Case conference

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Venial sin—a case for specific transmission of information?

The O'Reillys were a young family who had spent much of their life in England. There were four children, ranging in age from five to ten, and they were ruled and schooled by careful and commanding parents. Mrs O'Reilly did not go out to work, but spent such spare time as she had from her family supporting the local church in all its activities. She was a regular attender at her general practitioner, as she liked to be sure that her children were well cared for, and liked to 'catch things early'. Her doctor therefore knew her well, but was less well acquainted with her husband, who worked hard as a carpenter and seldom had time or inclination to attend the surgery. Thus it was all the more surprising when one Thursday evening he burst into the waiting room in an agitated state, and demanded to see the doctor immediately.

In the consulting room he was a little calmer, but very reluctant to get to the point, and spent some time talking about the pressures of his work, and the difficulty in keeping enough work going to support his young family. Eventually it transpired that he had become so tense the previous weekend that he had taken to drinking heavily. He had seldom ever done so to such an extent before, and as a result had become completely intoxicated. He remembered being in a rather shady part of town, getting very friendly with 'an individual', and finally waking up the next morning in the 'individual's' bed, having partial memories of an evening of love-making such as he had never had before. Seized by panic, in a dishevelled state he rushed round to his brother's house, and prevailed on him to ring his wife to say that they had been drinking together and that Mr O'Reilly had spent the night on his brother's sofa. After some time Mrs O'Reilly was persuaded to see the funny side of this, and her husband hoped against hope that she would soon forget it all.

Mr O'Reilly's guilt was painfully reinforced five days later when he developed a sore urethral discharge, and it hurt him to pass urine. When he realised what had happened he rushed to the doctor's surgery. In an attempt to erase the feeling of what he had done at the weekend he had had intercourse with his wife on the Monday evening – recently this had been a rare event – and therefore

he was sure that whatever he was suffering from, she would have it too. An assessment at a venereal disease clinic was impossible at that time of night, but the general practitioner took smears and slides and blood tests, and using his own microscope and a transport medium for the swabs, felt that he had covered the area adequately, and was justified in starting antibiotic treatment on the basis of a non-specific urethritis. When tests for gonorrhoea and syphilis came back negative he was relieved and thought Mr O'Reilly would be too, but was surprised when Mr O'Reilly seemed more and more agitated.

The crucial question that Mr O'Reilly was unable to face was that of telling his wife about what had happened, and bringing her up for treatment. He insisted that she would be unable to face the revelation, that the family would split up, and she would return to Ireland and leave him, which she had threatened to do once before when a few years ago he used to drink more heavily and regularly in the evenings. She came from a strict background, and always made him feel rather inadequate. His sexual interest in her had declined – and then there was 'that individual'. The doctor was beginning to see that there was more to this than met the eye, and so pushed Mr O'Reilly to the point where he broke down, and admitted that 'that individual' had been a young man. The experience had clearly not been that unpleasant, and in a series of sessions after that, Mr O'Reilly talked to the doctor about his repressed fantasies. With this ventilation it seemed clear to them both that he was still heterosexual: his feelings for his wife were submerged beneath a layer of guilt about her medical condition. Although she had been well, he was convinced that he must have transmitted the non-specific infection to her. He was now well, but was unable to sleep with her, for fear that he might stir up the infection in either of them. He besought the GP to see her and make an excuse to treat her and so solve the problem.

At first the doctor refused, as he did not believe that it was right to treat patients without their knowing why they were being treated: he also wanted to use Mr O'Reilly's concern for his wife as a way of getting him to face up to the problem and discuss it with his wife. Whatever support he offered, and whatever methods of pursuing this he proposed however, Mr O'Reilly persisted with his refusal and pleas to the doctor to treat his wife without her knowledge. Eventually the doctor gave in, and used

the moment of Mrs O'Reilly's attendance for a cervical smear to prescribe some tetracycline for 'a little infection of the cervix'. She left apparently content, and he felt that the situation might soon be resolved.

It was, but not in the way he expected. Mr O'Reilly came in a fortnight later to say that his wife had had a terrible row with him the previous night, had accused him of not loving her any more, and possibly even of having an affair. It seemed that she suspected 'a little infection of the cervix' could not have come about without some cause. She had packed her belongings in the night, and he had returned home to find an empty house and a curt note: 'We have all gone home'. He assumed that they had gone back to Ireland, and he stumbled out in tears.

So far, the doctor has heard no more.

Discussion

VENEREOLOGIST

I think it would help to clear up the clinical side first. Non-specific urethritis is increasingly common, and the diagnosis is still usually one of exclusion, as was done, one presumes, satisfactorily by the general practitioner. One also assumes that he found no other pathogens, such as trichomoniasis, to explain the situation, on the cervical smear. Although I would not have acted entirely like this, I think it would be foolish to enter into clinical discussion without clearing this up. The discovery of syphilis or gonorrhoea, the former in particular, would have changed the picture: it would have posed a very considerable risk to the health of Mrs O'Reilly or even her children, and I would have had no hesitation, and in some countries would be compelled by law, to notify her and if necessary the authorities.

GENERAL PRACTITIONER

But in the present case, the general practitioner clearly got himself caught within the relationships that had already been set up. This shows one of the strengths and weaknesses of the position of a personal physician. On the one hand he is acting remarkably, to counsel in and control what could have been a serious reaction to unexpected or repressed homosexual behaviour, and to bring the patient through this. On the other hand, the very strength of his involvement with the patient seems to have led him to collude seriously with him, or appear to the patient to do so, and so avoid the issue which he, rightly it seems, saw as central to family survival. He was unable to convince Mr O'Reilly that avoidance and lies would ultimately be much more destructive to the marriage than the infidelity had been.

COUNSELLOR

The crucial issue behind that seems to have been his fear of being accused of destroying the marriage if Mr O'Reilly had 'owned up' to his wife about his night out and the marriage had broken up as a result. No doubt Mr O'Reilly would have blamed the doctor for this, and it would have been a difficult time for them. Had he put the destructiveness of silence and lies more squarely to Mr O'Reilly and faced him with this, he might have achieved success.

However, this clearly points to the difficulties of professional coping *alone* with these sorts of problems. For a medical issue, a second opinion is in order, or even necessary. For a problem of how to act, or of behaviour in a patient, often there is no point of referral, and so the professional is left not only with a difficult problem but with only his own prejudices to guide him on how to act. A referral to someone else, either by referring the patient to another professional worker, or by discussing the issue with colleagues, might have opened the way to a different line of reasoning. If the GP had referred Mr O'Reilly to someone else who had shared his views, then more pressure might have been put on the patient, and that second professional could have taken some of the blame had things gone wrong, and the family doctor would have remained as the 'good and trusted' figure.

SOCIAL WORKER

I think we are avoiding not only the deeper ethical issues but also the important realities that this couple were locked in an unsatisfactory relationship with declining sexual interest, in the man at least, and probably rigid attitudes held on both sides. We do not know much about their background but one can guess. It would be a mistake to assume that what is expected of citizens of Hampstead could also be expected of the citizens of Cork: I don't mean that in any prejudiced way, but that those are the realities of religious and cultural backgrounds that are likely at moments of crisis to be deciding factors in how people act. That goes for the professional too, of course.

PHYSICIAN

Presumably the important ethical issue to examine here is that of breaking confidence when the health of another person is at risk if we do not. The difficulty also arises for the doctor that this second person is also his patient. The original Hippocratic statement was clear about complete confidentiality, but more modern codes have tried to reconcile the conflict that we are now facing. The American Medical Association states that confidences must not be revealed by the doctor 'unless he is required to do so by the law or unless it becomes necessary in order to protect the welfare of the individual or of the society.' It could be argued that it would

therefore sanction the doctor approaching Mrs O'Reilly with the medical issues in this case – although I am sure that few would feel that she should be faced with her husband's unusual homosexual activity. After the Browne case before the General Medical Council's Disciplinary Committee in 1971, however, when the doctor considered he was acting in the best interest of the patient (a girl under 16 on the oral contraceptive pill) by revealing to her parents the facts against her will, the British Medical Association made an addition to its Principles (1971): 'If in the opinion of the doctor, disclosure of confidential information to a third party seems to be in the best medical interest of the patient, it is the doctor's duty to make every effort to allow the information to be given to the third party, but where the patient refuses, that refusal must be respected'.

This seems to me to indicate that the advice the BMA might offer would be that the GP could not pass on information to Mrs O'Reilly in the case we are considering.

GENERAL PRACTITIONER

I disagree, as the person we are considering here is not Mr O'Reilly but his wife. It is not just a threat we are considering, as where an epileptic might continue to drive; nor is it a question of justice, where a criminal has actually committed a crime about which the police wish to know. In this case Mrs O'Reilly is directly threatened by a disease which it is highly likely has already been transmitted to her, and by standing by, in whatever

ethical or unethical posture, the doctor would knowingly allow that disease to continue and possibly develop without action. I can't possibly see how anyone could do that – however minor, as in this case, the effects of the infection on Mrs O'Reilly might be. There are ways, I'm sure, that the doctor would have in getting round a direct statement to Mrs O'Reilly of what had happened – but whatever the niceties of statements or of law, she must be put under treatment. What she makes of this, and how it affects her family life, are surely not the responsibility of the doctors, just as her husband's behaviour which caused the problem is not the responsibility of the doctors, and that first issue must be made plain to all concerned. I think this is a case in which thinking too deeply about the family issues, when confronted by a medical problem, will pervert the normal standards of clinical care we should expect from a doctor.

CHAIRMAN

I think there is an urgent need for some clarification of these conflicting codes, and of better guidelines when the professional is faced with these difficult problems of confidentiality. That this does not come to our attention more, shows, I think that the problems are usually solved pragmatically by *ad hoc* decisions. This might well cause the lay person, about to reveal a confidence, some disquiet. We clearly need further discussion of this particular area.

Editor's note

In this series all names are fictitious and steps have been taken to conceal the true identities of patients, their families, their doctors and all others involved.