Where does the doctor's responsibility lie?

A 35 year old married man visits his General Practitioner because he thinks he may have STD. On hearing the patient's history the General Practitioner suspects the patient may have chlamydia. The patient agrees to be tested, and treated for chlamydia if the tests come back positive, on the condition that his wife is not informed even though she may be infected herself. The patient feels that if his wife knew he was having an affair with another woman it would destroy his marriage. To add to the problem both the husband and wife are patients of the GP and have been trying to have a baby for the past 18 months. If her husband does have chlamydia and she has contracted it from him, without treatment she has a significant chance of developing salpingitis and becoming infertile. As chlamydia is often asymptomatic she may have the disease and not know it unless she is asked to come in for a check up.

Commentary

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The first step in this very complex problem lies in elucidating the various intricate issues involved

1 I have two patients here, and both have equal rights in the relationship.

2 The information gathered concerning two people in an intimate relationship applies to both and cannot be considered as privileged to one party.

3 In addition to the possible chlamydia infection there are two additional problems:

a) The extramarital affair

b) The infertility

both of which involve the two people equally.

If I agree to the condition imposed by the man, I may complete the diagnosis and treatment of his chlamydia, but in so doing I leave the woman's infection untreated and potentially make her infertility problem worse. If I do agree, I risk losing the patient and the chance of treating his infection and enroling his support in helping the other problems.

It has to be recognised that the main problem exhibited by this man is the imposition of conditions which may adversely affect other people, without their consent. My responsibility is to inform the man gently that as both parties are equally involved with me as their doctor, there is no way I can comply with his condition. There is a risk that he may storm out of the surgery but in the great majority of such cases the threat is an empty one and I would expect to be proceeding to help both parties with their marital difficulty, a major factor in which may be his domineering attitude. Someone has to stop the rot and it is appropriate that I stand my ground and challenge his assumption that the universe necessarily circulates around him.

Commentary

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One writer[1] has described chlamydia as the "most dangerous sexually transmitted disease today... in America." New Zealand may be no different. Chlamydia is three times as likely to cause sterility in women than is gonorrhoea[2] and it is responsible for about 6% of all causes of infertility[3]. If a woman becomes pregnant, and is untreated, the disease may increase the possibility of some degree of disability to a newborn, including blindness.

The patient has cause to be extremely concerned. If he does have this STD., chlamydia, his wife may have contracted it from him. He may be throwing away his chances of having a family in this marriage. Indeed, his marriage may be in immediate jeopardy, if his G.P. informs his wife about the situation. The "other woman" may have infected him, or conversely, he may have infected her.

If the man convinces the G.P.to adhere to his wishes, has the test, if the results are positive and he subsequently has treatment, no one apart from the G.P. need ever know of this man's guilty secrets. But surely this is merely wishful thinking? For if he does have chlamydia, and his wife has contracted it from him, has developed salpingitis and become irreparably infertile, how will he cope with the trauma of infertility diagnosis? How much more damaging will the revelations be later on when his wife begins to ask questions and discovers his deceptions have led to a far greater predicament?

The GP's first responsibility is to fully inform the man about the nature of chlamydia, including information about its effect on women and newborn children if left untreated. This responsibility to inform adequately is part of the therapeutic relationship. But the GP is also in a therapeutic relationship with the wife. If the results are positive, and the patient refuses to disclose the information to his partner, the G.P. will have a duty to prevent substantive harm to this patient too and may have to suspend his/her allegiance to confidentiality with respect to the husband.

The GP may be able to maintain his obligation of confidentiality to the man by passing responsibility for treating the couple's infertility to a consultant. We are not told in this scenario whether the GP has referred the couple for specialist evaluation of their infertility. But if she/he has, then in the course of any thorough investigation, the disease should be detected in the woman. The consultant may already have a positive test result for the wife. He/she may well be wondering whether to inform the GP and/or husband, if the wife has no other sexual contacts, and is puzzled by the results.

An infertility consultant will have taken a full sexual history of both husband and wife separately, so that "secrets" may be revealed if they are relevant, as well as serum and urine tests and the other usual physical examinations.

If the GP has not referred this couple, then there is a need for urgent referral in order to initiate infertility investigations. A telephone call to a consultant rather than a letter at this stage would hasten the process. The creating of a new clinical relationship, which by its very nature will allow the woman to be diagnosed and treated, fulfills her/his other obligation to protect her and others from harm. The GP must decide whether to inform the man at the outset that this will be his/her plan of action, if the man himself still does not inform his wife of the situation.

There is also an imperative for known sexual contacts to be treated, otherwise reinfection will be the recurring theme in this scenario. The "other woman" also has a right to be informed, as she may well suffer the same harm as the man's wife. She can not be forgotten in the judgmental fashion with which we so often discard "other" women. The GP should insist that the man inform her too, if his tests prove positive, so that she can be tested and treated.

The compassionate GP has a responsibility to protect from harm the man himself, his wife (and a potential child of the marriage) and all the known sexual contacts of the couple.

1 Eck Menning, Barbara Infertility, A Guide for the Childless Couple (2nd Ed.) Prentice Hall
2 Ibid
3 Hull, M.G.R. et al (1985) Population Study of Causes, Treatment and Outcome of Infertility. B.M.J. 291 : 169321697 (1985)

The New Accident Compensation Act

The New Act

The Accident Rehabilitation and Compensation Insurance Act 1992, in force 1 July of this year, will see substantial changes to New Zealand's accident compensation scheme. As a generality, the Act will provide cover in fewer circumstances than does the 1982 Act and the amounts paid to successful claimants will likewise be reduced. In this, the new Act simply continues the process begun nearly 20 years ago when the scheme was introduced, manifesting a philosophy with which I, for one, have yet to feel comfortable. A foundation stone of the accident compensation scheme (but not a necessary one in my view) is a total ban on the right to sue for compensatory damages "arising directly and indirectly out of personal injury" covered by the new Act. Parenthetically, it must be noted that the right to sue for "punitive" damages will still continue, but such claims are relatively rare as such damages are awarded to punish outrageous behaviour by defendants and not to compensate plaintiffs for their loss. The generality remains that there will be no lawsuits in New Zealand for personal injury damages. Thus we continue to be able to sue each other when we are defamed or the victim of numerous other legal wrongs (eg false imprisonment, breach of contract) but are excluded from the courthouse when injured in a car crash, an assault, or some similar incident. In these cases we must be content to take the ever dwindling amount set forth by the accident compensation scheme.

New categorisation of personal injuries

Though much could be said about some of the other provisions introduced by the new Act, space limitations dictate that I concentrate on the area of most interest to the readers of this publication - injuries occurring in a medical context. First, an accident is now (partially) defined as an event or events involving the application of force or resistance "external to the human body" that is not a "gradual process". This seems designed to exclude formerly successful claims of the type illustrated by two examples well known to observers of the scheme, namely that of a woman with a previously degenerating spine who suffered acute pain when bending down to pick up some milk bottles and that of an infant who received severe brain damage from an unexplained apnoeic attack. Even this new, more narrow definition of an accident specifically excludes "treatment by or at the direction of a registered health professional."

Such an occurrence can be covered under the Act, but only under the specific heading of a medical misadventure (itself newly defined). The new structuring of the Act results in cover only for personal injuries which are:

a. caused by an *accident* to the person concerned; or
b. caused by gradual process, disease or infection arising out of and in the course of employment; or
c. *medical misadventure;* or
d. *the consequence of treatment for personal injury*

Much could be said of (a) or (b), but I wish only to comment on (c) and (d).

Medical misadventure - (i) medical negligence

Of greatest protection for the medical profession is the new definition of medical misadventure. This makes it clear that all cases of "the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances" *(ie negligence)* are included and covered by the scheme. Remembering that the Act prevents any lawsuit arising out of injuries "covered by this Act", there should thus be little possibility of any successful suit based on a doctor's negligence after July 1992. Such a claim would be "covered by the Act" and the right to sue thereby barred. It is only because I am a nervous lawyer that I attach the rider that the courts have yet to interpret these provisions and contrary arguments (to anything I state in this note) may be possible. New Zealand doctors continue, of course to be open to lawsuits for such matters as breach of confidence, breach of contract or even punitive damages, but the new Act will see no widespread return to "malpractice" suits based on medical negligence.