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Features

Deathbed Confession: When a Dying Patient Confesses to Murder: Clinical, Ethical, and Legal Implications

Laura Tincknell, Anne O'Callaghan, Joanna Manning, and Phillipa Malpas

ABSTRACT

During an initial palliative care assessment, a dying man discloses that he had killed several people whilst a young man. The junior doctor, to whom he revealed his story, consulted with senior palliative care colleagues. It was agreed that legal advice would be sought on the issue of breaching the man's confidentiality. Two legal opinions conflicted with each other. A decision was made by the clinical team not to inform the police.

In this article the junior doctor, the palliative medicine specialist, a medical ethicist, and a lawyer consider the case from their various perspectives.

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INTRODUCTION

During an initial palliative care assessment, a dying 70-year-old man, in physical pain and existential distress, disclosed he had killed many people when he was a young man. Prior to his disclosure he asked what would happen to any information he revealed.

In this article the junior doctor, the palliative medicine specialist, a medical ethicist, and a lawyer consider the case from their various perspectives.

Consideration of the case offers no easy or satisfying answers. It is a powerful and compelling example of the doctor-patient relationship in action in clinical practice and illuminates particular challenges for health practitioners working with patients at the end of life.

THE CASE

EF was a 70-year-old man with advanced metastatic cancer. On his final admission to hospital he was referred to the palliative care service for difficulty with pain control. He was frail, in severe pain, could no longer get out of bed, was not eating or drinking much, and needed full nursing care.

During the initial palliative care assessment, EF complained of severe pain. He stated that he believed

he was at the end of his life and wished to discuss his life and some of the choices he had made. At the commencement of his story, he asked what would happen to the information he gave. It was explained that the information would not be disclosed unless it was thought he was at risk of doing himself or someone else harm.

He revealed he had become involved as a young man in gang culture and had performed "several contract killings" 50 years previously. He knew little of the people whom he had killed, but he thought the bodies of some these people may not have been found. He spoke of guilt at the lives he had cut short and of the families who may not have known what happened to a loved one. He reflected on his own situation: "I looked into their eyes—saw fear and pulled the trigger. The problem for me is now someone else has the gun and I am the one who is afraid. I always pulled the trigger first—but now I can't."

In his mid-20s he had served a prison sentence for accessory to murder. Following release he joined the merchant navy, stating that he had had to kill people in this line of work as well as to protect his boat and other crew members from acts of piracy.

On returning home after a few years at sea he felt he was a reformed character, and spent the next 40 years of his life trying to atone for what he had done with charitable works, monetary donations to good causes, and taking on "lost souls" to help them turn their lives around.

The conversation focussed on his feelings and emotions, with very little factual information given about the crimes. As he talked he had a remarkable transformation, becoming calm and measured with obvious relief showing in his voice and body language. The next day he was out of bed, walking and eating, and over the coming days his analgesic requirements fell significantly.

Following the consultation, the palliative care team sought advice from personal liability insurance lawyers and the hospital lawyers. The advice was conflicting. The personal liability opinion was that the individual practitioner had no legal obligation to disclose information about crimes that happened 50 years previously—citing New Zealand Health Information Privacy Code, Rule 11(2)(d)[1]—and that disclosure without express consent from the patient opened up the practitioners to complaint. Hospital legal advice was that "consent had been implied" by the patient's disclosure of the information, and therefore the police should be informed.

On follow up visits, EF remained pleased to have "confessed" and spoke of relief. He did not want to revisit the conversation and he did not give consent for the information to be shared. He was willing to talk about what to do with his knowledge, and decided he would write a letter detailing information relevant to his past crimes to be given to the police following his death. He did not want help with writing and insisted he would do it in his own time. He was offered, but declined, access to additional psychological and/or spiritual support.

He died at a residential facility six weeks after discharge from the hospital. He did not discuss his disclosure with the community palliative care team and it is not known whether he left a letter.

THE PALLIATIVE CARE SPECIALIST'S PERSPECTIVE

Knowledge of the approach of death can precipitate an existential crisis. The existential crisis may be manifest in a number of ways, including a worsening of physical symptoms, and is often conceptualized as "total pain," as described by Cicely Saunders.[2] The provision of effective palliative care thus means that practitioners should not only be experts in symptom control but should also have, or be able to access, skills in the psychological and spiritual domains, in order to relieve existential distress.[3] Work in the spiritual domain is often described as a process of making sense, making meaning, and making peace.[4] It may be best supported through establishing a therapeutic relationship based on trust and respect.[5]

In palliative care, when time might be short, effective relief of suffering is more likely to result when the practitioner has the capacity to form an effective therapeutic alliance with a patient in a short space of time, as occurred with this case.

In relation to EF, his physical condition was such that the admitting team, the palliative care team, and the patient all expected death to occur within a few days. His condition, however, improved following a palliative care consultation in which he was able to reveal his fears and regrets. Facing his own death triggered the memory of his experience of killing others and a need to "confess" to events that had occurred 50 years earlier. Revealing his actions, and also his 40-year attempts to atone for these, resulted in relief of both his physical pain and his anguished mental state.

As EF's death was expected to be imminent, the focus of care was on relieving his pain and distress and on capturing, if possible, any information about his crimes that might be of benefit to anyone. He did not consent to disclose details of his crimes to the palliative care team or to anyone else, but as it

became apparent that he might survive to be discharged to a nursing home, he agreed to document specific details to be revealed after his death. At the same time urgent legal opinions were sought, specifically whether the confession should be revealed to the police. The team attempted to balance the possible risks versus benefits in breaking confidentiality. The risk of disclosure, at worst, was that the therapeutic relationship between the patient and his healthcare providers would be lost with a recurrence of his distress, worsened through a sense of betrayal, resulting in a difficult death. This was coupled with the likelihood that he was deemed to be unlikely to reveal anything to the police that would incriminate himself. The benefit of disclosure, at best, was that he would agree to provide details of his crimes to the police, which might result in closure for some remaining relatives or friends of those whom he had killed. The legal opinions provided conflicting advice, and in particular the hospital legal opinion that "consent had been implied" differed from the view of the clinical teams.

After lengthy discussions, an uneasy decision was made not to inform the police. This was based on an assessment at the time of likelihood of harm versus likelihood of benefit. Had the crimes occurred more recently, had EF shown the slightest desire to use official channels to "make good" his deeds, and had he not been assessed as dying very soon, the decision might have been different. The case led to a desire to more fully explore the ethical and legal perspectives of disclosure both before and after death.

THE ETHICIST'S PERSPECTIVE

At the heart of this compelling case lies the ethical challenge of whether information given in confidence to a health practitioner ought to be disclosed to a third party without the patient's consent. Should confidentiality trump disclosure, and, if so, on what grounds?

Confidentiality sits as a cornerstone of medical practice and is in effect when an individual discloses information to another, either through words or actions, and the person who is given the information vows not to divulge it without the individual's consent.[6] Medical confidentiality generally finds its justification in a utilitarian framework of cost-benefit analysis—it is said that keeping patients' information confidential allows patients to speak freely and openly, thus ensuring appropriate and timely medical treatment. It has been argued that if patients could not trust health practitioners to keep information confidential, patients may not be willing to disclose significant information that may have an adverse impact on their subsequent medical treatment and care.

EF disclosed serious information within a therapeutic relationship bound by trust and confidence. He recognized the seriousness of the information by asking, prior to his disclosure, what would happen to it. He was assured that unless someone was at risk of imminent harm (including EF), the information would be kept confidential within the palliative care team. On that basis, he disclosed the information.

The principle of confidentiality, however, is not absolute. The New Zealand Medical Association *Health Information Privacy Code* allows health practitioners to disclose information about a patient in a limited range of circumstances, including when disclosure "is necessary to prevent or lessen a serious and imminent threat to—(i) public health or safety; or (ii) the life or health of the individual concerned or another individual."[7]

Would breaking EF's confidence (prior to his death) be ethically mandated? There are compelling reasons to think it is. First, an allegation of murder is serious and has profound implications for others. Most obviously, the murder victims suffered the ultimate harm in being killed. Moreover, was someone else convicted for the murders EF alleged that he committed? Second, we might think further that the victims' families have a right to know this information, as it is pertinent to them. Finally, some may claim that EF should be held to account and punished for his crimes. These are valid and sound reasons to consider disclosing such information to the police; however, I believe that breaching confidentiality whilst EF remained alive would be unethical.

The doctor-patient relationship, exemplified by trust and honesty, is central to ethical analysis of the case. In this case EF spoke of his past actions only when assured that his confidence would not be broken. Asking EF several days later about what should be done with the information exemplified respect for him and involved him in the dilemma the doctor faced. EF clearly stated that he did not wish to repeat the conversation with anyone else. If the police were told of EF's confession against EF's will, it was possible that EF would deny the allegations, potentially thwarting any further investigation. The palliative care team would then be left with a dying patient whose confidence had been violated and who might have refused to have anything further to do with them. They might have also face disci-

plinary action if a complaint was brought against them as a result of the disclosure.

Keeping EF's confidence and encouraging him to write down details of his crimes in a letter to be opened after his death might have resulted in far greater beneficial consequences than reporting his confession to the police. Even if such a letter was unable to identify victims, an investigation might have provided clarity on the crimes, the location of victim's remains, and might have offered the victims' families some resolution.

But what if no letter was written? Should the details have been disclosed to the police postmortem, or should EF's confidence been held evermore? I believe disclosure—postmortem—was ethically permissible. First, EF was in agreement with the idea of writing a letter in the days following his disclosure to, and discussion with, his doctor. He took responsibility for his past actions, and his decision to write a confessional letter suggested he was acting autonomously and with intent. His consent to disclose was strongly implied by these conversations and strengthened by his admission that he lived with the knowledge of what he did every day, and had spent more than half of his life attempting to repent for his actions. Given the seriousness of the crimes he committed and the harms suffered by others as a result, the moral obligation to disclose the information to the police should take precedence over any possible diminution of EF's memory.

Ethical analysis strongly supported keeping EF's confidence based on the bounds of the therapeutic relationship. Once that relationship was severed through EF's death, and given EF's desire to acknowledge his crimes, the interests of those harmed by EF's actions would justify the clinician's disclosure to the relevant authorities.

THE LAWYER'S PERSPECTIVE

The palliative care team were permitted to disclose EF's identity and any details of the "contract killings" in his youth to the police after his death without attracting legal liability.

It is an uncontroversial legal rule that a health professional owes a legal obligation of confidentiality to a patient, "whether he be a model citizen or murderer."[8] The key legal risks to the team from unauthorized disclosure were civil actions for breach of the duty of confidence and the tort of unreasonable interference with privacy,[9] complaint to New Zealand's Privacy Commissioner, and professional disciplinary proceedings. The privacy of medical information receives further protection in the United Kingdom from the human right to "respect for private and family life," but courts must balance it against the conflicting right of "freedom of expression."[10] Proportionate interference with each of these is permitted in the interests of (among other things) public safety, the prevention of disorder or crime, the protection of health, and the protection of the rights and freedoms of others.[11] Some jurisdictions have added additional legislative protections. New Zealand's Health Information Privacy Code (HIPC),[12] for example, generally prohibits health practitioners from disclosing an individual's health information.

In this case, establishing *prima facie* cases of breach of confidence and interference with privacy in the event of disclosure presented little difficulty. The information disclosed was obviously private and sensitive; its release could have both beneficial and negative consequences for others, such as surviving family or friends of EF himself or his victims. He unburdened himself only on being given an assurance of confidentiality, and reiterated that wish. The revelations were made in the context of a relationship understood by all to be confidential. The obligation is not restricted to medical information, but extends to any private information imparted in circumstances imposing an obligation of confidence. A civil claim of invasion of privacy requires proof that publicity given to private facts would be considered highly offensive to a reasonable person. Although the "highly objectionable" criterion prescribes an objective test, it is to be applied from the perspective of a reasonable person in EF's position.[13] One can readily envision the feelings of betrayal, distress, and fear that a person in EF's shoes might reasonably experience, had he learned before his death of disclosure against his wish, for example.

Although disclosure can now no longer harm EF, the ethical and professional duties continue after death.[14] Guidance from the U.K. General Medical Council is: "If the patient had asked for information to remain confidential [after their death], you should usually respect their wishes."[15] What little law there is on the point favors the legal obligation as also surviving the patient's death.[16] The time for which it persists depends on factors such as the nature of the relationship, the nature of the information, and any harm that may be caused by disclosure to the deceased's estate or those she or he may have reasonably wanted to protect.[17] EF's death was recent; he confided information when in extremis and in the context of a close therapeutic relationship. The information was sensitive, and could cause significant harm to his memory and distress to his surviving family and friends. A court would prob-

ably conclude that the team was still bound by its legal obligation.

The duty of confidence is not absolute. The only legal justifications for disclosure are that the patient consented, or where the public interest in disclosure outweighs the public interest produced by keeping the confidence.[18] Hospital legal advice was that EF implied consent to disclosure, presumably on the basis of his expressions of guilt and concern for his victims' families, consist with his intention to write a letter. But the law maintains a tight rein on implied consent, and will not imply it if it is inconsistent with the patient's express wishes, which are generally binding. EF refused consent to disclosure expressly and repeatedly.

A well-known public interest justification for disclosure, plainly inapplicable since EF presented no physical risk even before his death, is to prevent a serious and imminent threat to public health or safety or the life or health of an individual.[19] "There is no confidence as to the disclosure of iniquity," proclaimed Wood VC in *Gartside v. Outram*.[20] This refers to another recognized public interest justification: when disclosure is necessary to avoid prejudice to the maintenance of the law, including the prevention, detection, investigation, prosecution, and punishment of offenses.[21] The justification applies to past crime that has gone undetected and unpunished, as well as to crimes and misdeeds in contemplation. EF was not about to commit further crimes before death, and if he did, he could have been brought to justice. Disclosure could only assist the investigation and detection of his past crimes. This could, on occasion, also be of compelling public interest, however. Disclosure would likely promote the welfare of any surviving family of EF's victims, who might have benefitted from psychological closure from the identification of EF as the perpetrator, and the possible location of his victims' remains. And investigation and detection of criminal misconduct, even if unpunished because of the perpetrator's death, expresses powerfully society's condemnation of criminal wrongdoing and sense of solidarity with its victims, as well as sending a deterrent signal to others contemplating similar offenses that they risk punishment.[22]

The team was permitted, but not obliged, to disclose.[23] The discretion was exercised, taking into account ethical and professional obligations. Professional guidance recommended that a crime had to be sufficiently serious for the public interest to prevail; the likelihood that the crime would be solved with disclosure was also relevant.[24] Although the few factual details EF provided suggested that disclosure might not have significantly assisted police investigations, new forensic technologies, such as DNA profiling, might have permitted connection of him to the killings. The "contract killings" occurred long ago, and were unsolved. Without disclosure, there was no imperative for the police to reopen these "cold cases."

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BLINDING OF THE CASE

Details of the case were altered to protect the identity of the patient.

NOTES

1. [New Zealand] Health Information Privacy Code, Rule 11(2)(d), October 2008, *https://www.privacy.org.nz/assets/Files/Codes-of-Practice-materials/Health-Information-Privacy-Code-1994-plus-amendments.pdf.*

2. C. Saunders, "The symptomatic treatment of malignant disease," Prescriber's Journal 4 (1964): 68-73.

3. M. Kearney, "Palliative Medicine. Just another specialty?" *Palliative Medicine* 6 (1992): 39-46.

4. C.M. Puchalski, "The role of spirituality in health care," *Baylor University Medical Center Proceedings* 14 (2001): 352-7; K.E. Steinhauser et al., "Factors Considered Important at the End of Life by Patients, Family, Physicians, and Other Care Providers," *Journal of the American Medical Association* 284 (2000): 2476-82; H.M. Chochinov, "Dying, Dignity, and New Horizons in Palliative End-of-Life Care," *CA: A Cancer Journal for Clinicians* 56 (2006): 84-103.

5. "Therapeutic relationship," *The Free Dictionary by Farlex,* 2009, *http://medical-dictionary.thefreedictionary.com/therapeutic+relationship};* J.W. Mack et al., "Measuring therapeutic alliance between oncologists and patients with advanced cancer," *Cancer* 115 (2009): 3302-11.

6. T. Beauchamp and J. Childress, *Principles of Biomedical Ethics,* 6th ed. (Oxford, U.K.: Oxford University Press, 2009), 302-7.

7. [New Zealand] Office of the Privacy Commissioner, "Health Information Privacy Code 1994," Rule 10 (1)(d): 1-108, *https://www.privacy.org.nz/assets/Files/Codes-of-Practice-materials/HIPC-1994-2008-revised-edition.pdf.*

8 *Ashworth Security Hospital v. MGN Ltd* [2000] 1 WLR 515, 527.

9. The privacy tort is recognized in some jurisdictions, including New Zealand; see *Hosking v. Runting* [2003] 3 NZLR 383 (CA), but is rejected in the U.K., see *Wainwright v. Home Office* [2003] 2 AC 406.

10. See [U.K.] Human Rights Act 1998, Schedule 1, articles 8(1) & 10(1), *https://www.legislation.gov.uk/ukpga/1998/42/schedule/1.*

11. See [U.K.] Human Rights Act 1998, Schedule 1, articles 8(2) & 10(2), *https://www.legislation.gov.uk/ukpga/1998/42/schedule/1.*

12. See note 7 above.

13. *P v. D* [2000] 3 NZLR 391, para 39.

14. See the Hippocratic Oath, *https://www.nlm.nih.gov/hmd/greek/greek_oath.html*; New Zealand Medical Association, "Code of Ethics," Principle 5, *https://www.nzma.org.nz/__data/assets/pdf_file/0016/31435/NZMA-Code-of-Ethics-2014-A4.pdf;* [U.K.] General Medical Council, Confidentiality, 2009, para 70, *https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality.*

15. Ibid.

16. *Bluck v. Information Commissioner* [2007] 98 BMLR 1; *Lewis v. Secretary of State for Health* [2008] EWHC 2196.

17. Ibid.

18. *A-G v. Guardian Newspapers* (No 2) [1990] AC 109, 282.

19. See [New Zealand] Privacy Comissioner, "HIPC, Rule 11(2)," *https://www.privacy.org.nz/assets/Files/Codes-of-Practice-materials/Health-Information-Privacy-Code-1994-plus-amendments.pdf*; *W v. Egdell* [1990] 1 All ER 835.

20. *Gartside v. Outram* (1856) 26 LJ Ch 113, 114.

21. [New Zealand] Privacy Comissioner, "HIPC, Rule 11(2)," see note 18 above; *Malone v. Commissioner of Police* [1979] 2 All ER 620, 634.

22. See generally, J.A. Hughes and M. Jonas, "Time and Crime: Which Cold-Case Investigations Should Be Reheated?" *Criminal Justice Ethics* 34 (2015): 18-41.

23. If they chose to disclose, they would be advised to disclose only information of EF's past crimes and only to the police, and on condition that the information was used only for investigation purposes.

24. V. English, A. Sommerville, S. Brannan, and British Medical Association, *Medical Ethics Today: The BMA's Handbook of Ethics and Law,* 3rd ed. (Chichester, West Sussex, U.K.: Wiley-Blackwell, 2012), 203-4.