

1959

Medical Practice and the Right to Privacy

Minn. L. Rev. Editorial Board

Follow this and additional works at: <https://scholarship.law.umn.edu/mlr>



Part of the [Law Commons](#)

Recommended Citation

Editorial Board, Minn. L. Rev., "Medical Practice and the Right to Privacy" (1959). *Minnesota Law Review*. 2759.
<https://scholarship.law.umn.edu/mlr/2759>

This Article is brought to you for free and open access by the University of Minnesota Law School. It has been accepted for inclusion in Minnesota Law Review collection by an authorized administrator of the Scholarship Repository. For more information, please contact lenzx009@umn.edu.

Notes

Medical Practice

and the Right to Privacy

The author of this Note discusses the patient's right to privacy, focusing especially on disclosure of confidential information that the doctor acquires during the professional relationship. He concludes that the doctor should have discretion, bounded by reasonableness, to decide when interests in favor of disclosure override his patient's interest in secrecy, but at the same time he sets out several specific limitations on the exercise of this discretion.

If one of the late king's physicians had kept a diary of what he heard and saw, the court would not, in the king's lifetime, have permitted him to print and publish it.

Lord Eldon in *Wyatt v. Wilson*, 1820.

THE right to privacy is the "right of the individual to be let alone,"¹ and to be free from unwarranted and undesired publicity, whether true or false. Law books and legal periodicals teem with cases and articles on the right to privacy,² and the state of the law developing around the protection of that right is aptly described as that of a "haystack in a hurricane."³

Cases where a patient alleges that his right to privacy has been violated by his physician often involve a difficult balancing of conflicting interests. To enable proper diagnosis and treatment of his physical or mental disorders, the patient must reveal to his doc-

1. Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193, 205 (1890).

2. For a general discussion of the right to privacy, see PROSSER, TORTS § 97 (2d ed. 1955).

3. Privacy has been recognized as a common law civil right in most jurisdictions presented with privacy cases; only Rhode Island, Texas, and Wisconsin refuse to recognize the right. PROSSER, TORTS § 97 at 636-37 (2d ed. 1955). Three states—New York, Utah, and Virginia—have enacted statutes creating limited civil privacy rights: N. Y. CIV. RIGHTS LAW §§ 50-51; UTAH CODE ANN. §§ 76-4-7 to 4-9 (1953); VA. CODE ANN. § 8-650 (1957).

The New York statute, which is very similar to the Utah and Virginia statutes, reads as follows:

Sec. 50. Right of Privacy. A person, firm or corporation that uses for advertising purposes, or for the purposes of trade, the name, portrait or picture of any living person without first obtaining the written consent of such person, or if a minor of his or her parent or guardian, is guilty of a misdemeanor.

Sec. 51. Action for Injunction and for Damages. Any person whose name,

tor information concerning intimate personal matters. His right to prevent undesired public disclosure of this information very often collides head on with the public interest in having it disclosed to further the progress of medical science, to protect some third person likely to be affected by the patient's condition, or to aid in the care and treatment of the patient himself.

This Note will (1) examine the privacy problems raised by the doctor-patient relationship; (2) analyze the types of privacy interests involved in these problems, and the legal defenses or justifications for many privacy invasions; and (3) suggest some possible improvements in the law regarding enforcement of a patient's right to privacy.

THE DOCTOR'S DILEMMA

The physician's ethical duty to keep secret all confidential information obtained from his patients is founded on the Hippocratic oath, in which he pledges that "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of man, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about."⁴ The duty of professional secrecy has been adopted by the American Medical Association in its Principles of Medical Ethics;⁵

portrait or picture is used within this state *for advertising purposes or for the purposes of trade* without the written consent first obtained as above provided may maintain the equitable action in the supreme court of this state against the person, firm or corporation so using his name, portrait or picture, to prevent and restrain the use thereof; and may also sue and recover damages for any injuries sustained by reason of such use and if the defendant shall have knowingly used such person's name, portrait or picture in such manner as is forbidden or declared to be unlawful by the last section, the jury, in its discretion, may award exemplary damages. (Emphasis added.)

4. EDELSTEIN, *THE HIPPOCRATIC OATH, TEXT, TRANSLATION AND INTERPRETATION* 3 (1943).

5. AMERICAN MEDICAL ASSOCIATION, *PRINCIPLES OF MEDICAL ETHICS* 3-4 (1923).

Sec. 2.—Patience and delicacy should characterize all the acts of a physician. The confidences concerning individual or domestic life entrusted by a patient to a physician and the defects of disposition or flaws of character observed in patients during medical attendance should be held as a trust and should never be revealed except when imperatively required by the laws of the state. There are occasions, however, when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected, because the physician has knowledge, obtained through the confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case, the physician should act as he would desire another to act toward one of his own family under the circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

the British Medical Association has taken an even stronger position on this professional duty.⁶

The duty of professional secrecy is not based merely on an altruistic ideal of "sacredness of the relationship"; nor is it based solely on interests of common decency in protecting the patient's reputation or his peace of mind, although these factors are both important underlying reasons for keeping confidential information secret. The principal reason is that without some assurance that information given to the doctor will be kept in confidence, a patient might be reluctant to reveal embarrassing facts which could be vital to proper diagnosis or treatment.⁷ And so the physician has a very serious obligation, both to his patient and to his profession, to keep all the information he acquires during the course of his professional relationships absolutely secret.⁸

6. At the annual representative meeting of the Council of the British Medical Association in Dublin in 1952, the following addition to the principles of ethics was proposed:

There will doubtless occur certain special occasions when it may become a doctor's moral or social duty for the protection of innocent persons to make disclosure to an interested party if the patient, after having been properly and clearly advised as to the appropriate action which he should take, refuses or fails to do so on his own responsibility.

This proposal was decisively rejected; the present Association policy is unequivocal:

A practitioner shall not disclose voluntarily, without the consent of the patient, preferably written, information which he has obtained in the course of his professional relationship with the patient. This includes information concerning criminal abortion, venereal disease, attempted suicide, and concealed birth. The state has no right to demand information except where notification is required by Statute, such as in infectious disease.

Dawson, *The Duties of a Doctor as a Citizen*, 2:2 BRIT. MED. J. 1474, 1475 (1954).

7. The essence of professional secrecy is that the patient should be able to tell the practitioner everything that is necessary for his medical assessment and treatment. This means that the doctor must hear many things that otherwise would remain in the knowledge of the patient alone. The patient must be entirely confident that nothing he reveals will go further. Once there is a suspicion among patients that their confidences are not safe with a doctor the relationships between them become seriously impaired and quite unsuited to the proper practice of medicine.

HADFIELD, *LAW AND ETHICS FOR DOCTORS* 56 (1958). See also Note, *Legal Protection of the Confidential Nature of the Physician-Patient Relationship*, 52 COLUM. L. REV. 383, 384 (1952).

8. Many state statutes recognize the importance of the duty of professional secrecy. See, e.g., MINN. STAT. § 147.02 (1957), which provides that the Board of Medical Examiners "may refuse to grant a license to, or may suspend or revoke the license of, any person guilty of immoral, dishonorable, or unprofessional conduct. . . ." The statute defines the term "immoral, dishonorable, or unprofessional conduct" as meaning, among other things, "(4) wilfully betraying a professional secret."

Nebraska has a similar statute. In *Simonsen v. Swenson*, 104 Neb. 224, 227, 177 N.W. 831, 832 (1920) (dictum), the Nebraska Supreme Court recognized that:

The relation of physician and patient is necessarily a highly confidential one.

But occasionally a doctor may learn that some third person will be exposed to danger from the peculiar disease or disability of his patient, or that someone is about to commit a crime, or even that a crime has already been committed. In these cases, if his patient insists on secrecy, the doctor is in a very unenviable position; his ethical duty to remain silent may be at war with his "moral inclinations and duty as a citizen . . . to do all in his power to prevent harm to others."⁹ Furthermore, even legal compulsion to speak¹⁰ may not ethically justify disclosure of the confidential information in a particular case. Two eminent medical ethics authorities have recently asserted that "The principal element of a doctor's judgment should be concern for his patient. . . . Conscience must be above even law when it confronts political dictates that are unjustifiable from the medical standpoint."¹¹ What then should the doctor do? Although both legal and ethical problems are raised in these cases, this Note will discuss only the extent to which the patient can *compel* his doctor *as a matter of law* to respect his personal interest in privacy.¹²

ANALYSIS OF THE PRIVACY INTEREST

Cases defining a patient's right to privacy fall into two easily distinguishable groups. One group includes cases where the patient complains of intrusion on his physical solitude or seclusion.¹³ The

It is often necessary for the patient to give information about himself which would be most embarrassing or harmful to him if given general circulation. This information the physician is bound, not only upon his own professional honor and the ethics of his high profession, to keep secret, but by reason of the affirmative mandate of the statute itself.

9. Dawson, *supra* note 6, at 1474. For a general discussion see GORDON, TURNER & PRICE, *MEDICAL JURISPRUDENCE* 49 (1953).

10. See discussion of *Duty imposed by law*, *infra*.

11. Glorieux & Gilbert, *Some Aspects of Medical Responsibility*, 4 *WORLD MED. J.* 298, 307 (1957) (translated from the French). Both of these authors are associated with the Belgium Royal Academy of Medicine. Mr. Gilbert is also the Chairman of the Committee of Medical Ethics of the World Medical Journal, and Mr. Glorieux is an Honorary Professor of Medical Ethics at the University of Brussels.

12. Normally any "legal compulsion" comes through an action for damages against the doctor after he has invaded the patient's privacy. As a practical matter, the amount of recoverable damages in *some* cases would be too small to be considered "compulsion." The text statement is intended to distinguish the principal focus of the Note from a discussion of the doctor's ethical responsibilities.

13. The classification is Professor Prosser's. In his hornbook, the professor collects privacy cases under the following four groups: (1) "intrusion upon the plaintiff's physical solitude or seclusion"; (2) "publicity which violates the ordinary decencies, given to private information about the plaintiff"; (3) "putting the plaintiff in a false but not necessarily defamatory position in the public eye"; (4) "appropriation of some element of the plaintiff's personality for a commercial use." PROSSER, *TORTS* § 97 (2d ed. 1955). But since only groups (1) and (2) include cases arising out of a doctor-patient relationship, the discussion in this Note will be limited to those types of cases.

first of these cases, *DeMay v. Roberts*,¹⁴ came to the Supreme Court of Michigan in 1881, almost ten years before the right to privacy was recognized as a separate civil right. In that case, the doctor had brought an unmarried layman friend with him when attending his patient, at the time she was having a baby. The patient recovered for the "shame and mortification" she suffered when she learned that the doctor's friend was not also a professional man. The court said, "It would be shocking to our sense of right, justice and propriety to doubt even but that for such an act the law would afford an ample remedy. . . . The plaintiff had a legal right to the privacy of her apartment at such a time."¹⁵ In another case, a hospital was held liable to a woman patient who had been subjected to rude and excessive intimate physical examinations.¹⁶ The law of these cases is both clear and correct; these doctors had violated the basic principles of common decency, and there is nothing in the doctor-patient relationship that would justify discourteous, indecent, or brutal treatment of the patient.

The legal problems are more challenging in the second group of cases defining the patient's right to privacy. In these cases, the patient complains that the doctor has violated his duty of secrecy by publicly disclosing offensive private information. Several of these cases turn on the issue whether a doctor may publish photographs or moving pictures of his patient, taken during the patient's illness or confinement. Courts have consistently held that publication of these photographs violates the patient's right to privacy.¹⁷

14. 46 Mich. 160, 9 N.W. 146 (1881). Recovery in this case was based on a technical battery.

15. *Id.* at 165, 9 N.W. at 149. Notice the court's use of the term "privacy." The ordinary meaning of that term, as it is used in the context of the *DeMay* opinion, probably well sums up the legal privacy interest protected in this group of cases.

16. *Inderbitzen v. Lane Hospital*, 124 Cal. App. 462, 12 P.2d 744 (1932). The patient in this case, a pregnant woman, was subjected to twenty or thirty rectal and vaginal examinations by young men who had not first washed or sterilized their hands. She was rolled over, poked, and prodded during these examinations, and when she screamed protests the men laughed at her. A later examination disclosed that she had suffered a tear in her uterus, which had become infected. See also, *Stone v. Eisen*, 219 N.Y. 205, 208, 114 N.E. 44, 45 (Ct. App. 1916), an attempted rape case, where the court made the elementary observation that:

Decent and respectful treatment is implied in the contract [for medical services] from the confidential relation of the parties, and especially because of the necessary exposure of the person required of the patient in connection with the services to be performed. . . .

See also *Carr v. Shifflette*, 82 F.2d 874 (D.C. Cir. 1936), a case in which the plaintiff was subjected to medical treatment requiring exposure of her body to a nonprofessional person.

17. In *Griffin v. Medical Soc'y*, 11 N.Y.S.2d 109 (Sup. Ct. 1939), photographs taken before and after the patient's treatment were published in a medical journal, along with an article entitled "The Saddle Nose." The court was principally concerned with determining whether this was a use for "advertising" or "trade"

One court has even held a hospital liable to the parents of a dead child for publishing photographs of the child's deformed body.¹⁸ However, in no reported case where neither the published photograph nor any accompanying writing disclosed the patient's identity, has a court granted the patient any form of relief for invasion of his right to privacy. Probably the reason for this is that no publication failing to disclose the patient's identity¹⁹ is likely to be deemed offensive to the ordinary sensibilities of patients in similar circumstances.²⁰ According to this reasoning, there would be no actionable invasion of privacy by the publication of photographs of

purposes under the New York privacy law (see note 3 *supra*), and held that the doctor's motion to dismiss should be denied.

In *Clayman v. Bernstein*, 38 Pa. D. & C. 543 (Philadelphia County Ct. 1940), the doctor took photographs of his patient showing the facial disfigurement caused by her coronary thrombosis. The court ordered the doctor to turn over the negatives and all prints to his patient, and enjoined the doctor from using the photographs for any purpose.

Feeney v. Young, 191 App. Div. 501, 181 N.Y.Supp. 481 (1920), was an action based on a public showing of films of the patient giving birth to a child by Caesarean section. The court reversed a judgment dismissing the patient's complaint; however, this decision turned on an evidence issue.

Barber v. Time, 348 Mo. 1199, 159 S.W.2d 291 (1942), was an action for violation of a patient's right of privacy by publication of her picture along with a magazine article entitled "The Starving Glutton." The article described the patient's rare ailment, an abnormally functioning pancreas resulting in a condition that forced the patient to eat an enormous amount of food. The patient won a judgment against the magazine publisher for invasion of her privacy. Although *Barber* is not directly concerned with the doctor-patient relationship, since the defendant was not a doctor, the case does illustrate that a patient may have a good cause of action for invasion of his privacy aside from reliance on a doctor's special duties toward his patients.

18. *Bazemore v. Savannah Hosp.*, 171 Ga. 257, 155 S.E. 194 (1930). This case might indicate that the special privacy rights afforded by the doctor-patient relationship extend to the parents of a child patient. It is clear that the parents recovered for invasion of their own privacy rights in this case, and not for the privacy of their child. Except by statute in Utah and Virginia, the right of privacy does not survive the individual. PROSSER, *TORTS* § 97, at 641 (2d ed. 1955). But in a similar case, parents of a dead child successfully sued a photographer for publishing photographs of the child's deformed body. See *Douglas v. Stokes*, 149 Ky. 506, 149 S.W. 849 (1912).

19. Of course, the patient's identity could be disclosed in many ways, not necessarily only by use of the patient's name or of a photograph that is recognizable as that of the patient.

20. In *Samuel v. Curtis Publishing Co.*, 122 F. Supp. 327, 328 (N.D. Cal. 1954), the court said:

An invasion of the right of privacy occurs not with the mere publication of a photograph, but occurs when a photograph is published where the publisher should have known that its publication would offend the sensibilities of a normal person.

See 41 AM. JUR. *Privacy* § 12 (1942).

A comparison of two California Supreme Court decisions makes this point very forcefully. In *Gill v. Curtis Publishing Co.*, 38 Cal. 2d 273, 280, 239 P.2d 630, 634-35 (1952), a magazine publisher had printed a photograph of the plaintiffs, husband and wife, showing them in an amorous pose; the picture was used in

a patient's hand, arm, or foot; of an X-ray of the patient;²¹ of an operation on his heart; or even of a Caesarean section birth.²²

Only one American court has squarely met the issue whether a patient's right to privacy is invaded when his doctor discloses details about the patient's physical or mental condition.²³ In *Simonsen v. Swenson*,²⁴ the doctor had informed the owner of a hotel where his patient temporarily was staying that he had examined the patient and thought he was suffering from a "contagious disease." The Supreme Court of Nebraska indicated that such a dis-

connection with an article describing the various kinds of love, to illustrate the "wrong kind" of love. The court reversed a judgment for the defendant on the pleadings, holding that a complaint alleging the stated facts presented a good cause of action for invasion of the plaintiffs' right of privacy. The court said: "[L]iability exists only if the defendant's conduct was such that he should have realized that it would be offensive to persons of ordinary sensibilities. It is only where the intrusion has gone beyond the limits of decency that liability accrues." In the second case, *Gill v. Hearst Publishing Co.*, 40 Cal. 2d 224, 226, 253 P.2d 441, 442 (1953), the same plaintiffs complained of publication of the same photograph, this time illustrating "a short commentary reaffirming 'the poet's conviction that the world could not revolve without love,' despite 'vulgarization' of the sentiment by some, and that ballads may still be written about everyday people in love." The court held that these facts did not give rise to a cause of action for invasion of privacy, although it reversed the trial court's order sustaining a demurrer without leave to amend. The plaintiffs had failed to include in their complaint any relevant reference to the text accompanying the photograph, and the court ruled that they were to be given an opportunity to amend their complaint to allege invasion of privacy by the accompanying text.

21. In *Banks v. King Features Syndicate Inc.*, 30 F. Supp. 352 (S.D.N.Y. 1939), the plaintiff sued and recovered for invasion of her privacy when an X-ray of her abdomen was published in the defendant's magazine, along with an article describing the finding of a hemostat left in the plaintiff's body after a surgical operation. However, the plaintiff apparently was identified by name in the article which accompanied the reproduction of the X-ray.

22. In *Feeney v. Young*, 191 App. Div. 501, 503, 181 N.Y. Supp. 481, 482 (1920), the plaintiff sued for invasion of her privacy by the showing of movies taken during her Caesarean section operation. The court's holding that the judgment dismissing the plaintiff's complaint was reversed, was based on an issue under the best evidence rule regarding key evidence that "the picture as presented upon the screen was capable of identification as her picture." Apparently, without that evidence the plaintiff would have lost her case.

Of course, at least in cases where photographs were taken during an operation, or during an examination or treatment in which the patient was disrobed, there could be a privacy invasion by the mere presence of the photographer. See the discussion of *DeMay v. Roberts*, 46 Mich. 160, 9 N.W. 146 (1881), *supra* at note 14.

23. The facts of several cases could have presented this issue, although for one reason or another the privacy issue was never raised in the appeal. See *Munzer v. Blaisdell*, 49 N.Y.S.2d 915 (Sup. Ct. 1944) (delivery by a mental institution to a physician of a copy of patient's case record); *Shoemaker v. Friedberg*, 80 Cal. App. 2d 911, 183 P.2d 318 (1947) (physician's statements that patient suffered from a venereal disease); *Iverson v. Frandsen*, 237 F.2d 898 (10th Cir. 1956) (disclosure to school authorities of patient's mental retardation); *Berry v. Moench*, 331 P.2d 817 (Utah 1958) (disclosure of patient's psychiatric record to parents of girl about to marry patient).

24. 104 Neb. 224, 177 N.W. 831 (1920).

closure, unless somehow legally justified, would violate the patient's right to privacy.²⁵

Three cases from other common law countries are enlightening on this issue. In the oldest of these, *A.B. v. C.D.*,²⁶ a child had been born to the wife of the plaintiff, who was an elder of the Established Church of Scotland, six months after their marriage. The plaintiff hired the defendant to examine the child and give his confidential opinion whether or not it was premature. When the doctor decided that the child was not premature, he delivered a statement to that effect to the minister of the plaintiff's kirk. The plaintiff sued for damages from breach of the doctor's contract of secrecy, and the Scottish Lords unanimously agreed that the plaintiff had stated a good cause of action:

[T]hat a medical man, consulted in a matter of delicacy, of which the disclosure may be most injurious to the feelings, and possibly, the pecuniary interests of the party consulting, can gratuitously and unnecessarily make it the subject of public communication, without incurring any imputation beyond what is called a breach of honour, and without the liability to a claim of redress in a court of law, is a proposition to which, when thus broadly laid down, I think the Court will hardly give their countenance.²⁷

In the famous English case, *Kitson v. Playfair*,²⁸ a doctor's examination convinced him that his patient, who was also a member of the doctor's family, had suffered a recent miscarriage. And since the patient's husband had been out of the country for many months, the doctor concluded that she had committed adultery. He told his wife and family about the patient's condition and about his suspicions. In a suit for breach of the doctor-patient confidence, the patient recovered a verdict for £12,000.²⁹

The third case on this issue, *Furniss v. Fitchett*,³⁰ was decided by a New Zealand Supreme Court in 1958. The defendant had been the regular doctor for both the plaintiff and her husband. Several times the plaintiff had told the doctor that her husband was doping her and that he was insane. Although these accusations were unfounded,

25. See note 8 *supra*. The court did find legal justification for the disclosure in this case, however, and it affirmed a directed verdict for the defendant. This aspect of the case is discussed *infra*.

26. 14 Sess. Cas. 2d 177 (Scot. 1st Div. 1851).

27. Opinion of Lord Fullerton, *id.* at 180.

28. 1 BRIT. MED. J. 815, 882 (1896) (specially reported for the British Medical Journal).

29. In 1896, £12,000 was equivalent to about \$57,600. Both the finding of liability and the amount of the verdict drew several critical comments from contemporaneous writers. See, e.g., Legal Correspondent for the British Medical Journal, *The Obligation of Professional Secrecy*, 1 BRIT. MED. J. 869 (1896); Editorial, *The Obligation of Professional Secrecy*, 1 BRIT. MED. J. 861 (1896).

30. [1958] N.Z.L.R. 396 (Sup. Ct.)

they "engendered a certain amount of domestic discord," which had a serious effect on the husband's health. He had asked whether the doctor could have the plaintiff "certified" to a mental institution, and at one time he came to the doctor "almost desperate" and demanded: "You must do something for me, doctor—give me a report for my lawyer." The doctor gave him a letter summarizing his observations of the plaintiff, and concluding, "I consider she exhibits symptoms of paranoia and should be given treatment for same if possible. An examination by a Psychiatrist would be needed to fully diagnose her case and its requirements."³¹ About a year later, the plaintiff brought a separation and maintenance action against her husband. During cross-examination of the plaintiff, her husband's attorney disclosed the doctor's letter for the first time, and the plaintiff immediately sued the doctor for mental distress caused by the breach of his duty. The court overruled the defendant's motion for judgment, holding that

[T]he doctor owed to his patient at common law a duty to take reasonable care to ensure that no expression of his opinion as to her mental condition should come to her knowledge. The doctor did not take any precautions in that respect, and, in my opinion, a cause of action was thus disclosed in the statement of claim and in evidence adduced in support of it.³²

Although none of the courts in these three cases used the terminology "the right to privacy," the interests protected fit easily into that category. Even in the *Furniss* case, where the decision turned on negligence principles, the court considered the much broader interest of enforcing a duty of professional secrecy:

In some future case it may be necessary to determine whether, subject to some exceptions . . . , the duty to preserve a patient's secrets, may not be much more extensive than the duty I have here held to exist and approximate very closely to the duty described in the British Medical Association's Code of Ethics. I venture to express the hope, and the belief, that such is, indeed, the law. . . .³³

It should be safe to conclude that courts are quick to protect a patient against a doctor's intrusion on his solitude or disclosure of offensive or embarrassing information about him, *provided* the doctor has no legal justification for doing so. But the most perplexing problems in this area of the law are met in predicting the circum-

31. *Id.* at 398.

32. *Id.* at 404. For a discussion of some of the problems raised by this extension of the negligence doctrine, see Inglis, *Furniss v. Fitchett*, 34 N.Z.L.J. 235 (1958). See also *Negligence: A Doctor's Duty to His Patient*, 34 N.Z.L.J. 65 (1958); Davis, *Whom Should a Doctor Tell?* 21 MODERN L. REV. 438 (1958).

Barrowclough, C. J., pointed out that this was a novel question in English law. He cited *A.B. v. C.D.*, discussed *supra*, but distinguished that case as being a contract action. 1958 N.Z.L.R. at 400.

33. *Ibid.*

stances justifying measures that would otherwise violate the patient's right to privacy.

DEFENSES TO THE PATIENT'S PRIVACY ACTION

A doctor may raise any of three principal defenses to a patient's privacy action: (1) the patient may have consented to the particular privacy invasion; (2) the doctor may be required by law to invade the patient's privacy; and (3) the doctor's duty not to invade his patient's privacy interests may be outweighed by a more compelling duty to protect some other sufficiently important interest.

Consent

Consent to a particular privacy invasion, by a patient who fully understands all the relevant circumstances, will *always* be an absolute defense to any subsequent action based on that privacy invasion.³⁴ But even expressed consent will be insufficient to protect the doctor if, under the circumstances, he should have realized that the patient did not fully understand what he was consenting to, and that if the patient had understood he might have refused the consent. In *DeMay v. Roberts* the court held:

The fact that at the time, [the plaintiff] . . . consented to the presence of [the defendant's layman friend] . . . supposing him to be a physician, does not preclude her from maintaining an action and recovering substantial damages upon afterwards ascertaining his true character. . . . [The defendant was] guilty of deceit, and the wrong thus done entitles the injured party to recover the damages afterwards sustained.³⁵

Furthermore, even when valid consent has been obtained, the doctor will be liable for any privacy invasion exceeding that consent.³⁶

Of course, consent will be implied to any privacy invasion that the patient can reasonably expect to be necessary for proper diagnosis or treatment of his case. For example, by consulting a doctor, the patient impliedly consents to the doctor's keeping ordinary medical records of the patient's case, and to the customary and fore-

34. Of course, the general principles of the doctrine of consent are applicable to privacy cases. For a general discussion see PROSSER, TORTS § 18 (2d ed. 1955).

For a collection of written consent forms, see AMERICAN MEDICAL ASSOCIATION, MEDICOLEGAL FORMS 55-63 (1957). This booklet provides forms for: Authority to Admit Observers, Consent to Taking of Photographs, Consent to Publication of Photographs, Consent to Televising of Operation, Consent to Taking of Motion Pictures of Operation.

35. 46 Mich. 160, 166, 9 N.W. 146, 149 (1881) (discussed *supra*). See also Carr v. Shifflette, 82 F.2d 874 (D.C. Cir. 1936).

36. See Douglas v. Stokes, 149 Ky. 506, 149 S.W. 849 (1912); Feeney v. Young, 191 App. Div. 501, 181 N.Y. Supp. 481 (1920).

seeable use of these records.³⁷ However, in most cases no consent would be implied to photographing the patient, since normally he would not expect to be photographed by the doctor.³⁸

Duty imposed by law

A doctor can be forced to disclose confidential information whenever he is called as a witness in a lawsuit, unless his patient properly asserts the physician-patient privilege.³⁹ And in almost all states, a doctor is required by statute to inform designated public officials whenever he finds a patient suffering from certain highly contagious diseases;⁴⁰ these statutes often apply specifically to venereal dis-

37. Cf. *Iverson v. Frandsen*, 237 F.2d 898 (10th Cir. 1956). There may also be "implied consent" in some cases, where the doctor has acted to cope with an emergency. There are no doctor-patient privacy cases on this point, and any discussion of it here would be beyond the scope of this Note. See generally PROSSER, *Torts* § 18, at 84 (2d ed. 1955).

38. See *Clayman v. Bernstein*, 38 Pa. D. & C. 543 (Philadelphia County Ct. 1939). Of course, there would be no invasion of privacy if the photograph does not disclose the patient's identity. See text at notes 21-22 *supra*.

39. The physician-patient privilege is an evidentiary rule created by statute in over half the states, by which the patient can prevent, for the most part, any testimony by his doctor concerning confidential information the doctor obtains during the course of the professional relationship. Since this privilege is the patient's, the doctor can never rely on it in refusing to testify. If the doctor does refuse, he may be charged with contempt of court. See Note, *Legal Protection of the Confidential Nature of the Physician-Patient Relationship*, 52 COLUM. L. REV. 384 (1952). For a more extensive treatment see DEWITT, *PRIVILEGED COMMUNICATIONS BETWEEN PHYSICIAN AND PATIENT* (1958).

40. See, e.g., MINN. STAT. § 144.68 (1957):

Subdivision 1. Persons practicing healing arts. Every person licensed to practice the healing arts in any form, upon the request of the state board of health, shall prepare and forward to the board, in the manner and at such times as it designates, a detailed record of each case of malignant disease treated or seen by him professionally.

Subd. 3. Information without liability. The furnishing of the information required [by subdivision 1] . . . shall not subject the person . . . furnishing such information, to any action for damages or other relief.

See also ALA. CODE tit. 22, § 48 (1940); ALASKA COMP. LAWS ANN. § 40-2-7b (Supp. 1958); ARIZ. REV. STAT. ANN. § 36-621 (1956); CAL. HEALTH & SAFETY CODE § 211(a)(1); COLO. REV. STAT. ANN. § 66-3-49 (1953); CONN. GEN. STAT. § 19-89 (1958); DEL. CODE ANN. tit. 16, § 502 (1953); FLA. STAT. § 381.231 (1957); GA. CODE ANN. § 88-118 (1949); HAWAII REV. LAWS § 49-2 (1955); IDAHO CODE ANN. § 39-307 (1948); ILL. ANN. STAT. ch. 34, § 149 (Smith-Hurd 1935); IND. ANN. STAT. § 35-1102 (1949); IOWA CODE ANN. § 139.3 (1949); KAN. GEN. STAT. ANN. § 65-105 (1949); KY. REV. STAT. ANN. § 214.010 (1955); ME. REV. STAT. ANN. ch. 25, § 68 (1954); MD. ANN. CODE art. 43, § 100 (1957); MASS. GEN. LAWS ANN. ch. 111, § 111 (1954); MICH. STAT. ANN. § 14.104 (1956); MISS. CODE ANN. § 7040 (1942); MO. ANN. STAT. § 292.340 (1952); MONT. REV. CODES ANN. § 69-707 (1947); NEB. REV. STAT. § 71-503 (1958); NEV. REV. STAT. § 439.210 (1957); N.H. REV. STAT. ANN. § 141:1 (1955); N.J. STAT. ANN. § 26:4-15 (1940); N.M. STAT. ANN. § 12-3-1(5) (1953); N.Y. PUB. HEALTH LAW § 2101; N.C. GEN. STAT. § 130-81 (1958); N.D. REV. CODE § 23-0702 (1943); OHIO REV. CODE ANN. § 3701.24 (Page 1954); OKLA. STAT. ANN. tit. 63, § 12

eases or to tuberculosis. Some states also have enacted legislation requiring that whenever a doctor treats a woman for injuries caused by a criminal abortion, he must report the facts of the case to health authorities or to the police.⁴¹ Physicians who strictly comply with these statutes will not be liable for invasion of the patient's right to privacy.⁴²

Overriding competing interests

One British authority, curious whether doctors themselves feel they should violate their duty of professional secrecy under some circumstances by disclosing confidential information, has questioned a large group of doctors practicing in the area near Derby, England. The results of his study indicate overwhelmingly that most practicing physicians are willing to disclose confidential information in certain compelling cases, and that a sizable minority of them would do so in cases that arguably are *not* very compelling.⁴³

(1949); ORE. REV. STAT. § 433.005 (1957); PA. STAT. ANN. tit. 35, § 511 (1949); S.C. CODE § 32-552 (1952); TENN. CODE ANN. § 53-605 (1955); TEX. REV. CIV. STAT. ANN. art. 1074 (1953); UTAH CODE ANN. § 26-6-31 (1953); VT. STAT. § 7304 (1947); VA. CODE ANN. § 32-48 (1950); WASH. REV. CODE § 70.04.050 (1958); W. VA. CODE ANN. § 1278 (1955); WIS. STAT. ANN. § 143.04 (1957); WYO. COMP. STAT. ANN. § 63-120 (1945).

Many of these states also have statutes specifically applicable to certain diseases, and a few states require reports only of certain specified diseases. See D.C. CODE ANN. § 6-202 (1951) (new-born children with eye inflammation); LA. REV. STAT. ANN. § 40:1065 (1951) (venereal disease), and § 40:1281 (Supp. 1958) (rabies); S.D. CODE § 27-2302 (1939) (ophthalmia), and § 27-2402 (1939) (venereal disease). Rhode Island has a series of specific provisions: R.I. GEN. LAWS ANN. ch. 23, § 5-1 (1956) (poliomyelitis and meningitis); § 5-2 (malignant growths); § 5-4 (hearing defects in children); § 5-5 (occupational disease); § 8-10 (smallpox); § 10-2 (tuberculosis); § 11-6 (venereal disease).

For a general discussion see DeWitt, *Medical Ethics and the Law: The Conflict Between Dual Allegiances*, in *PHYSICIAN IN THE COURTROOM* 33, 36 (Schroeder ed. 1954).

41. See, e.g., *SANITARY CODE OF THE CITY OF NEW YORK* § 90 (1948).

42. It would be anomalous to hold the doctor liable for doing what he is required by statute to do. See *McGuire v. Amyx*, 317 Mo. 1061, 297 S.W. 968 (1927); *Boyd v. Wynn*, 286 Ky. 173, 150 S.W.2d 648 (1941). Cf. *Anthony v. Anthony*, 9 N.J. Super. 411, 74 A.2d 919 (1950).

At least one doctor has been tried and convicted of charges of harboring a fugitive, when he treated a criminal for gunshot wounds and then failed to report the matter to the police. See 32 MICH. L. REV. 1164 (1934).

The American Medical Association considers it part of the doctor's ethical duty to comply with the public health disclosure statutes. AMERICAN MEDICAL ASSOCIATION, *PRINCIPLES OF MEDICAL ETHICS* ch. IV, § 2 (1923): "... At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. . . ."

43. See Dawson, *The Duties of a Doctor as a Citizen*, 2:2 BRIT. MED. J. 1474 (1954). In this study, questionnaires were sent to thirty representatives of each of four groups—senior general practitioners, at least fifty years old; junior practitioners, no more than forty years old; consultants with the Derby Hospital; and

A patient's legal right to enforce his doctor's duty of professional secrecy quite obviously cannot be absolute. Like any other personal right, it must bow before more important competing interests. The problem is simply to determine what interests are "more important"; that is, to provide guides to help a doctor or an attorney decide whether an interest dictating disclosure in a particular case is sufficient to justify violating the patient's confidence.

medical officers of health in England and Wales. The following "yes or no" questions were asked:

QUESTION 1. A doctor diagnoses epilepsy in the case of an engine-driver who controls the engine of a main-line passenger train. The patient refuses permission to the doctor to disclose his disability to the railway authorities, and makes clear to the doctor his intention of continuing to earn his living as the driver of passenger trains. Has the doctor an overriding duty to ignore his patient's wishes and to report his state of epilepsy to the railway authorities?

QUESTION 2. A doctor attending a woman for abortion finds that it was criminally induced by a professional abortionist; he learns also the abortionist's name and address. The patient forbids the doctor to report the matter to the police, or even to disclose to them the abortionist's identity. Has the doctor a duty to disregard his patient's wishes and to report the abortionist to the police?

QUESTION 3. A doctor treats a man who is suffering from a rupture. Later the patient is involved in a minor accident at work and successfully, and fraudulently, claims industrial benefit and a pension in respect of the rupture, which he asserts resulted from the accident. The Ministry accepts his claim. His doctor knows that the rupture was neither caused nor aggravated by the accident. Has the doctor a duty to report his knowledge to the Ministry?

QUESTION 4. A doctor attending a patient in a patient's home notices, by chance, jewellery in the bedroom which clearly corresponds with a newspaper description of property recently stolen in a housebreaking raid. Is it the doctor's duty to report his discovery to the police?

The Code of Ethics of the British Medical Association fairly clearly dictates that the doctor refuse to disclose confidential information in each of these situations. See note 6 *supra*. Nevertheless, the doctors' answers were as indicated on the chart on p. 956 *infra*.

Possibly the doctors' answers to these questions would have been different had the questions been phrased in terms of liability for disclosure, rather than in terms of "duty" to disclose. However, analytically there should be no difference. The doctor does owe his patient a duty to keep confidential information secret. He should be liable for any damage caused by a breach of that duty, unless it is justified. Nothing short of another duty, in fact an overriding duty, to disclose the information should legally justify doing so.

In the article, the author analyzes comments to the "no" answers to question 1, and discards most of them as unacceptable. For example, two of the comments were, "The responsibility of a doctor ends with the treatment of the patient" (a perfect example of question begging) and "An accident may never occur" (a "shut your eyes and the problem may go away" approach). He then comments:

Only two reasons can be advanced for voting "No" to this question: (1) the preservation of professional secrecy overrides all other obligations (this in effect is the basis of the present B.M.A. policy); and (2) violation of professional secrecy, even under most exceptional circumstances, will impair the doctor-patient relationship. Quite surprisingly, neither of these reasons has been suggested by any doctor, nor has any doctor referred to his obligations under the Hippocratic Oath.

Question- naires	No.	Replies No.	%	Question 1			Question 2			Question 3			Question 4		
				Yes %	No %	P %	Yes %	No %	P %	Yes %	No %	P %	Yes %	No %	P %
G.P. s over 50 (senior)	30	25	83.5	76	24	0	44	56	0	24	72	4	36	64	0
G.P. s under 40 (junior)	30	22	73	82	9	9	50	50	0	36.5	63.5	0	27	73	0
Consultants	30	25	83.5	88	12	0	64	32	4	20	80	0	36	60	4
M.O.H. s	30	22	73	91	4.5	4.5	45.5	50	4.5	54.5	41	4.5	36.5	59	4.5
Totals	120	94	78.5	84	12.5	3.5	51	47	2	34	64	2	34	64	2

(Reprinted by permission of the author and the BRITISH MEDICAL JOURNAL.)

(1) *Protecting others endangered by the patient's condition.* *Simonsen v. Swenson*⁴⁴ is probably the strongest case for allowing the doctor to disclose confidential information. In that case, the patient was exposing other roomers in the hotel to his highly contagious disease. The court held that disclosure of this information to the hotel owner was justified. It would be unreasonable to expect the doctor, whose professional efforts are directed almost exclusively to preventing or relieving disease, to remain silent while one of his patients obstinately subjects others to the danger of being infected with a serious disease.⁴⁵

Doctors are often called upon to protect some third person by disclosing information concerning one of their patients. In *Berry v. Moench*,⁴⁶ a recent Utah case arising out of this type of situation, a psychiatrist was asked by another physician for "your impression of" one of his former patients. The letter explained that the patient was courting a young girl, and that the girl's parents had come to the physician for advice. The psychiatrist replied, in part:

Dear Doctor ———,

Since I do not have his authorization, the patient you mentioned in your last letter will remain nameless.

44. See text accompanying note 24 *supra*. See also the comment in 200 LANCET 822 (1921), a British medical periodical, on a case where the doctor had informed the manager of a public bath that one of the patrons was the doctor's patient, and that he was suffering from a contagious venereal disease. The patient's suit against the doctor was unsuccessful.

45. See DeWitt *supra* note 40, at 36. Most states have enacted statutes that would apply to the contagious disease situation. See note 40 *supra*.

A very similar problem is presented by Question 1 in the Dawson study, note 43 *supra*. In spite of the strict standards of the British Medical Association's Code of Ethics, almost 85% of the British doctors who replied to the questionnaire said that a doctor should disclose information under these circumstances.

Question 2 presents somewhat different considerations. The victim of a criminal abortion does not herself endanger others, but the abortionists do. These criminals have been very difficult to combat; too often the authorities learn about the victims only after they are dead. Therefore, the doctor probably should be free to disclose the abortionist's identity.

46. 331 P.2d 814 (Utah 1958). This case was based on an action for libel rather than for invasion of privacy, but the libel issues turned on the same principles that would govern a privacy action. The court explained that although ordinarily a person cannot commit libel if his statements are true, a doctor is not free to publish all information he obtains that would be derogatory to his patient, merely because it is true. This rule is designed to encourage ready disclosure of information to doctors so that they can properly diagnose and treat their patients. But in certain cases the doctor has a "qualified privilege" to disclose the information—the doctor's duty to remain silent may be outweighed by a more compelling duty to furnish information, although defamatory, to protect some other sufficiently important interest. However, the privilege applies to disclosure of this information only with the following limitations: (a) it must be done in good faith and reasonable care must be exercised as to its truth, (b) likewise, the information must be reported fairly, (c) only such information should be conveyed, and (d) only to such persons as are necessary to the purpose.

He was treated here in 1949 as an emergency. Our diagnosis was Manic depressive depression in a psychopathic personality. . . .
 He had one brother as a manic, and his father committed suicide. . . .
 The patient was attempting to go through school on the G.I. bill. . . .
 Instead of attending class he would spend most of the days and nights playing cards for money.

Because of family circumstances, we treated him for a mere token charge (and I notice even that has never been paid).

During his care here, he purchased a brand new Packard, without even money to buy gasoline.

He was in constant trouble with the authorities during the war, . . .

. . . did not do well in school, and never did really support his wife and children.

Since he was here, we have repeated requests for his record indicating repeated trouble. . . .

My suggestion to the infatuated girl would be to run as fast and as far as she possibly could in any direction away from him.

Of course, if he doesn't marry her, he will marry someone else and make life hell for that person. The usual story is repeated unsuccessful marriages and a trail of tragedy behind.⁴⁷

This letter was given to the girl's parents, who gave it to the girl herself. The Utah court said, "[The girl's] concern for her well-being and happiness was a sufficient interest to protect, and . . . it was within the generally accepted standards of decent conduct for the doctor to reveal the information which might have an important bearing thereon."⁴⁸

But not every case involving protection of others will justify disclosure. *Kitson v. Playfair*,⁴⁹ indicates that protecting the doctor's

47. *Id.* at 816.

48. *Id.* at 818.

49. 1 BRIT. MED. J. 815, 882 (1896) (discussed *supra* at note 28). Shortly after the trial of this case was ended, one commentator wrote:

Never before, so far as we know, has the tradition of medical secrecy been so severely tested. Dr. Playfair had to balance the grand traditions of medical confidence as against duties between relative and relative. . . . One thing is certain, that this memorable and most painful trial strengthens and fortifies the great doctrine which has long made the medical profession one that is everywhere trusted and respected as the keepers and confessors of family confidence. But it does so at a tremendous cost to an individual certainly guiltless of any evil intent, who acted, we fully believe, from the purest motives, and under a strong sense of duty, which compelled him, in his opinion, to treat this case as a legitimate exception to the general rule.

Editorial, *The Obligation of Professional Secrecy*, 1 BRIT. MED. J. 861, 862 (1896).

See also *Furniss v. Fitchett*, [1958] N.Z.L.R. 396, discussed *supra* at note 30. Although that case might indicate that protecting the health and peace of mind of another patient, who is also the husband of the plaintiff, will not justify disclosure, it could be explained on the basis of an improper *method* of disclosure under the circumstances. The holding was that the doctor was liable for failing to "take any precautions" to avoid having the patient learn about the statements that were made to her husband. *Id.* at 404. (Emphasis added.) The doctor was *not* found liable for violating a duty of secrecy.

own wife and family from associating with immoral women is not a sufficient interest to override the duty of secrecy.

(2) *Serving various interests of society.* Fairly clearly, neither publication of "newsworthy" material⁵⁰ nor advancement of medical science⁵¹ will justify an invasion of the patient's right to privacy. Some years ago, the Attorney General of New York was forced to balance these social interests against the patient's interest in privacy. The State Department of Health had sought an opinion on the legality of displaying at a state fair photographs of cancer victims "for educational purposes without the consent of the subjects of the photographs and without altering the photographs so as to make them unidentifiable." The Attorney General concluded that this display would violate the cancer victims' privacy:

While it is true that the contemplated use may have a distinct social value for the general instruction and information of the public, yet I believe that the unauthorized use of such pictures is barred by the provisions of the [privacy] statute. . . . The unfortunate person afflicted with a malignant disease such as cancer may very well have a perfectly natural and readily understandable aversion to having a photograph or picture showing his condition displayed before the public. Apart from the legal question involved, it seems improper, to say the least, to add to the mental anguish of one so afflicted the fear that photographs portraying his condition will be publicly displayed.⁵²

Ordinarily, of course, these interests of society can be fully satisfied without disclosing the identity of the patient whose case is described or discussed.

50. See *Bazemore v. Savannah Hospital*, 171 Ga. 257, 155 S.E. 194 (1930); *Barber v. Time*, 348 Mo. 1199, 159 S.W.2d 291 (1942).

51. See *Griffin v. Medical Soc'y*, 11 N.Y.S.2d 109 (Sup. Ct. 1939) (discussed in note 17 *supra*); *Clayman v. Bernstein*, 38 Pa. D. & C. 543, 548 (Philadelphia County Ct. 1940):

While the court appreciates the development of the art of photography generally, and in the medical profession particularly, not only as a means of diagnosis and treatment, but also as a means of instruction, its progress has not yet reached a stage at which physicians have been accorded the right to photograph their patients without their consent, nor has medical jurisprudence recognized the unlimited right of a physician to perform any test, administer any treatment or perform any operation without the authority of the patient.

Perhaps the rule that advancing medical science will not justify breaching the patient's confidence must be modified somewhat. It might be that a *very exceptional* case presenting a rare opportunity for medical study would afford sufficient justification. For example, a recent news item revealed the story of a patient who, as a child, had drunk scalding chowder that caused scar tissue closing off his esophagus. In order that he could be fed, surgeons cut an opening or "stoma" through his abdomen directly into his stomach. The patient lived for over sixty years with this condition, offering medical science a rare opportunity to study the functioning of the human stomach. An enlightening study was published, based on the information obtained by examining this patient. See *Tom's Stoma & Stomach*, *Time*, Jan. 12, 1959, p. 38.

52. 1934 Ops. ATT'Y GEN. N.Y. 374, 375.

But it would be a mistake to conclude that interests of society never justify disclosing confidential information. For example, the situation posed in Question 3 of the Dawson study,⁵³ where the doctor knew that his patient's claim for relief from a state fund was fraudulent, could very easily be held to justify such a disclosure. Although the interest in protecting a state fund from small fraudulent claims might be considered relatively insubstantial, it probably outweighs the patient's interest in making fraudulent personal gains. Furthermore, confidence in the integrity of the doctor-patient relationship is not likely to be substantially impaired if patients learn that their doctors could speak up whenever they fraudulently misrepresent the nature of their injuries.

(3) *Protecting the patient himself.* Only one case, *Iverson v. Frandsen*,⁵⁴ raises the issue whether protection of the patient himself will justify invading his privacy, although the court's holdings turned on a different issue.⁵⁵ In that case, the parents had taken the child patient to a mental hospital for help in overcoming her claustrophobia. The results of an I.Q. test and several other tests given to the patient at the hospital were recorded in a standard hospital report. These tests revealed that she was a "feeble-minded" high-grade moron, and the report predicted that "at the time she is about sixteen, she should have progressed to about the fourth grade level in reading, arithmetic, writing, etc."⁵⁶ A copy of the report was sent to the guidance director of the child's school, on his request, and a while later embarrassing rumors about the child's mental ability spread throughout the school.

The doctor could reasonably feel that for the good of the child, information about her mental and emotional problems should be given to the officials at her school. When they understand these problems, they can plan special instruction to help the child make the greatest possible use of the abilities she has. But the serious harmful effect on the child from embarrassing rumors likely to follow disclosure of this information could outweigh the advantages from informing the school authorities. Since in this type of case both of the competing interests concern only the welfare of the patient, he is best able to decide which is more important to him.⁵⁷

53. See note 43 *supra*.

54. 237 F.2d 898 (10th Cir. 1956).

55. The patient sued only a staff psychologist who had recorded the test results in hospital records. He had not sent the information to the school authorities. The patient's action was based on libel, and the court held that the psychologist had a conditional privilege to make ordinary hospital records of the test results, and to communicate this information to psychiatrists on the hospital staff who were also working on the case.

56. 237 F.2d at 900.

57. In some cases, as in *Iverson*, the patient will be unable to make this decision

Absent consent, then, the doctor should not be justified in revealing the confidential information.

CONCLUSION

One writer has recently stated:

It is doubtful that any useful purpose would be served by developing new legal measures designed to guard against the disclosure of confidential matter outside of judicial or quasi-judicial proceedings. The medical profession can, in the absence of legal compulsion, be expected to show due deference to the concept that information gained in the course of treatment should not be spread abroad. Whatever apparent equity there might be in allowing occasional tort actions for wrongful disclosure, confidence in the profession is not likely to be noticeably impaired if such actions are refused recognition by the courts.⁵⁸

But this writer overlooked two important points. First, some doctors have overstepped their limited privileges to disclose confidential information. And "legal measures" that protect patients against "disclosure of confidential matter" have already been developed in the application of privacy, libel, and even negligence principles. The question is no longer whether or not to legally enforce the doctor's ethical duty of secrecy, but rather to what extent should that duty be enforced? It would be absurd to suggest that decisions based only on the personal inclinations of individual judges in these cases would be preferred to those following a carefully developed body of governing principles.

Second, doctors frequently meet the problem,⁵⁹ and they must and do look to the law for guidance in resolving it. A recent medical journal article discussing the doctor's dilemma concludes, "Until

for himself, since he is either too young or mentally incompetent. His parents or guardian must then decide for him.

58. Note, *Legal Protection of the Confidential Nature of the Physician-Patient Relationship*, 52 COLUM. L. REV. 384, 398 (1952). This Note deals primarily with the physician-patient privilege; aside from the unfortunate digression quoted in the text here, it is quite informative.

59. In the past five years there have been no articles in legal periodicals discussing the patient's right to prevent disclosure, outside the courtroom, of confidential information. On the other hand, a glance at the *Index Medicus* for 1957 and 1958 alone will reveal a number of articles on this problem. E.g., Bortoluzzi, *Medical Secrecy in Foreign and Argentinian Jurisprudence*, 15 REVISTA DE LA FACULTAD DE CIENCIAS MÉDICAS DE LA UNIVERSIDAD NACIONAL DE CÓRDOBA 7 (1957); Elbel, *Publication of Patient Data as a Problem of Medical Professional Ethics*, 82 DEUTSCHE MEDIZINISCHE WOCHENSCHRIFT 1781 (1957); Friedman, *Medical Confidences and the Law in the United States and France*, 85 MED. TIMES, GREAT NECK 790 (1957); Lynch, *The Obligation of Professional Secrecy*, 39 HOSPITAL PROGRESS 48 (1958); Macerlean, *Professional Secrecy and Privilege*, 40 J. IRISH MED. ASS'N 102 (1957); Neuman, *Medical Secrecy and the Law*, 52 HAREFAUH 36 (1957); Thomson, *Professional Secrecy*, 179 PRACTITIONER 31 (1957).

One recognized British authority has treated the problems in a chapter of his recent book. See HADFIELD, *LAW AND ETHICS FOR DOCTORS* 55 (1958).

careful consideration is given to this problem, and appropriate statutes and ordinances are drafted and adopted, each physician will have to make his own decision in an area in which he cannot rely, in safety, even upon his good conscience."⁶⁰ Whether or not legislative action is the answer, the doctor's plea for help is well taken.

It is appropriate now to suggest a few general rules to govern lawsuits based on unauthorized disclosure of confidential information. As a basic principle, the law should honor the judgment of a doctor who reasonably decides that he must reveal certain information to protect an interest that he believes, in good faith, is more important than his patient's interest in keeping the information secret. The doctor, after all, is the one who must balance the conflicting interests in these cases, and as a practical matter his discretion in each case must be accepted.⁶¹ A court should inquire only whether, under the circumstances, the doctor exercised his discretion reasonably; preceding sections of this Note have discussed the reasonableness of disclosure in some of the more common situations. Any decision to divulge confidential information, however, should be subject to the following limitations:

- (1) The doctor must first explain to the patient that disclosure is necessary, except when he would hurt the patient by doing so.⁶² The patient should have an opportunity to determine to whom the information will be revealed, and the manner of disclosure.
- (2) The doctor must use all reasonable care to know that the information is both accurate and true.⁶³
- (3) The doctor must not disclose any confidential information unnecessary to protecting the competing interest.
- (4) The doctor must not disclose such information to anyone who is unnecessary to protecting the competing interest.⁶⁴
- (5) The doctor must take all reasonable precautions to avoid any

60. Stevens, *Priority of Allegiances, The Doctor's Dilemma Dissected*, 54 NORTHWEST MED. 1227, 1233 (1955).

61. The sole exception to the text statement is the situation where the competing interest involves protection of the patient himself. Then the patient, rather than the doctor, is in the best position to weigh the competing interests and determine whether the confidential information should be disclosed. Absent consent, therefore, the doctor's decision to disclose this information would never be reasonable.

62. This information should be given in the facts of all the cases discussed in this Note except one. In *Furniss v. Fitchett*, [1958] N.Z.L.R. 396 (discussed *supra* at note 30), the doctor probably would have thought that under the circumstances the patient would have been seriously harmed by learning what the doctor intended to do.

63. This rule and numbers 3 and 4 are qualifications on the doctor's privilege of disclosure under libel principles. See note 46 *supra*.

64. In *Berry v. Moench*, 331 P.2d 814 (Utah 1958) (discussed *supra* at note 46), the doctor could have protected the girl's interest by sending the confidential information directly to her, rather than to her parents' doctor.

foreseeable harm to the patient from the disclosure of this information.⁶⁵

So long as the doctor complies with these rules he can and must rely on his own good conscience.

⁶⁵. This is the basic principle underlying the decision in *Furniss v. Fitchett*, [1958] N.Z.L.R. 396 (Sup. Ct.).