in that case

Mrs A and her husband, Mr A, consulted different GPs at the same medical centre. Mr A was diagnosed with gonorrhoea while working overseas. He called his doctor in New Zealand (Dr B) anxious for his wife to have a medical check, but concerned that his own condition be kept secret.

Mr A told his wife he had a fungal infection and she was examined by her doctor (Dr C) who took cervical and vaginal swabs. Dr C said the practice would be in touch if the test results were untoward.

At a subsequent practice meeting, Dr B told Dr C about the husband's gonorrhoea and the request for secrecy. Two days later the wife's lab results were reported as positive for amoxycillin-sensitive gonorrhoea. Dr C rang and left a message on Mrs A's answer phone saying she had a bacterial infection that needed antibiotic treatment. In a later phone conversation with Dr C, Mrs A was told she had 'an infection' and that she should have more swabs after completing a course of antibiotics.

Eventually Mrs A found out from the practice nurse the nature of the STD, and Dr C followed up by phoning Mrs A and explaining that she had contracted gonorrhoea. When Mrs A asked if her husband could have been unfaithful, Dr C said he might have caught the infection from a toilet seat.

Unhappy with this explanation, Mrs A contacted a sexual health clinic, and was told that the toilet seat advice was incorrect and the 10-day amoxycillin treatment was not current recommended treatment.

The material for this case was provided by the Health and Disability Commissioner and based on a recently reported case.

response

Selena Ewing
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Dr B and Dr C probably both meant well. Possibly their concerns were to avoid confrontation, keep the peace, and protect a marital relationship. But doctors must be committed to the patient as an individual. Doctors must not make decisions concerning one patient in order to benefit another.

This case represents firstly a serious breach of patient confidentiality and secondly an instance of a doctor withholding the truth for paternalistic reasons.

One wonders about the nature of the practice meetings. Are patient details, along with identifying information, routinely shared? Or did Dr B feel obliged to protect his/her own patient? Either way, Dr C was then required to choose to be honest, or to become complicit in Mr A's dishonesty.

The use of an answering machine, while perhaps not posing an ethical dilemma, is not ideal for informing a patient of such test results. Dr C chose to be evasive and vague in order to protect the husband and perhaps to protect the wife's feelings or avoid uncomfortable questions. But patients can usually detect incongruities, and Mrs A's dissatisfaction with Dr C's response led her to seek out the truth for herself. Had Dr C not been told of Mr A's request for confidentiality – which should have gone without saying – the details of Mrs A's diagnosis would have been straightforward.

It also seems that some aspects of Dr C's clinical expertise may be outdated. A duty of care requires that doctors keep up with current best practice.

Harm had already been done by Mr A. One could surmise that more damage would have resulted from this sequence of events, not only to the marriage but also to the doctor-patient relationships concerned. Both doctors needed to follow principles of confidentiality and truth-telling, rather than muddling through even with the best of intentions.

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response

Dr Philip Jacobs
General Practitioner
Christchurch
RNZCGP Executive

A case of gonorrhoea within a relationship where disclosure as to natural history is not a desired outcome for the prime contractee.

This case is interesting because it highlights a number of important issues relevant to the doctor/patient relationship. From a medical point of view, it is relatively simple, i.e. the diagnosis and treatment of gonorrhoea and the mandatory disclosure by the patient to other contacts so that they may be checked and treated if necessary. Although the exact treatment of gonorrhoea under these circumstances has been deemed to be incorrect, this is not a key issue and I will concentrate more on the interaction between the partners in the relationship and their two different, but allied, general practitioners.

The three main areas of interest are:

1. Collusion
Dr B colluded with Mr A to hide the true nature of the infection from Mrs A. He did this by drawing Dr C into the collusion, effectively becoming an agent for Mr A's deceit. The collusion extended across all the consultations with Mrs A from the initial failure to divulge the true nature of the specific STD to the bizarre statement that Mr A may have caught the infection off a toilet seat. Collusion in medicine is common and although it is often generated for the purposes of 'what is in the best interests', it has the potential to disempower the patient with the problem. It can also destroy trust within a therapeutic relationship. In this case the collusion broke down when Mrs A sought clarification from the practice nurse who was not party to the collusion.

2. Privacy
Mr A had a right to have his privacy respected, but also had an ethical and legal duty to ensure that his contacts were informed of the nature of the infection and received appropriate treatment. Whilst doctors do and should share details of cases, mainly for education and information, the transmission of special knowledge from one patient consultation to a different consultation should only happen under very extraordinary circumstances. Doctor B should have discussed with Mr A the nature of the disease, natural history and requirement to treat all affected parties. If Mr A chose, as he indeed did, to underplay the nature of the infection, then he needs to be taken through, in a prospective manner, the implications of adopting this stance where the swabs should prove positive. The acquisition of an STD is Mr A's problem and he should be given guidance to help resolve the situation. It is not the doctor's responsibility to

solve it for him, nor is it appropriate for the doctors to be party to an inappropriate version of the truth.

3. The Truth

Telling the truth about the natural history of disease is a key part of Doctor's ethical duty. The 'toilet seat' deception was blatantly wrong and Mrs A would have been sufficiently aware from previous priming that all was not what it seemed. This aspect was a serious transgression and arguably the biggest error in the behaviour of Dr C. She should have contacted Mrs A as soon as possible after the confirmation that the swab was positive, and asked her to come in for a consultation. Under the circumstances it was inappropriate to leave any message as to the nature of the infection on an answer phone where others may access the information. This was a breach of Mrs A's privacy. Mrs A should have been told of the nature of the disease and be allowed to ask the appropriate questions, receiving honest answers. It then becomes her choice to discuss this with her husband as she sees fit.

The Medical Council of New Zealand has recently released a position paper of confidentiality and public safety (Medical Council of New Zealand, 2002). They say the following:

> Confidentiality in the doctor-patient relationship is a fundamental principle in medical practice. It is vital to maintain levels of trust that allow intimate and personal information to be divulged with confidence. However, when harm to a patient or another individual could be prevented by breaking that confidence and disclosing information, a doctor can legally disclose patient information. This disclosure must be limited to relevant details of the patient's information that would prevent harm and must be made to a person who is in a position to act in the interests of the patient or public safety.

Disclosure of health information is defined under the *Health Information Privacy Code 1994* and refers to the conditions where it is deemed permissible. Rule 11(2)(d) allows unauthorised disclosure where the disclosure of information is necessary to prevent or lessen a serious and imminent threat to:

1. public health or public safety; or
2. the life or health of the individual concerned or another individual

The intended disclosure should be discussed with the patient where possible. The patient should then be given the opportunity to disclose on his or her own account.

Discussion

Transgressing privacy in this case should have been a position of last resort and indeed under these circumstances never needed to be breached. Although it is appropriate for doctors to discuss cases, the information derived should not be used unless the above conditions relating to the Health Information Privacy Code are met.

This case has highlighted some very important issues around medical law and ethics. In different times, a paternalistic approach may have been acceptable to the profession. In the current environment a confidential, patient centred, honest relationship protects both patient and health professional.

References

Medical Council of New Zealand (2002). *Confidentiality and Public Safety* @ www.mcnz.org.nz, accessed September 1, 2002.

Health Information Privacy Code 1994, Wellington, New Zealand Government Publications.

response

Dr Jill McIlraith
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This case raises three important issues:

Firstly, the conflict between a duty to be honest to one patient but to also respect another patient's wishes. Secondly, the need to get informed consent before doing the tests. Thirdly, the difficult area of partner notification and treatment of sexually transmitted infections.

The first issue highlights the conflict between a duty to the individual patient and what another patient has requested, ie not to reveal his health status even though it is relevant.

When first contacted by Mr A, Dr B should have at this stage urged Mr A to be honest with his wife about why she needed testing. Although the doctor had to respect Mr A's confidentiality, he should have pointed out that it was going to be difficult to explain matters to his wife if she returned a positive test. This would have forewarned Mr A that his initial desire to keep his infection a secret was unrealistic.

But even though Dr B was duty bound to protect his patient's request for privacy, this should not have influenced Dr C about his duty to be honest with his patient, Mrs A. If Dr C had not subsequently been told by Dr B about the husband's infective status, would Dr C have been more open with Mrs A about what her swabs showed?

The second issue is that of informed consent. The question of why such tests were being requested should have at least been broached with the patient when the swabs were taken. Difficult as it may be for both doctor and patient, the doctor does need to state clearly what is being tested for and ask the patient to consider what a positive or negative result may mean. Without doing this, it could be argued that the patient has not given informed consent.

The time is long since past when one partner can be fobbed off and given treatment 'for an infection' and not be told what the infection is. Doing so goes against the fundamental principle of being honest with patients and obtaining informed consent to test and treat. If we as doctors are not prepared to deal with the potentially difficult consequences of getting positive results, should we be doing the tests in the first place?

Information to Mrs A about her own medical condition could have been given in a factual and non-emotive manner. Delivering this information with empathy and tact and avoiding passing judgment on Mr A or speculating about his behaviour would potentially have been more helpful than giving incorrect information in the hope of sparing Mrs A's feelings or the marriage. The attempt to fudge the true nature of her infection compounded the error and escalated, rather than solved, the dilemma faced by Mrs A.

Mrs A was probably already suspicious after being told by her husband to see her doctor for a 'fungal infection'. Being misled further, even if Dr C's motives were honourable, only added to this perception.

There is also the question of what other sexually transmitted infections Mr A could have picked up overseas and passed onto his wife such as HIV and syphilis. This needed to be discussed and tests offered. It would be difficult to tackle these even thornier questions if the basic trust had been affected by the handling of first infection.

When Dr C found this situation difficult, it may have been helpful to discuss it with his peers or staff at a sexual health clinic who would probably have urged Dr C to be honest with the patient and given advice about treatment. (In this case, rather than the 10-day course of amoxycillin, it would have been more appropriate to use amoxycillin 3g stat plus probenecid 1g stat orally or ciprofloxacin 500mg stat orally, as high dose antibiotic levels for a shorter time give better cure rates.)

Thirdly, there is the issue of partner notification and treatment.

Telling a partner that he/she needs testing and treatment is usually best done by the person concerned even though it is not a pleasant situation for anyone. With support and advice from medical and nursing staff as to what words to use and information to pass on, this is usually achievable. But it does mean in this case that the issue of infidelity would have to be faced. On the whole it is much more difficult and offensive to a patient to be told by a stranger (for example, the contract tracer from the sexual health clinic or a practice nurse) that they may have a sexually transmitted disease. For many patients this won't protect the anonymity of the person from whom they contracted the disease and will compound their feelings of anger and betrayal that this person did not own up and do the honourable thing.

Gonorrhoea is not a notifiable disease in New Zealand but there are some legal requirements under the Venereal Disease Regulations about ensuring patients with positive results are treated.

Contact tracing is an area that many doctors find difficult and it is often put in the too-difficult basket or delegated to practice nurses. However it is important to accept that encouraging individuals to treat their partners appropriately and to be honest with one another may be required before doing the tests in the first place.

In summary, the obligations felt by one doctor to his patient, adversely influenced the way the second doctor treated the second patient. While communication between health professionals is important, the consequences of sharing such information need to be fully explored and the pitfalls delineated beforehand, to avoid being faced with having to pick up the pieces after the event.

As is often so, in this case there were a series of smaller errors of judgment that were compounded and ultimately led to a less than desirable outcome for all concerned.