Medical neutrality

Confidentiality subject to national law

Should doctors always comply?

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It is certainly not the intention of this paper, despite its somewhat provocative title, to rally doctors against the due process of the law. Its purpose is rather to suggest that there are instances where the proper exercise of medical duties can come into conflict with the law of the land. This short study focuses on just one aspect of medical neutrality, namely the protection of medical confidentiality, and examines situations where national laws may oblige doctors to violate this principle. It further discusses the ensuing problems, particularly in countries under laws of exception and in those where there is blatant disregard for individual human rights.

What do we mean by medical neutrality?

The term 'medical neutrality' has long been a topic of debate. It was first coined during the elaboration of international humanitarian law in the course of the last century. Initially designed to convey the notion of non-discrimination in the delivery of medical care for the war wounded, the expression soon took on the additional meaning of protection for medical personnel engaged in this particular task. The concept was discussed and extended as international humanitarian law evolved over time. Today, however, the term 'medical neutrality' as such does not appear in the humanitarian law in force.

The rules of international humanitarian law define standards of conduct in conflict and war. The specificities and legal aspects of that law will not be developed here. Following a conference on medical neutrality in the Netherlands in 1991, an excellent and very comprehensive report was published on the subject, in which Professor Frits Kalshoven, professor emeritus and legal adviser to the ICRC, makes an extensive analysis of its complexities within the context of international humanitarian law. Professor Kalshoven reviews in detail how the concept of medical neutrality evolved from its initial sense to the meaning set out in the four Geneva Conventions of 1949 and their two Additional Protocols of 1977. In the general sense of the term, as applicable to situations of conflict and war, medical neutrality is divided into two distinct principles. In a nutshell, the first states that medical personnel are to perform their medical duties and give treatment to all victims of conflict and war without discrimination. The second principle establishes that in order to carry out such duties, medical personnel need to be protected. The notion of respect and protection for medical staff thus ultimately replaced the term of medical neutrality.

These two core principles were the initial themes. The concept of medical neutrality was subsequently fine-tuned and modified as international humanitarian law evolved and expanded. With the advent of the Additional Protocols in 1977, a further notion was added to protect the medical mission, namely that of medical personnel not being forced to divulge information about their patients. The idea was to protect victims and medical personnel alike in situations where the latter might be required to disclose information to non-medical authorities which might have harmful consequences for the victims.
Protocol I\textsuperscript{4} thus states in its Article 16, para. 3:

3. "No person engaged in medical activities shall be compelled to give to anyone belonging either to an adverse Party, or to his own Party except as required by the law of the latter Party, any information concerning the wounded and sick who are, or who have been, under his care, if such information would, in his opinion, prove harmful to the patients concerned or to their families."

Protocol II\textsuperscript{5} makes a similar statement in its Article 10, paras. 3 and 4:

3. "The professional obligations of persons engaged in medical activities regarding information which they may acquire concerning the wounded and sick under their care shall, subject to national law, be respected."

4. "Subject to national law, no person engaged in medical activities may be penalized in any way for refusing or failing to give information concerning the wounded or sick who are, or who have been, under his care."

These two articles were certainly designed to protect victims of war (i.e. the sick or wounded) so that they should not be denounced or otherwise informed on. Likewise, medical personnel are protected in that they are not to be compelled to disclose information on their patients and are not to be penalized for refusing to give such information.

While the basic intent is unquestionably positive, it must be noted that in both cases 'non-denunciation' by medical personnel is allowed only \textit{subject to national law}.\textsuperscript{6}

Does this mean that whenever 'national law' so stipulates, medical personnel are obliged to comply and denounce or otherwise disclose what they have learned from their patients? Is this the case even in countries where individual rights are not respected and such extraction of information may be put to misuse?

These clauses of the Protocols inevitably raise the issue of the inviolability of medical confidentiality, and as such warrant further scrutiny. The issue is referred to in slightly different terms in each of the Commentaries on Protocols I and II.

The Commentary on Protocol I denies that what is inferred by divulged information has anything to do with medical confidentiality.\textsuperscript{7}

The Commentary on Protocol II refers to medical personnel being required to respect "professional obligations" regarding any information gathered from their patients in the course of administering medical care. These "obligations" are not defined, although the commentary on Article 10, para. 3, states that "In the eyes of many representatives of the medical profession, this question [whether doctors are ever allowed to report on their patients to the authorities] is ... an integral part of medical ethics."\textsuperscript{8} The same commentary explains that the aim of paragraph 3 is to "preserv(e)
the obligation of professional Confidentiality", clearly establishing a parallel with the principle of medical confidentiality.

At this juncture, it should be recalled that international humanitarian law does no apply in peacetime or in situations which are sometimes known as situations of 'internal strife' or as 'states of emergency without outright conflict.

Can, however, analogies be drawn from what is stated in the Protocols – particularly Protocol II, as the purpose here is not to concentrate on international wars - regarding the question of confidentiality?

**Impartiality, confidentiality and the doctor-patient relationship**

On this particular angle of 'medical neutrality', i.e. the issue of confidentiality, is it possible to draw parallels with situations that lie outside the field of application of international humanitarian law?

Before venturing to answer that question one has first to explore what is really meant by medical confidentiality. Does the term only relate, as is apparently implied in the Commentary on Protocol I, to a patient's state of health and the treatment administered? Or does the confidentiality implicit in any normal doctor-patient relationship cover any and all knowledge on the patient?

**Confidentiality refers to any information that doctors may obtain on their patients and not just to details concerning diagnoses and prescriptions**

The principle of medical confidentiality for doctors is deeply imbedded in medical ethics. It is part of the requirements of the Hippocratic Oath, as well as the Oath's modern version, the Declaration of Geneva\(^9\). On the subject of confidentiality, the Declaration states: "I will respect the secrets which are confided in me, even after the patient has died ...
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This principle of keeping all information confidential is repeated in the World Medical Association's International Code of Medical Ethics, which stipulates the following: "A physician shall preserve absolute confidentiality on all he knows (italics added) about his patient even after the patient has died."

In theory, therefore, confidentiality refers to any information that doctors may obtain on their patients in the course of the delivery of medical care, and not just to details concerning diagnoses and prescriptions. Medical confidentiality is arguably not an absolute rule in all cases, however. Although practice is not the same everywhere, as some countries insist much more on the principle of confidentiality than others, there is certainly an argument that there will always be specific cases which warrant reservations. These are invariable instances where the 'general good' or 'duty to the general public' is at stake.

For example, the British Medical Association specifies in its textbook on medical ethics a series of circumstances which permit disclosure.\(^{10}\) Among these exceptions to the standard are the following:
- "if the law requires the doctor to disclose information" (this refers to certain specific contagious diseases);

- "if the doctor has an overriding duty to society to disclose the information, for instance when a serious crime... has been or is very likely to be committed";

- "if the doctor agrees that disclosure is necessary to safeguard national security"

In such circumstances, even the medical profession feels that a doctor has a duty to society which may well override the duty of silence inherent in confidentiality.

Doctors do not therefore have a categorical duty of non-denunciation in exceptional cases. This is implicitly understood in international humanitarian law, as indicated in the Commentary on Article 16 of Protocol I:

"... a doctor retains the freedom to denounce a patient on the basis that he may legitimately wish to prevent the patient pursuing activities which he considers to be dangerous for other human beings, just as, in peacetime, he may wish to prevent a criminal from continuing his criminal activities." Doctors who, under such circumstances, decide of their own volition to report one of their patients are expected to act responsibly and only if there are higher interests relevant to the case. Following the above reasoning, they may decide to do so if they believe that another person's rights are at stake. In many countries, the Ethics Committee of the national medical association, or a related body, can act as a kind of 'medical ombudsman' for consultation on specific and difficult cases.

Acceptable safeguards or selective screening for the police?

If all this is so, why then does the fact that the principle of confidentiality is 'subject to law' warrant any debate? If medical ethics in peacetime coincide with the stipulations of international humanitarian law, why ask the question whether doctors should comply with the law at all?

As has been suggested earlier, this question may be particularly relevant and important in countries where individual rights are not respected. This is sadly the case in many countries today. What is the situation for doctors in such circumstances?

Does the legal loophole on the principle of inviolability of medical confidentiality apply? Can and should 'the law', in such instances, oblige doctors to divulge information gleaned from patients during consultations?

The question of confidentiality is not the only matter at stake. Having to disclose certain facts about certain patients inevitably detracts from the principle of impartiality. A doctor who knows that he has to pass on information in his possession (and is known to do so) cannot be seen as impartial and concerned solely with the health of his patients.
The issue here is that the admitted exceptions to the principle of confidentiality take it for granted that 'the laws' with which doctors must comply are necessarily in everyone's best interest. This is unfortunately not always so.

In places where authoritarian régimes are in place, or where respect for basic individual human rights are not the norm, reservations ('subject to law') on medical confidentiality can be a problem. The crux of that problem lies in the legal obligation to denounce, i.e. the obligation for doctors to convey information on their patients to an authority which may use that information to the patient's detriment.

To discuss the fine-tuning of where 'information' ends and 'medical confidentiality' begins is arguably irrelevant. As has already been stated, all information on patients comes under the cloak of confidentiality. The controversy over disclosure concerns not the information itself but the exceptional situations warranting communication of that information to a non-medical authority.

If, for example, laws of exception in a given country determine that doctors who treat patients with certain types of injury (e.g. gunshot wounds) have to report their patients to the police, this may be an impingement on the physicians' medical role. Various cases can be imagined, depending on the situation in the country concerned.

At the very least, this may make patients wary of consulting the doctor, thereby impairing the relationship of trust that should prevail between them and the physician.

In extreme cases, this obligation may place the doctor in the position of auxiliary to the police, which has in fact happened in countries where security forces have been known to arrest all such patients and to put them through their regular circuit of interrogation. Many countries do use torture in police stations and in other interrogation centres. In certain cases, information pertaining to patients has definitely been used by security forces to tailor interrogations to the person arrested. The subject of physicians participating in torture goes beyond the scope of this paper, however, and has been discussed at length elsewhere.

Finally, there are recent examples of doctors who refused or were reluctant to comply with such laws and were then arrested themselves.

The question therefore is whether doctors should agree to surrender information on patients in situations where they know or strongly suspect that, in doing so, they will be acting against the interests of their patients. In some countries, doctors may thus even find themselves to be auxiliaries to ill-treatment or torture.

It is often difficult for doctors in countries where 'fair play' is an institution to understand that legal provisions running counter to medical confidentiality may be used in inappropriate ways. An obvious retrospective example would be a law requiring doctors to report all circumcised patients to the authorities in a country where Jews (or Arabs for that matter) are being persecuted.

Is it the role of doctors to screen patients for the police?

Even in less serious cases, is it the role of doctors to screen patients for the police?
Would it be acceptable for doctors to have to deliver lists of patients who come to have wounds treated and who speak with some distinct accent or belong to a particular ethnic group? Should they have to report patients who they suspect belong to a radical movement or party?

There may be situations where the rights of the individual are respected and where any such laws will merely be safeguards against wrongdoing. It is, however, questionable whether a doctor should be used as a substitute for police work. In the last analysis, should physicians be expected to verify and ascertain their patients' identities? Why should they? How can this be part of their medical duties? It is not inappropriate for a doctor to have to assume a role which cannot be said to be in the interests of the patient.

The relation between medical confidentiality and 'the law' is always a difficult one, and many of the above issues have already been debated in detail elsewhere.

The aim of this paper is to underline certain realities relating to medical confidentiality. What may be perceived in good faith as a safeguard for society in some cases may become an unlawful screening system in others. Worse still, having to obey 'the law' may make doctors accomplices to wrongdoing.

The drafters of the Protocols recognized that making confidentiality 'subject to law' created a potentially dangerous loophole. As is explained in the Commentary: "The aim [of Article 10, para. 3, of Protocol II was] to establish protection and respect for medical activities while preserving the obligation of professional confidentiality... Being subject to national law was the price paid for this rule."

As regards the exercise of medicine in general, it is hoped that medical associations will support doctors in safeguarding confidentiality, should the latter find themselves under the legal obligation to surrender information on their patients for unwarranted purposes.

**In conclusion**

Various instruments of international humanitarian law protect medical neutrality, defined as the duty of medical personnel to perform their duties without discrimination. The humanitarian treaties afford special protection to medical staff so that they are able to carry out those duties.

Although the term 'medical neutrality' as such has been dropped from humanitarian law in force today, the notion of 'protection and respect' for medical activities has been defined and fine-tuned over the years.

The two Protocols additional to the 1949 Geneva Conventions extend that protection in order to preserve the obligations of professional confidentiality. It is thus stipulated that obligations regarding information on a patient must be respected.

However, the relevant clause does specify that these remain 'subject to national law'. The obligations of professional confidentiality are a key element in medical practice. Analogies regarding this legal loophole of Protocol 11 can be made with situations...
lying outside the field of application of international humanitarian law. If physicians are to treat any and all patients that come to them for assistance with total impartiality, they should not be expected - nor is it their role - to pass on information to a non-medical authority, whether about their patients' health or about anything else they have learned in the course of a medical consultation.

It can be argued that there are cases where doctors are required, morally and sometimes by law, to disclose information on their patients. Likewise, doctors may sometimes have to decide on their own initiative whether to divulge information on a patient so as to prevent an act that may prove dangerous for other human beings. A patient's right to confidentiality may indeed end where the rights of the next patient begin. The general principle of beneficence must be respected. Doctors who decide to denounce a patient for specific reasons must knowingly do so as responsible professionals. In difficult borderline cases, a medical arbiter, such as a medical Ethics Committee or an 'ombudsman', should be consulted.

The position of arbiter has to be distinguished from that of an authority obliging doctors to disclose information concerning their patients. 'National laws', particularly emergency regulations in conflict situations, may put doctors under pressure to denounce any patient that the authority sees fit to screen and have arrested. This could arguably turn the doctor into an accomplice of the police, which is definitely not his role. Doctors should not have to surrender details on their patients' identity, political affiliation or adherence to specific associations, nor should they be forced to hand over any other such information that has come to their knowledge in the course of their medical work.

As has already been emphasized, the principle of confidentiality is one of the cornerstones of sound medical practice. Being compelled to serve as an instrument of the police or of any other coercive authority in effect jeopardizes a doctor's relationship with his patient. This may also lead an ill-intentioned authority to take steps that may prove deleterious to the health of the persons involved. This argument becomes particularly relevant in countries where the police or other security personnel violate basic human rights, for example through the use of torture or other forms of ill-treatment.

Some doctors may understandably - particularly in a coercive State - give in and transgress the principle of confidentiality. Others may be penalized, and sometimes arrested, for refusing to inform. In both cases, doctors should be able to appeal to higher medical authorities for support.

National and international medical bodies should find ways to assist them in the proper exercise of the medical profession, and to help them uphold the principle of confidentiality. It is highly unlikely that the 'subject to national law' loophole will be reviewed within the framework of international humanitarian law. Would there not, however, be a case for strengthening the principle of medical confidentiality in difficult situations where humanitarian law does not apply? It could surely be argued that doctors should enjoy at least the same degree of protection in their 'right to silence' as clergymen and lawyers.
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The views expressed in this paper reflect those of the author and not necessarily those of the International Committee of the Red Cross (ICRC).

References

2 It is not the intention of this paper to elaborate on the applicability of International humanitarian law. The Geneva Conventions and Protocol I apply to situations of International armed conflict, while Protocol II applies to non-international conflicts. For the layman, a conflict of the nature of the Spanish Civil War would have corresponded roughly to this latter field of applicability - but of course Protocol II and the 1949 Conventions did not exist at the time.
3 This notion was incorporated in each of the two Protocols, in the sections on General protection of medical duties. The first two paragraphs of both sections redefine the original concept of medical neutrality and stipulate that medical personnel must be allowed to work with complete Impartiality and must in no case be penalized for administering to someone in need.
4 Applicable in the event of international conflict.
5 Applicable in the event of non-international conflict.
6 In Protocol I, the language is the law of the latter [victims'] Party”.
7 [This]"is not the problem of 'medical confidentiality', as it has sometimes improperly been described ..." As a general rule, medical confidentiality refers to the discretion that a doctor must observe with respect to third parties regarding the state of health of his patients and the treatment he has administered or prescribed for them.” Commentary on the Additional Protocols of 8 June1977 to the Geneva Conventions of 12 August 1949. Y. Sandoz, Ch. Swinarski. B. Zimmermann (eds), ICRC/Martinus Nijhoff Publishers. Geneva, 1987, para. 670, p. 204 and footnote 21.
8 Ibid., para. 4696, p. 1427.
11 Op cit., paras. 671-688, pp. 204-208.
12 The discussion will be limited to doctors. as these are the medical personnel whose "corporation" has the most clear-cut guidelines in ethical matters.