications and Transactions Act 25 of 2002*; s.51(1).
³⁴⁴ *Electronic Communications and Transactions Act 25 of 2002*; s.51(2).
³⁴⁵ *Electronic Communications and Transactions Act 25 of 2002*; s.51(3).
³⁴⁶ *Electronic Communications and Transactions Act 25 of 2002*; s.51(4).

A party controlling personal information may use the information to compile profiles for statistical purposes and may freely trade with such profiles and statistical data, as long as the data cannot be linked to any specific data subject by a third party.³⁴⁹

This Act would also be applicable to electronically collected and stored personal information of a medical nature, and provides a good legislative framework for the protection of electronically stored personal information. Presently it is mainly the accounting records that are electronically stored in medical practice, but even these often contain a brief description of the diagnosis or treatment the patient has received. Medical aid schemes also have an electronic record of all the claims received from medical practitioners and they should also take note of these provisions as well as pharmacies that electronically enter all prescription details.

3. Canada

This section deals with the general background and historical development of the concept of “privacy” in Canada, as well as the legislative protection that is afforded privacy on both a constitutional, federal and provincial level.

3.1 Privacy in general

Burns states that the following about the common law of privacy in Canada: “there is no protection for personal privacy *per se*, at least outside the United States.”³⁵⁰ The right to privacy has not so far, at least under that name, received explicit recognition by British Courts. There is no general legal right but instead where the term privacy is used it is taken to be a statement of principle in support of some other already recognised right or cause of action. This is in contrast to the United States where many states recognise a right to privacy, which in turn is protected by the common law.³⁵¹

The Anglo-Canadian courts lack boldness in establishing new causes of action, which may be rationalised in terms of the generally accepted view of the constitutional position

³⁴⁷ *Electronic Communications and Transactions Act 25 of 2002*; s.51(6).

³⁴⁸ *Electronic Communications and Transactions Act 25 of 2002*; s.51(8).

³⁴⁹ *Electronic Communications and Transactions Act 25 of 2002*; s.51(9).

³⁵⁰ Burns “The law and privacy: the Canadian Experience” (1976) *Canadian Bar Review* 12.

³⁵¹ *Ibid.*

of Canadian courts, namely, that their function is to apply and not create law.³⁵² Although there is a marked absence of litigation brought in “invasion of privacy” there are many causes of action recognised at common law and equity that do protect privacy interests.³⁵³

3.2 Historical development

In 1989, the Canadian Standards Association (CSA) took up the challenge of creating Canadian privacy protection standards, taking the work done by the Organisation for Economic Cooperation and Development (OECD) as a standard. The ten CSA Model Privacy Codes (CSA Codes) are fundamental to understanding privacy legislation.³⁵⁴

The ten CSA Codes are the following:

- ❖ *Accountability* – Organisations must be able to describe what personal information they possess and account for how it is used.
- ❖ *Identifying purpose* – Organisations must define the purposes for which personal information is collected.
- ❖ *Consent* – Knowledge and consent of the individual is required for the collection, use or disclosure of personal information.
- ❖ *Limiting collection* – The collection must be limited to the purpose identified by the organisation
- ❖ *Limiting use, disclosure and retention* – Personal information can be kept only as long as necessary for the fulfilment of the purpose.
- ❖ *Accuracy* – “Personal information will be as accurate, complete and up-to-date as is necessary for the purposes for which it is to be used.”
- ❖ *Safeguards* – “Security safeguards appropriate to the sensitivity of the information will be used to protect personal information.”
- ❖ *Openness* – an organisation “will make information available to individuals about its information policies and practices relating to the handling and management of personal information.”

³⁵² *Ibid*; Burns quotes Fleming *The law of Torts* (4th ed, 1971) p 526-527.

³⁵³ Burns (1976) *Canadian Bar Review* 14. Burns illustrates this proposition by naming various causes of action including trespass to the person (physical interference or threats to the person is needed) and defamation. For more on causes of action in Canada see page 107.

³⁵⁴ Bickle & Appleby (2001) *Health law in Canada* 85.

- ❖ *Access* – “Upon request, an individual shall be informed of the existence, use and disclosure of his or her personal information and shall be given access to that information. An individual shall be able to challenge the accuracy and completeness of the information and have it amended as appropriate, or have a notice of disagreement added to the file.”
- ❖ *Challenging Compliance* – “An individual shall be able to address a challenge concerning compliance with the above principles to the designated individual(s) accountable” for the organisations compliance. ³⁵⁵

The *Personal Information Protection and Electronic Documents Act*³⁵⁶, which came into force on 1 January 2001, is based on the CSA codes. It was designed to cover all commercial activity, not health care specifically. The health care industry was asked to provide its input into the bill. The Canadian Medical Association, Canadian Dental Association, and Canadian Health Care Association participated in the discussions. They were however unable to present a united approach on two specific issues namely informed consent, and the secondary use of personal health information.³⁵⁷

According to Bickle the privacy concept seems uncomplicated enough when looking at the ten CSA codes. The patients’ right to control their health information is guaranteed. The problem is society is faced with a new reality “the intended primary use of personal information is being overtaken by demands from a much larger network of secondary users.”

Databases of personal information are accessible by drug and insurance companies, researchers, and the Canadian Institute of Health Information (CIHI). The databases are also widely accessed by government. The Internet has added to the problem, by enabling the development of global repositories. There is also the possibility that personal information can be exposed, stolen or used maliciously.³⁵⁸

³⁵⁵ Bickle & Appleby “Privacy legislation and health care” (2001) 21 *Health law in Canada* 86.

³⁵⁶ SC 2000 c.5.

³⁵⁷ Bickle & Appleby (2001) *Health law in Canada* 86.

³⁵⁸ Bickle & Appleby (2001) *Health law in Canada* 87.

Bickle feels that to manage personal health information effectively, a Trust Model must be developed and incorporated into all practice involved. This Trust Model consists of three pillars, namely privacy, security and confidentiality.³⁵⁹ Privacy is the main pillar and interfaces at the personal level. Privacy is about people and process. Confidentiality covers the “responsibilities of participating organizations in how personal information is protected and handled during internal processes and procedures.” The Security pillar includes “firewalls, authentication, privilege management, non-repudiation and a secure channel”³⁶⁰

While The *Personal Information Protection and Electronic Documents Act*³⁶¹ is the umbrella privacy legislation for Canada, implementation of privacy is actually a provincial responsibility. The provinces have three years to develop privacy legislation significantly similar to the *Personal Information Protection and Electronic Documents Act*.³⁶²

3.3 Constitutional Protection of Privacy

Canada’s Constitution and Charter of Rights and Freedoms does not explicitly provide for a right to privacy, but in interpreting Section 8 of the Charter, which grants the right to be secure against unreasonable search or seizure³⁶³, the Canadian courts have recognised an individual’s right to a reasonable expectation of privacy.³⁶⁴ Section 7 of the Charter also protects privacy. It states that everyone has the right to life, liberty and security of person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. “Section 15, which guarantees equality before and under the law and the equal protection and benefit of the law without discrimination, may

³⁵⁹ Bickle & Appleby (2001) *Health law in Canada* 88.

³⁶⁰ Bickle & Appleby (2001) *Health law in Canada* 88.

³⁶¹ SC 2000 c.5.

³⁶² Bickle & Appleby (2001) *Health law in Canada* 89.

³⁶³ Von Tigerstrom (2000) “Alberta’s Health Information Act and the Charter: a discussion paper” *Health law review* 8-9; What is essential to section 8 of the Charter is that the individual has a reasonable expectation of privacy in the subject matter of the search or seizure. See *R v Plant* [1993] 3 SCR 281 at 291. The Court has also recognised that individuals have a reasonable expectation of privacy in therapeutic records such as medical and counselling records protected by section 8. See *R v O’Conner* [1995] 4 SCR 411. Section 8 has been applied to records and samples of bodily samples in a medical context and individuals have a reasonable expectation that such samples will remain private and information from them not be used for other purposes. See *R v Dymont* [1988] 2 SCR 417 at 434; *R v Dersch* [1993] 3 SCR 768; *R v Colarusso* [1994] 1 SCR 20. (as taken from Von Tigerstrom).

also be relevant to privacy rights in some circumstances.” According to Von Tigerstrom, the right to privacy has been developed and explained through Supreme Court of Canada decisions.³⁶⁵

The right to privacy has the same status as other rights protected by the Charter, since there is no hierarchy of rights, and in the context of health information, it is reinforced and supported by the right to equality. The right to privacy is not absolute, but must be balanced against competing Charter rights and valid social objectives.³⁶⁶

The Charter applies to the actions of federal and provincial governments and is paramount over other laws. Any law that is inconsistent with the Charter³⁶⁷ is to the extent of the inconsistency, of no force or effect.

3.4 Legislation protecting privacy

3.4.1 Federal level legal framework

Canada makes use of a regulatory enforcement system, which makes provision for a comprehensive Act setting out the Principles of information protection as well as provisions dealing with the monitoring and enforcement of these principles.³⁶⁸

Privacy is protected by two acts at the Federal level namely:

- 1) the 1982 Federal *Privacy Act*³⁶⁹ and
- 2) the 2001 *Personal Information and Electronic Documents Act (PIPEDA)*³⁷⁰

³⁶⁴ South African Law Reform Commission (October 2005) 392; Referring to *Hunter v Southam*, 2 SCR 145 159-80 (1984).

³⁶⁵ Von Tigerstrom (2000) “Alberta’s Health Information Act and the Charter: a discussion paper” *Health law review* 3, 6-7.

³⁶⁶ Von Tigerstrom (2000) *Health law review* 4; In *R v Mills* [1999] 3 SCR 668 (para. 61), the Supreme Court explicitly recognised that the right to privacy has the same status as other Charter rights and is not absolute.

³⁶⁷ Von Tigerstrom (2000) *Health law review* 6; Part 1 of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK) 1982 c.11 s.32 and s. 52 referring to Charter being paramount.

³⁶⁸ South African Law Reform Commission (October 2005) 231.

³⁶⁹ *Privacy Act* [R.S., 1985, cP-21].

³⁷⁰ SC 2000 c.5.

3.4.1.1 Privacy Act

The Privacy Act, which applies to the public sector, is based on the OECD³⁷¹ guidelines, whereas PIPEDA adopted the CSA International Privacy Code (a national standard developed in conjunction with the private sector, and also based on the OECD principles) into law for the private sector.³⁷²

The federal Privacy Act regulates the confidentiality, collection, correction, disclosure retention and use of personal information held by the federal sector.³⁷³ In January 2004 the Act was extended to every organisation, whether or not the organisation was federally regulated.³⁷⁴

3.4.1.2 Personal Information and Electronic Documents Act (PIPEDA)³⁷⁵

The PIPEDA act adopts the CSA International Privacy Code into law for private sector organisations that process personal information in the course of commercial activity and for federally regulated employers with respect to their employees.³⁷⁶ Examples include telecommunications companies, airlines and banks. The law also applies to provincially regulated private sector organisations such as insurance companies.

PIPEDA established the parameters for the collection, use, disclosure, retention and disposal of personal information. It sets out ten privacy principles as standards, based on the CSA code that organisations must comply with when dealing with personal information, which includes confidential medical information.³⁷⁷

The *Privacy Act* and *PIPEDA* are both overseen by the Independent Privacy Commissioner of Canada who has the power to investigate, mediate, and make recommendations. It cannot however issue binding orders or impose penalties.³⁷⁸ If an individual is not satisfied with a resolution, the case can be taken to the Federal Court. The Court

³⁷¹ Organisation for Economic Cooperation and Development Guidelines.

³⁷² South African Law Reform Commission (2005) 111.

³⁷³ South African Law Reform Commission (2003) 255.

³⁷⁴ South African Law Reform Commission (2003) 256.

³⁷⁵ SC 2000 c.5.

³⁷⁶ South African Law Reform Commission (2003) 256.

³⁷⁷ *Ibid.*

³⁷⁸ South African Law Reform Commission (2003) 257.

can also award damages if warranted. The law empowers the Commissioner to encourage the development of codes as a further instrument of compliance with the law.³⁷⁹

There are also provincial information Commissioners' whose order making power encourages parties to settle their disputes before orders are made.³⁸⁰ There are two Commissioners at the federal level, one for Freedom of Information and one for Privacy.³⁸¹

3.4.2 Provincial level legal framework

On a provincial level privacy legislation is separated into three categories, namely public sector (data protection) law, private sector law and sector specific law. Every province and territory has privacy legislation governing the collection, use and disclosure of personal information held by government agencies, while nearly every province has an oversight agency, but they vary in their powers and scope of regulation. Alberta³⁸², Manitoba, Saskatchewan and Ontario have all passed health-specific legislation, which sets rules for the collection, use and disclosure of health information. These laws apply to health information held by health professionals, hospitals, and other health care facilities. Ontario is also currently working on including health privacy legislation in its general private sector legislation. Sector-specific laws unfortunately only provide a partial and fragmentary approach to the problem of regulation.³⁸³

Many provinces in Canada have enacted legislation that is designed to deal with issues of confidentiality; accessibility and use of computerised personal information in general.³⁸⁴ The statutes all apply to information held by the public sector, such as provincial governments, and typically such local public bodies such as hospitals and health boards.³⁸⁵

³⁷⁹ South African Law Reform Commission (2005) 235.

³⁸⁰ South African Law Reform Commission (2005) 263.

³⁸¹ South African Law Reform Commission (2005) 267; In South Africa it would be better to have one official combining both roles. It would be necessary to clarify the role of this officer in relation to the role of the Human Rights Commissioner, who has statutory functions in terms of the *PAIA*.
Health Information Act SA 1999, c H-4.8.

³⁸² *Health Information Act SA 1999, c H-4.8.*

³⁸³ South African Law Reform Commission (2005) 396-397 and Office of the Privacy Commissioner of Canada at http://www.privcom.gc.ca/fs-fi/02_05_d_15_e.asp, accessed on 23 March 2006.

³⁸⁴ Caulfield Canada *International encyclopaedia of law: Medical law* (1999) 72.

³⁸⁵ *Ibid.*

Quebec has provisions in the Act *Respecting the Protection of Personal Information in the Private Sector*³⁸⁶ that specifically relate to the confidentiality of health records.³⁸⁷ Quebec implemented a privacy law in 1994. Ontario and British Columbia have released privacy legislation consultation papers, but neither province has enacted privacy legislation.³⁸⁸

The *Regulated Health Professions Act (RHPA)*³⁸⁹,” which governs the disciplinary matters of various professional colleges in Ontario, compels every person employed, retained or appointed for the purpose of the administration of the Act,” to preserve the secrecy of the information that comes their attention in the course of their duties. The health professionals subject to this act must also report sexual abuse of patients or clients when there are reasonable grounds to suspect it.³⁹⁰

A number of provincial statutes have set out the confidential nature of the relationship that exists between a health care provider and patient. “Such legislation may impose a positive duty upon the health care provider either to hold in confidence all patient information, or to release such information only if required to do so by paramount legislation or by order of a court.”³⁹¹ Some provinces have enacted privacy legislation that allows a person to initiate a civil suit against anyone who violates their privacy. What amounts to an invasion of privacy is not defined, but if the statute requires the violation to be wilful, a negligent disclosure or breach of confidentiality would not apply.³⁹²

According to Rodgers-Magnet, four of the Canadian provinces have enacted legislation specifically providing for recognition of a right to privacy. “The acts of British Columbia³⁹³, Manitoba³⁹⁴, and Saskatchewan³⁹⁵ are similar in scope and fairly detailed in conception. The reference to privacy in the Quebec Charter of Human Rights and Free-

³⁸⁶ RSQ 1977 C p-39.1.

³⁸⁷ Caulfield (1999) 73.

³⁸⁸ Bickle & Appleby “Privacy legislation & health care” (2001) *Health law in Canada* 89.

³⁸⁹ *RHSA*, SO 1991 c.8(am 1993 c.37)

³⁹⁰ Bloom & Bay *A practical guide to mental health, capacity, and consent law of Ontario* (1996) 400.

³⁹¹ Caulfield (1999) 74.

³⁹² *Ibid.*

³⁹³ *Privacy Act*, 1968 S.B.C., c. 39; as quoted by Steel (1983) 289.

³⁹⁴ *Privacy Act*, 1970, S.M., c 74; as quoted by Steel (1983) 289.

³⁹⁵ *The Privacy Act*, 1974, 1973-74 S.S., c. 80; as quoted by Steel (1983) 289.

doms³⁹⁶ is declaratory.³⁹⁷ British Columbia and Saskatchewan define the statutory tort of violation of privacy as requiring the wilful violation of the privacy of another. Neither Quebec nor Manitoba requires wilful violation. The usefulness of the action is limited if wilfulness is required, since any negligent disclosure of information would fall outside the scope the acts.³⁹⁸

Each of these statutes provides that breach of privacy is actionable without proof of damage. The defence of privilege of the law of defamation is specifically made available by statute in all circumstances, and the statutes also import the American rule that there can be no recovery for invasions that the ordinary reasonable man would not find offensive. Neither in Ontario, nor in the other common law provinces has a common law tort of privacy given signs of development.³⁹⁹

Caulfield states that disclosing information maybe statutorily defined as unskilled practice or professional misconduct, resulting in a penalty ranging anywhere from disciplinary action to the imposition of a fine. Some provinces have enacted legislation that allows a person to commence a civil suit against anyone who violates his or her privacy. What amounts to an invasion of privacy is not defined, but left to the court's discretion. The statute may require that a violation be wilful, in which case it would not apply to a negligent breach of confidentiality.⁴⁰⁰

4. USA

This section deals with the general background, historical development of the concept of "privacy" in the United States of America, and the legislative protection that is afforded to privacy on both a constitutional, federal and state level.

4.1 Privacy in general

A "right to privacy", and even the word privacy are not explicitly mentioned in the United States Constitution or the Bill of Rights. According to Eddy this suggests that the four-

³⁹⁶ Quebec Charter of Human Rights and Freedoms, 1975 S.Q., c 6; as quoted by Steel (1983) 289.

³⁹⁷ Steel & Rodgers-Magnet (1983) 289.

³⁹⁸ *Ibid.*

³⁹⁹ Steel & Rodgers-Magnet (1983) 290.

⁴⁰⁰ Caulfield (2004) [Canada] *International encyclopaedia of law: Medical law* 78.

ders of the above documents thought that the states were capable of protecting citizens' privacy rights.⁴⁰¹ Eddy goes on further to state that,

“The concept of a fundamental right to privacy is bifurcated into two distinct rights: one right is based in natural law, the Judeo-Christian law, Aristotle and Locke’s philosophy of law and British common law; a second right is implied from the language of the United States Constitution.”⁴⁰²

A wide assortment of privacy laws is found in the individual states and at the federal level, but no comprehensive privacy protection law has been enacted for the privacy sector. There is also no independent privacy oversight agency in the United States. Oversight takes place on different levels, namely by the head of an agency, the Office of Management and Budget, the US President, Congress and the courts.⁴⁰³

4.2 Historical development

4.2.1. Common law right to privacy

The common law right to privacy was enforced through the law of tort, and initially it fell under the tort of battery. In 1880 Judge Thomas C Cooley wrote a treatise called *Law of torts*. Therein Cooley mentioned the “right to be let alone”, which he explained as a “right to one’s person or personal immunity”.⁴⁰⁴ Shortly thereafter the term privacy was used in a battery tort brought by a woman who was watched during childbirth⁴⁰⁵ without her consent.⁴⁰⁶ In 1890, Louis Brandeis and Samuel Warren developed further developed Cooley’s concept of privacy. This article has been one of the most influential law review articles ever written and Roscoe Pound remarked that it “did nothing less that add a chapter to our law”.⁴⁰⁷

⁴⁰¹ Eddy “A critical analysis of Health and Human Services’ proposed health privacy regulations in light of the Health Insurance Privacy and Accountability Act of 1996” (2000) 9 *Annals of health law* 6.

⁴⁰² Eddy (2000) 9 *Annals of health law* 6.

⁴⁰³ South African Law Reform Commission (2005) 68, 379

⁴⁰⁴ Eddy (2000) “A critical analysis of Health and Human Services’ proposed health privacy regulations in light of the Health Insurance Privacy and Accountability Act of 1996” 9 *Annals of health law* 7.

⁴⁰⁵ *De May v Roberts* 46 Mich 160 (1881).

⁴⁰⁶ Eddy (2000) 9 *Annals of health law* 7.

⁴⁰⁷ *Ibid.*

Brandeis and Warren stated that “political, social, and economic changes entail the recognition of new rights, and the common law grows to meet the demands of society.”⁴⁰⁸ They proposed two new rights namely the right to be let alone and the right to be protected from the unauthorized publicity of essentially private affairs. Brandeis and Warren state “the design of the law must be to protect those persons with whose affairs the community has no legitimate concern from having matters which they may properly prefer to keep private, made public against their will.”⁴⁰⁹ They urged the common law to “vindicate and protect these rights” and concluded that an individual has a type of ownership interest in the facts of his or her private life.⁴¹⁰ They viewed privacy as a means to preserve personal dignity.⁴¹¹ They also agreed that their proposed common law right to privacy was not absolute, and that matters of public interest could be published without legal recourse. Consent was seen as a defence to an invasion of privacy.⁴¹² Common law actions for invasions of privacy were covered under the traditional torts of property rights, contractual rights, defamation and breaches of confidence, whereas in fact the courts had recognised a right to privacy.⁴¹³

Between 1890 and the present, the tort of invasion of privacy has been recognised in some form, via statutory or common law, by all fifty states.⁴¹⁴

The tort of invasion of privacy is usually subdivided into four main groups, namely intrusions, disclosures, false light and appropriation, according to Prosser. One criticism of Prosser’s analysis is that it concentrates on the wrongfulness aspect in the light of the reported cases without attempting to define clearly the question of fault. McQuoid-Mason stated that this failure to consider the fault element in actions for invasion of privacy, has led to conflicting decisions in different states.⁴¹⁵ Intrusions upon an individ-

⁴⁰⁸ Warren & Brandeis “The right to privacy” (1890) IV *Harvard law review* 193.

⁴⁰⁹ Warren & Brandeis (1890) *Harvard law review* 214-215.

⁴¹⁰ Eddy (2000) “A critical analysis of Health and Human Services’ proposed health privacy regulations in light of the Health Insurance Privacy and Accountability Act of 1996” 9 *Annals of health law* 7-8.

⁴¹¹ Glenn (2000) 53 *Vanderbilt law review* 1613.

⁴¹² Eddy (2000) 9 *Annals of health law* 8.

⁴¹³ McQuoid-Mason (1978) 35.

⁴¹⁴ Eddy (2000) 9 *Annals of health law* 8.

⁴¹⁵ McQuoid-Mason (1978) 93-94.

ual's affairs or seclusion and public disclosure of private facts about an individual are relevant to this discussion.⁴¹⁶

Rodgers-Magnet states that the required element for Prosser's category of public disclosure of private facts is that of publication. Private disclosure, even to a small group of people is not actionable as an invasion of privacy. The degree of publication required limits the usefulness of this action. Prosser suggests that recourse for such a disclosure lies in the action for breach of contract or breach of a confidential relationship.⁴¹⁷

Two requirements must be met before the right to privacy arises. The information that is disclosed must consist of private facts, not public ones, and secondly the disclosure must be of a degree and kind that would be offensive.⁴¹⁸

4.3 Constitutional right to privacy

The second type of privacy right is Constitutional in nature and exists at both the state and federal level. Therefore state and federal protections overlap.⁴¹⁹

Rackett observed that the United States Constitution does not provide for a distinct provision that protects the right to privacy. "Rather, the Supreme Court has upheld the right to privacy against governmental invasions under the First⁴²⁰, Fourth⁴²¹, Fifth⁴²², and Ninth Amendments⁴²³, and the due process clause of the Fourteenth Amendment⁴²⁴, and the penumbra of freedoms in the Bill of Rights⁴²⁵." ⁴²⁶ Some states follow the federal government's lead and do not provide an explicit right to privacy in their constitutions. This has resulted in a patchwork of federal and state laws governing the somewhat vague right to privacy.⁴²⁷

⁴¹⁶ Eddy (2000) 9 *Annals of health law* 8.

⁴¹⁷ Steel & Rodgers-Magnet (1983) *Issues in tort law* 288.

⁴¹⁸ Steel & Rodgers-Magnet (1983) 289.

⁴¹⁹ Eddy (2000) 9 *Annals of health law* 9.

⁴²⁰ See according to Rackett, *Stanley v Georgia* 394 US 557, 564 (1969).

⁴²¹ See according to Rackett, *Katz v United States* 389 US 347, 350 (1967).

⁴²² See according to Rackett, *Boyd v United States* 116 US 616, 630 (1886).

⁴²³ See according to Rackett, *Griswold v Connecticut* 381 US 479, 486 (1965).

⁴²⁴ See according to Rackett, *Meyer v Nebraska* 262 US 390, 399 (1923).

⁴²⁵ See according to Rackett, *Griswold* 381 US at 484-485.

⁴²⁶ Rackett "Telemedicine today and tomorrow: why virtual privacy is not enough" (1997) 25 *Fordham Urb L J* 176.

Rautenbach states that the American legal position regarding the right to privacy must be treated with great circumspection. In America the right to privacy has been inferred from a number of constitutional concepts such as the concept of liberty in the due process and equal protection clauses of the fifth and fourteenth amendments, the open category of rights ‘retained by the people’ in terms of the ninth amendment, and the so called penumbra of rights in the first, third, fourth and eighth amendments.⁴²⁸

In *Roe v Wade*⁴²⁹ the United States Supreme Court recognised a constitutional right to privacy independent of any protections the Fourth Amendment could afford. In this case it was found that a state law that prohibited abortion under any circumstances, “except to save the life of the mother was an unlawful invasion of an individual’s constitutional, non-Fourth Amendment privacy right”.⁴³⁰ In *Roe v Wade*⁴³¹ the court found that there are circumstances where a person’s right to privacy outweighs the state’s interest in protecting a would-be life.⁴³²

The first case that tried to develop an implied constitutional right of privacy independent of the Fourth Amendment was *Griswold v Connecticut*.⁴³³ In this case it was held that a Connecticut law that forbade the use of contraceptives unconstitutionally intruded upon a person’s right to marital privacy.⁴³⁴ “*Griswold* signalled an analytical shift from the Fourth Amendment cases rights-based approach toward a broader interpretation of constitutional interests”, were the interests where balanced against government interests.⁴³⁵ Justice Douglas found a penumbral right to privacy arising from the Constitution

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Ibid.

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Rautenbach (2001) “The conduct and interests protected by the right to privacy in Section 14 of the Constitution” *TSAR* 115.

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Roe v Wade 410 US 113 (1973).

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Van der Goes (1999) “Opportunity lost: why and how to improve the HHS proposed legislation governing law enforcement access to medical records” 147 *University of Pennsylvania law review* 1030.

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Roe v Wade 410 US 113 (1973).

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Glenn (2000) “Protecting health information privacy: the case for self-regulation of electronically held medical records” *Vanderbilt law review* 1615.

433

Griswold v Connecticut 381 US 479 (1965).

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Van der Goes (1999) “Opportunity lost: why and how to improve the HHS proposed legislation governing law enforcement access to medical records” *University of Pennsylvania law review* 1031.

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Van der Goes (1999) *University of Pennsylvania law review* 1032.

and its First, Fourth and Fifth Amendments.⁴³⁶ Commentators have argued that because of this shift in reasoning there has been a development of privacy rights.⁴³⁷ *Katz*⁴³⁸ overturned this concept in 1967, after it had gradually gained favour through the years.

Using *Roe v Wade* as a foundation, the Court in *Whalen v Roe*⁴³⁹ issued its most comprehensive definition privacy.⁴⁴⁰ It said privacy comprised both an “individual interest in avoiding disclosure of personal matters” or the right to confidentiality and an “interest in independence in making certain kinds of important decisions” or the right to autonomy.⁴⁴¹ This case involved the constitutionality of a New York statute that made the keeping of a centralised computer database of prescriptions for certain lawful but potentially highly addictive drugs mandatory. The Court upheld the statute, that the keeping of a centralised database did not unconstitutionally invade the patients’ privacy interests, but only after it was satisfied that the state was taking adequate safety precautions to maintain the privacy of the patients concerned.⁴⁴²

It acknowledged the potential harm that could be caused if adequate safety mechanisms were not in place. The Court refused to decide whether it would uphold a statute without these safeguards saying: “ ‘we ... need not, and do not, decide any question which might be presented by ... a system that did not contain comparable security provisions.’”⁴⁴³ The majority decision declined to expressly establish a constitutional right to privacy in an individual’s medical record.⁴⁴⁴ The court recognised that “the accessibility of the data was troubling, and indicated that future technological developments might create the need to revisit this balancing and to restrict the government’s use of technology that would place privacy rights at risk.”⁴⁴⁵ Since 1977 great strides have been made

⁴³⁶ Eddy (2000) “A critical analysis of Health and Human Services’ proposed health privacy regulations in light of the Health Insurance Privacy and Accountability Act of 1996” *Annals of health law* 9.

⁴³⁷ Glenn (2000) 53 *Vanderbilt law review* 1614.

⁴³⁸ *Katz v United States* 389 US 347 (1967)

⁴³⁹ *Whalen v Roe* 429 US 589, 599-600 (1977).

⁴⁴⁰ Glenn (2000) 53 *Vanderbilt law review* 1615.

⁴⁴¹ Van der Goes (1999) 147 *University of Pennsylvania law review* 1033; Rackett (1997) 25 *Fordham Urb L J* 177.

⁴⁴² Van der Goes (1999) 147 *University of Pennsylvania law review* 1033.

⁴⁴³ Eddy (2000) 9 *Annals of health law* 10.

⁴⁴⁴ Glenn (2000) 53 *Vanderbilt law review* 1610.

⁴⁴⁵ Van der Goes (1999) 147 *University of Pennsylvania law review* 1033.

in the information technology business, which in turn has increased the accessibility of medical records via e-mail or the Internet. According to Glenn the Court should return to this issue because of the drastic changes in access to medical information since the *Whalen v Roe*⁴⁴⁶ decision.⁴⁴⁷

There has been a lot of criticism by commentators about the penumbral right of privacy since its inception. This has been because the right is not unequivocally stated in the Constitution and because the courts have asserted the right in a number of cases. Since *Whalen* the Supreme Court has been more hesitant to strengthen the privacy interests of people in the medical records context. Despite *Whalen's* cautionary language against doing so, lower courts have read the *Whalen* decision as severely limiting the right to informational privacy, thereby shifting the balance strongly in favour of governmental interests.⁴⁴⁸

In the USA, constitutional rights are usually not applicable unless “state action” can be found. The Constitution in other words, protects the individual from the government and not from private entities. Secondly, the rights created by the Constitution are “negative rights”, in other words they prevent certain kinds of governmental action, and at the same time there is no duty on the government to actively protect a person against invasion of his or her information privacy rights.⁴⁴⁹

The Supreme Court has not provided clear guidance on whether the Constitution protects the privacy of individuals’ medical records from unauthorised intrusion. As a result the circuits have split on the issue. The Sixth Circuit has found that no such right exists⁴⁵⁰ while the Third Circuit⁴⁵¹ has strongly disagreed.⁴⁵²

⁴⁴⁶ *Whalen v Roe* 429 US 589, 599-600 (1977).

⁴⁴⁷ Glenn (2000) 53 *Vanderbilt law review* 1611.

⁴⁴⁸ Van der Goes (1999) 147 *University of Pennsylvania law review* 1034.

⁴⁴⁹ Roos, A (2003) *The law of data (privacy) protection, a comparative and theoretical study* LLD Unisa 38.

⁴⁵⁰ *Jarvis v Wellman* 52 F3d 125, 126 (6th Cir 1995) where it was held that that the disclosure of a plaintiff’s medical records “does not rise to the level of a breach of a right recognized as ‘fundamental’ under the Constitution.”

⁴⁵¹ *Doe v SEPTA* 72 F 3d 125, 126 (6th Cir 1995) where it was held that “employee medical records deserve a measure of constitutional protection ;see also *United States v Westinghouse* 638 F.2d 570, 580 (3d Cir 1980).

⁴⁵² Glenn (2000) 53 *Vanderbilt law review* 1611.

Two lower court cases in particular demonstrate the judicial balancing framework and ultimate lessening of privacy interests in health information, namely *United States v Westinghouse*⁴⁵³ and *Doe v Southeastern Pennsylvania Transportation Authority (SEPTA)*^{454 455}

In *United States v Westinghouse*⁴⁵⁶ it was found that employees constitutional privacy rights were not sufficient to overcome a governmental demand for their confidential medical records for the purpose of investigating whether employees had been subjected to hazardous substances.⁴⁵⁷ For a court to allow intrusion into the privacy surrounding medical records, it must find that the “societal interest outweighs the privacy interest on the specific facts of the case.”⁴⁵⁸ To properly balance these competing interests, the *Westinghouse* court developed a seven-factor test to decide whether an intrusion into an individual’s privacy is justified.⁴⁵⁹

The following seven factors must be taken into account when deciding whether there is any justification for intruding into somebody’s privacy. The court did not indicate whether all the factors must be met before access to private medical information can be given, but it did find that the government satisfied every factor.⁴⁶⁰

1. the type of record requested
2. the information the record does or might contain
3. the potential for harm in any subsequent non-consensual disclosure
4. the injury from disclosure to the relationship in which the record was generated
5. the adequacy of safeguards to prevent unauthorised disclosure
6. the degree of need for access
7. whether there is an express statutory mandate, articulated public policy or other recognisable public interest favouring access⁴⁶¹

⁴⁵³ *United States v Westinghouse* 638 F.2d 570, 580 (3d Cir 1980).

⁴⁵⁴ *Doe v Southeastern Pennsylvania Transport Authority (SEPTA)* 72 F 3d 1133, 1135 (3d Cir 1995).

⁴⁵⁵ Van der Goes (1999) 147 *University of Pennsylvania law review* 1034.

⁴⁵⁶ *United States v Westinghouse* 638 F.2d 570, 580 (3d Cir 1980).

⁴⁵⁷ Van der Goes (1999) 147 *University of Pennsylvania law review* 1034.

⁴⁵⁸ Glenn (2000) 53 *Vanderbilt law review* 1617.

⁴⁵⁹ Glenn (2000) 53 *Vanderbilt law review* 1618.

⁴⁶⁰ *Ibid*

⁴⁶¹ Van der Goes (1999) 147 *University of Pennsylvania law review* 1034.

Although the Court in *Westinghouse* found such a constitutional protection of one's medical records exist, it refused to find that the plaintiff's constitutional right was violated, thus weakening the practical impact and arguably the precedential value of such a right.⁴⁶² According to Glenn *Westinghouse* created "a paradigm for determining when an intrusion into private medical records rises to the level of a constitutional violation."⁴⁶³

The *Westinghouse* test was again applied by the Third Circuit in *Doe v SEPTA*⁴⁶⁴. *SEPTA* (Southeastern Pennsylvania Transportation Authority) emphasised the move away from informational privacy rights towards valid interests of government. The court in *Doe* recognised that *Westinghouse's* seventh factor relating to the public interest intrusion outweighed many of the other factors weighing in favour of *Doe's* privacy rights.⁴⁶⁵ The court found that the "employer's need to access prescription records outweighed the employee's privacy interest in a case in which an employer discovered that an employee has AIDS based on the employee's drug purchases made through the employee health plan."⁴⁶⁶

In contrast to the Third Circuit's complete study of the constitutional zone of privacy surrounding medical records, the Sixth Circuit, in 1995, held that the Constitution does not provide a general right to nondisclosure of private information. The court in *Jarvis v Wellman*⁴⁶⁷ stated "inferring very broad constitutional rights where the Constitution itself does not express them is an activity not appropriate to the judiciary"⁴⁶⁸. The Sixth Circuit has held that "unwarranted disclosure of medical information does not violate the Constitution because such disclosure fails to infringe upon a fundamental right, and thus the court should not be involved."⁴⁶⁹

More recently, in 1999, the Fourth Circuit noted the argument over whether an individual possesses a constitutional right to privacy in medical records, but declined

⁴⁶² Glenn (2000) 53 *Vanderbilt law review* 1611; see *Westinghouse* 638 F 2d at 576.

⁴⁶³ Glenn (2000) 53 *Vanderbilt law review* 1619.

⁴⁶⁴ *Doe v Southeastern Pennsylvania Transport Authority* (SEPTA) 72 F 3d 1133, 1135 (3d Cir 1995).

⁴⁶⁵ Van der Goes (1999) 147 *University of Pennsylvania law review* 1035.

⁴⁶⁶ Van der Goes (1999) 147 *University of Pennsylvania law review* 1034.

⁴⁶⁷ *Jarvis v Wellman* 52 F 3d 125, 126 (6th Cir 1995).

⁴⁶⁸ Glenn (2000) 53 *Vanderbilt law review* 1620.

to definitively decide the question. The *Ferguson v City of Charleston*⁴⁷⁰ Court concluded that “even if Appellants possess a constitutional interest in the nondisclosure of their medical records, that interest is outweighed by the interest of the government in disclosure.”⁴⁷¹

Van der Goes feels that circuit court cases subsequent to *Whalen* show that deference to government interests has become almost impossible to overcome and that almost any police action intruding upon private medical records would survive judicial review. He said, “when courts employ a flexible balancing approach and the government can assert some legitimate purpose, many privacy interests appear insufficient to overcome the courts’ deference to the State.”⁴⁷²

4.3.1 Fourth Amendment protection of medical records

The Federal constitutional right to privacy can be traced back to Louis Brandeis. He advocated that the Fourth Amendment be broadly interpreted to insure that the government refrained from intruding into individuals’ privacy. Brandeis stated in his dissent in *Olmstead v United States*⁴⁷³ that “every unjustifiable intrusion by the government upon the privacy of the individual, whatever the means employed, must be deemed a violation of the Fourth Amendment.”⁴⁷⁴

The Fourth Amendment ban against unreasonable searches and seizures may appear to be the most likely source of constitutional protection against wrongful law enforcement access to private medical records.⁴⁷⁵ Many cases dealing with medical records privacy in the Fourth Amendment context use reasoning based on *United States v Miller* case.⁴⁷⁶ This case investigated the validity of “subpoenas ordering production of all records of the bank accounts held by two of the defendant’s banks.”⁴⁷⁷ The Supreme Court found that in no area in which the defendant had a protected Fourth Amendment

⁴⁶⁹ *Ibid*; as quoted from *Jarvis v Wellman* at 126.

⁴⁷⁰ *Ferguson v City of Charleston* 186 F 3d 469, 482-83 (4th Cir 1999).

⁴⁷¹ Glenn (2000) 53 *Vanderbilt law review* 1620; as quoted from *Ferguson v City of Charleston* 1999 at 483.

⁴⁷² Van der Goes (1999) 147 *University of Pennsylvania law review* 1036.

⁴⁷³ *Olmstead v United States* 277 US 438, 478 (1928).

⁴⁷⁴ Eddy (2000) 9 *Annals of health law* 9.

⁴⁷⁵ Van der Goes (1999) 147 *University of Pennsylvania law review* 1030.

⁴⁷⁶ *United States v Miller* 425 US 435, 440 (1976) .

⁴⁷⁷ Van der Goes (1999) 147 *University of Pennsylvania law review* 1038.

interest, had there been an intrusion.⁴⁷⁸ Although *Miller* deals with financial records, it is still relevant to medical record privacy.

Commentators have stated that a similar result to that of *Miller* would occur if a similar case involving medical information were to come before the Supreme Court, since *Miller* effectively governs the medical record context.⁴⁷⁹ Van der Goes states that despite severe criticism of the reasoning in *Miller* and the harm that it causes to Fourth Amendment protections of privacy, the essence of the case remains good in law. Very importantly, *Miller* “often serves as the philosophical foundation of court decisions which attack and undermine the expectation of privacy” that people often declare with regards to law enforcement intrusion into personal health information.⁴⁸⁰

The defendant in *Miller* appealed to the reasoning of *Katz v United States*.⁴⁸¹ *Katz* extended the Court’s previously restrictive view that “property interests control the right of the Government to search and seize”, and held that searches and seizures become unreasonable when the government’s activities run afoul of the privacy upon which individuals justifiably rely.⁴⁸² In *Katz* the court also stressed, “what a person knowingly exposes to the public is not a subject of Fourth Amendment protection.”⁴⁸³ However, information normally exchanged between a physician and patient would not be easily classified as such.

In *Miller* the court held that “there can be no protected privacy interest where there is neither ‘ownership nor possession’ of the thing sought to be kept private.” This reasoning fails to grasp the realities of modern technology and has led to considerable erosion of privacy protections regarding medical records.⁴⁸⁴

Van der Goes feels the approach followed in *Katz* is more appropriate. The court focused on two issues:

⁴⁷⁸ Van der Goes (1999) 147 *University of Pennsylvania law review* 1039.

⁴⁷⁹ *Ibid.*

⁴⁸⁰ *Ibid.*

⁴⁸¹ *Katz* 389 US 347 (1967).

⁴⁸² Van der Goes (1999) 147 *University of Pennsylvania law review* 1038.

⁴⁸³ *Ibid*; quoting *Katz* 389 US at 351.

⁴⁸⁴ Van der Goes (1999) 147 *University of Pennsylvania law review* 1040.

- 1) whether the defendant ‘exhibited an actual (subjective) expectation of privacy’ in the records; and
- 2) if so, whether that expectation is one that society is prepared to recognise as reasonable.⁴⁸⁵

Taking into account the public response to the *HHS Report* it seems that society appears to be willing to accept as reasonable general principles that strengthen medical record confidentiality laws.⁴⁸⁶

Glenn states that while older models such as the Hippocratic Oath gave physicians the exclusive power to protect patient privacy, “constitutional protections lack the capacity to protect privacy invasions from private actors seeking personal information.”⁴⁸⁷ He notes that at the present time it appears that “judicial formulations will rarely, if ever, allow individual privacy interests to trump the government’s interest in disclosure.”⁴⁸⁸ Even if the United States Constitution were interpreted to protect privacy rights in medical records, it would only apply to records held by the government. Many people do perceive the government as being a greater threat to their privacy, than private companies, but the reality of the situation is that medical care is becoming increasingly privatised. Glenn says, “although the Constitution may, in fact, offer a partial solution to the problems surrounding medical information privacy, such a solution remains inadequate in a modern context.”⁴⁸⁹

4.4 Legislation protecting confidentiality

4.4.1 Federal laws

The USA is a good example of a self-regulatory type enforcement system. Industries in the private sector are encouraged to self-regulate. USA privacy policies are derived from the Constitution, in part from federal laws, in part from state law and in part from

⁴⁸⁵ Van der Goes (1999) 147 *University of Pennsylvania law review* 1040-41; quoting *Katz* 389 US at 361.

⁴⁸⁶ Van der Goes (1999) 147 *University of Pennsylvania law review* 1041.

⁴⁸⁷ Glenn “Protecting health information privacy: the case for self-regulation of electronically held medical records” (2000) 53 *Vanderbilt law review* 1612.

⁴⁸⁸ Glenn (2000) 53 *Vanderbilt law review* 1621.

⁴⁸⁹ Glenn (2000) 53 *Vanderbilt law review* 1621-1622.

the common law.⁴⁹⁰ The USA has adopted a flexible approach to privacy protection and believes that self-regulatory initiatives combined with a governmental enforcement backstop, are effective tools for achieving meaningful privacy protections. However in certain highly sensitive areas such as medical records, legislative solutions are more appropriate.⁴⁹¹

Because there is no comprehensive privacy legislation, there is also no oversight agency. Individuals with complaints about privacy must engage in expensive lawsuits or they have no recourse at all.⁴⁹²

Congress has enacted federal legislation that affects peoples' health information privacy and law enforcement's access to such records. The two main statutes governing the issue are the *Privacy Act*⁴⁹³ and the *Freedom of Information Act (FOIA)*^{494 495}.

4.4.1.1 Privacy Act

The Privacy Act regulates the information practices of federal agencies by ensuring that federal agencies utilise fair information practices with regard to the collection, management, use, and dissemination of any record within a system of records.⁴⁹⁶ Disclosure of information to another person or agency is prohibited without prior written consent from the person to whom the data relates. The Privacy Act also allows a person to review, copy, and correct any mistakes pertaining to his own record. There are however ways to avoid the Privacy Act's central purpose of privacy protection. Federal organisations "may disclose and use information for so-called 'routine use', so that health information can be used for any 'purpose which is compatible with the purpose for which [the health data] was collected."⁴⁹⁷ The Privacy Act also provides considerable exceptions for law

⁴⁹⁰ South African Law Reform Commission (2005) 245-6.

⁴⁹¹ South African Law Reform Commission (2005) 274.

⁴⁹² South African Law Reform Commission (2005) 247.

⁴⁹³ *Privacy Act* 5 USC § 552a (1994).

⁴⁹⁴ *Freedom of Information Act* 5 USC § 552a(b)(7).

⁴⁹⁵ Van der Goes (1999) 147 *University of Pennsylvania law review* 1041.

⁴⁹⁶ *Ibid.*

⁴⁹⁷ Van der Goes (1999) 147 *University of Pennsylvania law review* 1042; see also according to Rackett (1997) 178 the many exceptions; § 552a(b)(1) which permits disclosure to agency employees who have a need for the information to do their job; § 552a(b)(3) which allows disclosure for "routine use" purposes; § 552a(b)(4) permits disclosure to the Bureau of Census for survey purposes; § 552a(b)(5) allows disclosure for statistical purposes; § 552a(b)(6) allows disclosure

enforcement authorities.⁴⁹⁸ The act allows for civil remedies, and occasionally criminal penalties, if a disclosure is made in wilful contravention of the Act. The act also provides no protection for privately held information.⁴⁹⁹

Most commentators believe that the *Privacy Act* has limited utility in ensuring the confidentiality of health care records for two reasons. Firstly, it does not apply to the vast majority of entities collecting health information outside the federal government and secondly it permits disclosure of personally identifiable information to another agency if the information is deemed necessary for the “routine use” of the receiving agency. This is a very broad exception. Other exceptions include “compelling reasons” affecting health or safety or for statistical or research purposes if the record is unidentifiable.⁵⁰⁰

4.4.1.2 Freedom of Information Act⁵⁰¹

The *Freedom of Information Act* requires that records of the executive branch of the federal government be made available to the public, with the exception of matters falling within nine explicitly exempted areas in the act.⁵⁰²

Medical records may under certain circumstances be exempt from FOIA requirements. One of the exempt categories includes ‘personnel and medical files and similar files, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.’ The severity of the invasion must outweigh the public’s interest in disclosure.⁵⁰³

The *Freedom of Information Act* (FOIA) is intended to protect the rights of citizens to obtain access to government information held by federal agencies. There are however a number of exceptions in the FOIA that permits agencies to withhold information to protect confidential records from improper disclosure. “For example, HHS typically uses Exemption Three to protect health data, and the Centres for Disease Control (CDC) has relied in the past on Exemption Four for similar purposes”. Exemption Six protects

for historical preservation purposes; § 552a(b)(8) allows disclosure if compelling circumstances affecting the health and safety of others can be shown.

⁴⁹⁸ Van der Goes (1999) 147 *University of Pennsylvania law review* 1043.

⁴⁹⁹ Glenn (2000) 53 *Vanderbilt law review* 1624; see according to Rackett 42 USC § 290dd-2(a); 42 CFR § 482.1.

⁵⁰⁰ Gates & Arons (2000) 108.

⁵⁰¹ *Freedom of Information Act* 5 USC § 552a(b)(7)

⁵⁰² Dennis (2000) *Privacy confidentiality of health information* 11.

⁵⁰³ Dennis (2000) *Privacy confidentiality of health information* 12.

'medical files' if their disclosure 'would constitute a clearly unwarranted invasion of personal privacy.'⁵⁰⁴ The *Privacy Act* does not protect information that must be disclosed under the FOIA. This limits the FOIA's effectiveness even further.⁵⁰⁵ Courts that review an application for disclosure of information under the FOIA, must employ a balancing test that weighs the individual's privacy right against the public's interest in the information in question.⁵⁰⁶ Normally agencies have the discretion, not the duty, to withhold disclosure if one of the exemptions applies and the agencies decision can only be reversed if the decision is seen as "arbitrary or capricious"⁵⁰⁷.

Gates & Arons maintain that the (FOIA) exempts from discovery "privileged or confidential data" (exemption 4) and "personnel and medical files" if the disclosure would invade personal privacy (exemption 6). The agency holding the data may in both situations, claim exemption from discovery, but is not required to do so.⁵⁰⁸

While federal operated hospitals and private healthcare facilities under contract with the federal government are covered by the *Privacy Act*, other institutions, such as those that are exclusively private are not covered by the *Privacy Act*.⁵⁰⁹ It applies to few hospitals outside of the Veterans Affairs (VA) and Defence Department hospital system. Under the FOIA, medical information is exempted from disclosure only when the disclosure would "constitute a clearly unwarranted invasion of personal privacy". "Some federal and state statutes give governmental agencies access to medical records on request or through administrative subpoena." Professional review organisations (PROs) have on request access to all medical records relevant to their federal review functions.⁵¹⁰

4.4.1.3 HIPAA Privacy Rule⁵¹¹

Van der Goes maintains that the "rapid and fundamental changes in technology, information systems, and the health care industry [has] created an environment in which

⁵⁰⁴ Van der Goes (1999) 147 *University of Pennsylvania law review* 1043.

⁵⁰⁵ Glenn (2000) 53 *Vanderbilt law review* 1625.

⁵⁰⁶ *Ibid.*

⁵⁰⁷ Van der Goes (1999) 147 *University of Pennsylvania law review* 1044.

⁵⁰⁸ Gates & Arons (2000) 108.

⁵⁰⁹ Glenn (2000) *Vanderbilt law review* 1625.

⁵¹⁰ Miller (2000) 560-561.

⁵¹¹ *Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996)*; its primary focus is health information standardisation, not privacy.

medical records are more accessible, and more frequently accessed, than anyone imagined even ten years ago.”⁵¹²

This resulted in a call from citizens’ groups and privacy advocates to the American federal government to replace the patchwork of inconsistent and incomplete state and federal laws protecting medical records privacy rights.⁵¹³ They called for the creation of a single, uniform, strong federal law.⁵¹⁴ The scale and complexity of the United States health care system unsurprisingly requires a complex structure of legal rules to maintain the confidentiality of health information. As a result of the complexities of the system it is impossible for individual patients to know whether these systems really safeguard their medical data. The object of the law must therefore be to protect privacy and to try and also produce public trust in institutions.⁵¹⁵

The new rules have three purposes. Firstly they are there to protect and enhance the rights of consumers by providing them access to their health information. Secondly their purpose is to improve the quality of health care in the USA by restoring trust in the health care system by all involved and thirdly to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection.⁵¹⁶

Unfortunately, the large number of exemptions limits the protection offered by the new rules. Examples include patient information being used for marketing and fundraising purposes. The federal regulation (Standards for privacy of individually identifiable health information – known as HIPAA Privacy Rule) became⁵¹⁷ effective for enforcement in April 2003. This Rule contains civil penalties for non-compliance and is enforced by the Office for Civil Rights within the Department of Health and Human Services. Criminal penalties for malicious misappropriation and misuse of health information, is enforced by the Department of Justice.

⁵¹² Van der Goes (1999) *Univ of Pennsylvania law review* 1011.

⁵¹³ Van der Goes (1999) *Univ of Pennsylvania law review* 1012.

⁵¹⁴ Roach (1998) 91 says that statutory provisions concerning health information are often scattered throughout the state’s code, for example in medical records act, hospital licensing act, medical practice act, HMO act etc. Most importantly protection can vary from state to state. Lack of uniform standards can cause problems where “interstate health care transactions, telemedicine, and ERISA health plans are common.”

⁵¹⁵ Starr (1999) *American journal of law and medicine* 193.

⁵¹⁶ Furrow B *et al.* (2005) [United States of America] *International encyclopaedia of law: Medical law* 104.

⁵¹⁷ South African Law Reform Commission (2005) 381.

The enactment of HIPAA was the start to the beginning of a complete federal legal structure addressing health information privacy. HIPAA clearly sets out standards and methods of how de-identification of records should be undertaken.⁵¹⁸

Glenn feels that because federal legislation offers protection for medical records based on the characteristics of the entity seeking access, it provides only a fragmented and unsatisfactory solution on its own. State legislation is however faced with similar problems and they have the added “difficulty of not having any real impact on medical information that crosses state lines, because this information is considered interstate commerce. These records become subject to federal, not state regulation.”⁵¹⁹ Glenn goes on to say that although the existing legislation may provide widespread protection of medical records held by government bodies, it covers very little else. The federal laws and regulations impose virtually no restrictions on what private healthcare providers may disclose to third parties. The few rules that do provide for privately held information, such as the HHS regulations, are limited by the fight over “whether federal legislation might actually erode protection of private medical records by pre-empting tougher state laws.”⁵²⁰

In response to HIPAA, the HHS⁵²¹ issued a report laying out its recommendations for a federal law. The report was entitled *Confidentiality of Individually-Identifiable Health Information* or the *HHS Report*. Van der Goes criticises the HHS report for failing to modify the general exception for law enforcement access to medical records.⁵²²

The standards of the report would still like some federal legislation in place for several reasons:

1. “HIPAA limits the application of the rules to health plans⁵²³, health care clearing-houses, and any health care provider who transmits health information in electronic form” Paper records are therefore not covered which severely limits the acts application.

⁵¹⁸ South African Law Reform Commission (2005) 90.

⁵¹⁹ Glenn (2000) *Vanderbilt law review* 1622.

⁵²⁰ Glenn (2000) *Vanderbilt law review* 1625; see also Hussong's view on p 92.

⁵²¹ Department of Health and Human Services (HHS).

⁵²² Van der Goes (1999) *Univ of Pennsylvania law review* 1012.

2. No enforcement authority such as a private right of action for individuals to sue for breach of confidentiality is provided for in HIPAA.⁵²⁴

Unlike some federal legislation, the rules do not require a different level of protection depending on the sensitivity of the information. The principle of “minimum necessary” is followed; this means the least amount of information needed to achieve the purpose is disclosed.⁵²⁵

A major criticism is that “doctor, hospitals, and plans could freely share patient information without consent so long as the purpose was treatment, payment and health care purposes generally.” Patients also have no right to learn who has received access to their record without consent.⁵²⁶

4.4.2 State level legal framework

The United States Constitution prevents only governmental invasions of privacy, and therefore Congress allows states to create their own laws to protect their citizens from private actors. At least ten states⁵²⁷ guarantee their citizens an express, albeit general, privacy right, while eight states have developed comprehensive medical confidentiality laws.⁵²⁸

Hussong feels that a much-debated issue surrounding privacy legislation is whether federal law should preempt state law.⁵²⁹ State laws are weak in affording patients the right to view and copy their medical records. Many states also do not require the patients’ consent for health care organisations, doctors, researchers and law enforcement officials to view patients’ records. However state laws have certain strengths such as providing patients with more protection against disclosure of their medical records with-

⁵²³ Health plan is defined as “an individual plan or group health plan that provides, or pays the cost of medical care.”

⁵²⁴ Furrow *et al* (2000) *Health law* 171.

⁵²⁵ Furrow *et al* (2000) 172.

⁵²⁶ Furrow *et al* (2000) 173.

⁵²⁷ See according to Eddy, McWirtter & Bible (1992) *Privacy as a constitutional right* 174, 175 n5 where the ten states are mentioned namely Alaska, Arizona, California, Florida, Hawaii, Illinois, Louisiana, Montana, South Carolina and Washington).

⁵²⁸ Rackett (1997) *Fordham Urb L J* 181; Eddy (2000) *Annals of health law* 10.

⁵²⁹ Hussong (2000) *American journal of law & medicine* 453.

out their consent. State laws usually provide more detailed rules protecting people from disclosure of sensitive conditions, such as mental illness, communicable diseases, cancer, or a genetic predisposition to certain diseases. The HHS rules do not override stronger state laws. Unless Congress implements legislation specifically implementing federal pre-emption, the HHS regulations will remain the national privacy law, and will continue to defer to stronger state laws. Advocates of federal pre-emption maintain that federal law will provide much needed uniformity. Health care organisations and insurers often operate across state lines, and inconsistent state laws cause confusion and increase administrative costs.⁵³⁰ However, others claim that federal legislation cannot address a population's specific needs.⁵³¹

Van der Goes states that although legal developments in state courts and legislatures have provided some protection for a person's medical information, these sources of law are characterised "more by their diversity and conflicting standards than by the quality of protection they afford".⁵³² There is a great variation in the level of protection offered people by state law governing medical records privacy. The most restrictive limitation of state legislation is the lack of consistency among the states. "When the law is comprehensive and well-considered, it can provide substantial protections". However, commentators have observed that only a few states' medical confidentiality laws tend to fit this description.⁵³³

A number of state constitutions include constitutional amendments designed to protect private information. Many of the techniques that the states use to create privacy protections mirror those used at the federal level, and they also have similar defects.⁵³⁴ State constitutional protections, like the Federal Constitution are inherently weak, in that they protect only against invasions of privacy by state actors.⁵³⁵

Van der Goes states that from his overview it becomes clear that, "existing legal protections afforded to individuals seeking to assert a privacy interest in their health records and prevent law enforcement intrusion are more disparate than standardized, more am-

530

Ibid.

531

Ibid.

532

Van der Goes (1999) *University of Pennsylvania law review* 1044.

533

Van der Goes (1999) *University of Pennsylvania law review* 1047.

534

Glenn (2000) *Vanderbilt law review* 1609.

535

Glenn (2000) *Vanderbilt law review* 1626.

biguous than defined, more conflicted than robust, and more incomplete than comprehensive.”⁵³⁶

5. Summary

The SALRC submits that effective information protection will only be achieved through regulation by legislation. This is due to firstly, the inherent conservatism of our courts, as well as the fact that the protection of privacy is still in its infancy in South African law. It is improbable that the application of the information principles by the courts will occur often or extensively enough in the future to ensure the protection of personal information. Major law reform should be the task of the legislature and not the judiciary, especially when it involves more than a few incremental changes to the common law.⁵³⁷

Therefore the SALRC has proposed with the *Draft Bill on the Protection of Personal Information* a regulatory enforcement system similar to that of Canada and not the flexible self-regulatory initiatives found in the USA.

Canada makes use of a regulatory enforcement system, which makes provision for a comprehensive Act setting out the Principles of information protection as well as provisions dealing with the monitoring and enforcement of these principles. The USA on the other hand is a good example of a self-regulatory type enforcement system. Industries in the private sector are encouraged to self-regulate.

USA privacy policies are derived from the Constitution, in part from federal laws, in part from state law and in part from the common law.⁵³⁸ The USA has adopted a flexible approach to privacy protection and believes that self-regulatory initiatives combined with a governmental enforcement backstop, are effective tools for achieving meaningful privacy protections. A wide assortment of privacy laws is found in the individual states and at the federal level, but no comprehensive privacy protection law has been enacted for the privacy sector. There is also no independent privacy oversight agency in the United States

⁵³⁶ Van der Goes (1999) *University of Pennsylvania law review* 1049.

⁵³⁷ South African Law Reform Commission (2005) 53.

⁵³⁸ South African Law Reform Commission (2005) 245-6.

The huge amount of literature that is available on the subject of privacy, has unfortunately failed to provide a clear or consistent meaning for the concept of privacy and therefore the jurisprudential discourse lacks coherence. As a result Devenish feels that American and foreign jurisprudence must be used with a considerable measure of circumspection by South African courts.⁵³⁹

The precise ambit of the right to privacy will have to be demarcated by the Constitutional Court and the application of the right, will not necessarily find expression in South African law, in the same way that courts in other jurisdictions have adjudicated on the particular right. The particular terminology used in the Bill of Rights as well as the South Africa's particular socio-economic and political circumstances also need to be taken into account. What needs to be asked is, what is a reasonable expectation of privacy in South Africa?⁵⁴⁰ How the right is interpreted will depend on both intellectual trends and the jurisprudence of the judges of the Constitutional Court, which means that the right to privacy is in a state of flux.⁵⁴¹

⁵³⁹ Devenish (2005) *The South African Constitution* 86.

⁵⁴⁰ Devenish (2005) 87.

⁵⁴¹ *Ibid.*

CHAPTER 3

Causes of action & defences for breach of medical confidentiality

1 Introduction

In this chapter a comparative study is made of the different causes of action and defences or grounds of justification that can be used when a breach of medical confidentiality occurs.

2 Causes of action in South Africa

2.1 Causes of action in general

Taitz states that an improper or unjustified breach of medical confidentiality by the doctor may bring an action against him by the patient for damages arising from 1) breach of the doctor-patient contract 2) defamation or 3) invasion of the patient's privacy.⁵⁴²

Strauss observes that generally speaking the disclosure of confidential information to an outsider, by a doctor without a patient's consent, is an actionable wrong, unless there are grounds of justification, such as necessity. This means that the patient may sue the doctor for damages for any harm caused by the disclosure and / or, at the very least, may apply for an interdict to restrain the doctor from continuing such disclosure.⁵⁴³

According to Van Oosten, at common law disclosure of the patient's private affairs may constitute civil and / or criminal *injuria*, defamation and even breach of contract.⁵⁴⁴

A plaintiff who wants to recover sentimental damages under the *actio injuriarum* must prove the elements of the action, but need not prove special damages. If the plaintiff

⁵⁴² Taitz "The rule of medical confidentiality v the moral duty to warn an endangered third party" (1990) 78 *SAMJ* 29.

⁵⁴³ Strauss "Professional secrecy and computerisation of patient data" (1958) *South African practice management* 5.

⁵⁴⁴ Van Oosten [South Africa] *International encyclopaedia of law: Medical law* (1996) 91.

proves that he has suffered pecuniary loss, such loss may also be recovered.⁵⁴⁵ McQuoid-Mason states that an action for negligent invasion of privacy could lie only where the plaintiff proves patrimonial loss.⁵⁴⁶

Legislative prohibitions against disclosure of confidential information might also well serve as the basis of a successful action based on breach of statute or in negligence.⁵⁴⁷

2.2 Defamation

Neethling defines defamation as “the wrongful, intentional publication of words or behaviour concerning another person which has the effect of injuring his status, good name or reputation.”⁵⁴⁸ Privilege, fair comment and truth and public interest are all important grounds of justification for defamation.⁵⁴⁹

It is important to distinguish between embarrassing and defamatory disclosures made by doctors concerning private medical records. If the disclosures are not defamatory, and would not lower a person’s reputation in the eyes of others but are embarrassing, they may be actionable as an invasion of privacy. It is a question of policy whether the disclosures should be recognised as actionable. Our courts are unlikely to restrict publication of items that are genuinely in the public interest, and they are also reluctant to restrict freedom of speech.⁵⁵⁰

2.3 Breach of confidence

In *Dun & Bradstreet (Pty) Ltd v SA Merchants Combined Credit Bureau (Cape) Pty Ltd*⁵⁵¹ the court held that the English law concept of “breach of confidence” did not form part of South African law as long as the action could be brought within the general principles of the *actio injuriarum* or *lex Aquilia*.⁵⁵² However, Copeling points out, that *Dun’s* case did not refer to *Goodman v Von Moltke*⁵⁵³, and suggests that “breach of confi-

⁵⁴⁵ McQuoid-Mason (1978) *The law of privacy in South Africa* 131-132.

⁵⁴⁶ McQuoid-Mason (1978) 98.

⁵⁴⁷ Steel & Rodgers-Magnet (1983) *Issues in tort law* 291.

⁵⁴⁸ Neethling, Potgieter, Visser *Law of delict (1994)* 319.

⁵⁴⁹ Neethling, Potgieter, Visser (1994) 323.

⁵⁵⁰ McQuoid-Mason (1978) 187.

⁵⁵¹ *Dun & Bradstreet (Pty) Ltd v SA Merchants Combined Credit Bureau (Cape) Pty Ltd* 1968 (1) SA 209 (C).

⁵⁵² McQuoid-Mason (1978) 189.

⁵⁵³ *Goodman v Von Moltke* 1938 CPD 153.

“... should be recognised in our law.”⁵⁵⁴ In *Goodman* Judge Centlivres said it “is actionable to communicate information in breach of an agreement not to do so, and such agreement may be express or may be implied from the fact that the person upon whom it is alleged to be binding is or was in the employ of the plaintiff or in other confidential relationship with him.”⁵⁵⁵ McQuoid-Mason maintains that Van der Merwe and Olivier appear to regard *Goodman*’s case as decided on the basis of contract.⁵⁵⁶

The leading case in South Africa on medical confidentiality is that of *Jansen van Vuuren v Kruger*⁵⁵⁷. A unanimous bench of five judges upheld an appeal in a breach of confidentiality claim against a doctor.

Facts of the case:

The defendant Dr Kruger had been Mr McGeary’s general practitioner for approximately 7 years. In 1990 Mr McGeary needed a HIV test done for insurance purposes. He consulted Dr Kruger in this regard. The laboratory let Dr Kruger know that Mr McGeary test was positive. Shortly afterwards Dr Kruger told Mr McGeary that he was HIV+. The following day Dr Kruger told Drs van Heerden (a GP) and Vos (a dentist) on the golf course, that Mr McGeary was HIV+. Soon thereafter, the fact that McGeary was HIV+ was known by many of his friends and acquaintances in the town.⁵⁵⁸

It was established that neither Dr van Heerden nor Dr Vos should have been considered fellow health care workers in terms of the SAMDC protocol⁵⁵⁹, since they were not directly involved in treating Mr McGeary at the time.

Both the court *a quo*⁵⁶⁰ and the appeal court stressed the fact that the doctor does not only have an ethical duty but also a legal duty to keep private information given out dur-

⁵⁵⁴ McQuoid-Mason (1978) 190.

⁵⁵⁵ *Goodman v Von Moltke* 1938 CPD 153 at 157.

⁵⁵⁶ McQuoid-Mason (1978) 190.

⁵⁵⁷ *Jansen van Vuuren v Kruger* 1993 4 SA 842 (A);

⁵⁵⁸ Taitz (1992) “Aids patients are entitled to the right of medical confidentiality” *SAJHR* 582.

⁵⁵⁹ Taitz (1992) *SAJHR* 580 states that should the patient continue to refuse to consent to the release of the information, then and only then, may the doctor reveal the patient’s condition to those health care workers concerned with the patient. The protocol states that “if a patient refused consent, even after extensive counselling, the doctor should tell the patient that he is duty-bound to divulge the information on a confidential basis to the health workers concerned.”

⁵⁶⁰ *McGeary v Kruger en Joubert* 1991-10-16, Case no. 25317/90(W); see also article by McLean, *GR HIV infection and a limit to confidentiality* (1996) *SAJHR* 452.

ing a consultation, confidential. The legal duty arises from the doctor-patient relationship, which in turn is based on the contract that exists between a doctor and his patient.

The court attached legal force not only to this particular duty towards HIV+ patients, but to the full range of ethical duties that doctors' have as set down by the rules of the South African Medical and Dental Council and the court adopted these rules as legal enforceable and actionable in the case of a breach of privacy.⁵⁶¹

The appeal court emphasised the right of the patient. The court used the reasonable man test, to determine whether Kruger had any social or moral duty to tell his two colleagues about the results. The court found that do such duty existed and by implication no such legal duty either. The breaching of medical confidentiality was in this case unreasonable and unlawful. The required *animus iniuriandi* was present.⁵⁶²

2.4 Breach of privacy

The elements of liability for an action based on an infringement of a person's privacy are an unlawful and intentional interference with a legally protected personality interest namely the right to privacy.⁵⁶³

For a common-law action for invasion of privacy based on the *action iniuriarium* to succeed, the plaintiff must prove the following essential elements: (i) impairment of the plaintiff's privacy, (ii) wrongfulness and (iii) intention (*animus iniuriandi*).⁵⁶⁴

Privacy may be infringed by unauthorised acquaintance by outsiders with the individual or his personal affairs.⁵⁶⁵ Acquaintance can occur in two ways. Firstly when an outsider *himself* becomes acquainted with the individual or his personal affairs. This is called intrusion or instances of acquaintance. Secondly, where the outsider acquaints *third parties* with the individual or his personal affairs. These affairs although known to the outsider, remain private. This is known as instances of disclosure or revelation.⁵⁶⁶ These

⁵⁶¹ McLean (1996) *HIV infection and a limit to confidentiality* SAJHR 12 452.

⁵⁶² Van Wyk (1994) *THRHR* 57 145.

⁵⁶³ South African Law Reform Commission (2003) 54.

⁵⁶⁴ *Ibid.*

⁵⁶⁵ Neethling & Potgieter & Visser *Law of delict* (1999) 354.

⁵⁶⁶ *Ibid.*

infringements are sometimes referred to as substantive and informational privacy rights respectively.⁵⁶⁷

An example of violating the right to privacy by disclosure is for instance the disclosure of private facts contrary to the existence of a confidential relationship⁵⁶⁸, such as that which occurs between a doctor and patient. The wrongfulness of the breach of privacy is determined by means of the *boni mores* or reasonableness criterion. The presence of a ground of justification⁵⁶⁹ will however exclude the wrongfulness for the invasion of privacy.⁵⁷⁰

The third element required by the common law before liability can be established is that of intention. This means that the perpetrator must have directed his will to violating the privacy of the prejudiced person, knowing that such violation could possibly be wrongful.⁵⁷¹

In the case of a Constitutional invasion of privacy a twofold inquiry is required. One needs to first ask if the invasive law or conduct infringed the right to privacy in the Constitution and secondly, if so, is such an infringement justifiable in terms of the requirements laid down in the limitation clause (section 36) of the *Constitution*.^{572 573}

In determining the current modes of thought and values of any community the spirit, purport and objects of the Constitution, will also play a major role in determining the “new” *boni mores* of South African society.⁵⁷⁴ In order to establish an infringement of the Constitutional right to privacy the plaintiff will have to show that they had a subjective expectation of privacy that was objectively reasonable. This must be weighted against

⁵⁶⁷ South African Law Reform Commission (2003) 56.

⁵⁶⁸ According to the South African Law Reform Commission discussion paper on Privacy and data protection (2005) 37, whether a specific relationship deserves protection will depend entirely on the surrounding circumstances.

⁵⁶⁹ Examples of grounds of justification include defence, necessity, provocation, consent, statutory authority, public authority and official command and power to discipline; as quoted from Neethling & Potgieter & Visser (1999) 74.

⁵⁷⁰ Neethling & Potgieter & Visser (1999) 355.

⁵⁷¹ South African Law Reform Commission (2003) 62.

⁵⁷² *Constitution of the Republic of South Africa, 2006*.

⁵⁷³ South African Law Reform Commission (2003) 55.

⁵⁷⁴ South African Law Reform Commission (2003) 58.

the conflicting rights of the community as well as other fundamental rights, such as the right to access to information.⁵⁷⁵

In *NM and others v Smith and others*⁵⁷⁶ the names of three patients undergoing experimental anti-retroviral treatment were disclosed in the biography of a prominent political figure in South Africa. Prior to this their names were released in the report written about the experimental trial and there was no indication to suggest that the report and accompanying letter were confidential. Schwartzman J found that when the book was published, the names and HIV status was not accompanied by any intention to injure and therefore there was no *animus injuriandi*. The decisive factor was that the Plaintiffs names and status was contained in what was all intents and purposes the report of an official inquiry, commissioned by a public body into a matter of public interest.⁵⁷⁷ The defendants were also not found to be negligent. Schwartzman J went on to state that the following:

“I accept that because of the ignorance and prejudices of large sections of our population, an unauthorised disclosure can result in social and economic ostracism. It can even lead to mental and physical assault.”⁵⁷⁸

The plaintiffs claims regarding breach of their right to privacy, dignity, psychological integrity and mental and intellectual well being was dismissed. Damages were however awarded to each of the three plaintiffs to the amount of R15 000 for the period of time that the third defendant had known that all sales of unexpurgated copies of the book were in breach of the Plaintiffs right to protect the privacy of their names and HIV status. The third defendant was also directed to delete from all unsold copies the plaintiffs names and pay the plaintiffs legal costs.

⁵⁷⁵ South African Law Reform Commission (2003) 56.

⁵⁷⁶ *NM and others v Smith and others* 2005 JDR 0590 (W).

⁵⁷⁷ *NM and others v Smith and others* 2005 JDR 0590 (W); par. 40.2.

⁵⁷⁸ *NM and others v Smith and others* 2005 JDR 0590 (W); par. 46.2.

3. **Defences for breach of privacy in South Africa**

It has been suggested by academic writers that the defences of privilege, fair comment and consent should be available as defences to actions of invasion of privacy, just as they are applicable in cases of defamation. The special defences of necessity and private defence should also be available. McQuoid-Mason submits that most of the traditional defences to actions under the *actio injuriarum* will be applicable to invasions of privacy causing sentimental loss.⁵⁷⁹ These defences have to be examined in the light of the Constitution.

The defences can be divided into those that exclude wrongfulness / unlawfulness and those that exclude fault. Neither list is exhaustive. Defences which rebut the unlawfulness of the defendant's conduct under the *actio injuriarum* and which could be used to defeat a claim for invasion of privacy include the following⁵⁸⁰:

- 1) justification: (the truth for public benefit)
- 2) qualified privilege: (in the exercise of a right, or discharge of a duty)
- 3) fair comment: (known as constitutional privilege in the USA)
- 4) consent
- 5) absolute privilege
- 6) necessity: (to prevent a threat of greater harm to person or property)⁵⁸¹
- 7) private defence
- 8) statutory authority⁵⁸²

McQuoid-Mason observes that if it is accepted that as a rule invasion of privacy falls within the scope of the *actio injuriarum*, the victim of a negligent invasion will not be able to succeed under an action for *injuria*. In principle however, there is no reason why such

⁵⁷⁹ McQuoid-Mason (1978) 217; and McQuoid-Mason (2000) *Invasion of privacy: common law v constitutional delict – does it make a difference?* AJ 236.

⁵⁸⁰ *Ibid.*; this list is not exhaustive.

⁵⁸¹ A legitimate interest must be protected and the breach of privacy must be exercised in a reasonable manner according to the *South African Law Reform Commission (2003)* 68.

⁵⁸² McQuoid-Mason (1978) 218-235; McQuoid-Mason (2000) AJ 242; Statutory authority may justify certain invasions of privacy that would otherwise be unlawful, such as the duty to report child abuse, mentally ill persons who are dangerous, or notifiable diseases, provided the statutes concerned satisfy the limitation requirements of the Constitution.

a victim should not recover under the Aquilian action if in addition to fault the victim can prove patrimonial loss.⁵⁸³ As long as the element of fault is satisfied, it shouldn't make a difference whether the defendant acted intentionally or negligently.⁵⁸⁴

Where the plaintiff suffers only sentimental damages his remedy will lie under the *actio injuriarum* in terms of which there can be no liability for negligence. The concept of negligence is very flexible, and the categories of negligence are never closed. The courts must therefore determine which categories of negligence they will recognise.⁵⁸⁵

The Constitutional Court has held that additional constitutional punitive damages should not be awarded in terms of the Constitution for infringement of fundamental rights and freedoms but because of constitutional entrenchment, the amount of satisfaction may be increased.⁵⁸⁶

Van Oosten states that the patient's right to privacy and the doctor's duty of confidentiality are not absolute but relative. The following justifications may operate as defences to the doctor's breach of confidentiality.⁵⁸⁷

- 1) Consent, be it either express or implied.
- 2) Privilege, where a legal, social or moral right or duty to communicate the information and the reciprocal right or duty to receive such information exists.
- 3) Court order, litigation between the parties or disciplinary proceedings.
- 4) Statutory authority or statutory duty
- 5) Emergency situations, public interest or *boni mores*.⁵⁸⁸

Taitz distinguishes between absolute defences and qualified defences. According to Taitz absolute defences are recognised by the court and by the SAMDC as being exceptions to the rule of medical confidentiality.⁵⁸⁹

⁵⁸³ McQuoid-Mason (1978) 252-3.

⁵⁸⁴ McQuoid-Mason (1978) 253.

⁵⁸⁵ McQuoid-Mason (1978) 254.

⁵⁸⁶ South African Law Reform Commission (2005) 51.

⁵⁸⁷ Van Oosten (1996) 92.

⁵⁸⁸ Van Oosten (1996) 92-94.

⁵⁸⁹ Taitz (1990) SAMJ 30.

3.1 Absolute defences

Taitz lists five absolute defences. They are the following:

- 1) **Order of court:** Because there is no doctor-patient privilege in South Africa, a doctor has no alternative but to breach medical confidentiality when ordered to do so by the court. The *Ethical rules of the South African Medical and Dental Council* require however that the doctor should protest before divulging any confidential information.⁵⁹⁰ According to Van Dokkum this condonation only applies to trial proceedings where the doctor would be expected to give oral testimony. It does not apply to motion or application proceedings where evidence is led by way of affidavit.⁵⁹¹

- 2) **Consent by the patient:** The consent must be express. In terms of the *Ethical rules of the South African Medical and Dental Council*, after the death of the patient disclosure of confidential information is permissible only on the express consent of the patient's executor or his next of kin.⁵⁹²

The consent must be voluntary and it must not be contrary to public policy or *contra bonos mores*. For this reason an irrevocable consent to violation of privacy is considered invalid.⁵⁹³

- 3) **Disclosure required by legislation:** In terms of regulations passed under section 45 of the *Health Act*⁵⁹⁴, a doctor is obligated to report any notifiable disease such as smallpox, cholera, typhoid fever, whooping cough, maternal death, measles, malaria, leprosy, acute rheumatic fever, and anthrax. HIV / Aids is not a notifiable disease⁵⁹⁵. A doctor is also required to report cases of child abuse.⁵⁹⁶

⁵⁹⁰ *Ibid.*

⁵⁹¹ Van Dokkum (1996) "Should Doctor-patient communications be privileged?" *De Rebus* 748; According to Van Dokkum a doctor cannot be compelled to submit an affidavit containing facts about information imparted in confidence see *Ex parte James* 1954 (3) SA 270 (SR).

⁵⁹² Taitz (1990) *SAMJ* 30.

⁵⁹³ South African Law Reform Commission (2003) 66.

⁵⁹⁴ *Health Act 63 of 1977*; the regulations under s.45 appear in R1802 of 24 August 1979. The whole of the *Health Act 63 of 1977* is to be repealed by the *National Health Act 61 of 2003* and although a number of sections were repealed as from 2 May 2005, section 45 has not yet been repealed. This will probably happen once new regulations have been put into place under the new act.

⁵⁹⁵ See: South African Human Rights Commission "Should HIV / Aids be a notifiable disease" (1999) 1 *Kopanong* 6-7.

⁵⁹⁶ Taitz (1990) 78 *SAMJ* 30.

Regulation 19 passed under Notice R2438 in *Government Gazette* 11014 of 30 October 1987, states that in terms of section 32 of the *Health Act* a medical practitioner must report a notifiable medical condition and furnish the following particulars: "Name, age, sex, population group, identity number or if the identity number is not available, the date of birth, and the address, place of work or school of the person in respect of whom the report is made, as well as the date of commencement of the notifiable medical condition and any available information concerning the probable place and source of infection."⁵⁹⁷

In terms of section 42 of the *Child Care Act*⁵⁹⁸ cases of child abuse or neglect must be reported.

- 4) **Where the medical practitioner is a defendant or accused:** The doctor may breach medical confidentiality in any case in which the doctor is the defendant or the accused charged with any crime or facing any civil claim relating to medical malpractice or a breach of medical ethics. He may do so only to the extent that the information is material to the case against him.⁵⁹⁹

- 5) **Where doctor warns a health care worker or the spouse or other sexual partner of a patient who is an AIDS sufferer or who is HIV positive in terms of the SAMDC resolution.**⁶⁰⁰

In the absence of legal justification, a medical practitioner will be held delictually liable for infringing the patient's right to privacy or contractually liable for infringing an implied term of the doctor-patient contract.⁶⁰¹

3.2 Qualified defences

Qualified defences are not capable of simple definition. Every case must be considered on its own merits. An example according to Taitz is where a doctor finds that his patient, who is an airline pilot or bus driver, suffers from epilepsy. Should the patient refuse to consent to the information being furnished to his employer, the doctor may not be

⁵⁹⁷ R2438 GG 11014 of 30 October 1987.

⁵⁹⁸ *Child Care Act 74 of 1983.*

⁵⁹⁹ Taitz (1990) *SAMJ* 30.

⁶⁰⁰ *Ibid.*; see Medical and Dental Professionals Board of the Health Professions Council of South Africa (2001) *Management of patients with HIV infection or Aids.*

unlawfully breaching medical confidentiality if he tells the patient's employer of their employee's condition.

Taitz maintains that a "rough-and-ready" criterion for a qualified defence may be achieved by weighing the possible damage to the public or individual members of the public on the one hand, against the possible damage to the patient on the other. The warning of an endangered third party falls within this area of qualified defence.⁶⁰²

According to Taitz the following are qualified defences:

1. Waiver of the right of confidentiality and / or of a right of action by the patient;
2. Disclosure of the information in the interests of the patient, (i.e. to near relatives and friends);
3. Disclosure in the interests of the general community, (i.e. for health purposes or publication of information for research purposes);
4. Disclosure of information in the interest of the administration of justice;
5. Disclosure in order to protect a person or group of persons who are in danger;
6. Disclosure of information to persons, firms or companies who have a right to receive the information by reason of their special relationship with the patient.⁶⁰³

3.3 Defences excluding intention

In the common law the general principles of the *actio injuriarum* apply to defences excluding intention. Once the other elements for invasion of privacy have been proved, *animus injuriandi* will be presumed. The evidential burden then shifts to the defendant to show absence of intention.⁶⁰⁴ *Rixa*, jest, mistake, and any other defence that can rebut intention or consciousness of wrongfulness such as insanity, intoxication and no intention to injure, are some of the defences, which may be used to exclude intention.⁶⁰⁵

3.4 In terms of the Constitution

The defences to a common law invasion of privacy still need to be examined in the light of the Constitution, to determine whether they are consistent with the provisions of section 36. If the plaintiff establishes that his right to privacy has been impaired, the defen-

⁶⁰¹ Van Dokkum (1996) *De Rebus* 748.

⁶⁰² Taitz (1990) *SAMJ* 30.

⁶⁰³ Taitz "Aids patients are entitled to the right of medical confidentiality" 1992 *SAJHR* 579.

⁶⁰⁴ South African Law Reform Commission (2003) 73.

⁶⁰⁵ *Ibid.*

dant's conduct may not be wrongful if the latter can show that the invasion of privacy was reasonable and justifiable in terms of Section 36(1) of the Constitution. The onus of proving that the infringement is reasonable and justifiable rest on the person alleging it, and it should be discharged on a balance of probabilities. Whether the purpose of the limitation is reasonable and justifiable will depend on the circumstances in a case-by-case application.⁶⁰⁶

Alternatively a defendant's fault is not a requirement for an action based on the infringement of a constitutional right to privacy, and therefore strict liability may be imposed for a breach of this right.⁶⁰⁷ This constitutional right to privacy may be regarded as so fundamental that defendants may not argue that they were ignorant of the unlawfulness of their act and may be held liable on the basis of negligence if their ignorance was unreasonable.⁶⁰⁸

A lot of privacy legislation takes place on the horizontal dimension, between non-state actors. This might suggest that such cases should be adjudicated as cases of direct horizontal application envisaged by section 8(2) of the *Constitution*.⁶⁰⁹ However, according to Currie and De Waal this does not mean that the remedies developed for infringement of the common law right to privacy have to be replaced by an entirely new set of remedies. The common law privacy jurisprudence will continue to have application in the resolution of privacy disputes.⁶¹⁰

⁶⁰⁶ South African Law Reform Commission (2005) 40-41.

⁶⁰⁷ South African Law Reform Commission (2003) 73.

⁶⁰⁸ *Ibid.*

⁶⁰⁹ *Constitution of the Republic of South Africa, 2006.*

⁶¹⁰ Currie and De Waal (2005) *The Bill of Rights handbook* 316-317.

4. Causes of action in Canada

4.1 Causes of action in general

Quebec applies a civil-law approach, while the other provinces follow Anglo-Canadian common law. According to McQuoid-Mason, the combination of statute and common law seems to incorporate most of the traditional categories of invasions of privacy.⁶¹¹

The general provisions of the three provincial statutes⁶¹² and the Quebec Civil Code cover one form of privacy, namely publication of private facts. In the other common-law provinces remedies may be available under torts such as defamation, copyright, breach of contract and breach of confidence.

Rodgers-Magnet states that the common law provides several remedies for the unjustifiable disclosure of confidential medical information. These remedies can be found in the “doctrines of contract and tort, in statute and in actions based on breach of statute.”⁶¹³ The availability of these remedies depends on pushing the legal basis of these actions to their outer limits. An extremely small number of these actions have been brought in common law jurisdictions including the United States.⁶¹⁴

The injured patient may make use of a variety of actions. These include actions alleging defamation, breach of contract, breach of confidence, actions based on breach of statute, and an action for negligence.⁶¹⁵

Picard observes that the requirement of confidentiality arises from the doctor-patient relationship and is older than the common law.⁶¹⁶ There was a transition period when the characterisation of the doctor-patient relationship changed from common calling to implied contract and eventually to negligence. During this period there was confusion

⁶¹¹ McQuoid-Mason (1978) 81.

⁶¹² *British Columbia Privacy Act SBC 1968 c 39 s2(1); Manitoba Privacy Act SM 1970 c 74 s 2; Saskatchewan Privacy Act SS 1974 c 80 s 2.*

⁶¹³ Steel & Rodgers-Magnet *Issues in tort law* (1983) 265.

⁶¹⁴ *Ibid.*

⁶¹⁵ Steel & Rodgers-Magnet (1983) 278.

⁶¹⁶ Picard & Robertson *Legal liability of doctors and hospitals in Canada* (1996) 15.

about the proper way to plead a case, although the substance remained essentially the same in all three of the above, namely the duty which the doctor owed the patient.⁶¹⁷

Caulfield feels that there are very few cases in Canada that address the wrongful or unwarranted disclosure of medical information. There are a number of causes of action that might be available such as defamation, negligence, breach of contract, breach of confidence and breach of a fiduciary duty.⁶¹⁸ These causes of action are not mutually exclusive. Cases⁶¹⁹ so far have not drawn a careful distinction between liability in contract and in tort for failing to maintain the confidentiality of medical records.⁶²⁰

Rodgers-Magnet is of the opinion that an action based in negligence or an action based on one of the existing Privacy acts provides the greatest chance of meaningful recovery. Mr Justice Krever was of the opinion that the impediments to resort to private litigation would be minimized by the creation of a statutory right of action, actionable without proof of damages and with a minimum statutory recovery of \$10.000.⁶²¹

There have been very few civil actions, but it is clear that in Canadian law an action for damages will lie for breach of confidentiality by a doctor. In *McInerney*⁶²² the Supreme Court of Canada affirmed the doctor's duty of confidentiality, and also held that the main remedy for breach of this duty is an award of damages. This is also reflected in two recent cases. In the British Columbia case of *Mammone v Bakan*⁶²³ a doctor gave a patient's medical file to a lawyer, in compliance with a court order, but included additional information, which was not authorised in the order. The Court held that it was a simple error or oversight on the lawyer's part, and the disclosure was done inadvertently and without malice. However, it still constituted a breach of contract for which the court awarded the patient \$1,000 damages for the distress and embarrassment suffered.

⁶¹⁷ Picard & Robertson (1996) 2.

⁶¹⁸ Caulfield (1999) 76.

⁶¹⁹ *Peters-Brown v Regina* [1996] 1 WWR 337 (Sask.QB) , aff'd [1997] 1 WWR 638 CA.

⁶²⁰ Caulfield (1999) [Canada] *International encyclopaedia of law: Medical law* 77.

⁶²¹ Steel & Rodgers-Magnet (1983) 298.

⁶²² *McInerney v MacDonald* (1992) 93 DLR 4th 415 at 423 SCC.

⁶²³ *Mammone v Bakan* [1989] BCJ No 2438 QL SC.

A few years later in the Saskatchewan case of *Peters-Brown v Regina District Health Board*⁶²⁴ a hospital put up a list containing the names of patients who had previously tested positive for infectious diseases such as hepatitis, in its laboratories and in a private room in its emergency department. Unauthorised third parties such as the police and ambulance drivers got hold of the list. The Court held that although the hospital had the right to inform its staff, it was negligent and therefore in breach of contract for the manner in which the list was put up. The hospital ought to have foreseen that unauthorised third parties would have access to it. The hospital was accordingly found liable and damages of \$5,000 were awarded.⁶²⁵

Picard states that these cases are important not only because they are among the few that address the issue of breach of medical confidentiality, but also because they show that a variety of causes of action may be available to a patient, including negligence, breach of contract, and breach of a fiduciary duty. The cases also emphasise that liability may be imposed even though the breach of confidentiality occurred negligently rather than deliberately.⁶²⁶

4.2 Defamation

An action in defamation requires patients to prove that false information that is harmful to their reputation has been published without their consent. The defence of qualified privilege may serve to protect the defendant, despite the information's truth, and therefore the usefulness of this action is debatable. The defendant can plead that the disclosure occurred without malicious intent and in answer to a vital obligation, such as public health legislation, which requires the occurrence of an infectious disease to be notified.⁶²⁷

Rodgers-Magnet is of the opinion that an action in defamation may well be the easiest and most appropriate basis for recovery from the damage caused by the unjustifiable comment on confidential matters concerning a patient's medical history. Plaintiffs often frame an action alleging unwarranted disclosure in defamation together with some other

⁶²⁴ *Peters-Brown v Regina District Health Board* 1995 [1996] 1 WWR 337 (Sask QB).

⁶²⁵ Picard & Robertson (1996) *Legal liability of doctors and hospitals in Canada* 37.

⁶²⁶ *Ibid.*

⁶²⁷ Caulfield (1999) 77.

ground, such as breach of contract. An action in defamation is easily recognised by a common law court, but it is not a very effective or satisfactory action to protect people from the unwarranted disclosure of confidential medical information.⁶²⁸

The classic Canadian application of the rules of defamation to a situation arising out of disclosure of confidential medical information arose in the case of *Halls v Mitchell*⁶²⁹ in 1928. In this case Hall's medical records stated that he had suffered from venereal disease while in the army. In actual fact he had suffered from a disease of the heart valve, the abbreviation of which closely resembled that for venereal disease. Untrue attribution of current infectious disease of a certain type was recognised early on by the common law to be so disturbing of the person's social relations as to be actionable *per se*.⁶³⁰

The imputation of venereal disease in *Halls v Mitchell*⁶³¹ was therefore actionable *per se*, in the absence of an appropriate defence. Since there was no truth to the imputation the defendant pleaded qualified privilege. This qualified privilege would exonerate the defendant, in the absence of malice. A defence of qualified privilege will depend on the facts of the case. According to Rodgers-Magnet, the courts have in many instances recognised that on the facts of a particular case, the defence of qualified privilege ought to be allowed where an action in defamation has been brought against a physician. In *Halls v Mitchell* however, the court found the defence to be inappropriate to the particular circumstances.⁶³² The defendant's duty was to inform the Workmen's Compensation Board of the plaintiff's injured eye, but this obligation did not entail the duty to betray the past confidences of the patient. The communication was unwarranted.⁶³³

4.3 Breach of contract

Originally a legal duty was placed on the doctor to use proper care and skill. This original basis for liability was superseded by contractual liability, with the development of the

⁶²⁸ Steel & Rodgers-Magnet (1983) 279.

⁶²⁹ *Halls v Mitchell* [1928]S.C.R. 125.

⁶³⁰ Steel & Rodgers Magnet (1983) 279.

⁶³¹ *Halls v Mitchell* [1928]S.C.R. 125.

⁶³² Steel & Rodgers-Magnet (1983) 280.

⁶³³ *Ibid.*

law of contract⁶³⁴ Many of the terms in the contract were implied by law, including the fact that the doctor should use due care and skill when treating the patient.⁶³⁵

Patients whose personal information has been disclosed without their consent can bring an action claiming breach of contract. The courts see the physician-patient relationship as being one of contract, although the contract is not normally put into writing. Courts would probably imply a requirement of confidentiality as a term of the contract, given the historical nature of the duty of confidentiality. Hospitals may also be subject to such a contractual term of confidentiality.⁶³⁶ Rodgers-Magnet observes that an action for breach of contract would lie whenever there is an unwarranted disclosure of information obtained in confidence. This is regardless of the accuracy of the information.⁶³⁷

4.4 Negligence

The last century and a half has been dominated by the tort of negligence and for nearly a century most actions against doctors have been based on negligence.⁶³⁸ The grounds underlying this cause of action are that the disclosure of confidential information and the breach of confidentiality are a result of the failure of physicians to maintain the standard of care to which they are subject. If patients as a result of the breach of confidentiality suffer foreseeable injuries, the attending physicians will be liable. This duty has also been applied to hospitals.⁶³⁹

Rodgers-Magnet feels the courts can utilise public statements such as the Hippocratic Oath and the Code of Medical Ethics to indicate the duty owed and the standard of care to be met. By basing the action in negligence, damages can be claimed. The reasonable standard of care provides for an element of flexibility that the courts, according to Rodgers-Magnet, seem to be searching for.⁶⁴⁰

⁶³⁴ Picard & Robertson (1996) *Legal liability of doctors and hospitals in Canada* 1.

⁶³⁵ Picard & Robertson (1996) 2.

⁶³⁶ Caulfield (1999) 77.

⁶³⁷ Steel & Rodgers-Magnet (1983) 285.

⁶³⁸ Picard & Robertson (1996) 2.

⁶³⁹ Caulfield (1999) 77.

⁶⁴⁰ Steel (1983) 294.

4.5 Breach of a fiduciary duty

There is also an action based upon the fiduciary nature of the physician-patient relationship. Because of this type of relationship the physician is duty bound to act with good faith and loyalty and to hold information received from or about a patient in confidence. If physicians were to breach this duty, the court could award damages against the physician.⁶⁴¹

The Supreme Court of Canada in *Mclnerney v MacDonald*⁶⁴² recognised that the legal duty of confidentiality is grounded in the fiduciary nature of the doctor-patient relationship.⁶⁴³ *Mclnerney* addressed issues of confidentiality and patients' access to their own medical records. The Court reaffirmed the general principle that the doctor-patient relationship is a fiduciary one, based on a relationship of trust and confidence.⁶⁴⁴ Certain duties arise out of this special relationship, such as the duty of the doctor to act with good faith and to hold information received from or about a patient in confidence.⁶⁴⁵ This decision has been affirmed in several other Supreme Court and lower court decisions.

It is important to note "that not every doctor-patient relationship is fiduciary, nor are the nature and extent of the fiduciary obligations necessarily the same in every case." This was expressly recognised in *Mclnerney*.⁶⁴⁶ An example would be where a doctor at the request of the defendant examines a plaintiff in a personal injury case.⁶⁴⁷

The Canadian courts have increasingly begun using the fiduciary nature of the doctor-patient relationships as a basis for a growing number of decisions. "The fiduciary nature of the relationship has been held to be the foundation of the doctor's duty of confidentiality and the patient's right of access to his or her own medical record."⁶⁴⁸

The option of framing the action in terms of breach of fiduciary duty may also allow the patient to avoid the statute of limitations defence that would otherwise apply.⁶⁴⁹

⁶⁴¹ Caulfield (1999) 78.

⁶⁴² *Mclnerney v MacDonald* (1992) 93 DLR 4th 415.

⁶⁴³ Picard & Robertson (1996) 15; Miller 2 (1994) *Health law journal* 156.

⁶⁴⁴ Picard & Robertson (1996) 4.

⁶⁴⁵ Caulfield (1999) 73.

⁶⁴⁶ *Mclnerney v MacDonald* (1992) 93 DLR 4th 415 at 423 SCC.

⁶⁴⁷ Picard & Robertson (1996) 6.

⁶⁴⁸ Picard & Robertson (1996) 5.

⁶⁴⁹ Picard & Robertson (1996) 6.

4.6 Action for breach of confidence

The Younger Commission Report on Privacy⁶⁵⁰ in Great Britain focussed on the action for breach of confidence. The Commission concluded that this action more directly or more comprehensively protects privacy than does any other of the common law remedies, but that the action still has to be fully developed by the courts.⁶⁵¹

Rodgers-Magnet states this action is above all appropriate where the parties *at litem*, are in no contractual relationship.⁶⁵² However, this does not seem to prevent basing an action in breach of contract and in the alternative in breach of confidence.⁶⁵³

According to Rodgers-Magnet it is often unclear whether the breach of confidence spoken of has as its legal basis as a breach of a term of an express or implied contract, a breach of a duty of confidence giving rise to an action in tort, an equitable duty similar to breach of trust, or simply a breach of confidence.⁶⁵⁴

In *Argyll v Argyll*⁶⁵⁵, a British case dealing with the action for breach of confidence in the context of personal information, the court based the injunction on several grounds relevant to medical confidences. Firstly it was held that an obligation of confidence need not be express, but can be implied. This is often the case in a doctor-patient relationship. The obligation of confidence does not need to find its source in contract, or in a proprietary interest. Secondly, relief could be granted not only against the person acting in breach of confidence, but also against third parties who had received the personal information. Thirdly, there is a proposition that public disclosure of similar information by the plaintiff would release the defendant from his obligation of confidence.⁶⁵⁶

Rodgers-Magnet states that “one of the yet to be clarified elements of the action for breach of confidence is the extent to which the defences available in a defamation action are available in a breach of confidence action. There is however, clear indication

⁶⁵⁰ *Report of the Committee on Privacy*, Kenneth Younger, Chairman, 1972, London, Cmnd. 5012; as quoted by Steel on pages 285.

⁶⁵¹ Steel & Rodgers-Magnet (1983) 285

⁶⁵² *Ibid.*

⁶⁵³ Steel & Rodgers-Magnet (1983) 286.

⁶⁵⁴ Steel & Rodgers-Magnet (1983) 288.

⁶⁵⁵ *Argyll v Argyll* [1967] Ch. 302.

⁶⁵⁶ Steel & Rodgers-Magnet (1983) 286-287; *Argyll v Argyll* [1967] Ch. 332-333.

that a plea of duty to disclose is available, and that therefore the court may engage in the act of balancing public and private interests.”⁶⁵⁷

It is not all together clear whether an action for breach of confidence will lie if the recipient is aware that the source is questionable at the time the information is received. Neither is it clear whether an action will lie where the information was innocently received but where the third party later realises the impurity of the source. The few cases dealing with personal information have resulted in the granting of an injunction which is obviously only appropriate prior to disclosure.⁶⁵⁸

The questionable right to recover damages as well as the scope of damages makes breach of confidence as a remedy only potentially preferable to an action for breach of contract.⁶⁵⁹ It is often unclear whether the breach of confidence has as its legal basis a breach of a term of contract (express or implied), breach of a duty of confidence giving rise to an action in tort, an equitable duty similar to breach of trust, or simply a breach of confidence from which a court may conclude that for such a blatant wrong the law must provide a remedy.⁶⁶⁰

4.7 Breach of a statutory duty

Confidentiality is also a statutory duty in many health care settings. It is found in legislation governing hospitals, and also in mental health legislation. The breach of this statutory duty could result in quasi-criminal liability, with a penalty of a fine or even imprisonment, and the possible disciplining of the individual by the employer.⁶⁶¹

5. *Defences for breach of privacy in Canada*

5.1 Patient consent

Firstly the patient may, at any time waive the duty of confidentiality or of non-disclosure that a physician owes a patient. For the physicians own protection it is recommended that they obtain their patients consent in writing. An example would be a patient asking

⁶⁵⁷ Steel & Rodgers-Magnet (1983) 296.

⁶⁵⁸ Steel & Rodgers-Magnet (1983) 286.

⁶⁵⁹ Steel & Rodgers-Magnet (1983) 287.

⁶⁶⁰ Steel & Rodgers-Magnet (1983) 288.

⁶⁶¹ Picard & Robertson (1996) 16.

that the doctor send a summary of the medical history to an employer, lawyer, insurer or another doctor. The patient must have the mental capacity to understand the nature and effect of consenting to the disclosure of information, for the consent to be valid.⁶⁶²

The patient may give consent expressly, or it might be implied. Consent by implication occurs for instance when patients put their health in issue, by commencing legal proceedings such as personal injury or medical negligence claims.⁶⁶³ This waiver of confidentiality applies only to information that may be relevant to the action. The information must be material to the suit.⁶⁶⁴ A doctor might also imply that the patient has consented to release or share information when a doctor consults with other doctors or health care professionals regarding his patient's care. However, according to Picard some discretion should be exercised. The information should be shared with other health care professionals only where it is necessary for the care and treatment of the patient, or perhaps for the safety of those treating the patient. Whether consent to release information can be implied or not is a question of fact.⁶⁶⁵ The doctor has the onus of proving that there was consent, should the patient object to information being released⁶⁶⁶

Picard questions whether there is implied consent to release information about the patient to a spouse or other family member. Forty years ago Canadian authorities answered yes to this question, but today the answer must be qualified.⁶⁶⁷ Picard states that on the one hand good medical public relations and common sense say there are family members who must be told. On the other hand the patient might want the information to be kept confidential. Likewise, children that have the capacity to consent to treatment are in a doctor-patient relationship requiring confidentiality. It would be best if the patient concerned is asked to appoint a person to whom the doctor can speak freely. "If this has been done or is not possible, it is probably reasonable for the doctor to speak to a spouse or near relative such as a parent, brother or sister, although it may

⁶⁶² Steel & Rodgers-Magnet (1983) 23.

⁶⁶³ Caulfield (1999) 78.

⁶⁶⁴ Picard & Robertson (1996) 27.

⁶⁶⁵ Picard & Robertson (1996) 25.

⁶⁶⁶ Steel & Rodgers-Magnet (1983) 25.

⁶⁶⁷ Picard & Robertson (1996) 25.

be otherwise if the doctor is aware of family strife or other factors which suggest that the patient may not want the family to be informed.”⁶⁶⁸

Steel observes that Canadian cases are divided on the issue of whether commencing legal proceedings for a personal injury or medical negligence claim, constitutes an implied waiver of the right to confidentiality. In *Hay v University of Alberta Hospital*⁶⁶⁹ it was held that there is a waiver of confidentiality. Two Ontario cases have however declined to follow *Hay* and have held that patients do not waive their right to confidentiality merely for putting their medical condition in issue. This question awaits determination by a higher court.⁶⁷⁰

It is very important that both the doctor and patient are clear as to the nature and extent of the information to be disclosed.⁶⁷¹ In the Ontario case of *Miron v Pohran*⁶⁷² a doctor attended to a patient on two occasions. The patient was attended to first in an emergency department and later at an employment physical examination. The doctor included a warning about the patient’s health in his report to her employer, based on the diagnosis he had made in the emergency department. The patient sued the doctor after subsequently losing her job. The Court held that the patient had consented because she did not limit the doctor to information based on the annual employment examination and she had signed a form giving an express authorisation.⁶⁷³

*Mammone v Bakan*⁶⁷⁴ is another case that illustrates the importance of making sure that the information disclosed does not exceed the scope of the authorisation. In this case the defendant in a personal injury action got a court order directing that medical records in the possession of the plaintiff’s doctor, relating to treatment that the plaintiff had received after the date of the accident, be disclosed to the defendant’s counsel. However, the doctor did not read the order carefully enough, and sent the plaintiff’s entire medical

⁶⁶⁸ Picard & Robertson (1996) 26.

⁶⁶⁹ *Hay v University of Alberta Hospital* (1990) 69 DLR (4TH) 755 (Alta Q B).

⁶⁷⁰ Steel & Rodgers-Magnet (1983) 26-27.

⁶⁷¹ Picard & Robertson (1996) 24.

⁶⁷² *Miron v Pohran* (1981) 8 ACWS 2d 509 (Ont Co Ct).

⁶⁷³ Picard & Robertson (1996) 24; Steel & Rodgers-Magnet (1983) 24.

⁶⁷⁴ *Mammone v Bakan* [1989] BCJ No. 2438 (QL) (SC).

record. The plaintiff sued the doctor for breach of confidentiality, and was awarded \$1,000 damages.⁶⁷⁵

Steel states that the right to confidentiality is the patient's and therefore if the patient requests that the doctor divulge information, the doctor cannot refuse, except in very exceptional circumstances. The Supreme Court of Canada in *McInerney v MacDonald*⁶⁷⁶ affirmed this.⁶⁷⁷

6. Causes of action / Common law protections in the USA

6.1 Causes of action in general

Pursuant to the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996, the United States department of Health and Human Services promulgated regulations requiring all health care organisations to adopt procedures to protect the confidentiality of patient medical records. However these records are only prophylactic and no private right of action is provided. Criminal penalties are provided for particularly wrongful disclosures. Remedies for patients injured by disclosures are not provided, so patients remain dependent on common law methods of discovery.⁶⁷⁸

Furrow states that four major theories have been used to impose liability on professionals who disclose medical information, namely 1) invasion of privacy, 2) breach of a fiduciary duty to maintain confidentiality, 3) violation of statutes defining physician conduct and 4) breach of implied contract.⁶⁷⁹

Van der Goes maintains that when a patient believes that a health care provider has improperly divulged his or her private medical information, they may have five causes of action namely 1) breach of a fiduciary relationship, 2) negligence, 3) breach of an implied term of contract, 4) defamation and 5) invasion of privacy.⁶⁸⁰ Professional negli-

⁶⁷⁵ Picard & Robertson (1996) 24; Steel & Rodgers-Magnet(1983) 24.

⁶⁷⁶ *McInerney v MacDonald* (1992) 93 DLR (4th) 415 (SCC).

⁶⁷⁷ Steel & Rodgers-Magnet (1983) 24.

⁶⁷⁸ Frankel "Do doctors have a constitutional right to violate their patients' privacy?" (2001) 46 *Villanova law review* 146-147.

⁶⁷⁹ Furrow (1998) [United States of America] *International encyclopaedia of law: Medical law* 100.

⁶⁸⁰ Van der Goes "Opportunity lost: why and how to improve the HHS proposed legislation governing law enforcement access to medical records" (1999) 147 *University of Pennsylvania law review* 1045.

gence and breach of fiduciary duty claims are appropriate when doctors disclose confidential information, and commentators often combine them into a single category namely breach of confidentiality. The underlying principle for defamation and invasion of privacy is that medical information is of a highly personal nature and that patients have a right of protection against large-scale dissemination of information concerning private matters. They both involve a balancing of the patient's privacy rights with competing interests.⁶⁸¹

Hall observes that redress for providers unauthorised disclosure of patient information, has been sought using theories including 1) infliction of emotional distress 2) malpractice 3) breach of a confidential relationship or of a fiduciary duty 4) invasion of privacy and 5) breach of contract. This variety according to Hall reflects the uncertainty in certain jurisdictions, as to what theory is best adapted and likeliest to prevail, "but strategic considerations may also be at play, relating to whether expert testimony is needed (as in a malpractice claim), the availability of damages and the existence of damage caps, and comparative limitation periods."⁶⁸²

The courts have relied on various theories of recovery including invasion of privacy, implied terms of contract, and breach of a fiduciary relationship. "While common law protection of confidentiality probably provides the most consistent safeguards, significant gaps exist in legal duties." For instance courts may limit the claim for breach of confidence to physicians. A tort action will usually succeed only against the person who holds information in confidence. These claims are weakened to the extent that courts recognise justifications other than consent. The primary justification is to protect a third party from harm.⁶⁸³

"Legal theories upon which patients traditionally have brought suit include invasion of privacy, negligence / malpractice, implied breach of contract, breach of fiduciary trust and intentional or negligent infliction of emotional distress."⁶⁸⁴ A number of practical and legal limitations exist that undercut the effectiveness of these causes of actions. Practi-

⁶⁸¹ *Ibid.*

⁶⁸² Hall *Health care law and ethics in a nutshell* (1999) 119.

⁶⁸³ Gostin (1995) 80 "Health information privacy" *Cornell law review* 509-511.

⁶⁸⁴ Frankel (2001) *Villanova law review* 148.

cally, such causes of actions occur after an improper disclosure. Legally, exceptions to the general duty of confidentiality cause these common law actions to be useless.⁶⁸⁵

6.2 Defamation

Hermann states that defamation is conduct, which is inclined to injure the plaintiff's reputation, diminish the esteem, respect, goodwill or confidence in which the plaintiff is held. Defamation may be oral (slander) or it may be written (libel).⁶⁸⁶

Various defences to defamation exist including truth, privilege and consent. Privilege may be absolute or conditional. Conditional / qualified privilege protects the speaker as long as malice, or knowledge of the falsity of the statement cannot be shown.⁶⁸⁷

In the United States, several early cases dealing with unauthorised disclosure were framed in defamation. Several of these cases resulted in the successful plea of qualified privilege.⁶⁸⁸ The leading case was *Berry v Moench*.⁶⁸⁹ In this case, Dr Moench wrote a letter giving his impressions of a certain Mr Berry who had been his patient seven years earlier. This letter was written to Dr Hellewell who asked for the information on behalf of previous patients of his, whose daughter was besotted with Mr Berry. The letter contained alleged defamatory statements about Mr Berry. Dr Moench pleaded the defence of qualified privilege.⁶⁹⁰ According to Rodgers-Magnet, this decision provides evidence of a blurring of the lines between defamation and breach of confidence. Justice Crockett outlined the situation in which the defence of qualified privilege is available: "where life, safety, well-being, or other important interest is in jeopardy, one having information which could protect against the hazard, may have a conditional privilege to reveal information for such purpose, even though it is defamatory and may prove to be false."⁶⁹¹ Indifference to the truth of the facts communicated destroys any claim of privilege, as does negligence in attempting to ascertain the truth. Information communicated

⁶⁸⁵ Van der Goes (1999) *University of Pennsylvania law review* 1046.

⁶⁸⁶ Hermann (1997) *Mental health and disability law in a nutshell* 115-116.

⁶⁸⁷ Herman (1977) 116.

⁶⁸⁸ Steel & Rodgers-Magnet (1983) 282.

⁶⁸⁹ *Berry v Moench* (1958) 73 ALR 2d 315.

⁶⁹⁰ Steel & Rodgers-Magnet (1983) 282.

⁶⁹¹ *Berry v Moench* (1958) 73 ALR 2d 321.

ought to be limited to what is relevant and publication should be to, as limited a group, as possible.⁶⁹²

There has been a general tendency to import the elements of a situation of qualified privilege from the law of defamation, into other forms of action, whether based in breach of confidence or even privacy. This legal borrowing can lead to a certain confusion of the forms of action without an examination of the common elements of these actions.⁶⁹³

It is the logical corollary of the principles of qualified privilege that courts have, in certain cases, gone so far as to impose a duty to disclose.⁶⁹⁴ *Tarasoff*⁶⁹⁵ remains the most controversial court case dealing with the duty to disclose.

6.3 Breach of contract

In the United States few actions have been based on breach of contract, notwithstanding the fact that the relationship between the doctor and patient has long been characterised as contractual in nature. According to Rodgers-Magnet this may be due in part, to dissatisfaction with the scope of contractual damages as a mechanism of compensation. One advantage of this action is that it is not subject to the limitation inherent in the action for defamation, namely that the information disclosed is true.⁶⁹⁶

In most cases the contract that exists between a doctor and patient is not reduced to writing. A court could however easily find that the requirement of confidentiality ought to be an implied term of such a contract. Rodgers-Magnet states that “where custom or usage is notorious, that custom will form the basis of an implied term...the notion of confidentiality contained in the Hippocratic Oath ... forms the basis of a notorious, certain and reasonable custom clearly not contrary to law.”⁶⁹⁷ Breach of a contract can give rise to an action in damages. Frankel observes that contractual damages must be calculable with reasonable certainty, and that generally emotional distress is not recoverable in contract actions unless special circumstances exist and are spelled out before-

⁶⁹² Steel & Rodgers-Magnet (1983) 282.

⁶⁹³ Steel & Rodgers-Magnet (1983) 283.

⁶⁹⁴ *Ibid.*

⁶⁹⁵ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553.

⁶⁹⁶ Steel & Rodgers-Magnet (1983) 284.

⁶⁹⁷ *Ibid.*

hand in the contract.⁶⁹⁸ Where an accurate disclosure of information is made in good faith for a legitimate purpose, courts are reluctant to impose liability. However, where a legislature has enacted a complex statutory scheme to protect confidential information, particularly if it relates to HIV or Aids, the courts have been more willing to allow such claims.⁶⁹⁹

6.4 Breach of fiduciary duty

Hall maintains that fiduciary duties arise as heightened aspects of general tort and contract law rather than through a separate branch of legal doctrine.⁷⁰⁰ Courts compare the doctor-patient relationship to other relationships that carry fiduciary obligations, and by grounding the implied duty in public policy, and the ethical codes of the medical profession. Patients' remedies focus on the restoration of the "trust" breached or return of the benefits received by the fiduciary.⁷⁰¹

6.5 Invasion of privacy

"The common law right to privacy has been crafted by and enforced through the law of tort, initially using the tort of battery."⁷⁰² In 1890 Brandeis and Warren stated, "Political, social and economic changes entail the recognition of new rights." They proposed two new rights, the right to be let alone and the right to be protected from unauthorised publicity of essentially private affairs.⁷⁰³ Brandeis and Warren submitted that this proposed common law right to privacy was not absolute, and that matters of public interest could be investigated and published without legal recourse. Between 1890 and the present, the tort of invasion of privacy has been recognised in some form, by way of statutory or common law, by all fifty states. The tort of invasion of privacy is usually divided into four groups, but only two are relevant when it comes to disclosure of medical information, namely intrusion into an individual's affairs or seclusion and public disclosure of private facts.⁷⁰⁴

⁶⁹⁸ Frankel (2001) *Villanova law review* 151.

⁶⁹⁹ Furrow (1998) 102.

⁷⁰⁰ Hall (1999) 116.

⁷⁰¹ Frankel (2001) *Villanova law review* 151.

⁷⁰² Eddy "A critical analysis of Health and Human Services' proposed health privacy regulations in light of the Health Insurance Privacy and Accountability Act of 1996" (2000) *Annals of health law* 7.

⁷⁰³ *Ibid.*

⁷⁰⁴ Eddy (2000) *Annals of health law* 8.

Under the latter action plaintiffs are required to show that the defendant publicised private information about the plaintiff that would highly offend the reasonable person. The information must not be of legitimate public concern, and must not be already public. It can be argued that medical records are private information, the publicity of which would offend most patients. The publicity element of this action however, limits its application. A doctor's disclosure of the patient's condition to an individual or small group would not meet the plaintiff's *prima facie* burden.⁷⁰⁵ According to Robertson recovery for invasion of privacy usually requires a public disclosure of private fact as opposed to disclosure to a person or a small group.⁷⁰⁶

6.6 Breach of confidence

A special kind of relationship is usually required in the breach of confidentiality tort. The patient must be able to demonstrate a clear expectation of privacy. Doctors in many sectors of society may play dual roles and have divided loyalties, for instance doctors practising in prison, in the military or in workplace settings such as employee assistance programs. In these settings, courts may determine that there is no clear duty to maintain confidentiality if the relationship cannot be characterised as one involving a doctor and a patient. A tort action will also usually only succeed against the person who holds the information in confidence, and this holder may be unclear in an automated health information system.⁷⁰⁷ No one actually "holds" electronic data.

6.7 Physician disclosure tort⁷⁰⁸

The Supreme Court of Ohio, in *Biddle v Warren General Hospital*⁷⁰⁹ upheld, on an independent basis, a patient's right to sue her health care provider for disclosing medical records to a third party without authorisation. This decision makes Ohio the first state to abandon traditional bases of disclosure liability by creating an independent tort for the unauthorised disclosure to a third party of private patient medical data. Frankel states, "as a specific and narrowly tailored remedy, this new tort has the potential to directly address the wrong of disclosure, while either avoiding or surviving a First Amendment

⁷⁰⁵ Frankel (2001) *Villanova law review* 148-149.

⁷⁰⁶ Robertson (1988) *Psychiatric malpractice: liability of mental health professionals* 12.

⁷⁰⁷ Gostin (1995) *Cornell law review* 510-511.

⁷⁰⁸ Frankel (1991) *Villanova law review* 157.

⁷⁰⁹ *Biddle v Warren General Hospital* 715 NE 2d 518 (Ohio 1999).

challenge.”⁷¹⁰Should it be challenged on First Amendment grounds, the tort should prevail as a content-neutral⁷¹¹ state action.⁷¹²

The court in *Biddle* was careful to recognise that where a doctor’s statutory or common law duty mandated or permitted disclosure, liability would not attach. The court stated that a third party’s need for private patient medical information may sometimes give rise to a legal justification to disclose, but it is strictly limited to disclosure to people with a legitimate interest in the patient’s health or medical treatment.⁷¹³ In *Biddle v Warren General Hospital*⁷¹⁴ the Court of Appeals of Ohio for the 11th District held that a “tort[u]ous breach of patient confidentiality is a legal cogni[s]able claim”.⁷¹⁵ According to Michel, *Biddle* is the first instance that the claim of breach of patient confidentiality has been expressly recognised. The appellate court found that the duty of patient confidentiality derived from four sources namely: “1) statutory physician-patient privilege 2) the Hippocratic oath 3) state statutory licensing provisions allowing sanctions for the wilful betrayal of professional confidence and 4) the fiduciary nature of the physician-patient relationship.”⁷¹⁶

The Ohio court adopting a test set by the Supreme Judicial Court of Massachusetts⁷¹⁷, held that, “[a] patient may recover in tort from a party who induces a physician to disclose confidential information about the patient when the following elements are proven:

- 1) the defendant knew or reasonably should have known of the existence of the physician-patient relationship;
- 2) the defendant intended to induce the physician to disclose information about the patient or the defendant reasonably should have anticipated that his actions would induce the physician to disclose the information and;
- 3) the defendant did not reasonably believe that the physician could disclose that information to the defendant without violating the duty of confidentiality that the physician owed the patient”⁷¹⁸

⁷¹⁰ Frankel (2001) *Villanova law review* 144.

⁷¹¹ *Cohen v Cowles Media Co.* 501 US 663 (1991) declares that a content-neutral law cannot 1) target the press, 2) target the message embodied in speech, or 3) target speech itself; as quote from Frankel (1991) 162.

⁷¹² Frankel (2001) *Villanova law review* 168.

⁷¹³ Frankel (2001) *Villanova law review* 159.

⁷¹⁴ *Biddle v Warren General Hospital* 715 NE 2d 518 (Ohio 1999).

⁷¹⁵ Michel “Consent: Ohio appellate court affirms confidentiality claim” (1998) 26 *Journal of law, medicine & ethics* 355.

⁷¹⁶ *Ibid.*

⁷¹⁷ *Alberts v Devine*, 395 Mass 59, 70-71, 479 N.E. 2d 113, 121 1985 as quoted by Michel (1998) 355.

⁷¹⁸ Michel (1998) *Journal of law, medicine and ethics* 355.

Although the court acknowledged the existence of an implied contract of confidentiality in doctor-patient relationships, the court concluded that tort liability was a more appropriate remedy for breach of confidentiality.

Michel maintains the *Biddell* decision may expand both the scope and extent of doctor and hospital liability for breach of patient confidentiality. Firstly, by recognising a claim based on disclosures made to a legal representative, the court suggests that there is only a small class of people to whom such disclosures can be made without prior consent. Secondly, by choosing to recognise the claim in tort rather than contract, the decision greatly increases the plaintiff's potential recovery. This decision should also prompt hospitals to review their consent forms to include an authorisation constituting "clear patient consent" for this type of information release.⁷¹⁹

7. Defences for breach of privacy in the USA

7.1 Consent

There is no liability for an invasion of privacy if the person consented to the release, the consent has not been revoked, and the defendant acted within the scope of the consent. The consent may either be express or implied.⁷²⁰ Consent may be presumed from the circumstances. Health care providers treating the patient have access to the record, with consent presumed from acceptance of treatment. Emergency treatment also presumes patient consent.⁷²¹ According to Robertson, the consent must be knowing and voluntary in order for it to be valid.⁷²²

7.2 Newsworthy events and matters of legitimate public concern or public interest constitute a defence to an invasion of privacy⁷²³

In determining whether a matter of legitimate public interest is involved, the inquiry focuses on the type of information disclosed, and asks whether truthful information of legitimate concern to the public is publicised in a manner that is not highly offensive to a

⁷¹⁹ *Ibid.*

⁷²⁰ *Corpus Juris Secundum* 77 § 28 54.

⁷²¹ Furrow B *et al.* (2005) [United States of America] *International encyclopaedia of law: Medical law* 110.

⁷²² Robertson (1988) 13.

⁷²³ *Corpus Juris Secundum* 77 § 29 525.

reasonable person. Where events occur that affect the individual alone, and do not touch the sphere of public concern, they are not within the public interest.⁷²⁴

7.3 Waiver or estoppel

The right of privacy may be waived by the individual or by anyone authorised by him and the waiver may be either express or implied. The right may be lost by a course of conduct that estops its assertion.⁷²⁵

8. Summary

South Africa shares three common causes of actions with Canada and the USA, namely that of defamation, breach of confidence, and breach of the doctor-patient contract. Breach of a fiduciary duty and negligence are also causes of actions used in both Canada and the USA for breaches of confidentiality. The most common defence in South Africa, the USA and Canada is that of consent.

⁷²⁴ *Corpus Juris Secundum* 77 § 29 526-7.

⁷²⁵ *Corpus Juris Secundum* 77 § 30 527.

CHAPTER 4

Exceptions allowing breach of confidentiality outside a court of law

1. Introduction

The right to privacy can never be absolute. Certain exceptions are allowed, namely disclosure that is required by legislation and the duty to warn an endangered third party. These two aspects are discussed further below.

2 Exceptions in South Africa

2.1 Exceptions in general

Either a positive act or an omission can constitute an offence. In the Appellate division case of *Minister van Polisie v Ewels*⁷²⁶ it was held that a person is not under a legal duty to protect another from harm. Liability will follow only if the omission was in fact wrongful and this will only be the case if a legal duty rested on the defendant to act positively to prevent harm from occurring. The question whether such a duty exists is answered with reference to the legal convictions of the community. In certain exceptional circumstances the law imposes a legal duty to act, as for instance where a statute or the common law imposes a legal duty, or where a special relationship exists between the parties. All the relevant circumstances must be taken into consideration to see if a legal duty to act exists in a particular case.⁷²⁷

2.2 Statutory disclosures

In terms of section 32 of the *Health Act 63 of 1977*, a doctor is obligated to report any notifiable diseases including diseases such as smallpox, cholera, typhoid fever and tu-

⁷²⁶ *Minister van Polisie v Ewels* 1975 (3) SA 590 (A) at 596-597.

⁷²⁷ Neethling and Potgieter (1994) *The law of delict* 50-62.

berculosis. AIDS is not a notifiable disease.⁷²⁸ A doctor is also required to report cases of child abuse.⁷²⁹

Section 42(1) of the *Child Care Act 74 of 1983* states that any dentist, medical practitioner or nurse who examines any child in circumstances giving rise to the suspicion that the child has been ill-treated, or suffers from any injury, single or multiple, the cause of which probably might have been deliberate, or suffers from a nutritional deficiency disease, shall immediately notify the Director-General or any officer designated by him for this purpose. Any medical practitioner, dentist or nurse that contravenes any provisions of this section shall be guilty of an offence.⁷³⁰ No legal proceedings shall lie against any dentist, medical practitioner or nurse in respect of any notification given in good faith in accordance with section 42.

According to section 13(2) of the *Mental Health Care Act 17 of 2002*, the head of a national or provincial department or the head of a health establishment, may disclose the information which a mental health care user is entitled to keep confidential, if the failure to do so would seriously prejudice the health of the mental health care user or of other people.⁷³¹ It is interesting to note that the section doesn't say *must* disclose, but rather *may* disclose. It is therefore not mandatory and the discretion therefore still rests with the head concerned.

2.3 Common law duty to protect third parties

In South Africa there is no general rule that requires an individual to take positive steps, in order to avoid damages or injury to another, to whom they owe no legal duty.⁷³² However, since the case of *Carmichele v The Minister of Safety and Security and An-*

⁷²⁸ Regulation 19(2) in Notice R2438 in *Government Gazette* 11014 of 30 October 1987, published in terms of section 32 of the *National Health Act 63 of 1977* says the following: "On making a report referred to in subregulation (1) the following shall be furnished: Name, age, sex, population group, identity number or if the identity number is not available, the date of birth, and the address, place of work or school of the person in respect of whom the report is made, as well as the date of commencement of the notifiable medical condition and any available information concerning the probable place and source of infection.

⁷²⁹ Taitz "The rule of medical confidentiality v the moral duty to warn an endangered third party" (1990) 78 *SAMJ* 30.

⁷³⁰ *Child Care Act 74 of 1983* s. 42(5).

⁷³¹ *Mental Health Care Act 17 of 2002*.

⁷³² Taitz (1990) *SAMJ* 30.

*other*⁷³³ that dealt primarily with the development of the common law delictual duty to act, the situation has changed somewhat.⁷³⁴ Where a court develops the common law, the provisions of section 39(2) of the *Constitution*⁷³⁵ oblige it to have regard to the spirit, purport and objects of the Bill of Rights. This duty of the courts to develop the common law is not purely discretionary.

As stated in *Carmichele*⁷³⁶ “it is implicit in s39(2) read with s173 that where the common law as it stands is deficient in promoting the s39(2) objectives, the Courts are under a general obligation to develop it to promote the objectives of the Bill of Rights. This obligation applies in both civil and criminal cases, irrespective of whether or not the parties have requested the court to develop the common law. “The first stage is to consider whether the common law, having regard to the s39 (2) objectives, requires development in accordance with these objectives. If the answer is positive, the second stage concerns itself with how the development should take place. “The consequent reconsideration of the case by the High Court⁷³⁷ and the Supreme Court of Appeal⁷³⁸ resulted in the development of the law of delict to encompass state liability in circumstances where state authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life or physical security of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.”⁷³⁹

It follows then that a person whose life is endangered by a dangerous mentally ill patient has a right to life according to section 11 of the *Constitution*⁷⁴⁰ and there is a duty imposed on the State and all of its organs to perform positively, by providing the appropriate protection, through laws and structures designed to afford such protection. In the

⁷³³ *Carmichele v The Minister of Safety and Security and Another* 2001 JDR 0524 (CCT).

⁷³⁴ For a more complete discussion see pages 142-3.

⁷³⁵ *Constitution of the Republic of South Africa, 2006*.

⁷³⁶ *Carmichele v The Minister of Safety and Security and Another* 2001 JDR 0524 (CCT) ; par.39.

⁷³⁷ *Carmichele v Minister of Safety and Security* 2003 (2) SA 656(C).

⁷³⁸ *Minister of Safety and Security v Carmichele* 2004 (3) SAS 305 (SCA).

⁷³⁹ De Waal and Currie (2005) 305.

⁷⁴⁰ *Constitution of the Republic of South Africa, 2006*.

United States, a distinction is drawn between an “action” and “inaction” in relation to the “due process” clause of their Constitution (the 14th Amendment).⁷⁴¹

Section 8(2) of the *Constitution*⁷⁴² deals with the direct horizontal application of the rights in the Constitution. It sets out the circumstances in which the conduct of private individuals may be attacked for infringing the Bill of Rights. Indirect horizontal application means that the rights and duties in the Bill of Rights are instead imposed by the common law and legislation, which in turn is influenced by the Bill of Rights.⁷⁴³ In the light of the above discussion one could therefore argue that a doctor does have the duty to act to protect an identifiable or non-identifiable third party from danger by the direct or indirect horizontal application imposed by the Constitution.

In *VRM v The Health Professions Council of South Africa and Others*⁷⁴⁴ a six months pregnant woman consulted a gynaecologist about delivering her baby. A blood sample was taken during the first consultation in January and thereafter she had three more consultations. In March she received an account from the pathologists and during a subsequent consultation her husband asked the gynaecologist to explain the account he had received. He and his wife asked what an HIV Elisa was and if it had anything to do with AIDS. The doctor said it had nothing to do with AIDS. In April the woman had a C-section but her baby was stillborn. The day after the birth the gynaecologist told her she was HIV positive and that HIV was the cause of the baby’s death. The day after he told her husband of her HIV status.

A Committee of Preliminary Inquiry of the Health Professions Council of South Africa initially found that the conduct of the gynaecologist couldn’t be said to be improper or disgraceful. The Court ordered the dismissal of the appellant’s action by the court *a quo* be set aside, and in addition ordered the HPCSA to refer the appellant’s case to a disciplinary committee to hold an enquiry into the question whether the doctor is not guilty of improper or disgraceful conduct. This case does not deal primarily with confidentiality but the issue is touched on. The gynaecologist claimed he had told the appellant’s hus-

⁷⁴¹ *Carmichele v The Minister of Safety and Security and Another* 2001 JDR 0524 (CCT) ; par.44.

⁷⁴² *Constitution of the Republic of South Africa, 2006*

⁷⁴³ Currie and De Waal (2005) 43

⁷⁴⁴ *VRM v The Health Professions Council of South Africa and Others* 2003 JDR 0769 (T).

band her status after he had asked her whether she would tell her husband. He claimed she asked him to do it, but the appellant denied this. The question is whether the doctor had the duty to disclose to his patient her HIV status. I think that he had without a doubt a duty to do so, in order to protect both her husband and unborn child, not to mention her right of autonomy, and dignity which was taken away.

A doctor in South Africa who warns an endangered third party, breaches an essential term of the doctor-patient contract. The patient may regard the breach of confidentiality as defamatory and / or an invasion of privacy. The doctor may however have a strong defence in a plea of necessity. The test for necessity is objective. According to Taitz it seems that a court in South Africa would uphold a defence of necessity raised by the doctor, who in seeking to warn the endangered third party had breached the rule of medical confidentiality.⁷⁴⁵

The Medical and Dental Professions Board of the Health Professions Council of South Africa produced an article on the management of patients with HIV or Aids. The principles of confidentiality apply in respect of the patient. The decision to divulge information to endangered third parties must be done in consultation with the patient. The consent of the patient should first be sought. If this is unsuccessful, ethical guidelines recommend that the medical practitioner should use his or her discretion whether or not to divulge the patient's HIV status. Such a decision must be made with the greatest of care after an explanation to the patient. Patients should be counselled on the importance of disclosing their status to their sexual partners. Support should be provided to the patient to make the disclosure but where the patients' still refuse to disclose their status the patient should be advised of the health care workers' ethical obligation to disclose such information and the patient's consent should once again be requested before disclosure.⁷⁴⁶

⁷⁴⁵ Taitz (1990) *SAMJ* 31.

⁷⁴⁶ Health Professions Council of South Africa (2001) *Management of patients with HIV infection and aids* 7. See also Van der Poel J "Omissions and a doctor's legal duty to warn identifiable sexual partners of HIV positive patients" (1998) *Responsa Meridiana* 18-40; Van Wyk CW "Vigs, boni mores en vertroulikheid" (1992) 55 *THRHR* 116-124; Van Wyk CW "Vigs, vertroulikheid en 'n plig om in te lig" (1994) 57 *THRHR* 141-147; Barrett-Grant (2003) *HIV / Aids and the law : resource manual*.

The Health Professions Council is confident that if doctors fully discuss with patients the need for other health care professionals to know of their condition in order to give them optimal treatment the reasonable person of sound mind, will not withhold his consent regarding divulgence to other health care workers. If it were to be found that an act or omission on the part of the health care worker led to the unnecessary exposure to HIV infection of another health care worker, the Council would see this in a very serious light and would consider disciplinary action against the doctor concerned.⁷⁴⁷

3. Exceptions in Canada

3.1 Exceptions in general

There are numerous exceptions to the general rule that doctors must keep confidential the information they obtain from their patients. These exceptions can be permissive where the doctor is not required to disclose confidential information, but has the legal power to do so. It provides the doctor with a legal justification or defence for disclosing what would otherwise be confidential. On the other hand these exceptions may be mandatory, where a legal duty is placed on the doctor to disclose the information. Civil and criminal liability may result, if the doctor does not disclose the information.⁷⁴⁸

3.2 Statutory disclosures

Statutes that are concerned with the confidentiality of personal medical information are often viewed by the courts as indicative of a public or legislative policy in support of the maintenance of confidentiality. This suggests that legislative prohibitions against disclosure of confidential information might well serve as the basis of a successful action based on breach of statute or in negligence. This is the case both in Canada and the USA.⁷⁴⁹ Although breach of a statute is not *prima facie* evidence of the common law tort of negligence, it is evidence that can be used towards proving negligence.⁷⁵⁰

There are numerous statutory exceptions to the general rule of non-disclosure of patient information without consent. According to Caulfield this reflects the balance that has

⁷⁴⁷ Lewis & Hellenberg (1995) "The legal doctor" *SA family practice* 1122-123.

⁷⁴⁸ Picard & Robertson (1996) *Legal liability of doctors and hospitals in Canada* 23; Steel & Rodgers-Magnet (1983) *Issues in tort law* 23.

⁷⁴⁹ Steel & Rodgers-Magnet (1983) 291.

⁷⁵⁰ Carey (1998) *Health law in Canada* 8.

been struck between the individual's personal interests and those of society.⁷⁵¹ These statutory provisions either permit or require disclosure to a broad range of people and bodies for a wide variety of reasons.⁷⁵² Numerous permissive exceptions can be found in the *Mental Health Act*⁷⁵³, the *Hospitals Act*⁷⁵⁴ and the *Public Health Act*.⁷⁵⁵

A good example would be public health legislation that requires the disclosure of communicable diseases. In terms of the *Health Protection and Promotion Act (HPPA)*⁷⁵⁶ of Ontario, a physician may breach a patient's confidentiality to fulfil a mandatory obligation of reporting to the Medical Officer of Health a patient who is suffering from a reportable and communicable disease.⁷⁵⁷ Statutory disclosure requirements have been upheld under the *Charter of Rights and Freedom*. Picard states that a breach of a statutory duty may result in quasi-criminal liability, with a penalty of a fine or even imprisonment. It may also result in the person being disciplined by their employer such as a hospital or professional organisation. The patient may, for breach of confidentiality also bring an action for damages.⁷⁵⁸

There are also statutes that aim to protect children. In Ontario in terms of the *Child and Family Services Act (CFSA)*⁷⁵⁹ health care professionals, teachers, school principals, social workers, family counsellors and peace officers must report child abuse if they have reasonable grounds to suspect that it is taking place. Possible unnatural deaths also need to be reported.⁷⁶⁰

⁷⁵¹ Caulfield (1999) [Canada] *International encyclopaedia of law: Medical law* 79.

⁷⁵² Picard & Robertson (1996) 27.

⁷⁵³ *Mental Health Act* R.S.A 1988 c. M-13.1 s 17.

⁷⁵⁴ *Hospitals Act* R.S.A 1980 c. H-11 s 40.

⁷⁵⁵ Miller (1994) "Physician-patient confidentiality and familial access to genetic information" *Health law journal* 2 141.

⁷⁵⁶ *Health Protection and Promotion Act (HPPA)* R.S.O. 1990 Chapter H.7.

⁷⁵⁷ Bloom & Bay *A practical guide to mental health, capacity, and consent law of Ontario* (1996) 400; R.S.O. 1990 c. H.7 s. 25(1); 1998 c. 18 Sched. G s. 55(2); R.S.O. 1990 c. H.7 s. 39(1) does however state that "no person shall disclose to any other person the name of or an other information that will likely to identify a person in respect of whom an application, order, certificate, or report is made in respect of a communicable disease, a reportable disease, a virulent disease or a reportable event following the administration of an immunizing agent". This subsection does have a few exception such as where the disclosure is made for the purpose of public health administration or with the consent of the patient or that would prevent the reporting of information under s72 of the *Child and Family Services Act*; In Canada no distinction is made between AIDS and other communicable diseases. A health care worker is obliged to report the occurrence of the disease to the Medical Officer of the province.

⁷⁵⁸ Picard & Robertson (1996) 16; see also Steel & Rodgers-Magnet (1983) 28.

⁷⁵⁹ *Child and Family Services Act* RSO 1990, c C11, s 72(4).

⁷⁶⁰ Bloom & Bay (1996) 396.

Some provinces have legislation that requires a physician to inform the Registrar of Motor Vehicles of the personal details of patients whose condition may make it dangerous to drive a motor vehicle. In Ontario every medical practitioner is obligated in terms of the *Highway Traffic Act (HTA)*⁷⁶¹ to report to the Register of Motor Vehicles the name, address and clinical condition of every person sixteen years and older, who is suffering from a condition that *may* make it dangerous for the person to drive.⁷⁶² Every physician or optometrist is obligated in terms of the *Aeronautics Act (AA)*⁷⁶³ to report to a medical advisor, every patient who is a flight crew member, air traffic controller or other holder of a Canadian aviation document, who he believes on reasonable grounds is suffering from a medical or optometric condition that is likely to constitute a hazard to aviation safety.⁷⁶⁴

The *Nursing Homes Act*⁷⁶⁵ requires that a doctor who suspects a patient has suffered from unlawful conduct, improper or incompetent treatment, or negligence while a resident of a nursing home, reports this suspicion to the director of the nursing home.⁷⁶⁶

Disclosure may also be permitted for certain administrative purposes such as disciplinary or peer review proceedings.⁷⁶⁷ In Canada a physician is not required by statute to disclose to the police medical information relating to a patient's past or potential criminal behaviour, with the exception of child abuse.⁷⁶⁸ No statute requires a physician to notify the police if a patient arrives with gunshot or stab wounds.⁷⁶⁹

A physician that voluntarily provides information regarding a patient's confession of a crime could be in breach of a duty of confidentiality.⁷⁷⁰ A doctor does not commit any criminal offence by refusing to answer questions from the police. It is not an offence to refuse to assist the police. It is only an offence to obstruct the police in their investigations. Picard says in cases where the patient has committed or is about to commit a

⁷⁶¹ *Highway Traffic Act* RSO 1990, c. H.8; Carey (1998) 7.

⁷⁶² Bloom & Bay (1996) 397; see also Picard & Robertson (1996) 28.

⁷⁶³ *Aeronautics Act*, rsc 1985, c A-3, s6.5(1).

⁷⁶⁴ Bloom & Bay (1996) 399; see also Picard & Robertson (1996) 29 & Steel & Rodgers-Magnet (1983) 29.

⁷⁶⁵ *Nursing Homes Act* RSO 1990, c N7, s25(1).

⁷⁶⁶ Carey "The law of doctor-patient confidentiality in Canada" (1998) 19 *Health law in Canada* 7.

⁷⁶⁷ Caulfield (1999) 79.

⁷⁶⁸ Picard & Robertson (1996) 31.

⁷⁶⁹ Caulfield (1999) 80.

very serious criminal offence, or poses a serious threat to public safety, “it is likely that the public interest is sufficiently compelling to justify the doctor breaching confidentiality.”⁷⁷¹ There are however many grey areas where doctors are faced with making difficult decisions in deciding on which side of the line the case falls.⁷⁷² However police use of the information itself does not necessarily violate the patient’s rights.⁷⁷³

3.3 Common law duty to protect third parties

According to Miller the common law recognises disclosure of confidential information without the consent of the patient, but only when there is an overriding public interest at stake.⁷⁷⁴

Traditionally a doctor was not obligated to warn third parties or the police of the possible danger that a certain patient posed. According to Caulfield there is now a trend in the common law towards the imposition of a duty to warn third parties. Doctors have also taken steps to recognise at least an ethical, if not legal duty to warn third parties.⁷⁷⁵

The public interest in safety can result in an intrusion into confidentiality between doctor and patient. Picard asks the question, when does a doctor’s duty to society so outweigh the obligation to maintain secrecy that he is justified in revealing confidential information without the patient’s consent, in order to protect someone else?⁷⁷⁶ Sometimes statutes provide the answer, by conferring a power or imposing a duty, such as reporting medically unfit drivers. According to Picard, what is clear, is that the common law does indeed recognise a public interest exception to the duty of medical confidentiality, although its exact scope is uncertain.⁷⁷⁷

The Canadian Medical Association maintains that it is not unethical for a physician to disclose a patient’s HIV / Aids status to intimate partners without the patient’s consent if and when the public interest outweighs the interest of the patient.⁷⁷⁸

⁷⁷⁰

Ibid.

⁷⁷¹ Picard & Robertson (1996) 31.

⁷⁷² Picard & Robertson (1996) 32.

⁷⁷³ Caulfield (1999) 80.

⁷⁷⁴ Miller 2 (1994) *Health law journal* 141.

⁷⁷⁵ Caulfield (1999) 80.

⁷⁷⁶ Picard & Robertson (1996) 31.

⁷⁷⁷ *Ibid* ; see also Steel & Rodgers-Magnet (1983) 31.

⁷⁷⁸ Miller 2 (1994) *Health law journal* 142.

The Supreme Court of Canada in *McInerney v MacDonald*⁷⁷⁹ acknowledged this public interest exception.⁷⁸⁰ Carey states that the doctor's positive duty to instigate communication with a third party regarding a potential harm is part of the Canadian common law.⁷⁸¹ This duty to warn stems from the case of *Rivtow Marine Ltd v Washington Iron Works*⁷⁸² The Supreme Court of Canada determined "that if a risk to people or property is known, there is a general duty to warn those affected. This duty is independent of any contractual relationship, and is owed to the person in danger."⁷⁸³

Physicians have taken steps to recognise at least an ethical, if not legal duty to warn third parties. *Tarasoff*⁷⁸⁴ has influenced this trend.⁷⁸⁵ According to Steel the public interest in protecting others may be so compelling that a doctor is not simply justified in breaching confidentiality, but is required to do so. Failure to do so may result in the doctor being held liable in damages if someone is injured. The famous *Tarasoff* case illustrates this well.⁷⁸⁶ The most significant difference between the *Rivtow*⁷⁸⁷ and *Tarasoff* is the California Supreme Court's insistence on the existence of a "special relationship." According to Carey in Canada the duty to warn requires merely knowledge of potential harm to a foreseeable victim.⁷⁸⁸

Tarasoff has been referred to in Canada, although not specifically applied.⁷⁸⁹ *Tarasoff* has been considered in detail in only one case in Canada, namely *Wenden v Trikha*⁷⁹⁰ where it was held that for *Tarasoff* to apply, two conditions must be satisfied. "First the relationship between the psychiatrist and the patient must be such as to impose a duty on the former to control the conduct of the latter. Secondly, sufficient 'proximity' must exist between the psychiatrist and the third party in danger." Unfortunately, since

⁷⁷⁹ *McInerney v MacDonald* (1992), 93 DLR (4th) 415 (SCC).

⁷⁸⁰ Steel & Rodgers-Magnet (1983) 31.

⁷⁸¹ Carey (1998) 19 *Health law in Canada* 52-63; 1998 CHL LEXIS 24.

⁷⁸² *Rivtow Marine Ltd. v Washington Iron Works* [1973] 6 WWR 692, 40 DLR (3d) 530 (SCC).

⁷⁸³ Carey (1998) *Health law in Canada* 2.

⁷⁸⁴ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553.

⁷⁸⁵ Caulfield (1999) 80.

⁷⁸⁶ Steel & Rodgers-Magnet (1983) 32.

⁷⁸⁷ *Rivtow Marine Ltd. v Washington Iron Works* [1973] 6 WWR 692, 40 DLR (3d) 530 (SCC).

⁷⁸⁸ Carey (1998) *Health law in Canada* 3.

⁷⁸⁹ Caulfield (1999) 81; referring to *Wenden v Trikha* (1991) 116 AR 81 QB.

Wenden does not really involve a *Tarasoff*-type problem, it is not particularly instructive.⁷⁹¹ In *Tarasoff* the main issue was the conflict between the duty to maintain confidentiality and the duty to protect the public, whereas in *Wenden* the duty to warn did not arise. Picard feels that it is likely that if the Canadian courts are faced with a true *Tarasoff* issue, they would endorse the general principles underlying the California Supreme Court decision.⁷⁹²

Carey observes that the regulations governing the medical profession have not kept pace with the common law. Ontario regulations, in particular, do not recognise the extenuating circumstances of patients who doctors believe are about to harm someone. In such a case, the regulations would distinguish disclosure by a physician as misconduct.⁷⁹³ In Ontario, doctors who release patient information are breaching their professional code, and they can be disciplined under the provincial *Medicine Act*⁷⁹⁴. However, there is a greater common law duty to warn. The doctors could therefore be in accordance with the common law and in breach of provincial regulations, or *vice versa*.⁷⁹⁵ In 1997 the Ontario's Medical Expert Panel on Duty to Inform recommended that changes be made to both Ontario's *Medicine Act* and to the standards of practice set by the College of Physicians and Surgeons of Ontario.⁷⁹⁶

Ontario's Medical Expert Panel report proposed a "Standard of Practice for Reporting Threats of Harm with Immediate and Clear Risk". A physician confronted with a patient who threatens to harm a person or group, must notify the police of "the threat, the situation, his or her opinion and the information on which it is based including identification of the patient."⁷⁹⁷

⁷⁹⁰ *Wenden v Trikha* (1991) 116 AF 81 QB, aff'd (1993), 14 CCLT 2d 225 (CA); In this case a voluntary psychiatric patient absconded from hospital and later caused a car accident caused by dangerous driving. The injured plaintiff sued one of the attending psychiatrists.

⁷⁹¹ Picard & Robertson (1996) 33; see also Steel & Rodgers-Magnet (1983) 3.

⁷⁹² Picard & Robertson (1996) 34; see also Steel & Rodgers-Magnet (1983) 34; see also Carey (1998) *Health law in Canada* 3.

⁷⁹³ Carey (1998) *Health law in Canada* 4.

⁷⁹⁴ O.Reg 856/93.

⁷⁹⁵ Carey (1998) *Health law in Canada* 4.

⁷⁹⁶ *Ibid.*

⁷⁹⁷ *Ibid.*

The criteria set out by the Expert Panel for notifying the victim is that there is a concrete plan that is concrete and ‘doable’, and secondly the method for carrying out the threat is available to the person now or during the period of risk. When the situation is unclear, and immediate risk is unlikely, the doctor must assess the situation for the risk of harm according to the standards of the profession, or refer the matter to another doctor. The panel states that “Physicians are not expected to predict dangerousness but to demonstrate due care in assessing the risk of violence.”⁷⁹⁸

It therefore appears from the above that where the courts consider the problem of protecting confidential information they do so on a continuum starting from absolute protection, where any release would be actionable, to the possibility that the defendant will believe he is under a necessity to disclose, to an obligation to disclose, wherein the failure to disclose may itself be actionable. The circumstances of each case will determine where one lies on the continuum.⁷⁹⁹

4. Exceptions in the USA

4.1 Exceptions in general

Courts, doctors and commentators have long recognised that absolute confidentiality is neither possible nor always desirable. Therefore, various exceptions have been created to permit, or even to mandate that a doctor breach patient confidentiality. Courts have allowed a breach when it is in the supervening interest of society, or when it is made to a person with a legitimate interest in the patient’s health.⁸⁰⁰

Furrow states that where an accurate disclosure of information is made in good faith for a legitimate purpose, courts are generally reluctant to impose liability⁸⁰¹ while according to Hall many state licensure laws provide that a breach of patient confidence constitutes unprofessional conduct that will subject a physician to discipline or license revocation.

⁷⁹⁸ Carey (1998) *Health law in Canada* 4-5.

⁷⁹⁹ Steel & Rodgers-Magnet (1983) 283.

⁸⁰⁰ Friedland “Physician-patient confidentiality: time to re-examine a venerable concept in light of contemporary society and advances in medicine” (1994) 15 *Journal of legal medicine* 257-258.

⁸⁰¹ Furrow (1998) 102.

These laws vary as to whether the violation must be intentional or whether a merely negligent disclosure will do.⁸⁰²

A duty to disclose may be based on a statute, or on the common law duty of psychiatrists or psychologists to warn identifiable persons threatened by their patients. The duty to disclose may conflict with the duty to protect confidentiality.⁸⁰³

Doctors and other health care professionals have “in many jurisdictions an affirmative obligation by statute or common law to disclose confidential information in order to protect third parties against hazards created by their patients.”⁸⁰⁴ Failures by psychiatrists or psychologists to warn third parties have been the source of substantial litigation, the most famous case being *Tarasoff v Regents of the Univ. of California*.⁸⁰⁵

4.2 Statutory disclosures

Doctors are required to report communicable diseases and wounds inflicted by bullets, knives or other weapons. If a patient brings a lawsuit where personal health is put in issue, then the patient is also deemed to have waived the testimonial privilege and the doctor may testify on the subject of the patient’s health. Under appropriated circumstances, it may also be permissible for a doctor to disclose to employers information regarding an employee.⁸⁰⁶

Doctors are also required to report a variety of medical conditions and incidents including: “venereal disease, contagious diseases such as tuberculosis, wounds inflicted by violence, poisonings, industrial accidents, abortions, drug abuse, child abuse, abuse of others such as the elderly or disabled.”⁸⁰⁷ These reporting statutes sometimes explicitly grant the provider immunity from liability to the patient, for any breach of confidence. Failure to report can result in civil or criminal sanctions, and doctors who do not report might be found liable to anyone who is injured.⁸⁰⁸

⁸⁰² Hall (1999) 120.

⁸⁰³ Furrow (1998) 104.

⁸⁰⁴ *Ibid.*

⁸⁰⁵ *Tarasoff v Regents of University of California, (1974), 13 Cal.3d 177, 529 P 2d 553.*

⁸⁰⁶ Friedland (1994) *Journal of legal medicine* 258.

⁸⁰⁷ Furrow (1998) 104.

⁸⁰⁸ Hall (1999) 122-123.

These laws have however tended to be very patchwork in nature. This has prompted the need to craft a comprehensive medical privacy law, at the federal level.

4.3 Common law duty to protect third parties

A legal duty to protect third parties may arise through the common law, whenever the patient's condition poses a significant risk or danger to others. For example, when a contagious disease is diagnosed, there is a duty to warn some persons at risk of exposure unless this is forbidden by statute. According to *Tarasoff*⁸⁰⁹ there is also a duty to warn identified persons that a patient has made a credible threat to kill. Courts have also recognised the duty of referral specialists to communicate their findings to the referring physician. A patient can however waive this duty by ordering the referral specialist not to communicate with the referring physician.⁸¹⁰

The duty to warn in *Tarasoff* involved a specific, readily identifiable individual. Some courts have limited the duty to warn to such a situation, or have rejected the duty to warn obligation. Other jurisdictions have expanded the duty to include readily identifiable individuals who would be at risk of the patient's violence, or even whole classes foreseeably at risk.⁸¹¹

Hall states that it is often extremely difficult to resolve these situations under the common law, since the existence and scope of the duty to third parties are often unclear. He goes on to state that where this duty competes with the obligation of confidentiality, the tension is likely to be very great and immediate, and the consequence to the treatment relationship of a breach of confidence can be quite destructive.⁸¹²

As *Tarasoff* recognised, "the discharge of the protective duty, does not require a warning *per se*, but instead requires 'whatever ... steps are reasonably necessary under the circumstances.'" Hall states that this is not entirely reassuring, given the ambiguity of what constitutes the correct choice and the potential liability for either decision. He feels

⁸⁰⁹ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553.

⁸¹⁰ Miller (2000) 562.

⁸¹¹ Furrow (1998) 105.

⁸¹² Hall (1999) 123-124.

that this is an area where it would be helpful for the law to confer qualified immunity to providers who, in good faith, follow either course.⁸¹³

Liability under *Tarasoff* turns on foreseeability. As a result one of the main duties that psychiatrists must fulfil under the Tarasoff doctrine is to evaluate their patients thoroughly and assess the potential of a patient for dangerousness. Sufficient data must therefore be collected in order to make a proper evaluation.⁸¹⁴

5. Summary

South Africa, Canada and the United States all have legislation in place that requires that certain notifiable diseases be declared to the proper authorities as well as any suspected cases of child abuse. Mental health patients that are a danger to themselves or society also need to be reported to the necessary authorities.

⁸¹³ Hall (1999) 130.

⁸¹⁴ Robertson (1988) 363.

CHAPTER 5

Aspects of confidentiality relating to mental health

1. *Introduction*

Certain types of health care information are considered sufficiently sensitive to warrant special attention. Nearly all the states in the USA have separate statutes that make confidential, mental health and substance abuse information.⁸¹⁵

Although confidentiality forms the foundation of all health care, in the case of mental health care the ability to preserve privacy and trust takes on special importance for two reasons. Firstly as a result of the highly personal nature of the information about a patient's mental state and secondly as a result of the stigma attached to mental illness.⁸¹⁶

Inappropriately disclosed information about mental illness may result in not only personal costs to the patient, but economic ones as well, for example resulting in loss of promotion at work or even dismissal, as well as being denied a loan or insurance policy. To avoid such a situation a number of people have chosen to forgo medical aid payments and pay cash instead, when visiting psychiatrists. Many people suffer in silence and isolation, not seeking the treatment they need, fearing that to do so would reveal their 'disgraceful' secret.⁸¹⁷

For mental health treatment to be effective, confidentiality in the doctor-patient relationship is important. Confidentiality encourages the patient to reveal intimate thoughts to the doctor, and it also protects the patient from any embarrassment that might accompany disclosure of such private information during treatment.⁸¹⁸

Confidentiality also serves a public interest function. A person may be more inclined to seek treatment knowing that communication with the doctor or psychologist will be con-

⁸¹⁵ Gates & Arons (eds) (2000) *Privacy and confidentiality in mental health care* 91.

⁸¹⁶ Gates & Arons (eds) (2000) xiii.

⁸¹⁷ Gates & Arons (eds) (2000) xvii, 1.

fidential.⁸¹⁹ Confidentiality also insures that the patient will not suffer from any social stigma that the public would normally attach to such a person that is receiving mental health treatment. Confidentiality of communications between the doctor and patient extends to the non-disclosure of patient records as well.⁸²⁰

In *Tarasoff* it is stated that assurance of confidentiality is important for three reasons. First, without substantial assurance of confidentiality, those requiring treatment will be deterred from seeking assistance, for fear of stigmatisation by other members of society. Secondly, the guarantee of confidentiality is essential in eliciting the full disclosure necessary for effective treatment. Thirdly, successful treatment is dependant on the patient trusting his or her therapist.⁸²¹

Studies have shown however that absolute confidentiality is not a prerequisite for a trusting therapy relationship, so long as the limits of confidentiality are discussed with the patient. Patients accept therapists' legal and ethical obligations to society. Trust, not absolute confidentiality is the cornerstone of psychotherapy according to Ralph Slovenko.⁸²²

This chapter will be discussing the protection of mental health information and the need for warning and protection of third parties that might be threatened by the mentally ill, in South African, Canadian and American law.

2. South Africa

Taitz in 1990 stated that in South Africa there is no special relationship between the physician and an identifiable or non-identifiable third party.⁸²³ This has relevance with regard the duty to act. The case of *Carmichele v The Minister of Safety and Security and Another*⁸²⁴ dealt primarily with the development of the common law delictual duty to

⁸¹⁸ Hermann (1997) *Mental health and disability law in a nutshell* 112.

⁸¹⁹ *Ibid.*

⁸²⁰ Hermann (1997) 111-112.

⁸²¹ *Tarasoff v Regents of University of California* 551 P. 2d 334 at 359.

⁸²² Bucker & Firestone (2000) *Journal of legal medicine* 222; quotes from Ralph Slovenko *Psychotherapy and confidentiality* 24 Cleve Sr. L. Rev. 375, 395 (1975).

⁸²³ Taitz "The rule of medical confidentiality v the moral duty to warn an endangered third party" (1990) 78 *SAMJ* 31.

⁸²⁴ *Carmichele v The Minister of Safety and Security and Another* 2001 JDR 0524 (CCT); For a complete discussion see *supra* p. 128-129.

act. Where a court develops the common law, the provisions of section 39(2) of the *Constitution*⁸²⁵ oblige it to have regard to the spirit, purport and objects of the Bill of Rights. This duty of the courts to develop the common law is not purely discretionary.

A person whose life is endangered by a dangerous mentally ill patient has a right to life according to section 11 of the *Constitution*⁸²⁶ and there is a duty imposed on the State and all of its organs to perform positively, by providing the appropriate protection, through laws and structures designed to afford such protection. Likewise one can argue that a doctor has a duty to protect an identifiable or non-identifiable third party from danger by the direct or indirect horizontal application imposed by the Constitution.

2.1 Ethics⁸²⁷

Ethical codes play an important role in providing guidance to health care workers with regards ethical issues such as patient confidentiality.

Rule 24 of the Draft ethical rules of the HPCSA, published in 2004, deals with the rights of confidentiality. It states that a psychologist shall safeguard the confidential information obtained in the course of his or her practice, teaching, research or other professional duties, subject only to such exceptions to the requirement of confidentiality as may be determined by law or a court of law. Furthermore, a psychologist may disclose confidential information to other persons only with the written, informed consent of the client concerned.

Rule 25 deals with the exceptions to the requirement of confidentiality. Firstly, “a psychologist is obliged to discuss with persons and organisations with whom he or she establishes a scientific or professional relationship (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) the exceptions to the requirement of confidentiality, including any such exceptions that may apply to group, marital or family therapy or to organisational consulting and the foreseeable uses of the information obtained.”

Unless it is contraindicated, a psychologist must discuss confidentiality at the outset of the relationship and thereafter as new circumstances warrant the discussion again.

⁸²⁵ *Constitution of the Republic of South Africa, 2006.*

⁸²⁶ *Ibid.*

⁸²⁷ See also: Szabo,(2000) “Ethics in the practice of Psychiatry in South Africa” *SAMJ* 498.

A psychologist shall also, “prior to doing so, obtain permission from the client concerned to record interviews electronically or to transmit information electronically and shall inform the client of the risk of breach of privacy or confidentiality inherent in the electronic recording or transmission of information.” When engaging in electronically transmitted services the psychologist must ensure that confidentiality and privacy are maintained and they must inform their client’s of the measures taken to maintain confidentiality.

A psychologist may “not withhold information from a client who is entitled to that information, provided it does not violate the right to confidentiality of any other person and provided the information requested is required for the exercise or protection of any rights.”

Rule 26 deals with the limits on invasion of privacy and states that a psychologist may, in any written report, oral report or consultations with a third party, disclose only such information as is relevant to the purpose for which that communication is made and may discuss confidential information obtained in his or her work only for appropriate scientific or professional purposes and then only with persons with a legitimate interest in such matters.

Rule 27 deals with disclosures. A psychologist may disclose confidential information only (1) with the permission of the client concerned (2) when permitted by law to do so for a legitimate purpose (3) to appropriate professionals and then for strictly professional purposes only (4) to protect a client or other persons from harm; or (5)) to obtain payment for a psychological service, in which instance disclosure is limited to the minimum necessary to achieve that purpose and (6) when required to do so by law or a court of law.

Rule 28 deals with multiple clients and states that when more than one client is provided with a psychological service during a joint session (for example with a family or couple, or a parent and child or a group), a psychologist shall, at the beginning of the professional relationship, clarify to all parties the manner in which confidentiality will be handled. The aforementioned clients must be given the opportunity to discuss with the psy-

chologist what information is to remain confidential and what information the psychologist is obliged to disclose.

Rule 29 deals with legally dependent clients such as children. A child's best interest is of paramount importance in the provision of psychological services and the psychologist must take special care when dealing with children of 14 years or younger. A psychologist shall, at the beginning of a professional relationship, inform a child or a client who has a legal guardian or who is otherwise legally dependent, of the limits the law imposes on that child's or client's right to confidentiality with respect to his or her communication with the psychologist.

Rule 30 deals with the release of confidential information and states that a psychologist must release confidential information when ordered to do so by a court of law or when required to do so by law or when authorised to do so in writing by the client concerned or the parent or legal guardian of a minor client.

Rule 31 deals with the reporting of abuse of children and vulnerable adults. In terms of any relevant law or by virtue of professional responsibility the psychologist must report the abuse of any child or vulnerable adult.

Rule 32 deals with professional consultations. "When a psychologist renders professional psychological services as part of a team or when he or she interacts with other professionals concerning the welfare of a client, the psychologist may share confidential information about that client with such team members or other professionals." The psychologist must take all reasonable steps to ensure that all persons who receive such information are informed of its confidential nature and are bound by the rule of professional confidentiality. When consulting with colleagues, a psychologist must not disclose confidential information that could reasonably be expected to lead to the identification of a client, research participant or other person or organisation with whom he or she has a confidential relationship unless the psychologist has obtained the prior consent of the client, research participant, person or organisation concerned; or the disclosure cannot be avoided; and the psychologist may disclose information only to the extent necessary to achieve the purposes of the consultation.

Rule 33 deals with the disguising of confidential information used for didactic or other purposes. “A psychologist shall not disclose in his or her writings or lectures or in any other public way confidential information or information that can be linked to an identifiable person which he or she obtained in the course of his or her work with a client, organisation, research participant, supervisee, student or other recipient of his or her psychological services, unless” all reasonable steps to disguise the identity of such client, organisation, research participant, supervisee, student or other recipient are taken or the aforementioned people have consented to such disclosure in writing or there is other ethical or legal authorisation to do so.⁸²⁸

In South Africa the Health Professions Council of South Africa has released guidelines⁸²⁹ pertaining to the warning of endangered third parties. This however only relates to HIV / Aids.

2.2 Statutory law

The legislation governing mental health care has changed recently. The new *Mental Health Care Act* 17 of 2002 was assented to already on the 28th of October 2002, but it only commenced on the 15th of December 2004 on the same day that the general regulations pertaining to the act were published.⁸³⁰

Section 8 of the above act protects the privacy of the mental health care user. It states that the “person, human dignity and privacy of every mental health care user must be respected.”⁸³¹

The ethical rules of the Health Professions Council of South Africa⁸³² state that children as young as 14 years have the right to medical privacy. In terms of the *Child Care Act*⁸³³

⁸²⁸ Health Professions Council of South Africa [Draft] *ethical rules of conduct for practitioners registered under the Health Professions Act* (2004) Annexure 12 Rules 24-31.

⁸²⁹ See Health Professions Council of South Africa (2001) *Management of patients with HIV infection or Aids*.

⁸³⁰ This new act repeals the old *Mental Health Act* 18 of 1973, except for Chapter 8 of the old act, which deals with Hospital Boards; the general regulations appeared under GN R98 in GG 27117 of 15 December 2004.

⁸³¹ *Mental Health Care Act* 17 of 2002; s 8.

⁸³² See *supra* p. 21 of thesis.

a child over 14 years is legally competent to consent to any medical treatment, excluding surgery. In the *Mental Health Care Act*⁸³⁴ however, an application to obtain involuntary care, treatment and rehabilitation of a minor under the age of 18 years must be made by a parent or guardian.⁸³⁵ Likewise an application for assisted care, treatment and rehabilitation services for a minor under the age of 18 years must be made by the parent or guardian of the minor.⁸³⁶ This could result in an invasion of the minor's privacy, but the fact that the minor is mentally ill and possibly mentally incompetent might justify the invasion of the minor's privacy on the grounds that the harm prevented is greater than the wrong caused by violating the doctor's moral duty to maintain confidentiality. According to Henley, circumstances in which confidentiality may be broken include suicidal ideation, serious substance abuse, life-threatening medical conditions such as eating disorders and disclosure of physical or sexual abuse.⁸³⁷

Section 13 deals with the disclosure of information. According to subsection (1) a person or health establishment may not disclose any information that a mental health care user is entitled to keep confidential in terms of any other law.⁸³⁸

Notwithstanding subsection (1) the heads of national or provincial departments or the head of a health establishment may disclose such information if failure to do so would seriously prejudice the health of the mental health care user or of other people.⁸³⁹

*The Constitution*⁸⁴⁰ gives every person the right of access to information. The *Promotion of Access to Information Act* 2 of 2000 was passed in 2000, to give the details and conditions of this right.

⁸³³ *Child Care Act 74 of 1983*; s. 39(4)(b) states that "any person over the age of 14 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any medical treatment of himself or his child."; The Children's Bill B70D-2003 is set to change /repeal all acts relating to children. The Parliamentary process is complete and it awaits The President's signature.

⁸³⁴ *Mental Health Care Act* 17 of 2002.

⁸³⁵ *Mental Health Care Act* 17 of 2002; s 33.

⁸³⁶ *Mental Health Care Act* 17 of 2002; s 27.

⁸³⁷ Henley (2003) "Confidentiality and the adolescent patient" 21 *CME* 18; Adolescents should be encouraged but not forced to involve their parents in medical care, but should it be necessary to breach confidentiality, the doctor should inform the adolescent first and try to include him or her in the process of disclosure.

⁸³⁸ *Mental Health Care Act* 17 of 2002; s 13.

⁸³⁹ *Mental Health Care Act* 17 of 2002; s 13 (1) & (2).

⁸⁴⁰ *Constitution of the Republic of South Africa, 1996.*

Access to records containing the following information must be denied:

- Personal information which includes medical information of a third party, unless the person has consented beforehand.
- Confidential information such as that which occurs between a doctor and patient.⁸⁴¹

2.3 Case law

The leading case in South Africa on medical confidentiality is that of *Jansen van Vuuren v Kruger*⁸⁴², and although it relates to HIV / Aids the principles relating to medical confidentiality would also apply in mental health care cases. A unanimous bench of five judges upheld an appeal in a breach of confidentiality claim against a doctor. Both the court *a quo*⁸⁴³ and the appeal court stressed the fact that the doctor does not only have an ethical duty but also a legal duty to keep private information given out during a consultation, confidential. The legal duty arises from the doctor-patient relationship, which in turn is based on the contract that exists between a doctor and his patient.

The appeal court emphasised the right of the patient. The court used the reasonable man test, to determine whether Kruger had any social or moral duty to tell his two colleagues about the results. The court found that do such duty existed and by implication no such legal duty either. The breaching of medical confidentiality was in this case unreasonable and unlawful. The required *animus iniuriandi* was present.⁸⁴⁴

The principles in this case can also be used in the mental health context when deciding whether breaching confidentiality to warn an endangered third party is reasonable, lawful and justifiable. This will have to be investigated on a case-by-case basis. The South African courts may also take note of foreign decisions⁸⁴⁵ such as *Tarasoff*.⁸⁴⁶

⁸⁴¹ Klinck (2001) "The Access to Information Act: implications for doctors" *South Africa Medical Journal* 465.

⁸⁴² *Jansen van Vuuren v Kruger* 1993 4 SA 842 (A) ; for a complete discussion see p.97.

⁸⁴³ *McGeary v Kruger en Joubert* 1991-10-16, Case no. 25317/90(W); see also article by McLean, GR *HIV infection and a limit to confidentiality* (1996) SAJHR 452.

⁸⁴⁴ Van Wyk (1994) *THRHR* 57 145.

⁸⁴⁵ *Constitution of the Republic of South Africa, 2006*; s.39(1)(c).

⁸⁴⁶ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553.

Section 39(1)(b) and (c) of the *Constitution*⁸⁴⁷ states that when interpreting the Bill of Rights, a court, tribunal or forum must consider international law and may consider foreign law. The Constitutional Court held in *S v Makwanyane*⁸⁴⁸, that comparative human rights jurisprudence will be very important while an indigenous jurisprudence is developed. The Constitutional Court added however that foreign case law would not necessarily provide a safe guide to the interpretation of the Bill of Rights. In *Sanderson*⁸⁴⁹ the Constitutional Court had the following to say: "...the use of foreign precedent requires circumspection and acknowledgement that transplants require careful management."⁸⁵⁰

In *NM and others v Smith and others*⁸⁵¹ the names of three patients undergoing experimental anti-retroviral treatment were disclosed in the biography of a prominent political figure in South Africa. Prior to this their names were released in the report written about the experimental trial and there was no indication to suggest that the report and accompanying letter were confidential. Schwartzman J found that when the book was published, the names and HIV status was not accompanied by any intention to injure and therefore there was no *animus injuriandi*. The decisive factor was that the Plaintiffs names and status was contained in what was all intents and purposes the report of an official inquiry, commissioned by a public body into a matter of public interest.⁸⁵² The defendants were also not found to be negligent. The findings of this case must be taken note of, before any research report on mentally ill patients' is undertaken and the informed consent of the patients' must be obtained in writing beforehand.

3. Canada

3.1 Ethics

The Canadian Psychiatric Association states that psychiatrists need to be vigilant in safeguarding the confidentiality of the patient's communications. It can only be revealed

⁸⁴⁷ *Constitution of the Republic of South Africa, 2006.*

⁸⁴⁸ *S v Makwanyane 1995 (3) SA 391 (CC).*

⁸⁴⁹ *Sanderson v Attorney-General, Eastern Cape 1998 (1) SACR 227 (CC); par. 26.*

⁸⁵⁰ De Waal and Currie (2005) 160.

⁸⁵¹ *NM and others v Smith and others 2005 JDR 0590 (W); for a complete discussion see supra p.100.*

⁸⁵² *NM and others v Smith and others 2005 JDR 0590 (W); par. 40.2.*

at the request of the patient, or when in law it is mandatory for the psychiatrist to do so.⁸⁵³

The Canadian Medical Association's *Code of Ethics* states "an ethical physician will keep in confidence information derived from a patient or from a colleague regarding a patient, and divulge it only with the permission of the patient except when otherwise required by law."⁸⁵⁴

3.2 Statutory law

Section 35 of the *Mental Health Act* (MHA)⁸⁵⁵ establishes a prohibition to the disclosure of a clinical record except where it is permitted by a patient who is competent to do so. Disclosure is also permitted to the substitute decision maker of a patient who is not competent to make a decision and to a staff member of the psychiatric facility where the patient is being treated to access or treat the patient. Likewise disclosure is permitted where the chief executive officer of any health-care facility in which the patient is currently being treated makes a written request for the record from the officer in charge of the facility where the record in question was compiled.

Disclosure is permitted also "to a person currently involved in the direct care of a patient in any health-care facility, if the delay involved in obtaining consent would cause or prolong severe suffering or put the patient at risk of severe bodily harm;" also where the patient has died, and his or her personal representative wants the record or where the counsel or staff for the facility requires the record or "where the record is to be used for research, academic pursuits or the her have been removed and no information regarding the identity of patient is compilation of statistical data, provided the patient's name and means of identifying him or otherwise disclosed;"

Disclosure is also permitted where ordered by summons, order or direction of a court of competent jurisdiction or under any Act with respect to a matter in issue, unless the attending physician states in writing that release of the record in whole or part is likely to harm the patient's treatment or recovery or cause bodily harm to or injure the mental condition of a third person, in which case compliance with the summons shall be by

⁸⁵³ Bloom & Bay (1996) 393.

⁸⁵⁴ *Ibid.*

⁸⁵⁵ *Mental Health Act* (MHA) R.S.O 1990, Chapter M.7.

court order made only following a hearing from which the public is excluded. Disclosure may still be ordered if it is essential in the interests of justice;⁸⁵⁶

The law with respect to retrospective disclosure of harmful events is silent. There are statutory exceptions, such as disclosure of past child abuse, but generally the law with respect to disclosure is focussed upon anticipated future harm. For example if a patient confesses robbing a bank the week before, the information by itself does not give rise to a duty to report. There is no obligation to assist the police with their investigation.⁸⁵⁷

3.3 Case law

In Canada, *Tarasoff*⁸⁵⁸ has only been described in detail in one case, namely *Wenden v Trikha*⁸⁵⁹, but not specifically applied. In the latter case it was held that

“for *Tarasoff* to apply, two conditions must be satisfied. First, the relationship between the psychiatrist and the patient must be such as to impose a duty on the former to control the conduct of the latter. Secondly, sufficient ‘proximity’ must exist between the psychiatrist and the third party in danger.”⁸⁶⁰

The *Wenden* case is however not particularly helpful because the facts of the case are not similar to that of *Tarasoff*. The duty to warn did not arise in the *Wenden* case and therefore there was no conflict of interest between maintaining the confidentiality of the patient and protecting the public interest. According to Picard it seems likely that faced with a true *Tarasoff* issue, a Canadian court would give their⁸⁶¹ support to the general principles underlying the California Supreme Court decision.

3.4 Practical implications

Bloom has set out in some detail a checklist that should be taken note of when a psychiatrist takes on a new patient.

⁸⁵⁶ Bloom & Bay (eds) (1996) *A practical guide to mental health, capacity, and consent law of Ontario* 387.

⁸⁵⁷ Bloom & Bay (1996) 402.

⁸⁵⁸ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553.

⁸⁵⁹ *Wenden v Trikha* (1991) 116 AR 81 (QB), aff'd (1993), 14 CCLT (2d) 225 (CA), leave to appeal to SCC refused in 1993.

⁸⁶⁰ Picard (1996) *Legal liability of doctors and hospitals in Canada* 33.

⁸⁶¹ Picard (1996) 34.

The limitations in the confidential nature of the relationship should be discussed with the patient at the outset of therapy. The possible impact of disclosure on the developing therapeutic relationship should also be discussed, so as to hopefully allow the therapeutic relationship to survive any such disclosure.⁸⁶²

The patient should be told of specific instances that could arise that *will* compel disclosure, such as obligations under the *Child and Family Services Act*, and the *Mental Health Act*⁸⁶³. The patient should be told of the obligation of the physician under the *Mental Health Act* to involuntarily detain a patient in hospital if he or she shows evidence of a mental disorder and acts dangerously towards himself or herself and others.⁸⁶⁴ The patient should also be told of the physician's obligations under other statutes such as the *Highway Traffic Act*, the *Aeronautics Act*, and the *Health Protection and Promotion Act*⁸⁶⁵ etc., and the patient should be told of instances that *could* possibly compel disclosure, such as declaring dangerous intentions towards another and the obligation to disclose confidential information if compelled to do so in court or before another tribunal.⁸⁶⁶

The discussion with the patient regarding the above facts should be documented, as well as the circumstances giving rise to the obligation to disclose.

A physician should not communicate confidential patient information to the patient's lawyer unless he or she is satisfied that the lawyer is acting with the patient's permission. Where possible, proposed communication with a lawyer should be discussed with the patient first and this should be documented.⁸⁶⁷

A call to a physician by an adverse party, or by counsel for an adverse party should be immediately referred to the patient's lawyer. According to Bloom it might not be appropriate for a health-care professional to acknowledge that the individual about whom an inquiry is being made is his or her patient, or that the individual has or does not have a

⁸⁶² Bloom & Bay (eds) (1996) 393.

⁸⁶³ *Mental Health Act* R.S.O. 1990 Chapter M.7

⁸⁶⁴ Bloom & Bay (eds) (1996) 393.

⁸⁶⁵ *Health Protection and Promotion Act* R.S.O. 1990 Chapter H.7.

⁸⁶⁶ Bloom & Bay (eds) (1996) 393.

⁸⁶⁷ *Ibid.*

lawyer. A general response should be given that “psychiatrists are obligated by law not to disclose any information whatsoever about any patient.”⁸⁶⁸

A physician / psychiatrist should not respond to a consent form authorising disclosure of patient information unless fully satisfied that the document has been duly signed, witnessed and dated by the patient, and that there are no defects on its face.⁸⁶⁹ ⁸⁷⁰Only the minimum amount of information necessary to respond to a request should be given.⁸⁷¹

If subpoenaed to court, the psychiatrist or counsel should raise the concern about disclosure at the outset of his or her evidence, or as a preliminary matter before anything confidential has been disclosed.

Where the therapeutic relationship has ended and the psychiatrist is subpoenaed without the knowledge of the former patient, an argument can be made for an ethical obligation to inform the former person of the request.⁸⁷²

The psychologist or psychiatrist should consider consulting the relevant medical association or private counsel.⁸⁷³ It may be possible to bypass having to disclose confidential information in response to a subpoena by contacting the party who issued it and negotiating a way not to attend.⁸⁷⁴ Bloom states that one must not make the mistake of assuming that a subpoena is sufficient authority to disclose confidential information on a patient to anyone, including to police or lawyers.⁸⁷⁵

The psychiatrist and counsel should be prepared to describe the expected harms to the patient or others if the record is disclosed.⁸⁷⁶

⁸⁶⁸ Bloom & Bay (1996) 394.

⁸⁶⁹ Bloom & Bay (1996) 394.

⁸⁷⁰ Bloom & Bay (1996) 394-395.

⁸⁷¹ Bloom & Bay (1996) 394.

⁸⁷² Bloom & Bay (1996) 395.

⁸⁷³ *Ibid.*

⁸⁷⁴ *Ibid.*

⁸⁷⁵ *Ibid.*

⁸⁷⁶ *Ibid.*

4. USA

4.1 Ethics

The California Evidence Code defines a psychotherapist as a psychiatrist, or a licensed psychologist, or a clinical social worker, or a credentialed school psychologist, or licensed marriage, family and child counsellor.⁸⁷⁷

The American Medical Association allows disclosure by a doctor only when legally compelled to do so, or when necessary to protect the safety of the patient or community. It is not always easy to make such a determination. Disclosure resulting from misjudgement about public harm, that is thought to justify disclosure, may result in legal action against the doctor or psychiatrist.⁸⁷⁸ Psychologists are bound by the set of ethical principles set out by the American Psychological Association. They are also required to protect the confidentiality of information, and a psychologist should determine the “immediacy of danger created by nondisclosure, the scope and purpose of disclosure, the client’s awareness of the limits of confidentiality, and the client’s consent to disclosure.”⁸⁷⁹

The American Psychological Association’s ethical principles of 1992 state that confidentiality is not absolute and “where permitted by law for a valid purpose, such as ... to protect the patient or client from harm”, confidentiality may be breached.⁸⁸⁰

A therapist has with some exceptions an ethical duty of client confidentiality. Many states have adopted statutes specifying this duty. The Florida Psychological Services Act, for example, provides that the failure of licensed mental health professionals to maintain confidential patient communication, except by written permission or in the face

⁸⁷⁷ Austin, Moline, Williams (1990) *Confronting malpractice: legal and ethical dilemmas in psychotherapy* 45.

⁸⁷⁸ Hermann (1997) 113.

⁸⁷⁹ Hermann (1997) 114.

⁸⁸⁰ Gates & Arons (2000) 92.

of a clear and immediate probability of bodily harm to the patient, client, or others, can result in disciplinary action.⁸⁸¹

4.2 Statutory law

Most states have separate statutes defining the confidentiality of mental health information. These statutes usually begin with the principle that records and other information gathered in treatment are confidential and are not to be disclosed absent a legislatively or judicially created exception, such as patient consent.⁸⁸² More than one health care provider will often treat a person who is being treated for mental illness. State laws are inconsistent on the question of whether consent must be obtained prior to disclosure to another provider. Some states permit disclosure without patient consent.⁸⁸³

Many states permit disclosure for reimbursement purposes. Because many of these state statutes were written before managed care emerged, they rarely limit the amount of information that payers can request. Another common exception is disclosure of information to caregivers. Their view is that information necessary for them to play a caregiver role should be made available even if the individual has not consented thereto.⁸⁸⁴

All states also reserve the authority to review patient records without consent to monitor treatment programs, quality issues, and compliance with regulatory requirements. Information may also be made available for research purposes as long as the patient cannot be identified. Generally patient consent is not required.⁸⁸⁵

Information may also be disclosed to law enforcement agencies, but exactly how much information should be revealed is complex and there is little uniformity among the states in addressing access to behavioural health information. In all states child abuse must be reported. In Massachusetts's confidential mental health communications may be made

⁸⁸¹ Robertson (1988) *Psychiatric malpractice: liability of mental health professionals* 12.

⁸⁸² Gates & Arons (2000) 96-97.

⁸⁸³ Gates & Arons (2000) 98.

⁸⁸⁴ Gates & Arons (2000) 90.

⁸⁸⁵ Gates & Arons (2000) 100-101.

known when the communication reveals the contemplation or commission of a crime or harmful act.⁸⁸⁶

As a general rule, state laws permit disclosure of confidential information, to attorneys representing clients. According to Gates & Arons in nearly all states, the question of what type of mental health information may be disclosed in court related proceedings is a mixture of statutory and judicial law.⁸⁸⁷ Many states have statutes that limit the disclosure of mental health information.⁸⁸⁸ Such laws generally provide for a testimonial privilege.⁸⁸⁹

4.3 Case law concerning the duty to protect

Statutory disclosure is a legitimate reason for disclosure of confidential medical information. A physician's duty to maintain confidentiality may conflict with a duty to disclose information, in order to warn endangered third parties. Such a duty to disclose may be based on statute or on the common law duty of psychiatrists or psychologists to warn identifiable persons threatened by their patients. This obligation normally extends only to the patients with whom the physicians have a legal relationship, either under an implied or express contract.⁸⁹⁰

Tarasoff focuses on the professional's duty to warn as a result of the special relationship recognised in the *Restatement (Second) of Torts*.⁸⁹¹ In *Tarasoff* it was said that generally, a person owes no duty to control the conduct of another. "Exceptions are recognised in limited situations where (1) a special relationship exists between the defendant and injured party, or (2) a special relationship exists between defendant and the active wrongdoer, imposing a duty on defendant to control the wrongdoer's conduct."⁸⁹²

Curran disagrees with the holding of *Tarasoff* that a doctor-patient relationship or a hospital-patient relationship alone is sufficient, as a matter of law, to establish a "special relation" under Restatement §315 (a). Curran feels there should be added to those ordi-

⁸⁸⁶ Gates & Arons (2000) 103-4.

⁸⁸⁷ Gates & Arons (2000) 104.

⁸⁸⁸ Furrow (2000) *Health law* 158.

⁸⁸⁹ For a more complete discussion see above p. 25.

⁸⁹⁰ Furrow (2000) 158.

⁸⁹¹ Robertson (1988) *Psychiatric malpractice: liability of mental health professionals* 11-12.

nary relationships the factor, required by Restatement §319, of taking charge of the patient. This means that the doctor or hospital is vested with a higher degree of control over the patient that exists in the ordinary doctor-patient or hospital-patient relationship before a duty arises concerning the patient's conduct.⁸⁹³

As *Tarasoff* recognised, “the discharge of the protective duty, does not require a warning *per se*, but instead requires ‘whatever ... steps are reasonably necessary under the circumstances.’” Hall states that this is not entirely reassuring, given the ambiguity of what constitutes the correct choice and the potential liability for either decision. He feels that this is an area where it would be helpful for the law to confer qualified immunity to providers who, in good faith, follow either course.⁸⁹⁴

The California Supreme Court in *Tarasoff*⁸⁹⁵ ruled that mental health professionals who can reasonably come to the conclusion that their patients might cause harm to identifiable third parties, must take the necessary steps to protect the third party. The approaches of the different states vary when it comes to addressing a similar scenario to *Tarasoff*. The primary difference is how much discretion mental health professionals enjoy in determining whether to take steps to protect third parties. Some states have enacted legislation that permits, but does not require disclosure. The decision to breach confidentiality is in this case a matter of professional judgement and not a mandatory duty. The state of Florida follows this approach. The Ohio Supreme Court is at the other end of the spectrum and appears to have extended the duty to the public at large.⁸⁹⁶

There is a duty to warn identified persons that a patient has made a credible threat to kill.⁸⁹⁷ The *Tarasoff*⁸⁹⁸ court considered foreseeability of harm to be the central factor in establishing duty.⁸⁹⁹ It is however a difficult task to predict the risk of harm to others. However, according to Furrow the risk that unnecessary warnings might be given is a reasonable price to pay for the lives of possible victims that might be saved.⁹⁰⁰

⁸⁹² *Tarasoff v Regents of the University of California* 551 *Pacific Reporter* 2d 334 at 358.

⁸⁹³ Curran (1998) *Health care law and ethics* 210.

⁸⁹⁴ Hall (1999) 130.

⁸⁹⁵ *Tarasoff v Regents of University of California*, (1974), 13 *Cal.3d* 177, 529 *P 2d* 553.

⁸⁹⁶ Gates & Arons (2000) 102-103.

⁸⁹⁷ Miller (2000) 562.

⁸⁹⁸ *Tarasoff v Regents of University of California*, (1974), 13 *Cal.3d* 177, 529 *P 2d* 553.

⁸⁹⁹ Furrow (1980) 51.

⁹⁰⁰ *Ibid.*

Hermann states that the duty imposed by *Tarasoff* is not merely to warn the third party, but a duty to protect the intended victim. For the duty to protect to arise there must be a serious threat of violence, and an imminent threat of harm, and an identifiable third party who is at risk of harm.⁹⁰¹ The therapist's duty to protect third parties from foreseeable violence by a patient has not been fully developed or adopted by every state, but most states have found that the therapist's duty extends only to identifiable victims. It does not extend to the public in general. The patient must also inform the therapist of an intention to cause bodily injury or death.⁹⁰² The majority in *Tarasoff* did not contend that the first exception is appropriate in this case.

Some states have rejected the rule that mental health professionals in outpatient settings have any obligation to third parties, mainly because it is thought that the mental health professionals have little physical control over their patients in such a setting. In all states a mental health facility has an obligation not to act negligently in discharging a patient into the community.⁹⁰³

Furrow states that case law indicates certain factors that are relevant to the obligations to warn third parties. Firstly the degree of control that the doctor has over the patient must be considered. A psychiatric inpatient is susceptible to much greater control than is an outpatient, and the range of protective measures that could reasonably be expected will therefore be proportionally greater with the hospitalised patient. The second factor to consider is the doctor's knowledge of the patient's propensities.⁹⁰⁴ The third factor to consider is the possibility of specifically identifying the victim. According to Furrow, where threats are made against groups and not against specific individuals, the scope of the therapist's duty to warn would be diminished or would disappear altogether, since there would be no specific victim to notify.⁹⁰⁵

Robertson maintains that liability in *Tarasoff* rests on foreseeability. Liability has therefore been imposed when specific threats were made, and also when there has been a significant history of violence. Liability has also been imposed where there was a failure

⁹⁰¹ Hermann (1977) 119.

⁹⁰² Hermann (1977) 120.

⁹⁰³ Gates & Arons (2000) 103.

⁹⁰⁴ Furrow (1980) 53-54.

⁹⁰⁵ Furrow (1980) 54.

to examine the patient properly or a failure to obtain prior records.⁹⁰⁶ Therefore psychiatrists have also got to determine whether any threats are significant enough to necessitate warnings, because the duty to warn must be balanced against the duty to protect confidentiality.⁹⁰⁷

The question whether confidentiality may be breached to prevent the suicide of a patient is a discrete question. In most jurisdictions it has been assumed that such a breach is warranted.⁹⁰⁸ Psychiatrists for instance readily breach confidentiality when suicide is imminent and the patient requires involuntary hospitalisation.⁹⁰⁹

Buckner states that in the light of developing case law, which is articulating a near strict liability standard in the continuing trend to compensate third parties, therapists must attend to this issue with greater sensitivity and detail. Past medical records, where applicable must be thoroughly reviewed and past therapists and referral sources must be queried where appropriate. Consultations and second opinions must be sought when threats of violence occur.⁹¹⁰ "If such a careful and reasonable approach is taken, including documentation of the assessment of the pertinent issues and treatment plan, then the therapist should not be held liable, even if harm should occur to a third party."⁹¹¹

The therapist is protected to a large extent by the customary practice defence, which measures the therapist's duty to warn by that of a reasonable practitioner similarly situated, and by the limited means of control that he possesses, primarily the ability to warn the victim or his family.⁹¹²

Suits brought against therapist for failing to maintain confidentiality are usually civil damage suits, and can be brought under defamation, invasion of privacy and breach of a duty arising from a confidential or nondisclosure professional relationship. According

⁹⁰⁶ Robertson (1988) 362-363.

⁹⁰⁷ Robertson (1988) 363.

⁹⁰⁸ Gates & Arons (2000) 103.

⁹⁰⁹ Petrila & Sadoff (1992) "Confidentiality and the family as caregiver" *Hospital and community psychiatry* 137.

⁹¹⁰ Buckner & Firestone (2000) "Where the public peril begins: 25 years after Tarasoff" 21 *Journal of legal medicine* 221.

⁹¹¹ Buckner & Firestone (2000) *Journal of legal medicine* 221.

⁹¹² Hermann (1977) *Mental health and disability law in a nutshell* 54.

to Hermann civil suits are the most effective method of enforcing a therapist's duty of confidentiality.⁹¹³

The plaintiff must show that the therapist disclosed information with malice or ill will, if punitive damage for breach of confidence is to be obtained. Actual damages may be awarded where the plaintiff suffers injury as a result of the wrongful disclosure of confidential information. Wrongful disclosure may also lead to disciplinary measures by state agencies licensing and regulating mental health professionals.⁹¹⁴ Hermann states that in addition to awarding the patient monetary damages, the therapist may also be fined under statutory provisions. Where the therapist has acted unprofessionally in making the disclosure of confidential information, the state licensing board may revoke the therapist's licence.⁹¹⁵

4.4 Practical implications

Austin states that "6.4% of total claims in malpractice suits against psychologists were brought because these psychologists either failed to maintain confidentiality or failed to report abuse when their state outlined the limits."⁹¹⁶

It is therefore recommended that all psychotherapists inform their clients during the beginning of therapy about the limits of confidentiality. The APA's *Ethical principles of psychologists* (1989) states: "You can place this information in writing and have your clients sign a form to demonstrate that they knew from the beginning of treatment about their rights or lack of them in regard to confidential information."⁹¹⁷

Psychotherapists should warn their clients that they lose the right to a confidential relationship:

"when they consent to disclosure
when a law requires reporting of an event, such as child abuse
when there is the duty to warn or protect

⁹¹³ Hermann (1977) 114-115.

⁹¹⁴ Hermann (1977) 117.

⁹¹⁵ Hermann (1977) 118.

⁹¹⁶ Austin (1990) *Confronting malpractice : legal and ethical dilemmas in psychotherapy* 73; as quoted originally by Pope (1989) p 25.

⁹¹⁷ *Ibid*; as quoted by Austin.

when reimbursement or other legal rules require disclosure
when they bring a lawsuit
in an emergency”⁹¹⁸

Some recommendations regarding confidentiality are the following:

1. Do not discuss a case unless ordered to do by a court, without a valid release.
2. Keep all medical records locked up in a safe place.
3. Make sure your secretary also understands that all information is confidential.
4. Know any laws that involve exceptions to confidentiality.
5. Send any information that is requested by certified mail.
6. Inform your client about what the law says about privileged information.
7. Know the age below which the law considers a person to be a minor. In the case of a minor the psychotherapist may not be able to maintain confidentiality.
8. When the law requires a psychotherapist to disclose information, the information given should be limited to only what is necessary and related to the issue at hand.⁹¹⁹

What do the families need to know?

Certain information is essential for illness management. According to Gates, families have long claimed that they don't want to know the intimate details of their relative thoughts and feelings, but that they do need to know the diagnosis so that they can research it and become knowledgeable enough for long-term treatment planning. They need to know about the patient's medication and the effect it will have on the patient's behaviour as well as the side effects of the drugs.⁹²⁰

Mental health professionals should seriously reexamine the application of rigid confidentiality rules, especially when they compromise the ability of families to function effectively as caregivers as there may be legal liability when mental health providers fail to share vital information with families, which leads to adverse consequences such as murder or violence.⁹²¹

⁹¹⁸ Austin (1990) 73; as quoted by Austin from Stromberg et al. (1988).

⁹¹⁹ Austin (1990) 74.

⁹²⁰ Gates & Arons (2000) *Privacy and confidentiality in Mental Health Care* 37.

⁹²¹ Petrila & Sadoff (1992) 43 *Hospital & Community Psychiatry*, 136-139; Gates & Arons (2000) 38.

From a risk management perspective it is better to keep the families informed, both as a source of information and as a caregiver. From both a clinical and ethical perspective it also makes little sense to maintain confidentiality when doing so may result in danger to another and to consequences that will ruin a patient's life.⁹²²

Cases like *Tarasoff*⁹²³ demonstrate that clinical practice, professional ethical norms and legal standards are interrelated. By making the interests of third parties relevant in certain circumstances, cases like *Tarasoff* have forced clinicians to rethink traditional notions about confidentiality. In the light of this Petril & Sadoff believe that the application of the principle of confidentiality to the relationship between clinicians and families acting in the role of caregiver must be reconsidered. Failure to share certain information with families may lead to allegations of malpractice.⁹²⁴

There are many types and sources of confidentiality law, some of which are quite detailed and others cursory. Some are more protective of confidentiality than others and some have been revised more recently than others.⁹²⁵

5. Summary

Due to the stigma attached to mental illness, it is extremely important that the information imparted to a psychiatrist should remain confidential. The right to privacy can however never be absolute. One such exception is the protection of identifiable third parties whose lives are threatened by the mentally disturbed. The role that the family plays as a caregiver also needs to be considered and possible exceptions made in breaching confidentiality if necessary, to enable the family to understand the nature of the patient's illness, side-effects of medication taken, and detection of signs of possible violence by the patient before any harm is caused.

⁹²² Gates & Arons (2000) 38.

⁹²³ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553.

⁹²⁴ Petril & Sadoff (1992) 137-138.

⁹²⁵ Gates & Arons (2000) *Privacy and confidentiality in Mental Health Care* 110.

CHAPTER 6

Observations and conclusions

1. Conceptualisation of matters related to confidentiality and privacy.

The concept of medical confidentiality is very old and universally accepted and arises from the doctor-patient relationship. Due to the sensitive nature of information sometimes disclosed to a doctor it is important that the patient can trust the doctor to keep the information confidential. This in turn encourages patients to come forward for treatment of sometimes embarrassing and life-threatening conditions that could possibly endanger public health. Respecting individual autonomy and human dignity is another reason why any information that is disclosed should remain confidential. The Constitution is the supreme law of the land and any law or conduct inconsistent with it is invalid.⁹²⁶

The different codes of medical ethics all contain rules about maintaining doctor-patient confidentiality. There has however been a gradual trend away from the absolute rules of confidentiality imposed by the Hippocratic Oath. The protection of the public interest always need to be considered and weighed up against the protection of the patient's right to privacy. One of the most difficult problems in medical ethics is deciding when it is justified to breach confidentiality. Every case has to be judged on its own merits, but failure to warn an endangered person can result in the doctor being held liable. *Tarasoff*⁹²⁷ serves as a good example where the court described the duty of confidentiality as ending where the public peril begins.

Civil and common law systems approach physician-patient disclosure, or judicially compelled disclosure of confidential information, differently. Civil law has limited judicially compelled disclosure in the physician-, nurse- or pharmacist-patient relationship.

⁹²⁶ Constitution of the Republic of South Africa, 2006; s. 2.

⁹²⁷ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553.

There is no absolute privilege for communications between a doctor and patient in South Africa. Doctors can be held in contempt of court and fined, if they do not comply with a court order to provide the necessary information. Such disclosure is however seen as an absolute defence to the breach of medical confidentiality.

Rogers-Magnet observes that the situation with regards evidentiary privilege in Canada is in an interesting state of confusion.⁹²⁸ Although the traditional common law rule in Canada rejects testimonial privilege for doctors, this can no longer be said to apply in every case. Any communication is potentially entitled to common law privilege on a case-by-case basis and the cases are analysed using the four-part Wigmore test. As a result of this case-by-case approach adopted by the Supreme Court of Canada, privilege will be held to be justifiable in some situations and not in others even when it concerns a sensitive relationship such as that which exists between a psychiatrist and a patient.

The civil law province of Quebec however, recognises a professional secret⁹²⁹ for communications between physicians, dentists and patients. Certain exceptions are recognised such as contagious disease, psychiatric detention, child abuse and medical malpractice actions instituted by the patient.⁹³⁰ Privilege can also be conferred by statute.

The position with regards criminal law is fairly stable. Neither the accused nor the witness appears to be free to object to the introduction of otherwise confidential personal information on any grounds of privilege *per se*. On the civil side the legal position is less clear.

In the USA almost every state has either a physician-patient or psychotherapist-patient privilege, and about two-thirds of the states have enacted a statutory privilege. These are however, often subject to many exceptions, which reduce the effectiveness of the privilege. Often they apply only to physicians and not other health care workers. Where

⁹²⁸ Steel (1983) 268

⁹²⁹ Professional secret is the civil law's counterpart to the common law's concept of privilege.

⁹³⁰ Shuman (1986) "The privilege study (Part III): psychotherapist-patient communications in Canada" *International journal of law and psychiatry* 393.

patients put their health at issue in a lawsuit, or fail to object to admission of testimony, their waiver of the privilege is implied.

In today's modern health care environment there is an increasing need to find a balance between the patient's need for confidentiality and other interested parties needs to access such information, mainly to control costs and increase performance. Examination of patient records has continued to expand due to the growth of electronic databases, third party utilisation review, managed care organisations, governmental oversight agencies and medical research. Insurance companies with obligations to bill, law enforcement authorities, and employers also need information. The government may require access to medical records for workplace or fraud investigations as well.

The above scenario has resulted in increasing tension between the need for confidentiality of patient records and the many legitimate claims for access to these records. This conflict is no longer easily resolved by professional ethics. In the USA it has resulted in increasing lawsuits.⁹³¹

2. The concept of privacy: its development and protection

2.1 South Africa

The right to privacy in South Africa is protected by both the common law and section 14 of the *Constitution*⁹³². The recognition of an action for invasion of privacy is a logical development under the *actio injuriarum* which affords a general remedy for wrongs to interests of personality. The right to privacy is recognised by the common law as an independent right of personality delimited within the *dignitas* concept. In most cases an action for invasion of privacy will be based on the *actio injuriarum*, with an infrequent subsidiary claim under the *lex Aquilia*. The recognition of the concept of privacy in the *Constitution* further confirms the independent existence of the right to privacy.

In *Bernstein*⁹³³ the Constitutional Court emphasised the interdependency between the common law and the constitutional right to privacy. A distinction was made between the

⁹³¹ Furrow (2000) [United States of America] *International encyclopaedia of law: Medical law* 145, 155.

⁹³² *The Constitution of the Republic of South Africa, 2006*

⁹³³ *Bernstein and others v Bester and others NNO* 1996 (2) SA 751 (CC).

two-stage constitutional inquiry into whether a right has been infringed and whether the infringement is justified, and the single inquiry under the common law, as to whether an unlawful infringement of a right has taken place. The Bill of Rights is applicable to all law, and therefore the courts have an obligation to develop the common law in accordance with the spirit, objects and purport of the Bill of Rights. Just as the common law right to privacy is not absolute, so is the constitutional right to privacy, which can be limited by the law of general application, namely section 36 of the *Constitution*.

*The Promotion of Access to Information Act*⁹³⁴ gives grounds of refusal for the disclosure of “personal information”, which includes information relating to sex, pregnancy, physical and mental health, well-being and disability. It relates to both the public and private sector. However, no protection of information is absolute and therefore sections 46 and 70 deal with the mandatory disclosure of information in the public interest.

Section 14(1) of the *National Health Act*⁹³⁵ protects the confidentiality of information relating to a persons health status, treatment and stay in hospital. Section 14 (2) allows however for the disclosure of information if required by law or if there is a serious threat to public health.

A new *Protection of Personal Information Draft Bill* has recently appeared and will go a long way in protecting personal information. The bill recommends that an Information Protection Commission should be established, who will be responsible for the implementation of both the *Protection of Personal Information Act* and the *Promotion of Access to Information Act*⁹³⁶.

The protection of informational privacy is still in its infancy in South African law. New legislation has appeared since 2000 relating to the promotion and protection of information and a new *National Health Act*⁹³⁷ also commenced in May 2005. These all have a role to play in protecting sensitive health information.

⁹³⁴ *Promotion of Access to Information Act* 2 of 2000.

⁹³⁵ *National Health Act* 61 of 2003.

⁹³⁶ *Promotion of Access to Information Act* 2 of 2000.

⁹³⁷ *National Health Act* 61 of 2003.

2.2 Canada

In Canada there is no general legal right to privacy, but instead where the term privacy is used it is taken to be a statement of principle in support of some other already recognised right or cause of action. The right to privacy *per se* is not recognised or protected by the common law.

Canada's Constitution and Charter of Rights and Freedoms does not explicitly provide for the right to privacy, but in interpreting Section 8 of the Charter, which grants the right to be secure against unreasonable search or seizure, the Canadian courts have recognised an individual's right to a reasonable expectation of privacy.

The *Privacy Act* and the *Personal Information and Electronic Documents Act (PIPEDA)* at the federal level, protect privacy. The Independent Privacy Commissioner of Canada oversees these two acts. The Commissioner encourages the development of codes of conduct, as a further instrument of compliance with the law.

On a provincial level privacy legislation is separated into three categories, namely public sector data protection law, private sector law and sector specific law. Alberta, Manitoba, and Saskatchewan have all passed health specific legislation, which sets rules for the collection, use and disclosure of health information. Many provinces in Canada have enacted legislation that is designed to deal with issues of confidentiality, accessibility and use of computerised personal information in general. Four of the provinces have enacted legislation specifically providing for recognition of a right to privacy.

2.3 USA

The right to privacy is recognised and protected by the common law in the USA.

The right to privacy and even the word privacy are not explicitly mentioned in the United States Constitution or the Bill of Rights. The Supreme Court has however upheld the right to privacy against governmental invasion under the First, Fourth, Fifth and Ninth amendments and the due process clause of the Fourteenth amendment and the penumbra of freedoms in the Bill of Rights. In the USA, the Constitution protects the individual from the government and not from private entities. The rights created are also

negative rights, in other words they prevent certain types of governmental action, but at the same time there is no duty on the government to actively protect an individual against invasion of their privacy rights, as is the case in South Africa.

Some states follow the federal government's lead and do not provide an explicit right to privacy in their constitutions. This has resulted in a patchwork of federal and state laws governing the somewhat vague right to privacy.

A wide assortment of privacy laws is found in the individual states and at the federal level, but no comprehensive privacy protection law has been enacted for the private sector. There is also no independent privacy oversight agency as is the case in Canada and as is proposed for in South Africa. This means that individuals with complaints about privacy must engage in expensive lawsuits or have no recourse at all.

The *Privacy Act*⁹³⁸ and the *Freedom of Information Act*⁹³⁹, protect privacy at the federal level. The Privacy Act does not apply to the vast majority of entities collecting health information outside the federal government. It also allows disclosure of personal identifiable information to another agency, if the information is deemed necessary for the "routine use" of the receiving agency. The Privacy Act does not protect information that must be disclosed under the FOIA. Courts that review an application for disclosure of information, must employ a balancing test that weighs the individual's right to privacy against the public's interest in the information. There are a number of exceptions to the release of information under the FOIA. One of the exempt categories includes personnel and medical files.

The enactment of the *HIPAA Privacy Rule* that became effective for enforcement in April 2003 was the start to the beginning of a complete federal legal structure addressing health information privacy. Unfortunately the large number of exemptions limits the protection offered by the new rules. It may provide widespread protection of medical records by state bodies, but imposes virtually no restrictions on what private healthcare providers may disclose to third parties. It only applies to electronic and not paper re-

⁹³⁸ *Privacy Act* 5 USC § 552a (1994).

⁹³⁹ *Freedom of Information Act* 5 USC § 552 a(b)7.

records and no private right of action for individuals to sue for breach of confidentiality is provided for in HIPAA.

At least ten states guarantee their citizens an express, albeit general privacy right, while eight states have developed comprehensive medical confidentiality laws. A much debated issue surrounding privacy legislation is whether federal law should preempt state law. State laws usually provide more detailed rules protecting people from disclosure of sensitive conditions, such as mental illness, communicable diseases, cancer, or a genetic disposition to certain diseases. The *HIPAA* rules do not override stronger state law. Advocates of federal pre-emption maintain that federal law will provide much needed uniformity. Health care organisations and insurers often operate across state lines, and inconsistent state laws cause confusion and increase administrative costs. There is a lack of consistency among the states with regards privacy legislation.

3. Causes of action & defences for breach of medical confidentiality

1. South Africa

In South Africa there has only been a few reported cases dealing with a breach of medical confidentiality.⁹⁴⁰

The following actions can be brought in South Africa for breach of medical confidentiality: Defamation, breach of confidence, breach of privacy, breach of a statute and negligence.

Defences which rebut the wrongfulness of the defendant's conduct under the *actio injuriarum* and which could be used to defeat the claim of invasion of privacy include the following: justification, privilege, fair comment, consent, necessity, self-defence and statutory authority.

Taitz⁹⁴¹ states that there are five absolute defences, namely order of court, consent by the patient, disclosure required by legislation, where the medical practitioner is the de-

⁹⁴⁰ *Jansen van Vuuren and another NNO v Kruger* 1993 (4) SA 842 (A); *N M and others v Smith and others* 2005 JDR 0590 (W); *VRM v The Health Professions Council of South Africa and others* 2003 JDR 0769 (breach of confidentiality was not the main issue, but was touched on in this case).

endant or accused, and where the doctor warns a health care worker or spouse or other sexual partner of a patient who has HIV / Aids in terms of the SAMDC resolution.

Then there are also qualified defences, which are decided by weighing the possible damage to the public or individual members of the public on the one hand, against the possible damage to the patient on the other. The warning of an endangered third party falls within this area of public defence.

The defences to a common law invasion of privacy still need to be examined in the light of the Constitution, to determine whether they are consistent with the provisions of section 36.

2. Canada

In Canada there have been very few cases addressing the wrongful or unwarranted disclosure of medical information.

The common law provides several remedies for the unjustifiable disclosure of confidential information. These remedies can be found in the doctrines of contract and tort, in statute, and in actions based on breach of statute.

The following actions can be brought in Canada for breach of medical confidentiality: Defamation, breach of contract, negligence, breach of fiduciary duty, action for breach of confidence, and breach of a statutory duty. These causes of action are not mutually exclusive.

The following are defences for breach of privacy in Canada: patient consent, the patient putting their medical condition in issue (undecided presently, awaiting determination by a higher court), duty to disclose and qualified privilege.

3. USA

The following actions can be brought in the USA for breach of medical confidentiality:

⁹⁴¹ Taitz "The rule of medical confidentiality v the moral duty to warn an endangered third party" (1990) 78 *SAMJ* 30.

Defamation, breach of contract, breach of a fiduciary duty, invasion of privacy, breach of confidence, physician disclosure tort, violation of statutes defining physician conduct, negligence / malpractice and intentional or negligent infliction of emotional distress.

The following defences may be brought for breach of privacy in the USA:

Truth, privilege and consent in the case of defamation, patient consent, newsworthy events and matters of legitimate public concern constitute a defence, waiver or estoppel, judicial compulsion, and compliance with legal mandates including a duty to warn third parties.

4. Exceptions allowing breach of confidentiality outside a court of law

Two aspects are considered, namely disclosure that is required by legislation and the duty of the physician to warn endangered third parties. Legislative prohibitions against disclosure of confidential information might well serve as the basis of a successful action based on breach of statute or in negligence. This is the case in the USA and Canada and I submit this would most probably also be the case in South Africa if tested in the Courts.⁹⁴²

Although breach of a statute is not *prima facie* evidence of the common law tort of negligence, it is evidence that can be used towards proving negligence.⁹⁴³

1. South Africa

Disclosure required by legislation:

In terms of the *Health Act*⁹⁴⁴, a doctor is obligated to report any notifiable diseases and in terms of the *Mental Health Care Act*⁹⁴⁵, under certain circumstances the head of a national or provincial department or the head of a health establishment may disclose the information which a mental health care user is entitled to keep confidential, if the failure to do so could seriously prejudice the health of the patient or other people.

⁹⁴² Steel & Rodgers-Magnet (1983) *Issues in tort law* 291.

⁹⁴³ Carey (1998) *Health law in Canada* 8.

⁹⁴⁴ *Health Act 68 of 1977*.

⁹⁴⁵ *Mental Health Care Act 17 of 2002*.

Duty to warn an endangered third party:

In South Africa there is no general rule that requires a person to whom they owe no legal duty, to take positive steps, in order to avoid damage or injury to that person. It seems as if a doctor who fails to warn an endangered third party incurs no legal liability under South Africa law. However according to the Health Profession Council of South Africa guidelines⁹⁴⁶ if it were to be found that an act or omission on the part of the health care worker led to the unnecessary exposure to HIV infection of another health care worker, the Council would see this in a very serious light and would consider disciplinary action against the doctor concerned.

2. Canada

Disclosure required by legislation:

In terms of the *Health Protection and Promotion Act (HPPA)* a physician may breach a patient's confidentiality to fulfil a mandatory obligation to the Medical Officer of Health to report a patient suffering from a reportable and communicable disease.⁹⁴⁷

In Ontario in terms of the *Child and Family Services Act (CFSA)*⁹⁴⁸ health care professionals must report child abuse if they have reasonable grounds to suspect that it is taking place.⁹⁴⁹

Some provinces have legislation that requires physicians to inform the Registrar of Motor Vehicles of the personal details of patients whose condition may make it dangerous to drive a car.⁹⁵⁰ Every physician or optometrist is obligated in terms of the *Aeronautics Act (AA)*⁹⁵¹ to report to a medical advisor, every patient who is a flight crew member, air traffic controller or other holder of a Canadian aviation document, who he believes on reasonable grounds is suffering from a medical or optometric condition that is likely to constitute a hazard to aviation safety.

⁹⁴⁶ Health Professions Council of South Africa (2001) *Management of patients with HIV infection and aids* 7.

⁹⁴⁷ Bloom & Bay *A practical guide to mental health, capacity, and consent law of Ontario* (1996) 400.

⁹⁴⁸ *Child and Family Services Act* RSO 1990, c C11, s 72(4).

⁹⁴⁹ Bloom & Bay (1996) 396.

⁹⁵⁰ *Highway Traffic Act (HTA)* RSO 1990, c H8 (of Ontario).

⁹⁵¹ *Aeronautics Act*, rsc 1985, c A-3, s6.5(1).

A physician is not required by statute to disclose to the police, medical information relating to a patient's past or potential criminal behaviour, with the exception of child abuse. No statute requires a physician to notify the police if a patient arrives with a gunshot wound.⁹⁵²

Duty to warn an endangered third party:

Traditionally a doctor was not obligated to warn third parties or the police of the possible danger that a certain patient posed. There is however, now a trend in the common law towards the imposition of a duty to warn third parties, which stems from the case of *Rivtow Marine Ltd.*⁹⁵³

Doctors have also taken steps to recognise at least an ethical, if not a legal duty to warn third parties, which again has been influenced by the American case of *Tarasoff*⁹⁵⁴. The regulations governing the medical profession have however, not kept pace with the common law. In Ontario, doctors who release patient information are breaching their professional code, and they can be disciplined under the provincial *Medicine Act*.⁹⁵⁵ There is however a common law duty to warn. The doctors' actions could therefore be in accordance with the common law but in breach of provincial regulations, or *visa versa*.⁹⁵⁶

3. USA

Disclosure required by legislation:

The various states have their own legislation regarding what must be disclosed. Doctors are required to report communicable diseases and wounds inflicted by bullets, knives or other weapons, as well as poisonings, industrial accidents, abortions, drug abuse, child abuse and abuse of the elderly and disabled.

Failure to report can result in civil or criminal sanctions, and doctors who do not report can be found liable to anyone who is injured.

⁹⁵² Caulfield (1999) 80; see *supra* Chapter 4 for more information.

⁹⁵³ *Rivtow Marine Ltd. V Washington Iron Works* [1973] 6 WWR 692, 40 DLR (3d) 530 (SCC).

⁹⁵⁴ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553.

⁹⁵⁵ O.Reg 856/93.

⁹⁵⁶ Caulfield (1999) 80; Steel & Rodgers-Magnet (1983) 32; Carey (1988) 4.

These state laws tend to be very patchwork in nature and what is needed is a comprehensive medical privacy law, at the federal level.

Duty to warn an endangered third party:

A legal duty to protect third parties may arise through the common law, whenever the patient's condition poses a significant risk or danger to others. According to *Tarasoff*⁹⁵⁷ there is also a duty to warn identifiable persons that a patient has made a credible threat to kill. This does not have to be a warning *per se*, but requires according to *Tarasoff* whatever steps are reasonable necessary under the circumstances. The liability under *Tarasoff* turns on foreseeability and therefore one of the main duties of doctors and psychiatrist's specifically is to evaluate their patients thoroughly in order to assess the patient's potential for violence or the causing of harm.

5. Aspects of confidentiality relating to mental health

Certain types of health care information are considered sufficiently sensitive to warrant special attention. In the case of mental health care the ability to preserve privacy and trust takes on special importance, due to the highly personal nature of the information about a patient's mental state and secondly as a result of the stigma attached to mental illness.

1. South Africa

The new *Mental Health Care Act*⁹⁵⁸ commenced on the 15th December 2004, at the same time as that of the regulations. The Act protects the privacy and human dignity of the mental health care user, in accordance with the spirit of the Constitution, where all people, including the mentally ill, should be treated equally.

It acknowledges however, that no right is absolute and that the rights of others should also be considered. Therefore according to section 13(1) and (2) the head of the health establishment or national or provincial departments may disclose information if the failure to do so, would seriously prejudice the health of the mental health care user or that of other people.

⁹⁵⁷ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553.
⁹⁵⁸ *Mental Health Care Act* 17 of 2002.

As far as can be ascertained there has been no case relating to medical confidentiality and the mentally ill.

2. Canada

The Canadian Psychiatric Association states that psychiatrists should be vigilant in safeguarding the confidentiality of their patient's communications. Section 35 of the *Mental Health Act (MHA)*⁹⁵⁹ established a prohibition to the disclosure of a clinical record, except under specified circumstances. In Canada, the American case of *Tarasoff* has only been described in detail in the case of *Wenden v Trikha*⁹⁶⁰, but not specifically applied, since the facts of the latter case are not similar to that of *Tarasoff*, and the duty to warn did not arise. It seems likely however, that faced with a true *Tarasoff* issue, a Canadian court would give their support to the general principles underlying the California Supreme Court decision.⁹⁶¹

3. USA

The American Medical Association allows disclosure by a doctor only when legally compelled to do so, or when necessary to protect the safety of the patient or community. The American Psychological Association's ethical principles of 1992 state that confidentiality is not absolute and "where permitted by law for a valid purpose, such as ... to protect the patient or client from harm",⁹⁶² confidentiality may be breached.

Most states have separate statutes defining the confidentiality of mental health information. Exceptions are normally allowed for a legislative or judicially created exception. Often exceptions are allowed for reimbursement purposes and for the given out of information to caregivers. All states also reserve the authority to review patient records without consent to monitor treatment programs, quality issues, and compliance with regulatory requirements.⁹⁶³

A physician's duty to maintain confidentiality may conflict with a duty to disclose information, in order to warn endangered third parties. Such a duty may be based on statute

⁹⁵⁹ *Mental Health Act* R.S.O 1990, Chapter M.7.

⁹⁶⁰ *Wenden v Trikha* (1991) 116 AR 81 (QB), aff'd (1993), 14 CCLT (2d) 225 (CA).

⁹⁶¹ Bloom & Bay (eds) (1996) 393.

⁹⁶² Gates & Arons (2000) 92.

⁹⁶³ Gates & Arons (2000) 90.

or on the common law duty of psychiatrists or psychologists to warn identifiable persons threatened by their patients. This obligation normally extends to the patients with whom the physicians have a legal relationship, either under an implied or express contract.⁹⁶⁴

*Tarasoff*⁹⁶⁵ ruled that mental health professionals who can reasonably come to the conclusion that their patients might cause harm to identifiable third parties, must take the necessary steps to protect the third party. The various states vary in the amount of discretion mental health professionals enjoy in determining whether to take steps to protect third parties. Some states have enacted legislation that permits but does not require disclosure. Some states have rejected the rule that mental health professionals in outpatient settings have an obligation to third parties.⁹⁶⁶

Mental health professionals should seriously reexamine the application of rigid confidentiality rules, especially when they compromise the ability of families to function as caregivers. It is better to keep the families informed about the patient's medication and the effect it might have on the patient's behaviour, but it is not necessary that they should know the patient's intimate thoughts. Failure to share certain information with families may lead to allegations of malpractice.⁹⁶⁷

6. Final conclusions

The notion of respecting a patient's privacy and keeping all information imparted confidential, goes back a very long way to the time of Hippocrates.⁹⁶⁸ This right is protected both in terms of the common law and in terms of legislation in South Africa, Canada and the USA. However, in all three countries researched, it is acknowledged that the right to privacy is not absolute and that the legitimate interests of others and the public interest should be weighed up against the right of the patient to privacy.

There are operational difficulties in protecting the confidentiality of health information. The sheer number of people who have access to health information is one of the difficulties faced, especially in a hospital setting. Often, not all who have potential access

⁹⁶⁴ Furrow (2000) 158.

⁹⁶⁵ *Tarasoff v Regents of University of California*, (1974), 13 Cal.3d 177, 529 P 2d 553.

⁹⁶⁶ Gates & Arons (2000) 102-103.

⁹⁶⁷ Petrila & Sadoff (1992) 38,137-138.

actually need all the information. It may be impractical however to segregate records physically in a way that prevents unauthorised staff from having access. With computerised health systems, unless the system has a way of recording who is “officially” involved in caring for a patient, it may be possible for any nurse, doctor, laboratory technician or other health care professional to look up any patient’s information.⁹⁶⁹

Another operational difficulty is the challenge of educating health care professionals about their role in protecting patient’s privacy and confidentiality.⁹⁷⁰ The day-to-day responsibility of protecting patient confidentiality must rest with every health care provider.⁹⁷¹ Health professionals must avoid careless conversations in the workplace and gossip outside the workplace that could jeopardise patient confidentiality. The design of most modern health care facilities, with semiprivate rooms, caregiver stations within earshot of waiting rooms and registration areas in the main foyer, has compounded⁹⁷² the problem. Staff needs to be trained in the practical aspects involved in maintaining confidentiality. Every effort should be made to work around these operational difficulties and still maintain confidentiality. In South African state hospitals this is a tall order, but it is non-negotiable in a society that prides itself in protection of people’s rights.

Good reasons to gain access to health information such as research, quality assurance, and public health protection do exist, but the questions in each case is how much information is enough for the purposes mentioned.⁹⁷³ One may have to take note of the conflicting rights of others such as insurance companies and medical aid schemes that have to pay the medical bills. They may demand certain information that they deem necessary to control their expenses. The public health question that includes the fight against contagious diseases also needs to be taken into account.⁹⁷⁴

⁹⁶⁸ Hippocrates was born on the island of Cos between 470 and 460 BC.

⁹⁶⁹ Dennis (2000) *Privacy and confidentiality of health information* 4.

⁹⁷⁰ *Ibid.*

⁹⁷¹ Dennis (2000) 2.

⁹⁷² Dennis (2000) 26-27.

⁹⁷³ Gates & Arons (2000) xix.

⁹⁷⁴ South African Law Reform Commission (2005) 135-136.

What is clear is that great care must be taken to define what information is made available, to whom it is made available, and to what purpose it is being put, as the decision could have a profound effect on a person's life.⁹⁷⁵

The protection of the right to privacy in South Africa is still in its infancy and it is unlikely that actions based on breach of privacy will be brought before our courts very often. It is therefore important that such matters be regulated by legislation.⁹⁷⁶ Section 7(2) of our *Constitution* states that the state must respect, protect, promote and fulfil the rights in the Bill of Rights and this includes the right to privacy⁹⁷⁷, the right to access to information⁹⁷⁸ and the right to health care.⁹⁷⁹ This has resulted in a number of new acts being promulgated within the last five years or so, such as the *Promotion of Access to Information Act 2 of 2000* and the *National Health Act 61 of 2003*. Data storage technologies and informatics have changed so rapidly that the laws and policies governing the protection of personal information has not been able to keep pace and for this reason, as well as to protect the right to privacy the *Protection of Personal Information Draft Bill* has taken shape. The *Mental Health Care Act 17 of 2002* also recognises that the Constitution prohibits unfair discrimination of people with mental disabilities. South Africa compares favourably to Canada and the USA, with all these new statutes in place.

South Africa is actually in a better position to that of the USA and Canada, in the sense that there is no patchwork of laws that protect the right to privacy. We have similar legislation either in place or in the making and not such a confusing array of provincial and national legislation.

In the USA, constitutional rights are usually not applicable unless "state action" can be found. The Constitution in other words, protects the individual from the government and not from private entities. Secondly, the rights created by the Constitution are "negative rights", in other words they prevent certain kinds of governmental action, and at the same time there is no duty on the government to actively protect a person against inva-

⁹⁷⁵ Gates & Arons (2000) xx.

⁹⁷⁶ South African Law Reform Commission (2005) 76.

⁹⁷⁷ *The Constitution of the Republic of South Africa, 1996* s.14.

⁹⁷⁸ *The Constitution of the Republic of South Africa, 1996* s. 32.

⁹⁷⁹ *The Constitution of the Republic of South Africa, 1996* s. 27.

sion of his or her information privacy rights.⁹⁸⁰ There constitutional protections lack the capacity to protect privacy invasions from private actors seeking personal information.”⁹⁸¹ Because there is no comprehensive privacy legislation, there is also no oversight agency. Individuals with complaints about privacy must engage in expensive lawsuits or they have no recourse at all.⁹⁸² In this sense South Africa is in a much better position. Our Constitution protects the individual from both the state and private entities with the horizontal application of rights being possible in certain instances. Our rights are not negative rights but impose actual duties on the State to act, as was seen in the case of *Carmichele*.⁹⁸³ What is proposed in the *Protection of Personal Information Draft Bill* is a comprehensive privacy act that makes provision for an oversight agency in the form of the Information Protection Commissioner, which will put us in the same position as Canada.

What still needs to be put into place is and what is suggested in the *Protection of Personal Information Draft Bill* is the office of the Information Protection Commissioner to monitor compliance with the legislation, handle complaints, do research and help with the drawing up of codes of conduct. What is needed is a code of conduct that pertains specifically to the protection of health information. Grey areas such as parental access to minors’ medical records need to be clarified and clearly spelled out. The fields of medicine and technology continue to change rapidly with the likes of telemedicine etc. and the law needs to take note of these changes and put legislation in the form of regulations or policies in place, to protect the patient’s right to privacy.

The courts must decide whether they wish to regard the common law delictual action for invasion of privacy or the constitutional right to privacy as the main means for protecting people from unwanted disclosures. In accordance with the principle of constitutional supremacy, a court must test a challenged law or conduct against all possibly relevant provisions of the Bill of Rights, whether the applicant relies on them or not. The duty of the courts to develop the common law is not purely discretionary. As stated in *Car-*

⁹⁸⁰ Roos, A (2003) *The law of data (privacy) protection, a comparative and theoretical study* LLD Unisa 38.

⁹⁸¹ Glenn “Protecting health information privacy: the case for self-regulation of electronically held medical records” (2000) 53 *Vanderbilt law review* 1612.

⁹⁸² South African Law Reform Commission (2005) 247.

⁹⁸³ *Carmichele v The Minister of Safety and Security and Another* 2001 JDR 0524 (CCT); par. 39.

*michele*⁹⁸⁴ “it is implicit in s 39(2) read with s 173 that where the common law as it stands is deficient in promoting the s 39(2) objectives, the Courts are under a general obligation to develop it appropriately.” When the common law is developed it must be done on a case-by-case basis. The development can also not take place in the abstract. The courts must apply the law as it is found in the case before them. This approach has also found favour when the Bill of Rights is directly applied to the common law, since the consequences of a direct application differ from those of an indirect application. De Waal states that one of the most important limitations on the power to develop the common law via the indirect application of the Constitution is the doctrine of *stare decisis*.⁹⁸⁵

Common law privacy jurisprudence will continue to have application in the resolution of privacy disputes. The so-called traditional principles looked at above⁹⁸⁶ should be fully utilised. These principles are based on the ordinary delictual principles as influenced by the Constitution. Remedies developed for infringement of the common law right to privacy do not have to be replaced by an entirely new set of remedies.

The right to privacy, as a fundamental right, can be limited by section 36⁹⁸⁷ of our Constitution. On a case-by-case basis, the right to privacy will have to be weighed up against conflicting interests and rights of the community such as the right of access to information, and a balance will have to be found.⁹⁸⁸ State demands for information that is reasonably required for official statistical purposes or for statutory reporting requirements concerning information about child abuse⁹⁸⁹ and mental patients who are dangerous⁹⁹⁰, are likely to be regarded as reasonable and justifiable.⁹⁹¹

⁹⁸⁴ *Carmichele v The Minister of Safety and Security and Another* 2001 JDR 0524 (CCT) ; par.39.

⁹⁸⁵ De Waal and Currie (2005) *Bill of Rights Handbook*.

⁹⁸⁶ For more on actions and defences see p. 95.

⁹⁸⁷ Known as the limitation clause it states: “The rights in the Bill of Rights may be limited only in terms of a law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including (a) the nature of the right (b) the importance of the purpose of the limitation (c) the nature and extent of the limitation (d) the relation between the limitation and its purpose and (e) less restrictive means to achieve the purpose.”

⁹⁸⁸ South African Law Reform Commission (2005) 30.

⁹⁸⁹ *Child Care Act 74 of 1983* s 42.

⁹⁹⁰ *Mental Health Care Act 17 of 2002*; s 13 (1)

⁹⁹¹ McQuoid-Mason (2000) *AJ* 249.

The right to privacy and confidentiality remains a complex issue. Every case needs to be handled on its own merits, because the right to privacy is not absolute and a careful weighing up of interests always needs to take place. What the most reasonable solution is should always be considered, since this promotes fairness and equality.⁹⁹² At all times when interpreting the common law or legislation pertaining to privacy, the spirit and purpose of the Constitution must be taken into account.

⁹⁹² Pearmain (2004) *A critical analysis of the law on health service delivery in South Africa* LLD 1299-1300.

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Explanatory notes on formatting

In the main body of the dissertation, the initials of the author are not given. The more complete citation, which contains the author's initials, is found in the bibliography. The surname is followed directly by the date of publication.

If there is more than one article or book written by the same author, the correct reference is distinguishable by the date of publication.

In every chapter, the first reference made to an article or book is given more completely. Subsequent references in the same chapter are abbreviated. Abbreviations are given for the titles of journals, but the full title can be found in the bibliography and in the list of abbreviations.

Eg. First reference for a journal: McQuoid-Mason (2000) "Invasion of privacy: common law v constitutional delict – does it make a difference?" *AJ* 260.

Subsequent reference for a journal: McQuoid-Mason (2000) *AJ* 260.

First reference for a book: Dennis (2000) *Privacy and confidentiality of health information* 4.

Subsequent reference for a book: Dennis (2000) 4.

References to cases and acts are given fully every time and are written in italics. References to case names appear in the main body of the text in italics except when they are intended to as references to the people themselves in which case they appear as normal text.

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DRAFT BILLS

Protection of Personal Information Draft Bill

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Mental Health Care Act 17 of 2002
National Health Act 61 of 2003
Promotion of Access to Information Act 2 of 2000

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LIST OF ABBREVIATIONS

AJ	Acta juridical
PER	Potchefstroom electronic law journal
SA family practice	South African family practice
SAJHR	South African journal on human rights
SALC	South African Law Commission
SALRC	South African Law Reform Commission
SALJ	South African law journal
SAMJ	South African medical journal
THRHR	Tydskrif vir hedendaagse Romeins-Hollandse Reg
TSAR	Tydskrif vir die Suid-Afrikaanse reg
Fordham Urb L J	Fordham Urban law journal