Ethical debate

Child sexual abuse: when a doctor's duty to report abuse conflicts with a duty of confidentiality to the victim

Fifteen years after she has been admitted to hospital with unexplained bruising, a woman asks to see her paediatric medical records. Professor T J David describes the dilemma surrounding her allegations of sexual abuse, and a general practitioner, lawyer, and community paediatrician offer their opinions.

The woman who wanted to see her paediatric hospital records

T J David

A 21 year old woman asked to see her medical records from a children's hospital, and because I had been the paediatrician in charge of her case I was approached by the hospital administration. The case was one of possible non-accidental injury. Because of the risk of misunderstanding what had been written in the notes, not to mention their poor legibility, I met the woman and went through the medical records with her. I also gave her a full photocopied set to keep.

The woman had been our patient 15 years before. At 6 years of age she had been admitted to hospital for a few days' observation because she had a large number of bruises for which there was no adequate explanation. Screening tests gave no evidence of a coagulation disorder and a skeletal survey showed no fractures.

Careful inquiries were made of social services, the National Society for the Prevention of Cruelty to Children, the health visitor, the child's general practitioner, and her school. All reports were favourable. The girl came from a good family, there were no concerns, and there was nothing in her background to suggest that this was a case of non-accidental injury. As a result, social services decided not to hold a case conference and the child was discharged. We notified all the above agencies about the bruising and it was suggested that any further episodes of bruising should be reported immediately to social services. The child was never seen again with injuries.

When I saw the woman I had no idea why she wanted to look at her records. I was concerned that the family might have been disrupted because of our earlier inquiries into possible child abuse or that we had failed to detect abuse and she had been injured further.

After I had gone through her hospital notes, the woman explained that the bruises we had seen had been inflicted deliberately, and that she had wanted to see from her medical notes if we had known about the sexual abuse that she had experienced. She had been

sexually abused by a male babysitter over a period of weeks, and had been beaten up by this man whenever she had shown an unwillingness to cooperate. He had threatened to harm her if she ever reported him; she did not report him.

The woman said that this man still lived in the same neighbourhood and now had a young daughter of his own. We discussed at length what action she might take. She was unwilling to report the matter to the police or social services, and she repeatedly said that I should not under any circumstances share this information with anyone else. She told me that she had had bulimia for some years. This she attributed to her childhood experiences, and she feared that bringing the subject out into the open now would make her distressed and depressed.

The woman's request to maintain confidentiality placed me in a difficult position. Her story, if true, suggested that other children might have been harmed or might still be at risk, and I saw little reason to doubt her. The question was whether I had a duty to report the matter that outweighed respect for the woman's demand that I tell no one.

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Social services can act on anonymous information about abuse

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The link between physical and sexual abuse was not well recognised 15 years ago. It is now known that about one sixth of physically abused children have also been sexually abused.¹ When this child was admitted to hospital for investigation, had she been referred because of her parents' or general practitioner's concern? The admission gave staff an opportunity to observe her behaviour and her attachment to her parents. Why hadn't her parents noticed she was upset? Did she talk to the nurses? Did she have any genital symptoms such as soreness or dysuria? Did anyone ask the child why she had so many bruises? Probably not in 1980, but all these questions spring to mind in 1997.

In 1997 there is a greater awareness of the various ways in which sexual abuse may present, and children are more likely to be spoken to and treated as people rather than "objects of concern."²⁻⁴ Paediatricians are also more likely to be direct with parents. But even today most sexual abuse goes unrecognised. Even in proved cases of sexual abuse in children similar to the one described above, neither the general practitioner nor school (or school nurse) is likely to have voiced concern, and these families are not known to the National Society for the Prevention of Cruelty to Children or to social services.

Why were there no more bruises? Paedophiles are likely to continue to abuse, but perhaps the parents knew more than they had volunteered? Had the parents challenged the babysitter? Would this distressed young woman be able to talk to her parents now? If they were aware or suspicious of sexual abuse all those years ago, they might be able to help their daughter understand her abuse even at this late stage, unless they were in some way involved.

What should the paediatrician do with this new information? In particular, what is his or her responsibility towards the "babysitter's" children?

The General Medical Council gave the following advice in 1993: "Where a doctor believes that a patient may be the victim of abuse or neglect the patient's interests are paramount and will usually require a doctor to disclose information to an appropriate, responsible person or officer of a statutory agency."⁵ In this case the former babysitter's daughter is not the paediatrician's patient. But he has been given very worrying information. If the young woman were given support, would she be able to talk to a social worker? Did she seek out her hospital notes so that someone in authority would take on this responsibility?

The police cannot investigate unless the young woman is able to make a complaint, but the social services department can act on information given anonymously. The paediatrician could contact a senior social worker, giving details of the alleged abuser but not the victim. The social worker could do the usual checks, could talk to the police, and might of course already know the man and his family. Further action would then be the responsibility of the social services department.

Whatever happens, the young woman clearly needs help and with skilled therapy may learn to live with the knowledge of her childhood abuse more comfortably. If the allegations are unfounded, preliminary investigations will be negative and the former babysitter's family will be undisturbed. Or might this be a repetition of the original mismanagement?

- 1 Hobbs CJ, Wynne JM. The sexually abused battered child. *Arch Dis Child* 1990;65:423-7
- 2 Department of Health and Social Security. *Diagnosis of child sexual abuse: guidance for doctors*. London: HMSO, 1988.
- 3 Hobbs CJ, Wynne JM. Clinical aspects of sexual abuse. In: *Child abuse and neglect, a clinician's handbook*. London: Churchill Livingstone, 1993: 139-94.
- 4 Butler-Sloss E. *Report of the inquiry into child abuse in Cleveland*. London: HMSO, 1987.
- 5 General Medical Council. *Duties of a doctor (confidentiality)*. London: General Medical Council, 1995.

Confidentiality may be overvalued

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With a disturbingly high prevalence of physical and sexual abuse in the community, it is not uncommon for doctors to become involved in situations of the kind described. Here, the paediatrician has presented two possible courses of action—to report the matter, thereby breaching confidentiality, or to maintain confidentiality by not disclosing the incident.

Legally, either option is defensible. This is reflected in the General Medical Council's guidelines.¹ These advise that confidentiality should be respected, but that disclosure "may be necessary in the public interest where a failure to disclose information may expose the patient, or others, to risk of death or serious harm." Information should then be disclosed "promptly to an

appropriate person or authority." What is of particular relevance to this case is the statement in the guidelines that in some circumstances disclosure may be "necessary for the prevention or detection of a serious crime."² However, the law and codes of conduct inform only partly the moral deliberation that should precede any action that is taken.³

Two particular elements of this case stand out, each of which is central to the ethical analysis. Firstly, the victim is no longer a patient and, secondly, it is the victim rather than the perpetrator who is confessing to the doctor.

At this stage, the relationship between the woman and her former doctor could not be considered a therapeutic one, although it remains professional.

Does the doctor have a duty to respect confidentiality in this kind of relationship? To answer this it is important to understand the moral foundations of confidentiality within the doctor-patient relationship. In terms of utilitarian doctrine, envisage a society without trust or honesty and then extend this to the health-care domain. The consequences for patient care are obvious. But today there is a tendency to overvalue confidentiality. This has arisen through the influence of bioethics (its emphasis on principles and, especially, respect for patient autonomy) together with somewhat anachronistic medical codes which still imbue strongly Western medical culture.⁴

In the professional relationship illustrated here a duty of confidentiality does exist, but it is less strong than that in a therapeutic relationship. Any such duty diminishes further when considered in the context of historical overstatement.⁵ Weighed against this, the doctor, like anyone else, also has duties to society that include, in this case, the perpetrator's family, the neighbourhood, and the more nebulous concept of society in general.

The second point, that somewhat unusually it is the victim rather than the perpetrator of a crime confessing to the doctor, highlights some important practical issues. The woman claimed that she wanted to see the notes to find out if the sexual abuse had been documented. To make the effort without wanting to take the matter further simply does not make sense. Surely this is a plea for support as well as justice? If, however, the woman really refuses to become embroiled in further investigations, there is little likelihood of any legal case being brought against her abuser.

The doctor has more choices than the two described, but more information is needed before any decision can be made. Disclosure may be the best course in view of the wider considerations; thus it depends on what further information yields.

- 1 General Medical Council. *Duties of a doctor (confidentiality)*. London: General Medical Council, 1995:8.
- 2 Brazier M. *Medicine, patients and the law*. London: Penguin, 1992:44-59.
- 3 Seedhouse D, Lovett L. *Practical medical ethics*. Chichester: Wiley, 1992.
- 4 Davis R. The principlism debate: a critical overview. *J Med Philosophy* 1995;20:85-105.
- 5 Van Heteren G, Kessel A. Beyond the "two-worlds" perspective in medicine. *Health Care Analysis* 1995;3:353-7.

Wider public interest may come before issues of confidentiality

Margaret Brazier

"Must I let this patient to see her records?" is the question a lawyer would generally expect to be asked. Some doctors are wary of allowing patients unrestricted access to their records, but this paediatrician offered his former patient open access. He sought to ensure that she would understand what she read and that she had support in dealing with the potential distress caused by discovering a childhood trauma. Since the Access to Health Records Act 1990 applies only to notes compiled after November 1991, he was under no legal obligation; none the less, he chose to recognise his ethical obligation to share information with his former patient.

What ensued was not, as the doctor feared, some possible trauma to his former patient caused by recall of her injury or the allegations of parental abuse. Instead he found himself torn between his obligation of confidentiality to her and his duty to protect other children from abuse. This dilemma was triggered not by what was disclosed in the records but by what the records caused the patient to disclose.

The paediatrician does owe a duty of confidentiality with regard to this woman's disturbing disclosures. She may no longer be his patient, but a duty of confidentiality arises whenever one person gives information to another in circumstances where it is clear that that information is proffered on the understanding that confidence will be assured. The doctor-patient relationship is just one example of a much wider category of confidential relationships protected by law, a category wide enough to embrace confidences between friends.¹

None the less, in English law the obligation of confidence is not absolute. The law recognises a public interest in medical confidentiality, as well as the

patient's private interest in protecting her secrets. But the wider public interest in preventing harm to others and preventing crime can exceptionally outweigh both the private and public interest of confidentiality. The courts are rightly wary of claims to justify breach of confidence.² There must be a real and serious risk of some other person or persons suffering harm if the confidence is not broken. Breaking confidence must be shown to be the only effective means of avoiding or minimising that harm. Where a mentally disordered patient was judged to continue to pose a threat to life if released from high security accommodation, the courts held that a breach of confidence was justifiable.³ The patient's claim to privacy was of a lesser order than the life and health of others.

This case, however, is one of extraordinary difficulty. The paediatrician has to balance not just his former patient's privacy against the welfare of other children whom her abuser may abuse, but her health and welfare as well. There is clearly a risk that the woman's physical and emotional health will be seriously damaged if she is forced to re-live the miseries of her past. Set against that risk to her, is the fear that the abuser is continuing to subject children, including his own child, to physical and sexual abuse accompanied by vicious intimidation.

Ideally, the doctor should try to find a way to ensure children at risk from this man are assessed without disclosing the details of his former patient's story or identity. If that is not possible, this is a tragic example of a case where the interests of an individual patient should be subordinated to the interests of others.

- 1 *Stephens v Avery* [1988] 2 All ER 477.
- 2 *X v Y* [1988] 2 All ER 648.
- 3 *W v Egdel* [1990] 1 All ER 855.

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