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Medical Privilege

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It is the year 1776. The scene is Westminster Hall, and the occasion is the trial before the Right Honourable the House of Peers of Elizabeth, Duchess of Kingston, for bigamy.[1] The noble lady is charged with having gone through a form of marriage with the Duke of Kingston while her first husband, Augustus John Hervey (later Earl of Bristol), was still alive. To prove the first marriage Mr. Caesar Hawkins, a surgeon, who had attended the noble lady in his professional capacity, is called to the stand. The following dialogue takes place:

> Q. Do you know from the parties of any marriage between them?
> A. I do not know how far any thing that has come before me in a confidential trust in my profession should be disclosed, consistent with my professional honour.[2]

Thereupon Lord Mansfield expressed the view of the court in language which has become a classic upon the subject:

> I suppose Mr. Hawkins means to demur to the question upon the ground that it came to his knowledge some way from his being employed as a surgeon for one or both of the parties. . . . If all your Lordships acquiesce, Mr. Hawkins will understand that it is your judgment and opinion, that a surgeon has no privilege, where it is a

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[1] The trial of Elizabeth, Duchess of Kingston (1776), 20 Howell's State Tr. 355.

[2] *Ibid.*, p. 574

> material question, in a civil or criminal cause, to know whether parties were married or whether a child was born, to say that his introduction to the parties was in the course of his profession, and in that way he came to the knowledge of it. I take it for granted that if Mr. Hawkins understands that, it is a satisfaction to him, and a clear justification to all the world If a surgeon was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honour, and of great indiscretion; but to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever.

From this statement of the legal obligation of the medical doctor when he takes the witness stand, English law has never departed. Were this paper concerned merely with a declaration of the law on whether a doctor is entitled to professional privilege it could end at this point. Our law is clear. He has no such right.

But the subject has many ramifications. I should like, therefore, to examine the nature of professional privilege itself, to indicate briefly how it affects professions other than medicine, to touch upon the experience of other jurisdictions, notably the United States, where medical privilege has been conferred by statute and, finally, to deal with the interesting problem whether the doctor is obliged by law to preserve professional secrecy *outside* the courtroom, and, if so, what are the limits of that obligation.

The Nature of Professional Privilege

It is to the lawyer, and virtually to the lawyer alone, that English law accords professional privilege. The rule exists not for his protection but for the protection of the client. The confidences passing between a lawyer and a client who seeks his professional advice are (with certain exceptions[3]) protected from disclosure. The client cannot be compelled to reveal them. The lawyer will not be allowed to reveal them without the client's express consent.

Why this special solicitude for the legal profession? It is not alone because of the confidential nature of its work, for other relationships of a like character are not accorded the right of professional privilege. One can hardly imagine a more confidential relationship than that of priest and penitent. But by the common law of England a religious adviser is not entitled to privilege.[4] In

[3] For example, communications in furtherance of a fraud or crime: Phipson on Evidence (9th ed.) p. 205.

[4] *Wheeler* v. *LeMarchant* (1881), L.R. 17 Ch. D. 675, at p. 681; *Normanshaw* v. *Normanshaw* (1893), 69 L.T. 468. An excellent article by G.D. Nokes, Professional Privilege (1950), 66 L.Q. Rev. 88, calls attention to the fact that English decisions on the subject have not dealt directly with the position of the priest in the confessional. In some cases (*e g.*, *R.* v.

passing I may mention that this is not the law of Quebec, where by special statutory provision the professional confidences of a religious adviser are given the same protection from disclosure as those of the legal adviser.[5] I need not emphasize, I am sure, the delicate situation which would arise in any of the other provinces of Canada if the common-law rule were strictly enforced against a priest who insisted upon preserving inviolate the secrets of the confessional.

It is not primarily because the lawyer's work is confidential but because it is essential to the administration of justice that the privilege arises. More than a century ago Lord Brougham expressed the matter thus:

> The foundation of this rule is not difficult to discover . . it is out of regard to the interests of justice which cannot be upholden, and to the administration of justice, which cannot go on without the aid of men skilled in jurisprudence, in the practice of the courts, and in those matters affecting rights and obligations which form the subject of all judicial proceedings. If the privilege did not exist at all, every one would be thrown upon his own legal resources; deprived of all professional assistance, a man would not venture to consult any skilful person, or would only dare to tell his counsellor half his case . .[6]

I have said that the legal profession stands alone on this matter of professional privilege. Generally speaking that statement is correct. But two limited exceptions may be noted. First, there is in England a rule of practice which is applied, in the discretion of the court, for the benefit of newspapers sued for libel, under which the defendant, except in special circumstances not very clearly defined, is not obliged to disclose its source of information.[7] It is of interest to note, however, that recently a Canadian judge refused to apply this English rule of practice to the different system of discovery prevailing here, and ordered a journalist to disclose the names of his informants.[8] This judgment was upheld on appeal.

Hay (1860), 2 F & F. 4) the court insisted on disclosure by the priest but asserted that the matters in question did not arise from a ritual confession. In other cases there are obiter dicta expressly denying a right of privilege to all clergymen, priest included. But the author's conclusion (p. 100) is "that no professional privilege from disclosing the secrets of confession can be shown to exist in modern English law, and that there is no compelling reason for the recognition of such a privilege".

[5] Quebec Code of Civil Procedure, art. 332: "He [a witness] cannot be compelled to declare what has been revealed to him confidentially in his professional character as religious or legal adviser, or as an officer of state where public policy is concerned".

[6] *Greenough* v. *Gaskell* (1833), 1 Myl. & K 98, at p. 103

[7] *Vide*, for example, the case of *Lyle-Samuel* v. *Odhams Limited et al.*, [1920] 1 K.B. 135.

[8] Whittaker J. in *Wismer* v. *Maclean-Hunter Publishing Company Limited and Fraser*, (1953) 10 W.W.R. (N S.) 114 (B.C.). While the decision

A second exception exists in England—and in my view is soundly based and deserves to be followed here—whereby communications made to a probation officer[9] or marriage counsellor, in the course of negotiations for the purpose of bringing about a reconciliation between husband and wife, are privileged. In one case it was stated that "the privilege . . . applies not only to probation officers, but also to other persons such as clergy, doctors or marriage guidance counsellors, to whom the parties resort with a view to reconciliation when there is a tacit understanding that the conversations are without prejudice".[10] Although it will be observed that reference is made to "doctors", it should be borne in mind that the limited privilege accorded to them in such cases is not *qua* doctors but rather *qua* intermediaries seeking to bring about a reconciliation between husband and wife.

Criticisms and Justifications

It need hardly be emphasized that the denial of professional privilege to medical men has not escaped criticism. Indeed there have been several pronouncements from the English bench on this theme. As long ago as the year 1792 one judge expressed himself as follows: "There are cases to which it is much to be lamented that the law of privilege is not extended; those in which medical persons are obliged to disclose the information which they acquire by attending in their professional character".[11] A great Lord Chancellor observed in 1833 that "it may not be very easy to discover why a like privilege has been refused to others, and especially to medical advisers".[12] Members of the medical profession have often spoken in a similar vein. They have strongly proclaimed that there is a social interest in free communication between the sick and their doctors, and that communication can best be secured if the patient knows that

was upheld by the Court of Appeal, (1954) 10 W.W.R. (N.S.) 625, it should be noted that the appellate court (O'Halloran J. A. dissenting) felt that the newspaper, by publishing the article signed by Fraser, had already divulged the source of its information, and that accordingly it was not necessary to decide whether publishers of newspapers have the protection of this "rule of practice".

Mention may be made also of a recent act passed by the Parliament of New South Wales, the Sydney City Council (Disclosure of Allegations) Act, requiring disclosure to the police of certain information, and particularly aimed, it would appear, at newspapers, though applicable to others as well. *Vide* despatches from Melbourne by R. L. Curthoys in the Winnipeg Free Press of December 11th, 1953, and January 8th, 1954.

[9] *McTaggart* v. *McTaggart*, [1948] 2 All E.R. 754.

[10] *Mole* v. *Mole*, [1950] 2 All E.R. 328, *per* Denning L.J. at p. 329.

[11] Buller J in *Wilson* v. *Rastall* (1792), 4 Durn. & East's Rep. 753, at p. 760.

[12] Lord Brougham in *Greenough* v. *Gaskell*, *supra*.

the doctor is obliged by law to maintain secrecy even in the court-room. In a word, the medical profession has sought the same privilege as is possessed by its legal brethren.

But, I suggest, there are differences between the two professions, of a character which justifies the distinction that is made between them. Wigmore, the great American authority on evidence, has given us the answer. In his classic work on evidence he outlines four conditions which are essential to the establishment of the kind of privilege with which we are here concerned. These are as follows:

> (1) The communications must originate in a *confidence* that they will not be disclosed;
>
> (2) This element of *confidentiality must be essential* to the full and satisfactory maintenance of the relation between the parties;
>
> (3) The *relation* must be one which in the opinion of the community ought to be sedulously *fostered*; and
>
> (4) The *injury* that would inure to the relation by the disclosure of the communications must be *greater than the benefit* thereby gained for the correct disposal of litigation [13]

How does the practice of medicine stand with respect to these conditions? Except as regards the third—that the patient-doctor relationship should be fostered—little can be said in favour of the view that the practice of medicine satisfies these conditions. Let us consider them briefly:[14]

(1) Do communications by patients to doctors originate in a confidence that they will not be disclosed? In rare cases, yes. But surely in most cases, no. Remember that we are here concerned with disclosure as such, and not with disclosure by the doctor. Nearly all patients are consumed with an overwhelming passion to discuss their ailments with friends, neighbours and, given the chance, even unsuspecting strangers. How can it be maintained that communications by the patient to his doctor originate in a confidence that they will not be disclosed, when the patient himself is usually quite ready to disclose them?

(2) Is the element of confidentiality *essential* to the relation? Here again the answer must be in the negative. The medical profession has carried on for centuries in England without the protection of professional privilege. It carries on without protection in about half the states of the United States and in nearly all the provinces of Canada. Can it seriously be contended, for example,

[13] Wigmore on Evidence (3rd ed.), Vol. 8, p. 531.

[14] For a more detailed and convincing case on this point, see Wigmore, *op. cit.*, pp. 811 et seq.

that the patient-doctor relationship is noticeably different in Manitoba, where the privilege is absent, from what it is in Quebec, where the privilege exists? It would be difficult to support such a thesis. The absence of medical privilege is no visible deterrent to frank consultations by patients with their doctors.

(3) Should the relation be fostered by the community? Emphatically and unchallengeably, yes. The practice of medicine meets the third of Wigmore's conditions in an eminently satisfactory way.

(4) Would the injury to the relation by disclosure be greater than the social benefit gained by courtroom secrecy? In almost every type of physical ailment there could be not the slightest impairment of the relationship by frank testimony on the part of the doctor. On the other hand to seal the lips of the doctor in the witness box —as is done in those jurisdictions which have medical privilege by statute—is often to open the way, as we shall see, to a denial of justice, sometimes ludicrously so. There are occasions—Wigmore cites cases of abortion and venereal disease as examples—in which the patient would no doubt prefer secrecy on the part of his physician. But even in this minority group of ailments it is at least arguable that the injury to the relation by the doctor's testimony is outweighed by the benefit to society from his assistance in the administration of justice.

Medical Privilege By Statute

There are several parts of the world in which medical privilege has been conferred by statute. A brief examination of its operation in some of these jurisdictions may be of value. In that connection it is of interest that in Britain there was at least one attempt to have Parliament enact a bill creating medical privilege. It was introduced in the House of Commons in 1937 under the title, "Medical Practitioners' Communications (Privilege) Bill".[15] It failed to pass second reading. I am not aware of any further attempts to secure the enactment of such a bill.

In about half the states of the United States of America medical privilege exists by statute. The State of New York in 1828 was the first to pass such legislation. Several other states followed, with the result that there is now a vast and growing jurisprudence on the subject, dealing with the various statutes, their effect and their limits. A reference to one or two of the decided cases will be made here.

[15] A discussion on this bill will be found in (1937), 83 L.J. 320.

In the State of Minnesota the statute which was before the court in the case of *Palmer et al.* v. *Order of United Commercial Travellers of America*[16] read as follows:

> A licensed physician or surgeon shall not, without the consent of his patient, be allowed to disclose any information or any opinion based thereon which he acquired in attending the patient in a professional capacity and which was necessary to enable him to act in that capacity.

An action was brought to recover death benefits under an accident policy which excluded asphyxiation by carbon monoxide. Palmer had been seen working in his garage about 2:00 p.m. At 3:40 p.m. his wife found him lying on the floor of the garage, with the motor of the car running. There were bruises on his forehead and nose, evidently caused by his collapse either against the car or upon the floor of the garage. Two doctors were at once summoned by Mrs. Palmer. They attended and sought, without success, to revive the stricken man.

At the trial the defendant sought to establish a defence based on death through asphyxiation by carbon monoxide. For this purpose it called as witnesses the two doctors, who, over the objection of the plaintiff, testified that Palmer's face presented that cherry red appearance which is characteristic of carbon monoxide. The defendant won, and the plaintiff appealed on the ground that the doctors should not have been permitted to give this testimony because it was privileged under the statute. The Supreme Court of Minnesota agreed with this contention; the evidence of the two doctors was excluded; without it the defence offered by the defendant failed; and the plaintiff accordingly recovered under the policy.

A case in some respects similar to the *Palmer* case was decided under the New York statute. *Meyer* v. *Supreme Lodge, Knights of Pythias* also involved a claim under an insurance policy.[17] Suicide was the defence, and its proof depended upon the admissibility of the evidence of one Dr. Bruso. This doctor had been summoned to the aid of the dying man without his consent and against his protests. He found the man in a hotel room suffering intense pain and vomiting. Let me quote from the judgment:

> Meyer told him to get out of the room—that he did not want him there—but he did not leave. . . . He learned from Meyer . . . that he had taken a preparation of arsenic 'because he wanted to die'. . . . Thus informed of the nature of the disease, he at once administered a remedy, and soon followed it by another. The helpless man . . . hopeless of life

[16] (1932), 245 N W. 146.

[17] (1904), 70 N.E 111.

> and courting death, objected, and tried to curse him away from his bedside. The doctor, loyal to the instincts of his profession, refused to listen to the ravings of the would-be suicide, and continued to prescribe in order to relieve suffering and prolong life. . . .

Meyer died a short time later in the hospital, and this action was brought on the life insurance policy. Should Dr. Bruso have been allowed to testify to the facts just recited? The Court of Appeals of New York said, No. The evidence was privileged under the statute. The relationship of patient and doctor was found to exist, even though Meyer did not want it to exist. Thereupon the statute came into operation, and Dr. Bruso's evidence had to be excluded.

It is not unfair to say that the statutory medical privilege in the United States has been the subject of much criticism. The decisions to which it has given rise are sometimes confusing and contradictory. Time and again in Wigmore's footnotes the cases dealing with some particular aspect of this subject are collected and classified under two headings, one called "Accord", the other, "Contra".[18] Thus there are cases on both sides of the question whether the privilege extends to certificates of death;[19] whether the privilege has been waived by the patient in certain specific circumstances, as when he himself testifies in a personal injury action;[20] and whether a waiver in respect of one physician's testimony is a waiver of the privilege in respect of other physicians who have examined the patient.[21]

In 1937-38 this whole subject received the attention of the American Bar Association's Committee on the Improvement of the Law of Evidence. The following is an extract from its report:

> The amount of truth that has been suppressed by this statutory rule must be extensive. We believe that the time has come to consider the situation We do not here recommend the abolition of the privilege, but we do make the following recommendation. The North Carolina statute allows a wholesome flexibility Its concluding paragraph reads: 'Provided that the presiding judge of a superior court may compel such a disclosure if in his opinion the same is necessary to the proper administration of justice'. This statute has needed but rare interpretation. It enables the privilege to be suspended when suppression of a fraud might otherwise be aided

The committee concluded its report by recommending the enactment of the North Carolina proviso.

May I venture the observation that if there is to be a statutory

[18] Wigmore, *op. cit.*, pp. 817-840.
[19] Wigmore, *op. cit.*, at p. 827, sets forth cogent reasons why the privilege should not apply to death certificates, but some cases to the contrary are referred to at p. 828.
[20] Wigmore, *op. cit.*, pp. 833-4. [21] Wigmore, *op. cit*, p. 839.

medical privilege at all—and I believe the case against it is a strong one—a proviso on the North Carolina pattern represents an essential minimum safeguard.

The State of Victoria in Australia has the following statutory provision, first enacted in 1857:[22]

> No clergyman of any church or religious denomination shall, without the consent of the person making the confession, divulge in any suit, action or proceding, whether civil or criminal, any confession made to him in his professional character according to the usage of the church or religious denomination to which he belongs
>
> No physician or surgeon shall, without the consent of his patient, divulge in any civil suit, action or proceeding (unless the sanity or testamentary capacity of the patient is the matter in dispute) any information which he has acquired in attending the patient, and which was necessary to enable him to act for the patient.

It will be observed that the privilege of clergymen applies both in civil and criminal proceedings; that of the doctor, on the other hand, is confined to civil proceedings only. A New Zealand statute is in substantially similar terms. The Victoria statute has been the subject of judicial criticism. In one case[23] the Chief Justice of Victoria said that "repeal or amendment of the section is urgently called for in the interests of justice".

Medical privilege is expressly provided for in section 60(2) of the Quebec Medical Act[24] as follows: "No physician may be compelled to declare what has been revealed to him in his professional character".

Perhaps it will be of interest to know how the new state of Israel is dealing with this question. Israel's legal system is derived from several sources, of which the common law of England is one. The state is presently undertaking a large-scale revision of its laws. In the furtherance of this objective it is receiving the assistance of the Harvard Law School, through a special project known as "The Harvard Law School-Israel Cooperative Research for Israel's Legal Development". An Evidence Bill for Israel was drafted recently by the Ministry of Justice of the state of Israel, section 97 of which reads:[25]

> The court shall not compel an advocate or a physician to testify re-

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[22] Now the Victoria Evidence Act, 1928, s 28. The words "or testamentary capacity" were added in 1946. *Vide*, *F (otherwise M.) v. F*, [1950] V.L.R 352.

[23] *Warnecke* v. *Equitable Life Assurance Society*, [1906] V.L.R. 482. *Vide* also *National Mutual Life Association* v *Godrich* (1909), 10 C.L.R 1.

[24] R.S.Q., 1941, c. 264.

[25] According to the translation made by the Harvard Law School-Israel Co-operative Research for Israel's Legal Development.

> garding a matter communicated to them by their client or patient and which they consider a professional secret, unless the client or patient expressly or impliedly waived the secrecy of the communication.

An earlier bill had been drafted by a committee composed of Israeli judges and lawyers. This bill provided for privilege only in the case of lawyers. But the Ministry of Justice in its own draft bill extended the privilege to include doctors as well. An unusual feature of this section of the bill is that it sets up a subjective test both for the lawyer and the doctor. It is for him to determine whether the subject matter of the communication should be considered "a professional secret", a circumstance which constitutes a novel departure from the usual type of legislation on the subject.

Having surveyed the situation in certain other parts of the world, I return to the law of England, which on this subject is also the law of Manitoba. The situation admits of a categorical answer: Our law does not recognize any privilege of a doctor in the witness box. This rule will apply even where a patient is urged to submit himself to medical care in a venereal disease clinic, under assurances that secrecy will be maintained.[26] If the doctor is brought to the witness stand he will be obliged to tell what he knows about the case, and the court will not be able to give effect to his objection that the matter is secret in character. True enough, it sometimes happens, especially on matters which are not considered vital, that the court will ask counsel not to press a particular question, and counsel will usually accept the suggestion of the court. But in such cases the doctor merely receives a dispensation by courtesy. The law remains the same: So far as doctors are concerned there is no courtroom secrecy. This rule will apply as well to medical evidence given in quasi-judicial proceedings, such as those of an administrative tribunal.

Secrecy Outside the Courtroom

What about the obligation of the doctor to maintain secrecy outside the courtroom? Expressed another way, is there an implied condition of secrecy in the contract between the patient and the doctor?

In the *Duchess of Kingston* case Lord Mansfield said that a doctor who voluntarily revealed professional secrets "would be guilty of a breach of honour, and of great indiscretion".[27] Does the matter stop there? Is it only a matter of personal honour and pro-

[26] *Garner* v. *Garner* (1920), 30 T.L.R. 196.
[27] *Vide* footnotes 1 and 2, *supra*.

fessional ethics? Or is there a legal obligation to respect the professional confidences of a patient? It is noteworthy that there is hardly any English or Canadian case law directly on the subject. That in itself constitutes a great tribute to a profession whose members possess and practise a high standard of ethical conduct. Although there are no English decisions directly on the point, there are several obiter comments,[28] all supporting the view that the relationship between doctor and patient is confidential in character. Moreover, the Supreme Court of Canada, as we shall see, has considered the matter, though the case before it[29] went beyond the mere breach of secrecy, since it was there found that the doctor's statements were untrue and libellous.

The issue, however, was squarely faced in a Scottish case, *A. B.* v. *C. D.*[30] In that case the pursuer was a Kirk elder. His wife gave birth to a child six months after the marriage. He thereupon consulted the defendant, a doctor, as to whether the child was fully developed or premature. The doctor made the required examination, concluded that the child was fully developed, and so reported to the pursuer. He sent an additional report, however, without the pursuer's knowledge or consent, to the minister of the Kirk. As a result the pursuer was expelled from the session. He then brought action against the doctor for damages for breach of the condition of secrecy implied in the contract between a patient and a doctor.

Lord Fullerton, in delivering judgment, pointed out that, although communications made by a patient to a medical man are not privileged if disclosure is demanded in a competent court, they are none the less subject to an obligation of secrecy. This obligation is not absolute. It would have to yield to the demands of justice. It might be modified if disclosure were conducive to the ends of science, though even there the concealment of individuals is usual. He continued thus:

> But that 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

Although this case would not be binding on a Canadian court,

[28] *E.g.*, *Tournier* v. *National Provincial & Union Bank of England*, [1924] 1 K.B. 461, at p. 480; *C.* v. *C.*, [1946] 1 All E.R. 563.
[29] *Halls* v. *Mitchell*, [1928] S.C.R. 125.
[30] (1851), 14 Dunlop 177.

it would be of great persuasive value. Its reasoning, it appears to me, is sound. Moreover the case is especially useful because it deals on the basis of principle with the question of implied secrecy in the patient-doctor relation. It will be noted that what the doctor communicated to the minister was true, and accordingly would not qualify as libel or slander. The doctor was held responsible, however, merely because he had wrongfully disclosed confidential information which he had acquired in his professional capacity.

The case to which I have referred as coming before the Supreme Court of Canada is *Halls* v. *Mitchell*.[31] Halls was an employee of the Canadian National Railways at Toronto. In 1924 he made a claim to the Ontario Workmen's Compensation Board for compensation for certain injuries, which he claimed produced the condition known as iritis. Dr. Mitchell was Assistant Chief Medical Officer of the C.N.R. at Toronto, and he was directed by his company to investigate the medical aspects of the claim. Now it happened that four years earlier, in 1920, Halls had been a patient of Dr. Mitchell. A reading of the judgment suggests that mistakes were made in connection with certain of Halls' medical records.[32] In any event Dr. Mitchell, relying on his records and on his recollection of what the plaintiff had told him, reported in writing to two other doctors that Halls had contracted gonorrhea in 1918. This fact was denied by the plaintiff, and it would appear that he had been, to quote the language of the court, "the victim of a cruel error". There was evidence that iritis could be a consequence of earlier gonorrhea. The Workmen's Compensation Board dismissed the plaintiff's claim for compensation.

It is important to note that the case came before the court as an action for libel. The defence was not that the words written were true, but rather that they were written on a privileged occasion, without malice. The case, therefore, does not directly deal with the law as to disclosure by a doctor of truthful information about his patient; it concerns the communication of false information. Four of the five judges who heard the case in the Supreme Court were of the opinion that Dr. Mitchell was not under a duty to disclose information which had come to him as the personal physician of the plaintiff, and that, therefore, the occasion was not privileged; the fifth judge thought that the doctor *was* under some such duty

[31] *Vide* footnote 29, *supra*.

[32] The plaintiff's medical records at the office of the Department of Soldier's Civil Re-establishment had been seen by Dr. Mitchell. These contained the abbreviation "V.D.G."—venereal disease, gonorrhea—by error, in place of "V.D.H."—valvular disease of the heart.

with respect to one of the reports he made, and that accordingly the occasion of that publication was privileged. But the majority judgment written by Duff J. (later Sir Lyman P. Duff, Chief Justice of Canada) contains numerous passages indicating that there is a clear obligation on a doctor to maintain professional secrecy. I need quote only one or two:

> We are not required, for the purposes of this appeal, to attempt to state with any sort of precision the limits of the obligation of secrecy which rests upon the medical practitioner in relation to professional secrets acquired by him in the course of his practice. Nobody would dispute that a secret so acquired is the secret of the patient, and, normally, is under his control, and not under that of the doctor.[33]
>
> It is, perhaps, not easy to exaggerate the value attached by the community as a whole to the existence of a competently trained and honourable medical profession; and it is just as important that patients, in consulting a physician, shall feel that they may impart the facts touching their bodily health, without fear that their confidence may be abused to their disadvantage.[34]

Fortified by the opinions I have quoted, I hold the view that, over and beyond the dictates of professional etiquette, there is a legal duty on the doctor to maintain secrecy. Such a duty arises from the confidential character of the relationship. It is an implied term of the contract between the patient and the doctor. But this duty of secrecy is not absolute in its nature. It is subject to certain limits or exceptions, to which I shall now make brief reference.

Exceptions to the Duty of Secrecy

(1) *In court*

As we have already seen, the duty to respect the confidences of the patient must give way to the demands of justice. When the doctor is testifying in court, except in those jurisdictions where a statute provides otherwise, he is not entitled to claim privilege and the duty of secrecy to his patient will no longer apply.

(2) *When disclosure is required by statute*

In the interests of the general welfare of the community a doctor is sometimes required by law to communicate to a public authority or officer the facts of his patient's disease. The usual sphere within which this obligation operates concerns infectious diseases. By the regulations[35] passed under the Public Health Act of Manitoba a

[33] *Ibid.*, p. 136. [34] *Ibid.*, p. 138.

[35] Manitoba Regulations 42/51, s. 46(1)(a). Cf., for Ontario, s. 13 of the Venereal Diseases Prevention Act, R.S.O., 1950, c. 408.

physician who treats a person suffering from venereal disease is required to report the case to the Minister of Health within twenty-four hours. Clearly the usual implied term of secrecy would be displaced in such circumstances by the statutory duty to make the report. The regulations in fact specifically provide that no report of a physician given for the purpose of the regulation, bona fide and without negligence, renders him liable to an action.[36]

(3) *When disclosure is required or justified as a matter of public policy*

Here we come to a very difficult aspect of medical privilege. When is a doctor under a duty in the public interest (apart from statute) to make disclosure of professional confidences? Let us look at the question from the standpoint of (a) criminal, and (b) civil cases.

A bank robber, as he is about to emerge from the bank, is shot in the left leg, but manages to get away. The public is alerted by press and radio notices. A few hours later a doctor, who has heard the radio broadcast, is visited by a man suffering from a recent gun-shot wound in the left leg. The man is clearly in need of immediate medical attention, which the doctor, quite properly, renders to him. Does his duty end there? Should he notify the police? If he does, is he guilty of a wrongful breach of medical secrecy? If he does not, does he run the risk of trouble with the police himself? I am sure that to some persons the conflict of duties presented by such a problem will admit of an easy and ready solution. Others, however, may have more difficulty with the answer. Let us see how this type of problem has been viewed by some whose opinions are entitled to weight.

In 1922 Lord Dawson of Penn considered the matter at a meeting of the Medico-Legal Society in London.[37] In his view a distinction should be made between the case of a doctor learning that a crime is about to be committed and that of a doctor learning of a crime already committed. In the former, Lord Dawson thought there is a duty to communicate, in the latter he was not at all sure that the doctor is under a like duty. This view did not meet with universal favour at the meeting. A legal member suggested that the claims of justice come ahead of the need for confidence between patient and doctor. Lord Dawson replied that "it would

[36] Manitoba Regulations 42/51, s. 54.
[37] Noted in (1922), 153 L.T. 228 and 253.

be better, in his opinion, that justice should occasionally fail than that this sense of confidence should be destroyed".

On the other hand, Professor Zechariah Chafee, Jr., of the Harvard Law School, arrived at the opposite conclusion, though admittedly the case with which he was dealing is somewhat special in character. He writes thus:

> A similar but more perplexing conflict of loyalties was presented to Dr. C. E. May of Minnesota. While Dillinger, the former Public Enemy No 1, was fleeing from prison, he went to Dr May to be treated for gunshot wounds incurred during his escape. Was Dr. May ethically bound as a physician to preserve secrecy or was he under a duty as a citizen to notify the police? In fact he neglected to inform the police of his ministrations and was consequently imprisoned two years for harboring a fugitive wanted under a federal warrant. The Lancet commented that 'colleagues in every country will applaud his action in not betraying a professional trust'. (1934) 226 Lancet 1183. Not many laymen are likely to join in the applause.[38]

Lest it be thought that lawyers and judges tend always to lean in favour of disclosure, it must be admitted that there are clear differences of opinion among them. Thus Lord Brampton (then Hawkins J.), in the case of *Kitson* v. *Playfair*,[39] expressed himself in the most emphatic terms against the existence of any general duty on the part of doctors to report to the public prosecutor whenever in the course of their medical attendance they find that a crime has been committed. To say there is such a general rule was something which did not meet with his approbation, and he hoped it would not meet with the approbation of anyone else. On the other hand, Mr. Justice Avory, in charging a grand jury on December 1st, 1914, in the case of a woman committed for trial as a result of an illegal operation, took the contrary view.[40] Three medical men had attended the deceased woman, and to one at least she confided the name of the person who performed the act. No information, however, was communicated to the police. His Lordship said that there were cases, of which this was one, where the desire to preserve the confidential relation of patient and doctor must be subordinated to the duty cast upon every good citizen to assist in the investigation of a serious crime.

It was possibly as a result of Mr. Justice Avory's observations that on January 27th, 1916, the Royal College of Physicians of London adopted a series of resolutions on the duties of medical

[38] Privileged Communications: Is Justice Served or Obstructed by Closing Doctor's Mouth on Witness Stand? (1942-43), 52 Yale L.J. 607, note 39.

[39] Referred to in (1906), 70 J.P. 420.

[40] See (1914), 78 J.P. 604.

practitioners in cases of criminal abortion.[41] These resolutions, apparently adopted after legal advice, asserted the moral obligation of every medical practitioner to respect the confidence of his patient; suggested that, if he is convinced that criminal abortion has been practised on his patient, he should urge her to make a statement for use against the person who performed the operation; but then declared that if the patient refuses to make such a statement, he, the doctor, is under no legal obligation to take further action. In referring to these resolutions I need hardly add the reminder that the Royal College of Physicians is not a law-making body, and that although the resolutions set forth certain rules of conduct for the guidance of members of the college, they have not the force of law.

Perhaps at this point some reference should be made to what the Criminal Code of Canada has to say on accessories after the fact. It gives the following definition:

> An accessory after the fact to an offence is one who receives, comforts or assists any one who has been a party to such offence in order to enable him to escape, knowing him to have been a party thereto [42]

But suppose a doctor says that, though he knew the patient was a party to the offence, his ministrations to him were merely to save life or to relieve pain, in accordance with his clear professional obligation, that they were not rendered in order to enable the patient to escape, that if as an incidental result of this treatment the patient was better able to escape and did escape, that was, nevertheless, not the purpose of the treatment; and that a distinction should be made between the object of the treatment—which

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[41] *Vide* Taylor's Principles and Practice of Medical Jurisprudence (10th ed., 1948), Vol. II, p. 104.

[42] Criminal Code of Canada, s. 71. *Vide* also ss. 191 and 192, dealing with the special situation of escaped prisoners. The common-law position is described in 1 Hale's P.C. 332 thus: ". . . therefore it seems, even by the common law, if a physician or surgeon ministers help to an offender sick or wounded, though he knows him to be an offender, even in treason, this makes him not a traitor, for it is done upon the account of common humanity, not *intuiter criminis vel criminosi;* but it will be misprision of treason, if he know it, and do not discover him".

The Court of Criminal Appeal in England in *R.* v. *Aberg*, [1948] 1 All E.R. 601, dealt with a charge of "misprision of felony", *i.e.*, concealment of felony. The Lord Chief Justice said (p. 602): "Misprision of felony. . . is generally regarded nowadays as having become obsolete or as having fallen into desuetude . . If in any future case it is thought necessary or desirable to include in an indictment a count for misprision of felony, great care should be taken to see what . . . are the constituents of the offence. . . . It may be that the court will have carefully to consider whether it is necessary to show a concealment for the benefit of the person charged." This language is a clear discouragement against the laying of any future charges of misprision of felony.

is purely a medical consideration—and its direct or indirect results. In the absence of surrounding circumstances from which a jury could infer that the treatment was rendered in order to enable the patient to escape, it would be difficult indeed to make the doctor an accessory after the fact.

I am of the view, however, that this is not the sole test of a doctor's duty in the face of conflicting loyalties. Perhaps in a given case he could not be convicted as an accessory after the fact. None the less he may be justified in the public interest in communicating with the police. It would ill become the criminal patient to complain of his doctor's disclosure to the authorities on the ground that non-disclosure would not have exposed the doctor to criminal liability as an accessory. The matter rests on higher ground than that. The doctor's duty to his patient is owed to him, not merely as an individual, but as a member of society. It is my decided conviction that if the general good of society requires disclosure, the duty of secrecy comes to an end. The circumstances of each case will determine the particular decision that must be made.

In civil cases, again, we are concerned with the general welfare of society, not however with respect to the prevention and detection of crimes against the state, but with the securing of rights and the redress of claims between individuals.

About a year ago the Ontario Section of the Canadian Bar Association conducted a panel discussion in which five eminent members of the Ontario bar participated.[43] A question was put to them of this nature: A doctor is consulted by a patient who is subject to epileptic fits. The patient is a street car operator. Should the doctor inform the highway traffic authorities? Suppose he does not, the patient takes a fit while on duty and his street car runs into and kills someone. Is there any liability on the doctor? I add another question. Suppose the doctor informs the patient's employers, and the patient loses his job as a result? Has he a good cause of action against the doctor?

This is precisely the type of problem which points up the conflict of duties arising in medical practice. The members of the panel (with the possible exception of the chairman who put the question) unanimously felt that the doctor was not under an obligation to inform any public authority. One member suggested that because certain statutes, such as the Venereal Diseases Prevention Act, requires communication with a public authority, the absence of any

[43] (1953), 31 Can. Bar Rev. 503, at p. 535.

similar statutory duty in the case of epileptics freed the doctor of an analogous obligation. Although this argument has merit, especially in its particular context, it should not be supposed that a doctor may *never* make disclosure except under statutory sanction. The duty of secrecy to the patient must always be weighed against the duty to the community as a whole.

Sometimes a doctor may have to decide whether to inform a householder that one of his roomers, a patient of the doctor, is afflicted with syphilis in a communicable stage. In a well-known American case a doctor did so inform the householder.[44] The Supreme Court of Nebraska dismissed the action brought by the patient against the doctor, holding that a disclosure of the patient's condition for the purpose of preventing the spread of the disease could not be regarded as a betrayal of the confidence of the patient. The court there found that disclosure was reasonably necessary to prevent the spread of the disease and that the doctor's communication had been made in good faith to one who had an interest in its subject matter.

That case has been the subject of considerable comment, not all of it favorable, and medical practitioners should consider their position carefully before acting as did the doctor. A Canadian authority[45] on the subject suggests, in a somewhat similar case, that the doctor should notify only the medical officer of health. This would probably be just as effective and would seem to be the more prudent course.[46]

In resolving the conflict of duties it is at least arguable that the claims of the public interest will count for more in a criminal than in a civil case, which is not to say that the public interest will be of negligible importance in a civil case. The securing of private rights is one aspect of the general public good. In its attainment, a disclosure by a doctor may assist the cause of truth. But, mindful of his duty to his patient, a doctor should also remember what was once said by an English judge: "Truth, like all other good things,

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[44] *Simonsen* v. *Swenson* (1920), 177 N W. 831.

[45] K. G Gray, Law and the Practice of Medicine (1947) p. 39.

[46] Section 23 of the Regulations under the Public Health Act of Manitoba (*vide*, footnote 35, *supra*) somewhat obliquely implies a right on the part of a doctor so to notify a householder. It says: "When any householder . . . knows, or *is informed by a physician* . . . that any person in his . . premises has any communicable disease. . . . ". But Dr. Gray's recommendation is still the safer one. Some statutes, however, give more direct protection. *Vide, e g.*, Ontario Venereal Diseases Prevention Act, R.S.O., 1950, c. 408, s. 13(3), and Quebec Venereal Diseases Prevention Act, R.S.Q., 1941, c. 186, s. 12.

may be loved unwisely—may be pursued too keenly—may cost too much".[47]

(4) *When the patient consents*

Finally, it cannot be doubted that disclosure is permitted by the doctor whenever the patient consents. The case of express consent offers no difficulty. But sometimes the consent of the patient must be taken as implied. A doctor, for example, will often hand a prescription to a druggist to be filled. The prescription may, and often does, disclose to the druggist the particular ailment from which the patient is suffering. I do not think there would be any trouble in concluding that such a disclosure by the doctor, being necessary for effective treatment, is made with the implied consent of the patient.

There is the case, too, of responding to inquiries made by near relatives. A man has an operation. His anxious wife asks the doctor about the case. Is the doctor bound to get his patient's express consent before he answers an inquiry of that sort? To ask the question is to answer it. If in the ordinary case doctors insisted on observing such extreme precautions their public relations would suffer badly. No doctor could carry on his practice successfully if he could not answer normal inquiries of that sort without securing express permission from his patient in each case. Unless, therefore, the circumstances are unusual and of such a character as to put the doctor on his guard, I suggest that there is an implied consent for the doctor ordinarily to answer proper inquiries made by near relatives.

If the patient consents to disclosure of information, the doctor should not place unnecessary difficulties in the way. In a matrimonial case in England in 1946,[48] in which the husband and the wife had both been examined for venereal disease by the same doctor, the two parties with the consent of their solicitors submitted a series of six questions to the doctor. The answers to the questions would have been of material assistance in the presentation of the claim or of the defence. The doctor refused to answer the questions, stating that he would, if subpoenaed, give his evidence in court. When the matter came on for hearing, the trial judge said: "Is a doctor . . entitled . . . to say: 'Go on with your case in the dark and I will tell you in court when I am subpoenaed what my conclusions are?'" The court concluded that the doctor's

[47] *McIntosh* v. *Dun*, [1908] A.C. 390, at p. 400.
[48] *C.* v. *C*, [1946] 1 All E.R. 562.

reticence was not justified in the circumstances, and made an express direction to that effect, to serve as a guide in future cases.

Conclusion

Summing up, it can be said that, except in those jurisdictions in which medical privilege exists by statute (of which Manitoba is not one), the doctor is not entitled to preserve secrecy in the courtroom; that out of court there is a duty, arising from an implied term in the contract, to preserve inviolate the secrets of the patient; that the duty is not absolute, but will give way when disclosure is required by statute, or is justified as a matter of public policy in criminal cases and, though perhaps less frequently, in civil cases, or is permitted by the consent of the patient, express or implied. This statement of the law does not in any sense exhaust the subject.[49] It merely touches on certain aspects of the patient-doctor relationship and on some of the problems to which that relationship gives rise, problems sometimes as perplexing as they are important.

Educational Reconciliation

. . the conversation was, I think, symptomatic of a deeper cleavage in educational theory Do we learn to lead adequate and useful lives by being encouraged to *think* or by being taught to *do*? And is the technique of doing, whether in sport or politics or the arts, the basic equipment for life, or are techniques something that one muddleheadedly teaches oneself as a result of specialized thinking and feeling?

There is something to be said, perhaps, on both sides. Technical and vocational education starts from the initial question 'How can I earn my living?' Education in thinking first and doing afterwards is the result of asking 'How can I fulfil myself?' The United States of America has decided, almost unanimously, to follow the first theory. Europe still clings to the second. Canada, which is in danger of developing a permanent squint by keeping one eye loyally fixed on England while the other is jealously on the watch for the latest developments in the U.S.A., is perhaps in doubt as to which path to follow when the struggle develops between humanism and efficiency. Perhaps it is Canada's destiny to discover the formula for compromise between the Old World and the New. Or perhaps a better word would be reconciliation. (Eric Newton, Art and Journalism, from Saturday Night, Dec. 5th, 1953)

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[49] There is a useful survey of professional privilege, particularly as it applies on the Continent, by H. A. Hammelmann, entitled Professional Privilege: A Comparative Study, in (1950), 28 Can. Bar Rev. 750. It indicates that medical privilege has existed for many years in France and Germany.