Crime, confidentiality, and clinical judgment

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While walking my dog one morning in front of the local hospital, I heard a woman scream. Turning, I saw her body crumple to the ground and a man running away. Blood from her face marked the pavement. Deciding that she needed help from the emergency department more than my sidewalk assistance, I pursued the fleeing culprit. 1 km later, the assailant was subdued and held until the police arrived.

This incident raises questions about crime and how it relates to a doctor's responsibility. Why didn't others track the attacker? Do doctors, in or outside their clinical work, feel or bear a greater responsibility than others to respond to criminal acts? How should doctors respond when their duty to society potentially conflicts with obligations to their patients?

The laws of several western countries provide some guidance. In most US jurisdictions, clinicians must report injuries resulting from certain crimes despite the inherent stresses on doctor-patient confidentiality. For instance, California law requires that doctors report injuries resulting from suspected child, elder, or domestic abuse; firearms and hand weapons; or other criminal activity. Brazilian law sets out similar expectations. In some Australian and Canadian jurisdictions, doctors only have to report signs of child abuse. Canadian authorities occasionally receive clandestine calls from clinicians, since hospitals are prohibited from reporting other suspected crimes. In Germany, without an acceptable defence, a breach of doctor-patient confidentiality is a punishable offence. In the UK, the Common Law provides varying bases for confidentiality requirements.

Various circumstances provide doctors with opportunities to act as agents of the state. For example, injured victims necessarily turn to the medical profession for care, making doctors excellent early warning delegates. In addition, some victims endure oppressive interpersonal relationships or environments dominated by violent behaviour, making it dangerous for them to discuss their situation with anyone except their doctor.

Many doctors by virtue of their chosen specialty infrequently encounter such clinical circumstances. While psychiatrists may witness suicide attempts and crime confessions, many do not encounter typical "Saturday night trauma" on a regular basis. For a junior emergency doctor, it may not be apparent why a male teenage patient's gunshot wound frequently enters the thigh heading downwards. One explanation (not cited in most textbooks) is that firearm-naive inner city youths are likely to carry a gun in their trouser pocket with one finger on the trigger. Excited, they may inadvertently shoot themselves—if not in the proverbial foot—at least in a lower extremity. Furthermore, outside the clinic, society does not burden us with special obligations regarding social pathologies. No one demands that the doctor in the bank queue accost a robber or tackle a fleeing purse-snatcher.

So why do it? Probably by self-selection and certainly by way of training, doctors view human beings as societal organisms. The public must be healthy in order for individuals (and society) to flourish. In this light, doctors may see "crime" as a social disease needing treatment. Problem-solvers by nature, thus we intervene.

However, a doctor's definition of what constitutes a crime varies. Some consider war a criminal act, some work in the military, others allegedly commit war crimes. Some doctors label the death penalty as criminal and participation in it unethical; others would disagree. In this latter situation, confidentiality principally serves the doctor. Occasionally, doctors participate in state-approved executions perhaps by placing an intravenous line or supervising the procedure, believing that their presence fulfils an obligation to reduce suffering by avoiding a botched procedure or by replacing other, more brutal methods such as hanging or electrocution. Newspapers splash the executed "patient's" name across their headlines, but the state keeps the doctor's identity confidential. A breach carries potentially serious consequences. American doctors who oppose the death penalty, penetrating this confidentiality barrier, propose to charge fellow doctors with professional misconduct. Little wonder, then, that the confidentiality practices of doctors who clinically encounter criminal activities vary so widely.

The Greeks recognised the relative nature of confidentiality. Doctors swore, in the ancient Hippocratic Oath, to uphold the covenant only according to their ability and judgment—quite a large loophole. Even more curious, the Oath forbids doctors from gossiping in general and does not actually touch upon a patient's confidentiality privilege. The canon required silence if doctors learned that "which on no account one must spread abroad", and this obligation applied to information learned during or outside treatment. This contrasts with the pastel proscriptions of the so-called "modern version" of the Oath, which call only for doctors to "respect" the privacy of a patient.

In other words, Hippocrates recognised the need for patients to view doctors as trusted confidantes. Theoretically, breaching confidentiality violates this trust and risks harm to patients if they refuse treatment later as a consequence of this loss of trust. Innocent victim-patients usually accept the fact that reporting information is in their best interest. This consent

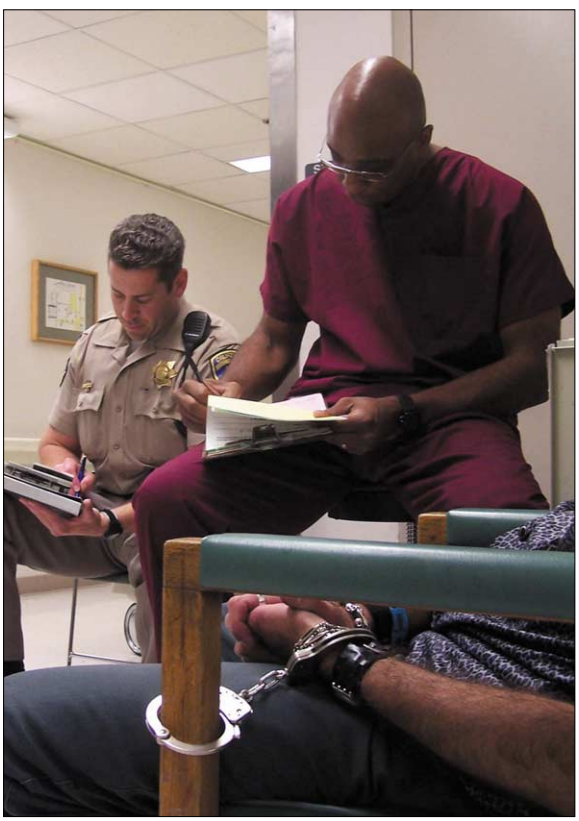
obviates the confidentiality conflict. In other situations, reporting may cause more harm. For instance, reporting toxicology screens of pregnant women or newborns, required in a minority of US states, rarely serves any therapeutic goal. Few treatment centres accept pregnant women, and separation may compound the harm to the baby. Recently, one of the authors suggested not reporting a domestic abuse case because of the patient's explicit fear—firmly grounded in experience—that this would escalate the abuse. Later, the social worker said the patient had generated so many prior reports that the police would undoubtedly ignore another unless it served to guide an arrest after her death. When weighing patient trust, and individual versus societal interests, doctors must frequently choose between competing duties.

Most doctors who perceive a serious threat feel little compunction in acting to prevent further illness or injury, irrespective of state mandate. We might inform authorities, warn someone potentially endangered, or counsel those who might counteract the threat. It hardly matters whether these threats stem from an infectious mycobacterium needing isolation, a self-mutilating superego needing restraints, or a psychopathic id needing incarceration. Upon perceiving an indication, we develop a treatment plan for the patient's body or the body politic, and enlist society's help to realise that plan. We call in officers from public health or other policing agencies, just as we would call in a consultant surgeon.

However, the paradox lies in a doctor's predictive ability. A family doctor who reports a diabetic patient's worsening eyesight to a driver's licence bureau knows that progressive blindness hampers the patient's driving skills. Forensic pathologists reliably issue reports of mass gravesites, as in Srebrenica; these reported diagnoses, although lacking prognoses, carry clear implications as well: more massacres will harm the public. Issues get cloudier when we try to prognosticate before we diagnose, as may be the case with predictions of mass civilian casualties stemming from military interventions. When we attempt to predict—sometimes wrongly—the effects of an armed intervention, we stray from reporting injury from past criminal actions, and may, as a result, lose our credibility and effectiveness.

And what of the greatest criminal syndromes affecting the body politic, in which entire nations suffer the effects of war crimes, crimes against humanity, human rights abuses violating civilised norms—regime-sanctioned torture, summary executions, ethnic "cleansings", child-soldier mayhem, drug lord and warlord despotism, and sectarian violence? In these circumstances, doctors confront horrific criminal activities in various ways. A few willingly participate; others are coerced; others treat the survivors.

These black holes of societal amorality flourish in part because of secrecy and complicity. Regimes expect doctors inside the afflicted zones to demonstrate loyalty through silence—a total perversion of the confidentiality ethic's Hippocratic intent of trusting intimacy. Some doctors, at great personal and familial risk, try to stop the juggernaut by reporting its atrocities.



A police officer dealing with a suspected criminal issue in a local emergency department

In view of our inclination to treat social disease, those of us outside the parameters of these lawless zones may be uniquely positioned to address their atrocities. The virulence and morbidity of these mass forms of criminal activity exceed that of ordinary street or white-collar crime; reporting atrocities does not violate anyone's privacy. Rather, the cure might optimistically lie in exposing this secret pathology to the healing exposure of public light.

Thus, in pointing the torch, we should remain well within our expertise. These execrable situations present as chronic processes, easily diagnosed, positioned where rule of law does not exist or where authoritarian regimes have co-opted this law for their own nefarious purposes. Reporting—not to the state, but to the court of world opinion—can protect afflicted populations in need of access to the usual therapies of local policing and administration of justice. John Snow demonstrated the relation of cholera to poisoned pumps; likewise, today we can heal by reporting the social diseases prevalent under contaminated regimes.