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Maintaining Patient Confidentiality in Emergency Departments: Challenges and Suggestions

(Memelihara kerahsiaan pesakit di Jabatan Kecemasan: Cabaran dan Cadangan)

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Abstract

Doctor-patient confidentiality has long been established as a legal and ethical obligation imposed on all doctors and other medical practitioners. This duty, derived from various ethical guidelines, statutes, and English common law, has also been adopted by the Malaysian courts. In essence, it requires medical practitioners to protect patients' confidential information from unauthorised disclosure to other parties. While maintaining patients' confidentiality in other clinical settings may be reasonably achieved, the task may be more arduous in an Accident & Emergency department. The unique situation of an Accident & Emergencxy department such as overcrowding, limited space, and demands from patients' family and friends may pose some hurdles for healthcare practitioners in fulfilling this duty. This paper addresses the overarching issue by first establishing the legal and ethical basis for doctor-patient confidentiality in Malaysia. The challenges of preserving patient confidentiality in Accident & Emergency departments are then analysed, along with whether any exceptions provided by law or guidelines can be applied in these situations. Finally, this paper concludes by providing recommendations and tips for doctors and other healthcare workers in Accident & Emergency departments to ensure that patient confidentiality is not violated.

Keywords: Medical law; Doctor-patient confidentiality; Accident & Emergency departments; ethics.

Abstrak

Prinsip kerahsiaan antara doktor dan pesakit telah diterima sebagai tanggungjawab undang-undang dan etika yang perlu dipatuhi oleh doktor dan semua pengamal perubatan. Kewajipan ini diasaskan dari garis panduan etika, statut dan prinsip undang-undang Inggeris yang telah diterimapakai oleh mahkamah di Malaysia. Secara am, kewajipan ini memerlukan pengamal perubatan untuk sentiasa melindungi kerahsiaan pesakit dari pengetahuan pihak lain yang tidak berotoriti. Di dalam situasi klinikal lain, tugas menjaga kerahsiaan pesakit boleh dikatakan sebagai munasabah untuk dicapai. Namun, pengamal perubatan di Jabatan Kecemasan dan Trauma mungkin menghadapi cabaran yang lebih getir dalam melaksanakan tanggugjawab kmemelihara kerahsiaan pesakit. Beberapa keadaan di Jabatan Kecemasan dan Trauma seperti kesesakan, kesempitan ruang dan permintaan dari keluarga pesakit merupakan cabaran yang dihadapi oleh doktor dan pengamal perubatan di jabatan tersebut. Situasi ini menjadi isu utama yang dikupas dalam penulisan ini. Untuk itu, penulisan ini dimulakan dengan memperkenalkan asas undang-undang dan etika untuk kewajipan memelihara kerahsiaan pesakit oleh pengamal perubatan. Ini diikuti dengan analisis mengenai cabaran yang dihadapi oleh pengamal perubatan di Jabatan Kecemasan dan Trauma dalam memenuhi kewajipan ini. Penulisan ini turut mengenalpasti pengecualian (sekiranya ada) yang boleh diaplikasi dalam kewajipan kerahsiaan ini dalam konteks Jabatan Kecemasan dan Trauma. Diakhir perbincangan, penulisan ini mengutarakan cadangan dan tip untuk para doktor dan pengamal perubatan di Jabatan Kecemasan dan Trauma dalam memastikan tugas memelihara kerahsiaan dan privasi pesakit dapat dipenuhi.

Kata kunci: Undang-undang perubatan; prinsip kerahsiaan pesakit; Jabatan Kecemasan dan Trauma; etika

INTRODUCTION

Healthcare professionals, particularly doctors and nurses, working in accident and emergency (A&E) departments face several obstacles in managing their daily duties that make them vulnerable to a claim in negligence by patients. For example, doctors and nurses in A&E are frequently encountered by a high number of patients daily who may require urgent treatment (Zahiid 2023). Allegations of negligence against healthcare workers in A&E departments have occasionally surfaced (Noh 2023). Healthcare workers in A&E department also face another hurdle in discharging their legal and ethical duty to maintain a patient's confidentiality. For example, healthcare workers in A&E departments often receive requests from the patient's family and friends inquiring on the patient's condition. Furthermore, the busy environment in A&E departments increases the risk of violating patients' confidentiality. This can happen when patients are initially interviewed by the triage nurse or medical assistant when they arrive for treatment or when patients' names are called in for treatment. Not to mention, essential medical information needs to be discussed between doctors with other healthcare workers including specialists and nurses which expose them to the risk of breaching patient confidentiality (Geiderman, Moskop, & Derse 2006). According to Brenner et al. (2024), it is more difficult to protect patient confidentiality in the A&E department than in other settings due to the limited space and fast-paced nature of the department.

These unique situations in A&E raise concerns about healthcare workers' legal and ethical duty to preserve patient confidentiality, and whether the law provides exceptions to this duty for those working in A&E departments. The legal and ethical duty of healthcare workers in Malaysia to preserve patient confidentiality, particularly in A&E departments, is examined in this paper, with attention to the unique challenges posed by this environment. The potential application of exceptions provided by law or guidelines in these settings is also explored. The paper begins by outlining the foundation for doctor-patient confidentiality, followed by an analysis of specific challenges in A&E, and concludes with recommendations to ensure that confidentiality is maintained.

LEGAL AND ETHICAL DUTY ON CONFIDENTIALITY

Healthcare professionals' duty to maintain patient confidentiality are mandated in several Malaysian guidelines and statutes, as well as English common law and Malaysian case laws.

Ethical Guidelines

Firstly, doctors'duty to respect patient confidentiality can be traced back to the early Hippocratic Oath sworn by doctors which states:

"Whatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. (Britannica 2024).

The duty to 'maintain doctor-patient relationship' is also recognised as one of the 'ten golden rules of medical practice' in the Malaysian Medical Council (MMC) Good Medical Practice 2019 (Malaysian Medical Council, 2019). The ethical duty for doctors to maintain patient confidentiality is further embedded in several other guidelines issued by the Malaysian Medical Council (MMC). For instance, the MMC Code of Professional Conduct 2019 (Malaysian Medical Council, 2019) expressly states that:

"A registered medical practitioner is responsible for the confidential information obtained from a patient. The practitioner must ensure that the information is effectively protected against improper disclosure when it is transmitted, received, stored, or disposed of." (section 1.5)

Further, section 2.2.2 of the same Code indicates that:

"A practitioner must not improperly disclose information which he obtained in confidence from or about a patient."

The same obligation can also be found in the MMC Guidelines on Confidentiality 2011 which contain extensive guidance on doctor-patient confidentiality requirements (Malaysian Medical Council 2011). Firstly, section 1 outlines the principle that:

"Patients have the right to expect that there will be no disclosure of any personal information, which is obtained during the course of a practitioner's professional duties, unless they give consent.

The justification for this information being kept confidential is that it enhances the patient-doctor relationship. Without assurances about confidentiality patients may be reluctant to give doctors the information they need in order to provide good care."

According to the case of *Nurul Husna Muhammad Hafiz & Anor v Kerajaan Malaysia & Ors [2015] 1 CLJ 825*, the guidelines issued by the MMC have persuasive force should the issue arise for adjudication in the Malaysian courts. In addition, doctors who violate any of the MMC Guidelines are also subject to disciplinary actions by the MMC under the Medical Act 1971.

Statutory Provisions

The obligation of healthcare professionals and institutions to protect patient confidentiality is also incorporated in several statutes. Firstly, Section 43 of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006 (created under the Private Healthcare Facilities and Services Act 1998) states:

"(1) The licensee or person in charge of a private healthcare facility or service shall have an appropriate patient's medical record system comprising of facilities, procedures and organization for keeping a patient's medical record;

(2) The licensee or person in charge of a private healthcare facility or service shall –

(a) Ensure that separate patient's medical record is kept for each patient…;

(b) Be responsible to safeguard the information on the patient's medical record against loss, tampering or use by unauthorized persons.

(5) Any person who contravenes this regulation commits an offence and shall be liable on conviction to a fine not exceeding RM10,000 or to imprisonment term not exceeding 3 months or to both."

Similar provisions are also found in Section 29(2) (b) and 3 of the Private Healthcare Facilities and Services (Private Medical Clinics or Private Dental Clinics) Regulations (created under the Private Healthcare Facilities and Services Act 1998). The obligation to safeguard confidential information is also embedded in the Personal Data Protection Act 2010 (PDPA). The PDPA protects data privacy by, among other things, regulating the handling, transmission of data and tampering of data (Lim 2024). The above-mentioned statutes are only applicable to private institutions. Hence, healthcare professionals working public healthcare facilities are bound by the duty of confidence contained in the MMC Guidelines cited above and the duty under English common law which has been adopted in Malaysian case laws.

Duty of Confidentiality under English Common Law and Malaysian Cases

English common law has long established duty of healthcare practitioners to maintain patient confidentiality. For example, in *Hunter v Mann* [1974] 2 All ER 414, it was stated that:

"…a doctor was under a duty to his patient not to disclose voluntarily, without the consent of his patient, information which the doctor had gained in his professional capacity unless compelled by law to do so…"

Furthermore, in *AG Guardian Newspapers (No. 2)* [1990] 1 AC 109, duty of confidence was enunciated when the court said:

"The law has long recognised that an obligation of confidence can arise out of particular relationships. Examples are the relationships of doctor and patient, priest and penitent, solicitor and client, banker and customer. The obligation may be imposed by an express or implied term in a contract but it may also exist independently of any contract on the basis of an independent equitable principle of confidence…"

In addition, the court in AG Guardian Newspapers (No. 2) [1990] 1 AC 109 further laid down the conditions to be satisfied for an information to be considered as confidential. Firstly, the duty only applies to information that has the quality of confidence. Information that has been made public, for example, are no longer protected under this duty of confidence. Secondly, the duty of confidentiality does not apply to information that is considered as useless or trivia. Finally, duty of confidentiality is applicable to information which, on public interest, must be safeguarded from disclosure. At the same, this duty may be overridden by compelling public interest as stated by the court:

*"It is that, although the basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure. This limitation may apply, as the learned judge pointed out, to all types of confidential information. It is this limiting principle which may require a court to carry out a balancing operation, weighing the public interest in maintaining confidence against a countervailing public interest favouring disc*losure."

Also, in *W v Edgell* [1990] 1 All ER 835, the English court again reiterated the duty of confidence that a doctor holds when the court remarked that: "The question in the present case is not whether Dr. Edgell was under a duty of confidence, as he plainly was." The Malaysian courts have also adopted and applied the duty of confidence created by the English common law. This duty has been judged to arise not only within healthcare settings but also applies to all other information, subject to established conditions. In *Schmidt Scientific Sdn Bhd v Ong Han Suan* [1997] 5 MLJ 632, it was held

that the first, second, third and fourth defendants who were ex-employees of the plaintiff have a duty "not to use, divulge and/or disclose" all confidential information or trade secrets obtained during their period of employment to anyone. The court then further ruled that the fifth defendant, as the recipient of the confidential information was also placed with a duty to refrain from using such information. In reaching this decision, the court adopted an English case of *Coco v AN Clark (Engineers) Ltd (No 2)* [1969] RPC 41 where Megarry J laid down three criteria to be satisfied in order to succeed in a claim for breach of confidence, namely:

"(1) The information which the plaintiff is seeking to protect is of a confidential nature;

(2) The information in question was communicated in circumstances importing an obligation of confidence; and

(3) There must be an unauthorised use of that information to the detriment of the party communicating it."

In addition, the High Court in *Scientific Sdn Bhd v Ong Han Suan* [1997] 5 MLJ 632 acknowledged that breach of confidence is actionable under the law of tort as the judge said:

"I am of the view that a breach of confidence should also be regarded as a tort with damages to be awarded to the successful plaintiff. After all, the word tort is derived from the Latin 'tortum' which means a wrong; and a tort is nothing more than a breach of a duty, other than under contract leading to an award of damages. Since the categories of tortious liability remain open, the ingenuity and resourcefulness of the human mind can and ought to lead to fresh categories of tort being established. Into the list of categories of tort, I would include breach of confidence."

The three criteria to establish confidentiality applied in *Schmidt Scientific*'s case discussed above were again applied by the Malaysian court in *Repco (Malaysia) Sdn. Bhd. V Tan Toh Fatt & Ors* [2013] 7 MLJ 408. Here, the plaintiff's claim for breach of confidence was dismissed as he failed to prove the existence of the three elements: namely, the information must possess the quality that denotes its confidentiality, must have been conversed in a way that attracts the duty of confidence and must have been unlawfully disclosed to the detriment of the plaintiff.

The issue of confidentiality was considered again in *Dimerco Express (M) Sdn Bhd v Patricia Lee Siew Mei & Ors (Awot Global Logistics (M) Sdn Bhd, intervener)* [2024] MLJU 2116, where the High Court quoted, with approval, the following passage from an English case of *CF Partners (UK) LLP v. Barclays Bank Pic & Ors [2014] EWHC 3049 (Ch),* on the duty of confidentiality:

"The legal principles defining the duty of confidence are well established and there was a large measure of common ground both as to their content and as to their application. Even in the absence of a contractual relationship and stipulation, and in the absence too of an initial confidential relationship, the law imposes a "duty of confidence" whenever a person receives information he knows or ought to know is fairly and reasonably to be regarded as confidential…The subject matter must be "information", and that information must be clear and identifiable…To warrant equitable protection, the information must have the "necessary quality of confidence about it…Confidentiality does not attach to trivial or useless information: but the measure is not its commercial value; it is whether the preservation of its confidentiality is of substantial concern to the claimant, and the threshold in this regard is not a high one…"

From the cases discussed above, the requirements to establish duty of confidence can be gathered as follows:

1. The information must be confidential in nature;
2. The information must have been confided in a manner that invites the duty of confidence;
3. The information must have been divulged without the consent of the person who initially disclosed it;
4. The disclosure of the information must cause adverse repercussions to the person who initially imparted it;
5. The information must not be trivial and has not been publicly disclosed;
6. The information must be protected on public interest; and
7. At the same time, the information may be disclosed on public interest grounds.

The duty of confidence established by the courts has been unequivocally applied to a doctor-patient relationship. In *Dato' Vijay Kumar Natarajan v Choy Kok Mun* [2010] 7 MLJ 215, the High Court expressly stated that information shared during the course of a professional relationship, such as between a doctor and a patient, denotes confidentiality if the information warrants its protection. Mohd Hishamudin J stated:

"Now, the tort of breach of confidence requires more than merely an agreement by the recipient of an information that the information should be kept

confidential. The law looks at the nature of the information itself. The law does not protect just any information: the information must be of a nature that the courts, through judicial precedents, have always recognised its confidentiality and has accorded it judicial protection; for example, trade secrets; or information of sexual relationship between spouses; or information between a professional (a doctor, for instance) and his client." (emphasis added)

Thus far, a few cases involving breach of doctor-patient confidentiality have been litigated in the Malaysian courts. In *Dr. Tan Ah Ba v Dr. Wong Foot Meow* [2012] MLJ 467, the plaintiff commenced an action against the defendant who was an Oral and Maxillofacial surgeon for a breach of confidentiality by disclosing his medical report to an unauthorised third party. In finding in favour of the plaintiff, the court remarked: "Where a professional man like the defendant acquires confidential information from their clients, they are duty bound to keep it confidential." Similarly, in an unreported case of *Mohd Zairi Rasidi bin Abd Hadi v Pengarah Pusat Perubatan UKM & 5 Ors [21NCVC-238-11/2012]*, the defendants were held liable for the unlawful disclosure of the plaintiff's medical records. In the High Court, JC Vazeer reportedly uttered that the hospital and its personnel has a duty to safeguard patients' medical information from unauthorised disclosure and that this duty should not be taken lightly (Nazlina 2013).

The duty of confidence for healthcare practitioners was deliberated again in *Lee Ewe Poh v Dr. Lim Teik Man* [2011] 1 MLJ 835. In this case, the plaintiff suffered haemorrhoids and sought treatment from the first defendant who was a colorectal surgeon. The first defendant performed a surgery on the plaintiff under anaesthesia. However, after the surgery, the plaintiff learnt that the first defendant had taken photographs of her private parts during the surgery. The plaintiff then sued the defendants for infringing her privacy and/or dignity and for an injunction to prevent the defendants from disseminating the photos. In their defence, the defendants raised several arguments, namely:

1. An action based on violation of privacy is not recognised in Malaysia;
2. Medical practice accepts taking photographs during surgery;
3. The photographs were taken in the clinical environment solely for the plaintiff's own medical records and were not published;
4. The plaintiff's identity cannot be identified from the said photographs.

The High Court, nevertheless, rejected the defendants' defence and ruled in favour of the plaintiff. On the question of whether the claim of violation of privacy is actionable in Malaysia, the court ruled in the affirmative by applying the Court of Appeal's decision in *Maslinda bt Ishak v Mohd Tahir bin Osman & Ors* [2009] 6 MLJ 826 where Chew Soo Ho JC ruled that:

"Drawing an analogy of this Court of Appeal case, I am inclined to hold the view that since our courts, especially the Court of Appeal, have accepted such an act to be a cause of action, it is thus actionable. The privacy right of a female in relation to her modesty, decency and dignity in the context of the high moral value existing in our society is her fundamental right in sustaining that high morality that is demanded of her, and it is ought to be entrenched. Hence, it is just right that our law should be sensitive to such rights. In the circumstances, the plaintiff in the instant case ought to be allowed to maintain such claim."

In the alternative, Chew Soo Ho JC in *Lee Ewe Poh v Dr. Lim Teik Man* [2011] 1 MLJ 835 further ruled that even if the court's decision on the existence of the cause of action on breach of privacy is mis founded, the plaintiff's claim could still succeed as a breach of confidence by the surgeon for taking those photographs of the plaintiff's private parts. The High Court's decision in this case reinforces the long-established duty of confidence owed by a doctor towards his patient and further expanded the cause of action for violation of privacy from unlawful disclosure of medical information without patient's consent. From the discussion so far, it is undisputed that healthcare practitioners owe a duty to maintain patient confidentiality and protect such information from unauthorised disclosure. With this background, this paper proceeds with the analysis on the prevalent situation in emergency departments and the challenges encountered in upholding patient confidentiality.

CONFIDENTALITY IN EMERGENCY DEPARTMENTS: THE CHALLENGES

Healthcare practitioners working in A&E departments may encounter several challenges in ensuring that patient confidentiality is safe-guarded due to the unique working environment. In what follows, the challenges encountered in A&E departments in protecting patients' confidence and privacy are identified and examined according to the available law/guidelines in Malaysia.

Confidentiality within the A&E Department

Overcrowded A&E departments pose significant challenges in protecting patients' privacy and

confidentiality. For example, a public hospital's emergency department in Kuala Lumpur reportedly manages 60 cubicles and treats approximately 250,000 patients each year (Kementerian Kesihatan Malaysian Hospital Kuala Lumpur 2024). From the triage process until initial treatment in the A&E department, patients' information or medical condition may be exposed to others such as visitors or other patients (Geiderman, Moskop, & Derse 2006). Generally, when a patient arrives at the A&E department, he will be interviewed by a triage nurse or medical assistant. In this process, the patient will need to disclose his medical information such as his symptoms and medical history. From this, the patient will then be classified according to the different zones depending on the severity of the patients' conditions (Kementerian Kesihatan Malaysia Hospital Selayang n.d.). During the triage process, the patient's medical and other information may be exposed to other people in the area. As such, extra care should be taken so as not to compromise patients' information at this point.

Additionally, when patients wait at the waiting area for example, the risk of overhearing private confidential conversations between other healthcare workers and patients cannot be dismissed (Brenner, et al. 2024). The situation is made worse in the event of overcrowding that causes insufficient space for patients to be treated in private rooms or cubicles (Brenner et al. 2024). This situation poses difficulties in managing patients' privacy and confidentiality. Methods that can be adopted to address this issue include the use of transitory blockades or dividers and controlling one's voice when speaking at busy areas (Brenner, et al. 2024).

Similarly, in a busy A&E department, conversation among healthcare workers about the patient's medical and personal information should also be kept private and secured. According to Kling (2016), patients' medical information may be accidentally disclosed or overheard by unauthorised party during discussion among healthcare workers, be it at the hospital corridor, canteen or other places in the hospital. Consequently, he added that: "In the ED, confidentiality may be difficult to preserve, given the physical environment, the acuity of the patient's medical condition, and multiple team members who may be involved in the patient's care" (Kling 2016).

The MMC Guideline on Confidentiality 2011 can be referred to for guidance on this issue. Section 8 of the said Guideline provides:

"Many improper disclosures are unintentional. The practitioner shall not discuss a patient's information in an area where the practitioner can be overheard or leave patient's records, either on paper or on screen, where they can be seen by other patients, unauthorized health care staff or the public. The practitioner shall take all reasonable steps to ensure that consultations with patients are private."

Another concern arises when upon initial examination, the A&E doctor needs to refer the patient to other doctors or specialists. In this scenario, the MMC Guideline on Confidentiality 2011 requires the doctor to inform the patient of the need for referral:

"A practitioner shall ensure that patients understand why and when information may be shared between healthcare team members, and any circumstances in which healthcare team members may be required to disclose information to third parties." (section 23)

However, the Guideline continues to state that no expressed consent is required when disclosing information among healthcare practitioners for a treatment that the patient has consented to, such as disclosing information for preparation of a referral letter or to order for diagnostic procedure (section 24). However, if medical emergency arises where the patient's consent cannot be obtained, section 25 of the MMC Guideline on Confidentiality allows the sharing of information among healthcare workers for the patient's best interest. Other than that, another significant hurdle that healthcare workers in A&E departments may encounter is the request of information on the patient by third parties particularly the patient's family.

Disclosure of Medical Information to Patient's Next of Kin, Friends or Relatives

When a patient is brought into A&E department for an emergency treatment due to an accident, for instance, healthcare workers in the department may be approached by the patient's friends or relatives wishing to find out about the patient's condition (Geiderman, Moskop, & Derse 2006). Here, if careful measures are not taken, healthcare workers may face the risk of breaching the patient confidentiality. Healthcare workers are reminded not to divulge information about the patient to a third party without the patient's consent. As seen in *Dr. Tan Ah Ba v Dr. Wong Foot Meow* [2012] MLJ 467 discussed earlier, disclosure of patients' information (in that case, the disclosure involves the patient's medical report) to a third party without the patient's consent constitutes a breach of the duty of confidence owed by a doctor to a patient. The MMC Guideline on Confidentiality 2011 also reminds medical practitioners not to disclose information to a third party without the patient's expressed consent as stated in section 28:

"28. As a general rule, a practitioner shall seek a patient's expressed consent before disclosing identifiable information for purposes other than the provision of care."

Nonetheless, there are several provisions in the MMC Guideline on Confidentiality 2011 that permit disclosure of information to the patient's "spouse, partner, carers, relatives or friends" (Part VIII). Section 54 requires medical practitioners to consult the patient on the person with whom the patient wishes to share his medical information with. Section 56 permits medical practitioners to engage in a discussion with persons close to the patient who wishes to do so. However, the practitioner must clearly inform that person that the practitioner may disclose that discussion or concern to the patient. The same provision further stipulates that medical practitioners should not refrain from listening to the patient's spouse, partner, or other persons on the grounds of confidentiality, particularly when their opinion promotes the patient's best interest. However, caution must be exercised with that:

"The practitioner will need to take cognizance of whether the patient would consider the practitioner's listening to the concerns of others about the patient's health or care to be a breach of trust, particularly if they have requested the practitioner not to listen to certain people." (section 56)

In summary, when encountered queries by persons claiming to be close to the patient, it is important for healthcare workers to confirm the identity of that person. In addition, the practitioner should seek consent from the patient before making any disclosure on the patient's health condition (Geiderman, Moskop, & Derse 2006). If, however, the patient is not able to give consent at that time due to lack of capacity, reference may be made to Part VII of the MMC Guideline on Confidentiality 2011. Section 50 of the said Guideline contains the following advice:

1. If the patient's incapacity to consent is temporary, then the practitioner should wait until the patient regains his capacity;
2. The practitioner should consider if the patient has expressed any preferences before;
3. The practitioner should take into consideration, the opinion of the persons whom the patient has asked the practitioner to consult or any person legally authorised to make decision for the patient or the person who has been appointed to represent the patient;
4. The practitioner must evaluate of the views of the person close to the patient on the patient's preferences; and
5. The practitioner's and the medical team's opinion or knowledge on what the patient's wishes, beliefs or feelings is also relevant in deciding whether disclosure is warranted.

Nonetheless, if the patient brought to the A&E department is terminally ill, it may not be reasonable for healthcare practitioners to withhold information from the patient's spouse, family or close friends (Blightman, Griffiths, & Danbury 2014). This is particularly so in the Malaysian society where family plays an influential role in a person's medical treatment (NIK-Sherina & Ng 2006) (Haniwarda 2019). The MMC Guideline on Confidentiality acknowledges the role of patients' family in healthcare and decision-making which is evident in its guidelines. On the issue of disclosure of information to a patient's family, the MMC Guideline on Confidentiality 2011 endorses such a disclosure in circumstances where the medical practitioners judge that informing patient's family would be in the patient's best interest. This position is evident in section 32 of the said Guideline:

"Rarely a practitioner may judge that seeking consent for the disclosure of confidential information may be damaging to the patient, but that the disclosure would be in the patient's interests. For example, a practitioner may judge that it would be in a patient's interests that a close relative should know about the patient's terminal condition. In such circumstances information may be disclosed without consent"

The permissibility to share a patient's medical information to the patient's close relatives may be further derived from the MMC Guideline on Consent for Treatment of Patients by Registered Medical Practitioners 2016 (Revised 2017) that allows medical treatment to be carried out without the patient's consent in a medical emergency (Malaysian Medical Council Guideline 2016). Section 5 of which states that in an emergency situation where the patient's consent cannot be obtained and when there is no relative or legal guardian present, treatment may be carried out if it is necessary to save the patient's life or prevent serious harm to the patient's health. In this circumstance of emergency, the said Guideline encourages medical practitioners to perform the emergency treatment after reaching a written consensus by the treating doctor and a second registered practitioner on the need for the treatment. The crucial point to be derived from this provision is the authority provided to the patient's next-of-kin or relatives to authorise the medical treatment/surgery on behalf of the patient. In order for the patient's family to consent on the proposed emergency treatment, necessary information pertaining to the treatment which may

include the patient's medical condition needs to be revealed to the patient's family. This provision, in a way, arguably authorises a healthcare practitioner's action in divulging patient's medical information to the patient's family in emergency settings.

Nevertheless, obtaining consent for emergency treatment from the patient's next of kin (which also requires disclosure of the patient's information) must be exercised with caution due to the High Court's remarks in *Liew Ju Min v Choo Wee Poh & Ors and another case* [2017] MLJU 133. Here, Lim Chong Fong JC was of the opinion that:

"…there is also non-existence of inherent or natural personal right of relatives and next of kins in the context of medical treatment of patients as illustrated in the English court of appeal case of Re T (adult: refusal of treatment) [1992] 4 ALL ER 649 wherein Lord Donaldson MR succinctly held as follows at 653:

"There seems to be a view in the medical profession that in such emergency circumstances the next of kin should be asked to consent on behalf of the patient and that, if possible, treatment should be postponed until that consent has been obtained. This is a misconception because the next of kin has no legal right either to consent or to refuse consent."

The High Court Liew Ju Min's case, in a way, did not recognise the rights of a patient's family to make decisions on the patient's medical treatment even in an emergency situation. The said decision was made based on English common law that has never accepted the role or authority of a patient's family in making medical decisions on the patient's behalf. The preferred approach, according to English common law, is for the medical practitioners to authorise the treatment on the patient's best interest as decided in *Re T (adult: refusal of treatment) [1992] 4 ALL ER 649*. Be that as it may, consultation with the patient's family is encouraged if such a conversation may assist medical practitioners in determining the patient's wishes and beliefs. Nonetheless, Lord Donaldson Of Lymington Mr in *Re T (adult: refusal of medical treatment), [1992] 4 All ER 649* cautions medical practitioners that:

"Neither the personal circumstances of the patient nor a speculative answer to the question 'What would the patient have chosen?' can bind the practitioner in his choice of whether or not to treat or how to treat or justify him in acting contrary to a clearly established anticipatory refusal to accept treatment but they are factors to be taken into account by him in forming a clinical judgment as to what is in the best interests of the patient."

In a nutshell, sharing a patient's medical information to the patient's close family or friends must be exercised with great care and caution so as not to infringe upon the patient's right to confidentiality. Whenever possible, it is always advisable for healthcare practitioners to obtain the patient's consent before making any disclosure to a third party including the patient's own family and friends.

CONCLUSION

Protecting patient confidentiality has been accepted as a legal and ethical duty owed by healthcare practitioners towards their patients. In Malaysia, this duty has been enforced by the courts against healthcare practitioners who failed to keep their patients' information confidential and safe from unauthorised disclosure. In an A&E department, it is acknowledged that upholding this duty could be an arduous task due to the chaotic and intense environment that healthcare practitioners endure each day. Nonetheless, the unique situation in A&E departments cannot be relied upon as a defence or justification for breaching patients' confidentiality and privacy. This paper has identified some challenges faced by healthcare practitioners in an A&E department in maintaining patients' confidentiality and offered some suggestions and recommendation to alleviate the risk of violating this duty. The MMC Guideline on Confidentiality 2011 could be referred to and applied by all healthcare practitioners in A&E departments to ensure that patients' information is kept confidential and safe. Apart from that, this paper also paves the way for hospital administration to seek better ways and procedures so that patient confidentiality can be successfully preserved within the challenging situations in A&E departments.

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