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Case conference

Drunken drivers: what should doctors do?

Aberdeen Medical Group

Case conference editor's note

This discussion was held under the auspices of the Aberdeen Medical Group on 11.6.85. The participants were: Dr Steve Krikler, medically qualified, postgraduate student; Mr Alastair Matheson, Accident and Emergency consultant, Aberdeen Royal Infirmary; Mr Douglas Cusine, Senior Lecturer in Conveyancing, University of Aberdeen; Inspector G Flett, Grampian Police Force; Dr Gordon Rhind, General Practitioner; Dr Elizabeth Russell, Senior Lecturer in Community Medicine, University of Aberdeen; Professor Lynn Wardle, Professor of Law, Brigham Young University, Utah, USA; Dave Blanchard, PhD, final year medical student.

The problem

Dr Krikler: A young man was brought into the Accident and Emergency department with only minor injuries sustained when his car hit a lamp-post. He was obviously under the influence of alcohol, but as no one else had been involved the police had not been called. I patched up his injuries, but wondered if I should notify the police to have him breathalysed. I did not. For the next week or two I wondered if I had failed in my duty as a citizen, and whether, if he drank and drove again but next time caused injury to someone else, I would be in any way (morally or legally) responsible?

Some time later, a similar patient arrived in similar circumstances. As usual there were a few police officers milling about in the department, so, remembering how I had felt after not getting the patient (or culprit) breathalysed last time, I informed a policeman who did breathalyse him. This time I spent the next week or two feeling that I had betrayed my patient.

The British Medical Association, Medical Defence Union and Medical Practitioner's Society were contacted. Their advice was non-commital, but to the effect that a doctor is under no obligation to inform the police in these circumstances. However that did not relieve my dilemma. Ethically, what should I have done?

Key words

Confidentiality; doctor-patient relationship; doctor's social duties; road traffic accidents; drinking, alcohol.

The discussion

Mr Matheson: We do try to give some guidance to junior staff on this sort of thing. I think that in the first instance you were right and in the second instance you were wrong. Other people may not agree with what I am saying because their situation is different from mine – Inspector Flett, for example. But you were there to deal with that man's injuries, and I don't think that a patient seen in a casualty department should be approached any differently from a patient going to his own general practitioner. Any information about that visit should be confidential, and the doctor has no right to pass on to any other party information gleaned from the patient. There are, perhaps, one or two circumstances where one might be prepared to breach confidentiality – if there were sufficient grounds, because of a wider responsibility to society – but not in this particular instance. You said he was obviously under the influence of alcohol; how obvious was this? The law demands now that you have a breath test and a blood test. Presumably these were not performed, and it was very much a subjective test that was applied, so that this is perhaps not quite as obvious as you suggest.

Mr Cusine: As far as the law is concerned, the duty of confidentiality towards the patient is recognised subject to a number of exceptions, and this situation is not one of them. The police may ask for information from a doctor to enable them to identify a driver who has been involved in, or is thought to have been involved in, certain offences under the Road Traffic Act. However, this collision with a stationary lampost is not one of them because there is no obligation on the part of the doctor to report, although there is an obligation to provide the police with information if asked. It seems to me a very important principle that if the doctor starts giving information about patients without their prior permission, he puts at risk his ability to retain the trust which is essential for the treatment of patients.

Inspector Flett: We would always be aware of the need for sensitivity on any issue, and we would always honour confidentiality, but we have a duty to society,

and a statutory requirement to enforce the law. The incident you outline involved damage to property, and so comes under the terms of section 168 of the Road Traffic Act, 1972. This gives the police authority to ask any person who has it in his power, to give information which may lead to the identity of the driver. Failing to give that information is an offence. However, there is a defence to this; if the person can prove that he did not have the information, and could not readily get it, then he will not be convicted. It is possible to view the position in which you found yourself in various ways. The welfare of any person who is injured is our main concern, and always will be. At the same time we have to temper that with our procedure. When I look at the drunk-driving situation, and I look at the moral responsibilities of everybody in this country, and I consider the number of people we see (and doctors are possibly the only other category of person with similar experience because the majority of people don't see the victims) then I tend to think that if more people did what you did the second time, we would have a considerable number more people alive each year. However that doesn't detract from your responsibility to your patient. I would not like to see the time come when people are apprehensive about going to hospitals or doctors, but there is no criticism that we would bring in response to your action; we would welcome it, though we would not go overboard to encourage it.

Dr Krikler: You would welcome it if doctors were more prepared to volunteer information?

Inspector Flett: We would always be happy to enforce law that will save people's lives, but we will always use only legal and fair means.

Dr Rhind: Getting back to the first case, the fellow who was obviously drunk, and you didn't inform the police; did you advise him yourself against driving a car?

Dr Krikler: To be honest, I can't remember whether I did or not, but I think that the fact that he had his face stitched up in casualty from having gone through a windscreen would have been fairly strong advice to him that he should not be driving in that state.

Dr Rhind: Yes, but you see, you feel that you were involved in a dilemma here. If you advise a person, he may or may not take your advice, that's up to him, but at least you have helped your own moral problem because you can then say to yourself 'Right. I told the guy what to do and what not to do, if he goes ahead and drives a car, that's up to him, but at least I told him he shouldn't be doing it'. I think that's an important point.

Dr Russell: I wonder whether you also try to give them a cup of coffee to sober them up, and sit them in a corner? Do you feel that is a responsibility of the staff?

Mr Matheson: I don't think it's a responsibility, although it happens. However, the sad fact of the matter is that most drunken drivers that I come into contact with are simply incapable of driving for the rest of the night because of their injuries.

Dr Krikler: Suppose then that a man is brought in. He's smashed his car up, he's injured himself a little bit. He goes home and a week later he does the same thing again only this time, instead of hitting a lampost he drives into a bus queue or, let's say, he knocks over and kills a child. The parents of the child discover that only a week ago he was in casualty having done the same thing, and they somehow discover that it was recognised by a doctor in the casualty department that this person had been driving under the influence of drink, and had therefore committed a criminal offence. Would they have any grounds for complaint against the doctor for not doing anything about it the first time?

Mr Matheson: Absolutely not, for several reasons. One, even if the doctor had done something about it, that driver would almost certainly have been free to go and drink again, to drive again, and to mow into that bus queue, because the way the law works he would not have been off the road within that time.

Professor Wardle: Of course he would have had something hanging over his head, something a little more substantial than the mere wagging of the finger of a doctor, namely the criminal charge against him.

Dr Krikler: Let's say it happened six months later, during which period he could have been prosecuted and lost his licence. Could the parent of the child sue the doctor for failing to report what he could obviously see was a criminal offence?

Mr Matheson: I don't see why you should home in on the doctor, because he doesn't carry all the responsibility. The person who carries most of the responsibility is the driver himself and, beyond that, society. People will be drinking tonight and they will be driving on the roads and there will be accidents. And sections of society will say 'there but for the grace of God . . .' etc. Society, if it really wanted to get in among the drunken driving, could do much more. Random breath tests, for example, having police cars sitting outside any pub car park and just picking them off. Why not, if society really feels strongly about this? Or why 80mg, why not zero? You do not drink and drive: if you want to drink, get somebody else to drive. But society doesn't adopt this attitude, and because it doesn't, then I don't think one can put too much of the blame on the doctors.

Mr Cusine: Even if you don't accept the view that society ought to take a stricter view of drinking and driving, there are other people, apart from the doctor, who may come into contact with your particular individual. They may be aware of his previous history and know a lot more about him than you do. You have only seen him on two occasions, his wife has maybe seen him every day of the week like that. Aren't his wife and members of his immediate family equally responsible to the parents of the unfortunate child who was mown down?

Dr Russell: So doctors are equal with other members of society in their responsibility, or are they even less so?

Mr Cusine: It depends on the circumstances. If I

know about somebody who goes to the pub every night of the week and drives home drunk, then I know a lot more about him than does the doctor who has seen him once because he has battered a lampost. If there is a moral obligation it rests more with me.

Dr Rhind: I have been told by the police that the majority of the anonymous phone calls they receive about drunken drivers come from the driver's wife. It must take enormous courage.

Inspector Flett: Enormous courage, yes. I have come across cases where women have admitted they were driven to that. And their fear was not mainly for the husband, but for some innocent person.

Professor Wardle: Don't you think that it's as important to protect the relationship that woman has with that man, as it is to protect the one the doctor has with the man and that that relationship is as precarious as the relationship the doctor might have with that man?

Inspector Flett: In most cases there's no relationship left to be quite honest. It's a sad fact, but it's a fact.

Dr Russell: Or the relationship is good enough for her to do it and tell him she's done it. I do know that that has happened and it has brought the whole thing out into the open, and she will say 'I have done it for your own sake'.

Professor Wardle: But the question is, do we want to create a duty? Should there be a duty for wives, for children? After all, they don't want to see daddy stumble in stone-drunk every night. Do you want to create a duty for them, since they are obviously in the best position to report? I raise this question because the relationship seems to be the key, and the reason that we insulate doctors from that duty. For doctors, that duty would seem to be logical, since they are in a position to know, and yet we don't create a duty, and the question is why? It serves social purposes; the benefit of confidentiality is in the public interest, and yet there are exceptions. Should there be an exception here? The next question is, even if the law doesn't create a duty for doctors to disclose, should the medical profession, as a matter of ethical self-regulation, imposé upon itself a duty? For instance, do doctors in Britain have an ethical duty to report child abuse when there is clear evidence?

Inspector Flett: There is a code of practice.

Dr Russell: It's more than ethical.

Professor Wardle: Is there a legal duty?

Dr Russell: It's not actually legal.

Inspector Flett: It's a code of practice; it has been established and it is honoured; and the confidentiality is honoured by the police, the medical profession and the social work department.

Professor Wardle: Why is there an ethical obligation to report in that context, but no ethical obligation to report in this context?

Dr Rhind: Because society's view of drinking is different from society's view of battering children.

Mr Matheson: The person being protected when you are discussing child battering is the child whose bruises you can see. The person who is being protected in the case of the drunk driver is unknown, he may not exist and he may never exist.

Professor Wardle: A profession that deals with statistical evidence might be able to visualise the victim. But the first answer is more intriguing, when you say that it's because society views child battering one way and alcohol abuse another way. However, the question I have asked isn't whether there should be a social duty to report, it is whether there should be a professional duty? The fact that society doesn't expect doctors to do this is an excuse not to, but is it a moral justification?

Dr Krikler: A corollary of that is the role doctors play in the views taken by society. For example the British Medical Association (BMA) has made a big stand on smoking and tobacco advertising, and is beginning to do the same on alcohol, so as you say, maybe it is just an excuse when doctors say that society regards alcohol abuse as less serious than child abuse.

Mr Cusine: I think it would be very difficult for doctors to impose upon themselves an obligation to do something which society did not approve of, or actively opposed. Then the patient who goes to the doctor has at the back of his mind 'Well, what do I tell this guy? These people have set themselves up as moral authorities and I have no guarantee that what I tell him will be treated in confidence'.

Dr Blanchard: If the initiative to take a stand against something they see as wrong doesn't come from the doctors in society, where is it going to come from? For example, it was the medical profession that took the stand against smoking and that's being very effective, so why shouldn't they make a stand about alcohol and say 'We see these drunk drivers every Friday night in Accident and Emergency departments, why can't we start reporting them?.

Mr Cusine: I think the smoking issue is rather different. What doctors are saying to people is 'Don't smoke because it's bad for your health'. The analogy would be 'Don't drink because it's bad for your health'. But what we are talking about here is going a stage further and saying 'Not only do I as a doctor not approve of your drinking, but if I find you drinking or suspect that you have been drinking, then I will report you'.

Dr Blanchard: The thing is that the people who see the effects of alcohol are the police and the doctors. Maybe the doctors could make a stronger point than they do. I'm not saying they should turn every drunk in, but I wonder if maybe drunkenness has been tolerated too long, maybe we ought to make a change?

Inspector Flett: I think you've probably got a point there, it has been tolerated too long, and it's getting worse. How bad does it have to be before something is done about it? It's 20 years since the first people died in football stadiums. It's taken those years and two events where 50 and 30 or so people died before society has reacted. It's only when, eventually, the public is shocked that something is done and presently it is not

yet shocked by the alcohol problem.

Dr Rhind: There are a lot of vested interests as well, just as there are in smoking. Alcohol is cheaper now in real terms than it has ever been.

Dr Russell: There is also a difference in the consequences of a doctor acting over drunk driving or child abuse. In drunk driving you are passing the person into the hands of the law as a potential criminal. In child abuse it is in part criminal, but there is also the assumption, certainly on my part, that by reporting a suspect you are putting him into a position where he will be cared for as though he were ill. In other words, I think there is still a difference in society's attitudes, and certainly in mine, about the sickness component of child abuse and of drunkenness.

Professor Wardle: Which would you rather be reported for?

Dr Russell: Drunkenness.

Professor Wardle: Which does the law require you as a doctor to report?

Dr Russell: It's not the law, it's a voluntarily agreed procedure.

Professor Wardle: Then your professional obligation?

Dr Russell: Child abuse.

Professor Wardle: You are suggesting that the difference in consequences is that in child abuse a person is put into a less stringent regimen than are drunks. I would sugget that it's not quite true. In fact, stigma attaches much more heavily to child abuse.

Mr Cusine: I'm not sure that stigma is necessarily the thing which distinguishes them. The law, at least in Scotland, is reasonably clear, that if you have a patient you suspect is trying to murder somebody, you have a duty to society to report it to the police. The reason is the gravity of the suspected offence. Last century there was a case concerning a Dr Pritchard who was murdering his wife; the general practitioner was aware of the arsenical poisoning and said nothing about it. The GP's argument was that he thought he should keep the information to himself because of his obligation of confidentiality, but the judge held that the wider public duty should prevail. If that is right, how serious does the offence have to be? And then, is it right to draw distinctions on the basis of seriousness of offence, or is there some other criterion such as you suggest, a sickness element?

Dr Russell: What is the underlying reason for having to report murder? In the drunkenness example, what we've been implying is ultimate prevention. Does the same thinking apply to the judgement that you have a duty to report even after the event?

Mr Cusine: The point in the case I mentioned was that somebody who was identifiable at the time was going to suffer as a direct result of the patient's activities. The distinction here, which might well be made in all alcohol cases, is that we may not ever have a victim.

Mr Matheson: I know attitudes change with time, and I think most doctors these days would take action if they suspected a colleague was murdering his wife.

Mr Cusine: It might depend on the wife!

Mr Matheson: Where the police have come to me and said they wanted information, my question to them has been 'What crime is being investigated?' If it's murder or rape, then I will break my patient's confidence in order to protect society whereas, if the crime were a lesser one, for example crime against property, I might not.

Dr Rhind: If the police had said 'We're investigating a robbery, and the burglar went through the window and hurt himself; did you treat this man?'

Mr Matheson: Yes, I would reply honestly to that.

Dr. Rhind: Would you agree that it's perfectly in order to say to the police 'Yes, I treated Joe Bloggs' and no more than that?

Mr Matheson: That is my point.

Mr Cusine: What is the difference between that question and 'Have you treated within the last ten minutes someone who had lacerations on his hands and face?'

Mr Matheson: Because the police are not entitled to the information they seem to be seeking – the name of a patient. I may have treated several people in the last ten minutes, and if I say 'Yes, I have treated A, B and C, then the police will immediately be interested in all of them. For all I know, they may all be innocent.

Mr Cusine: If you had only treated one man?

Mr Matheson: That's when I would start asking questions as to what was being asked. Then I would be able to judge, and at the end of the day I have to make up my own mind on the matter.

Inspector Flett: As far as I have found, there is no legal requirement to tell the police anything other than the statutory requirement I mentioned earlier (Section 168 of the Road Traffic Act). If when asked by the police a person who does know chooses not to say, then there is obviously nothing else the police can do, and it falls to the Procurator Fiscal (in Scotland) to decide. He can require that person to attend at his offices or wherever, and if the person refuses to answer questions then he has committed an offence. It is then for the court to hear the evidence and if necessary summons that person who is required there and then to answer. If he doesn't, he commits contempt of court. But we would hope that things would never get to that stage. Also, I would hope that there would always be sensitivity in seeking out information. For example, the situation at 3 am might be very urgent, and you would give information which at 3 pm you might not, because the police may have other ways of getting that information during the day.

Mr Cusine: What Inspector Flett has been talking about is predicated upon the assumption that he has been given information from another source and is then coming to you with a certain part of the picture and asking you to fill in the rest. In the first problem presented here, there was no police involvement at all, simply a doctor making up his own mind about a certain part of the picture, and whether he ought to

inform the police. I think this is a different situation altogether.

Dr Russell: Is the position any different if you have taken a blood sample for any reason and you have information that the blood alcohol level is above 80mg?

Mr Matheson: No. The blood alcohol level, if measured, is of the highest confidentiality. Even the very fact that we have measured it is secret. It is tacitly agreed between me and my patient that when I withdraw blood from him and do certain tests, the information will be used in the patient's best interests, and to behave otherwise would be a breach of confidence.

Mr Cusine: In law, that would amount to assault because the consent is predicated upon the assumption that certain things will or will not happen, and if these assumptions aren't correct, then you don't have consent from the patient.

Mr Matheson: Let me give you a different model then, that is absolutely real. A patient came in, and he'd been drinking and driving, the police were involved and asked if they could breathalyse him. He was breathalysed and it proved negative. A blood sample taken for clinical purposes was 300mg. What should I do? I did absolutely nothing.

Dr Krikler: What happened in the accident? Was anyone else injured?

Mr Matheson: I don't know.

Dr Krikler: You say if you knew of a serious crime being committed, like murder or rape, and the police asked you for information, you would give it. If you knew that a death had occurred as a result of the accident, even if it wasn't murder, would you still feel in this context that you would withhold the information that his blood was 300mg? If, for example, the police came to you and said 'This man seems drunk, he smells of alcohol, we've breathalysed him but it's negative, do you have any suggestions?' What would you do?

Mr Matheson: You would be making the immediate assumption that the police test was in error and my test was correct. That is an assumption you are not entitled to make.

Dr Krikler: I think blood alcohol would be a more reliable test than a breath test wouldn't it?

Mr Cusine: You could take the cynical view that if the police want to breathalyse people, then it's up to them to have the correct equipment to do so, but they don't.

Professor Wardle: Then that's their problem.

Dr Krikler: This may all be true from a legal point of view, but partly we are talking about moral issues as well. My view of the law is that it's an approximation to what we feel is morally correct, and new laws are enacted as we feel moral imperfections appear in the old laws. So if we can decide what is morally correct the law will eventually be changed to come into line with that moral viewpoint.

Dr Russell: Can I come back to the question of what is going to happen if society's attitude to drinking does change, as it may well do over the next ten years in Britain, and it wishes more action to be taken? Supposing society says to doctors 'You are the people who are most likely to be in a position where you can blow the whistle during an event where you can get the kind of evidence that is necessary, so go ahead and do it'. What is the medical profession's response going to be at that point?

Professor Wardle: I suspect that if it were perceived as possibly driving a wedge between professionals and patients, it would be resisted. There is a traditional impetus in the medical profession, in my country at least, that vehemently resists any kind of imposition or regulatory duty, sometimes even when it would not do any harm, just because of the principle that the medical profession ought not to be doing other things than delivering competent medical treatment and medical care. That's a very single-minded approach to their role in society, but it has the advantage that if doctors are doing just doctoring, we might get more competent doctors and a more effective medical service. However, doctors are just a sub-set of society, and when social attitudes change the attitudes within the profession are likely to change, and so the professional ethics themselves will change correspondingly. It will then be easier for the individual doctor to disclose a little more information, in the sense that it's not really a medical matter he's involved in, rather, he's really doing something to protect society at large. Every doctor will at some point have to make a decision whether to act in concordance with what fellow doctors consider to be appropriate professionally, or with what he in the privacy of his own ideals considers to be appropriate. There may be a danger of trying to implement our own individual standards through the professional position we hold. This runs the risk of turning the profession into something other than the profession it is intended to be. That is, we don't want doctors to be too paternalistic. When I go to a doctor, I want him to be able to cure my medical ills competently, and not act from morals which he thinks are in my best interests.

Dr Krikler: It seems that the consensus amongst people here is very largely in favour of my first action. In other words, one's moral obligations as a doctor treating a drunk driver are such that one does not report the driver to the police, even though it may be obvious, in one's subjective assessment, that he has committed what is a statutory crime.

Inspector Flett: Obviously, that's not the feeling of the police, for the reasons I've given.

Dr Russell: And obviously it's not absolute. Over time, our judgement of what is serious enough to take action as regards our duty to society will change, and there is no absolute ethical underlying principle; it is a question of relative judgement of what is the greatest damage to society.

Dr Krikler: Thank you all very much for coming along this evening and participating in what has turned out to be a very stimulating discussion.

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