Medisch beroepgeheim en de zorgplicht van de arts bij kindermishandeling in de rechtsverhouding tussen arts, kind en ouders

Sombroek-van Doorm, M.P.

Summary

MEDICAL CONFIDENTIALITY AND THE DUTY OF CARE OF THE DOCTOR IN CASE OF CHILD ABUSE WITHIN THE LEGAL RELATIONSHIP BETWEEN DOCTOR, CHILD AND PARENTS.

Introduction

If doctors suspect that their child patient is being abused, are they obliged to observe their duty of medical confidentiality or not? Recently, several legislative and administrative choices have been made to combat child abuse. These focus on revealing confidential information despite the obligation to respect medical confidentiality. The paradigm seems to have shifted from remaining silent-unless to speaking-unless. This shift calls for a study on how the legislative and administrative choices for revealing information can be framed in the light of the existing and well-accepted exceptions to medical confidentiality, which depart from the principle that the doctor is silent-unless.

This thesis offers an analysis of the most important norms for medical confidentiality and for its breach by doctors and their implications in the context of child abuse. Moreover, it provides an understanding of the role and added value of the duty of care in this respect. It changes the dogmatic view on the concept of medical confidentiality. Rather than a separate duty of doctors, medical confidentiality is presented as part of the duty of care, in short the duty to deliver good care. Article 2 of the Healthcare Quality, Complaints and Disputes Act provides that the care should be of a good quality and standard. This means that the care should be safe, effective and patient-centred. It also means that when performing their work doctors must observe the care befitting a good provider of care and must act in accordance with the responsibility falling upon them as a result of the professional standards applicable to providers of care. This duty of care is laid down in article 7:453 of the Dutch Civil Code in the context of the contract of medical treatment. Even where the regulation of the Medical Treatment Contracts Act does not apply, it could be argued that a duty of care may exist based on medical ethics and professional rules.

Part I: Medical confidentiality

Chapter 2 discusses the justification of the existence of a duty of confidentiality between patient and doctors. Firstly, information about a person's health and medical treatment is paradigmatically private, and it could therefore be argued that the patient has a right to control it, the right of self-determination being part of the right to privacy. In this view, it is argued that the individual interest of the patient can be served by silence (article 88 Individual Health Care Professions Act and article 7:457 paragraph 1 Dutch Civil Code), but also by breaching medical confidentiality based on the consent of the patient.

Secondly, good medical care can be provided only if patients feel free to be candid with their doctor. This in turn will be possible if patients believe that their doctor is under a duty not to disclose personal information. Without assurances about confidentiality, patient may be reluctant to give doctors information they need in order to provide good care. This is the general interest of medical confidentiality. Both interests of medical confidentiality – individual and general – may conflict since the patient may wish to reveal information, whereas the general interest demands that private information not be revealed. However, it is argued that this conflict does not automatically weaken medical confidentiality.

Chapter 3 analyses the duty of silence; being one part of medical confidentiality. This duty has different legal grounds: article 7:457 paragraph 1 of the Dutch Civil Code, article 88 of the Individual Health Care Provisions Act, article 272 of the Criminal Code, article 9 paragraph 1 of the General Data Protection Regulation (GDPR) and article 22 paragraph 1 of the General Data Protection Regulation Implementation (GDPRI). Four areas of law come together: civil law, criminal law, public law and disciplinary law. The duty of silence forms a private-law obligation of the doctor towards the patient and is a matter of common interest and therefore regulated in the Individual Health Care Provisions Act, and the starting point of the GDPR and the GDPRI. It is sanctioned under criminal and disciplinary law. The differences in content and scope of the respective regulations can be explained by the different rationales behind and backgrounds of the respective laws. Despite these differences, the boundaries of the duty of silence are defined in the professional practice since it is argued that all information doctors receive in their professional capacity is confidential.

Thinking about medical confidentiality is thinking in dilemmas. This chapter discovers that in the legal relationship between doctor, child and parents the duty of care as laid down in article 7:453 BW forms the legal basis for the way how the doctor should deal with the duty of silence. This duty of care, arising from good care provision and the professional standards that go with it, determines the boundaries of the doctor's duty of silence as to the question towards whom the doctor should or not remain silent and in which situations. This chapter shows that the duty of silence as well as its breach,

may be considered as part of this duty of care. After all, it is in the light of the duty of care that the duty of silence gains significance, not the other way round.

Chapter 4 analyses legal privilege, being the other side of medical confidentiality. Together with the duty of silence, legal privilege shapes medical confidentiality and it strengthens the duty of silence *in foro*. The obligation to respect confidentiality in court coincides with the duty of silence in the sense that they both have the same substantive scope. Although legal privilege is presented as a right in article 165 paragraph 2 under b of the Code of Civil Procedure, article 218 of the Code of Criminal Procedure and article 68 paragraph 5 of the Individual Health Care Provisions Act, it is argued that it in fact constitutes an obligation. However, breaches of this obligation are possible, as is the case with the duty of silence. Legal privilege is considered to be an extension of the duty of silence and it is argued that the privilege can be considered a part of the duty of care in which the duty of silence is integrated as well.

In *chapter 5* it is discovered that thinking about medical confidentiality, and especially about the boundaries of medical confidentiality, is developing. These boundaries are discovered in the breaches of medical confidentiality. It is argued that the number of breaches is increasing and will continue to increase. This chapter shows that the concept of conflicting duties has a restrictive assessment framework based on the silence-unless philosophy. It is argued that this has led to other grounds for breaching medical confidentiality, such as compelling interests and most exceptional circumstances. Compliance with medical confidentiality is not self-evident in a society that is changing its views on that principle of medical confidentiality. It could even be argued that basically the right and duties originating from medical confidentiality are respected more by the breach than by the honoring, despite the values medical confidentiality serves. Therefore it is recommended that medical confidentiality as well as its breaches be conceptualized in a different manner, namely as an aspect of the duty of care. It is argued that the weighing of the different interests is something doctors do in the performance of their duty of care, rather than that it is informed by their duty of confidentiality. The duty of care may imply that a doctor speaks or is silent, depending on the specific situation. Can this view of medical confidentiality as part of the duty of care help us to legally shape the legislator's choice to combat child abuse by giving preference to speaking over silence?

Part II: Medical confidentiality and the duty of care in case of child abuse within the legal relationship between doctor, child and parents.

Chapter 6 analyses the scope of the legal definition of the term 'child abuse' as laid down in article 1.1 of the Youth Act and article 1.1.1 of the Social

Support Act by analyzing its different elements. The analysis of the scope of the legal definition of child abuse is necessary because this definition appears to be the starting point of all legal and professional measures in the combat of child abuse. Doctors should therefore know its scope.

This chapter shows that this legal definition is broad and sometimes even unclear. This grey area – i.e. when uncertainty arises whether an action, a victim, perpetrator, relationship or harm falls under the legal definition of child abuse – is also taken into account in this research. It is argued that additional viewpoints are necessary to interpret and limit the definition. For these reasons, research has been done to the possible added value of the definition of abuse under criminal law. This definition is known as a narrow and limited one. It obtains the element of intent, and it is argued that this is a useful additional viewpoint to define whether an action can be addressed as child abuse as laid down in article 1.1 of the Youth Act and art. 1.1.1 of the Social Support Act. However, the definition under criminal law excludes future harm. This element is included in the legal definition of child abuse (article 1.1 of the Youth Act and art. 1.1.1 of the Social Support Act). Since it is the core business of doctors to protect patients from harm and future harm, preference is given to the legal definition of child abuse even though this is broad and not very specific.

Chapter 7 provides an overview of all legal measures that provide a justification for breaching the duty of silence in case of child abuse or suspicions thereof. It shows that the majority of the regulations according to which a doctor can reveal confidential information without consent of the person(s) concerned were originally placed in the context of conflicting duties. This automatically means that this point of the departure in these regulations is that the doctor, who has not been given permission to breach the duty of confidence, is silent-unless (article 5.2.6 of the Social Support Act, article 1:240 of the Dutch Civil Code, and article 7.3.11 paragraph 4 of the Youth Act and article 7.1.4.1 of the Youth Act). This departure point conflicts with the desire to exchange information when child abuse occurs, as this does not call for a restrictive assessment framework, but one that is based on the speak-unless philosophy. A solution to the conflict seems to be offered in situations in which information is communicated to the Safe at Home Centre (*Veilig Thuis*) by the Domestic Violence and Child Abuse (Obligatory Reporting Code) Act and the accompanying Decree from 2013, from which a basic reporting code ensues, and the subsequent Decree from 2017. After all, these measures provide for an alternative assessment framework by offering a roadmap based on the doctor-speaks-unless philosophy. However, it remains unclear how these measures allowing information to be revealed without the patient's consent relate to 'conflicting duties' as common ground for breaching confidentiality. Moreover, this roadmap does not apply when child abuse is reported to other agencies (Child Care and Protection Board (*Raad voor de Kinderbescherming*), police). In this chapter, it is argued that disclosing confidential information in cases of child abuse or a suspicion thereof is not legally framed in a clear

manner and it is argued that this can have a prohibitive effect on exchanging information.

Chapter 8 focuses on the professional Reporting Code (2015) for doctors in the context of child abuse. It discloses how the shift in this professional code towards revealing information relates to the exception to medical confidentiality, i.e. conflicting duties and its assessment framework, which is based on the silence-unless principle. It distinguishes between (i) the situation where doctors decide to report of their own accord to the Safe at Home Centre, to (ii) other agencies and (iii) the situation in which the doctor is being questioned by different agencies (the Safe at Home Centre, Child Care and Protection Board, the police). This chapter shows the undesirable situation that the Reporting Code (2015) uses different assessment frameworks for the breach of confidentiality, and at the same time shows that the duty of care under article 7:453 of the Dutch Civil Code offers a solid ground for not only breaching confidentiality, but also of respecting it. Last but not least, it discloses that 'conflicting duties' is no longer a ground for breaching confidentiality where doctors decide to report child abuse or suspicions thereof of their own accord to the Safe at Home Centre.

Chapter 9 focuses on the way disciplinary courts judge the breaching of the duty of confidentiality in cases of child abuse or suspicions thereof. In the situation in which doctors report child abuse or suspicions thereof of their own accord to the Safe at Home Centre, the disciplinary norm and the professional norm as addressed in the Reporting Code (2015) coincide, unlike the situation in which the doctor has been asked by the agencies the Safe at Home Centre or Child Care and Protection Board to reveal information. Disciplinary courts tend to frame the breach of the duty of silence in the concept of 'conflicting duties' while referring to the Reporting Code. It is argued that this causes legal uncertainty for doctors because the Reporting Code could be interpreted in another way: if doctors are requested to provide information by the agencies Safe at Home Centre and Child Care and Protection Board in the context of an investigation of child abuse, they should provide information. If disciplinary courts were to judge breaches of medical confidentiality accordingly it is argued that fewer disciplinary measures would follow. This confusion about the applicable assessment framework in this situation is undesirable. Moreover, in all other situations – i.e. when doctors do not report to the Safe at Home Centre of their own accord or when they are asked to reveal information by the agencies Safe at Home Centre or the Child Care and Protection Board – the breach of confidence is judged according to the conflicting duties assessment framework. This labyrinth of different assessment frameworks does not do much for the principle of legal certainty, the trust between the doctor, child patient and the parents, and even less for the child's protection under the law.

Chapter 10 proposes a single assessment framework for all situations of child abuse and suspicions thereof. The ground for breaching the duty of confidentiality is the doctors' duty of care. This duty of care can be based on

article 7:453 of the Dutch Civil Code in the context of medical treatment of the child; and even where the regulation of the medical treatment contract does not apply, it is argued that this duty of care can be based on ethical or professional grounds. In this view there is no longer room for the concept of conflicting duties and the assessment framework ensuing from it. The duty of care may result in a duty to reveal information or a duty to respect silence. Both duties are integrated in the duty of care. A system with a roadmap and standards of care leads to a clear decision, either to reveal information or to respect medical confidentiality. Although revealing information without consent of the person(s) concerned may hurt the relationship of trust between doctor, child patient and parents, it is argued that combatting child abuse is not so much served by respecting medical confidentiality as by providing good care. Trust in good care outweighs trust in medical confidentiality in cases of suspicion of child abuse within the legal relationship between doctor, child patient and parent.