



MEDICINE AND THE LAW

Disclosing the health status of public figures

Privacy versus public interest – when may doctors make disclosures?

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The recent furore about the disclosure of the health conditions of Shabir Shaik and the Minister of Health and a press statement by the Health Professions Council of South Africa (HPSCA)¹ have raised the question of when it is justified for medical practitioners to disclose the medical condition of public figures to the public or other persons.

Everyone has a constitutional² and common law right to privacy³ concerning their health status, but the right is not unlimited and may be infringed where the person concerned consents; where there is a statutory duty to make disclosure (e.g. child abuse);⁴ where it is reasonable for the media to make the disclosure;⁵ where the disclosure is true and in the public interest; or where the disclosure is privileged.⁶ The defences to an action for invasion of privacy are similar to those for defamation.⁷ The defences of truth for the public interest and privilege are particularly relevant to disclosures concerning the health status of public figures.

Who is a public figure?

Public figures are people who have by their personality, status or conduct exposed themselves to such a degree of publicity as to justify public disclosures of certain aspects of their private lives.⁸ Such persons include politicians, actors, entertainers, sportsmen and sportswomen, war heroes, and others who are regarded as having a limited right to privacy. This is because they have sought or consented to publicity, their personalities and affairs have already become public, and the media have a duty to inform the public about them.⁹

Disclosures about public figures should be relevant to how they conduct themselves in public or where their private affairs are in the public interest. For instance, it would be in the public interest to know that a public official, a judge or a person in charge of a professional body has a drug or alcohol problem

where such problem interferes with their ability to carry out their public or professional duties properly. Likewise, it would be in the public interest to know about the disease that afflicts a senior health official who is so ill that he cannot carry out his public duties because he is using an unorthodox treatment regimen that he is publicly promoting instead of conventional medicine. Similarly, it would be in the public interest to know that an ex-Presidential spokesperson had died of an AIDS-related illness some time after he had publicly rejected the opinion of thousands of reputable scientists who had stated that there was a direct link between HIV and AIDS.

Public figures are more likely than ordinary people to have disclosures about aspects of their private lives disclosed (including their health), because they seek or are exposed to publicity and their private acts or omissions may impinge on their public life.

Defence of truth for the public benefit

A disclosure concerning a person's health status may not be unlawful if the statement is true and for the public benefit.⁶

Truth

Truth does not mean that the disclosure has to be true in all respects – provided it is substantially true in the sense that the material facts are true.¹⁰ For instance, if a statement is made that a person died of AIDS instead of an AIDS-related illness the statement could be regarded as substantially true because the phrase 'died of AIDS' is commonly used by lay people. Truth by itself will not be a defence to a public disclosure concerning a person's health status – it must be linked to public benefit or interest for the defence to succeed.¹⁰

Public benefit and public interest

Public benefit means the same as public interest and refers to 'material in which the public has an interest' – not 'what the public finds interesting'.⁵ Public interest includes aspects of the private lives of public figures that are relevant to their public lives. For example, if an HIV-positive parliamentarian is opposed to the idea of the government rolling out an antiretroviral programme but is herself taking antiretroviral

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drugs it will be in the public interest to disclose the fact that she is on a treatment regimen that she is seeking to deny others.

Public interest also includes matters that are in the public domain such as politics, governance, administration of justice, administration of public or professional bodies, sport and the arts. It also includes people catapulted into the public eye – even against their will – for example people charged with crimes or the victims of natural disasters, crimes or public scandals.⁸ In such cases the disclosures must be relevant to the person's predicament and the public interest. For example, if a high-profile politician is convicted of a crime and manages to avoid being incarcerated in prison because of illness it would be in the public interest to disclose his health status if his illness does not justify keeping him out of prison.

It can be argued, however, that if it is shown that the disclosure about a person's health status was motivated by malice or spite the defence of truth for the public benefit will be defeated because it would be an abuse of rights, as is the case with the defence of qualified privilege.¹¹

Defence of privilege

The defence of privilege takes two forms – absolute and qualified privilege.⁶

Absolute privilege

Disclosures concerning a person's health made during national and provincial parliamentary proceedings are subject to an absolute privilege and may not give rise to legal proceedings – even if made out of spite or malice.¹² For example, if a national or provincial parliamentarian discloses the health status of the President, a Cabinet Minister, another parliamentarian, a Member of the Executive Council, or a member of the public during parliamentary proceedings, such disclosure will be privileged and not subject to legal action – no matter what motivates the disclosure.

Qualified privilege

A relevant disclosure about a person's health status made in the discharge of a legal, moral or social duty to a person who has a legitimate interest or duty in receiving the disclosure will be regarded as subject to a qualified privilege.¹¹ The same applies to relevant disclosures published during judicial or quasi-judicial proceedings or in reports of the proceedings of courts, parliament or public bodies.¹³

The test is whether an ordinary, reasonable person having regard to the relationship of the parties and the surrounding circumstances would have made the disclosure.¹¹ For example, a third-party private hospital doctor may tell a prison official that a sentenced prisoner who is in a private ward in order to avoid imprisonment is not so ill that he cannot return to prison to carry out his prison sentence. It could be argued that a similar disclosure could be made by the doctor to a newspaper

reporter on the basis that the doctor would have a moral or social duty to expose medical fraud by a prisoner and the mass media would have a duty to inform the public about such conduct.⁵

The privilege is regarded as qualified because it may be defeated by proof of malice or spite on the part of the person making the disclosure.¹¹

Ethical rules of the HPCSA

Rule 12 of the ethical rules of the HPCSA provide, *inter alia*, that:

'A practitioner shall only divulge verbally or in writing any information regarding a patient which he or she ought to divulge in terms of a statutory provision or at the instruction of a court of law or where justified in the public interest'.¹⁴

Rule 12 recognises that when it is in the public interest there may be ethical grounds for making a disclosure about the health of a patient. The test for when a disclosure about a person's health status will be in the public interest will be the same as that required by the law. Thus it would not be unethical to disclose that a dishonest HIV-positive parliamentarian was receiving antiretroviral drugs while seeking to deny the right to others, or that a prominent prisoner was fraudulently avoiding imprisonment on flimsy medical grounds.

Statutory provisions

The National Health Act provides that all information concerning a user or patient, 'including information relating to his or her health status, treatment or stay in a health establishment, is confidential'.¹⁵ Furthermore, no person may disclose any information about a patient unless (i) the patient consents to the disclosure in writing; (ii) a court order or any law requires that disclosure; or (iii) non-disclosure of the information represents a serious threat to public health.¹⁶

The National Health Act therefore allows disclosures about a person's health status, treatment or stay in a health establishment, *inter alia*, if a law requires such disclosure, or non-disclosure will pose a serious threat to public health. The law does not require disclosures concerning a person's health in situations where it is true and for the public benefit or on a privileged occasion. However, the law will protect a person who makes a disclosure under such circumstances – for instance, disclosures about the health status of the hypocritical HIV-positive parliamentarian on antiretroviral drugs who opposes their being given to others. It could also be argued that such a person poses a serious threat to public health by seeking to deny HIV-positive people access to life-saving drugs.

The National Health Act therefore recognises that the right to privacy is not unlimited and that disclosures about a person's health status may be made under certain restrictive circumstances – this is particularly so where the public interest is involved.



Conclusion

Public figures, like ordinary people, have a right to privacy, but their rights are more limited because they seek publicity or conduct their affairs in public. If the health status of public figures is relevant to their public activities it may be disclosed by doctors in situations where such disclosure is true for the public benefit or is made on a privileged occasion.

1. *Sunday Times* 4 March 2007.
2. Section 14 of the Constitution of the Republic of South Africa Act No.108 of 1996.
3. *Bernstein v. Bester* NO 1996 (2) SA 751 (CC) para 68.

4. Section 42 of the Child Care Act No.74 of 1983.
5. Cf. *National Media Ltd v. Bogoshi* 1998 (4) SA 1196 (SCA) at 1212.
6. Cf. *Khumalo v. Holomisa* 2002 (5) SA 401 (CC) para 18.
7. *Jansen van Vuuren v. Kruger* 1993 (4) SA 842 (A).
8. McQuoid-Mason DJ. *The Law of Privacy in South Africa*. Cape Town: Juta & Co., 1978: 222.
9. Keeton WP. *Prosser and Keeton on Torts*. 4th ed. St Paul, Minnesota: West Publishing Co., 1984: 859-860.
10. Cf. *Johnson v. Rand Daily Mail* 1928 AD at 190 and 204.
11. Cf. *Borgin v. De Villiers* 1980 (3) SA 556 (A) at 577.
12. Sections 58(1) and 117(1) of the Constitution of the Republic of South Africa Act 108 of 1996.
13. Cf. *Van der Berg v. Coopers & Lybrand Trust (Pty) Ltd* 2001 (2) SA 242 (SCA) at 252-253.
14. *HPCSA Guidance for Good Practice in Health Professions: Ethical and Professional Rules of Health Care Professions Booklet 3* (2006).
15. Section 14(1) of the National Health Act No. 61 of 2003.
16. Section 14(2) of the National Health Act No. 61 of 2003.

ISSUES IN MEDICINE

Male circumcision – the new hope?

A Myers, J Myers

Before we rush to administer the ‘silver bullet’ of circumcision in the fight against HIV/AIDS, it is important to take a long cool look at the practice, and the historical and contemporary rationales for its use.

Circumcision practices

In his book *Circumcision, A History of the World’s Most Controversial Surgery*,¹ medical historian David Gollaher makes the intriguing suggestion that ‘as the history of female circumcision suggests, if male circumcision were confined to developing nations, it would by now have emerged as an international *cause célèbre*, stirring passionate opposition from feminists, physicians, politicians, and the global human rights community’.

There are clearly ethical issues involved in practising genital surgery on non-consenting infants and children in a modern human rights context; however, because male circumcision has long been familiar in the West, it continues to be justified and escape scrutiny.

Rationalisations for circumcision

Over the centuries there have been various justifications for male circumcision. The practice has served in part to identify those outside the religious/cultural group. The unsubstantiated rationale is that the circumcised penis is ‘cleaner’ than the uncircumcised one. This argument is often encountered among Jews, Muslims and Americans, all of whom circumcise the majority of males in infancy or childhood, but the notion is absent for example in Scandinavian countries where circumcision is rare.

More serious and superficially more convincing justifications for this surgery, such as ‘health benefits’ or ‘medical’ reasons have abounded since the mid-19th century. The first medical justification was that circumcision prevents masturbation,² which Victorians believed led to a range of maladies including insanity, idiocy, epilepsy, tuberculosis and paralysis.³ This claim proved false. At the turn of the 20th century it was claimed that circumcision prevents sexually transmitted diseases (STDs), with studies⁴ finding differences in the rates of syphilis and other STDs among Jews and non-Jews. These early studies did not adjust for confounding factors, and later well-conducted studies failed to find a protective effect.⁵ In the 1930s circumcision was said to prevent penile cancer.⁶ However, because penile cancer is so rare (every year there is 1 case per 100 000 men in the USA and 0.3/100 000 in Japan⁷), the American Cancer Society estimates that the number of fatalities from circumcision would exceed the number of fatalities from penile cancer.⁸ In the 1950s an association was observed

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between circumcision and low rates of cervical cancer in women; however, this finding was not substantiated in further studies.⁹ In the 1980s the new scare was urinary tract infection in the first year of life.¹⁰ It was argued that the likelihood of this would be decreased if the infant was circumcised. However, even accepting this to be true, the absolute risk reduction is very small (under 1%).¹¹ Interestingly, girls are far more susceptible to urinary tract infections than both circumcised and intact boys. In girls (and in the small number of excess cases in intact males), antibiotic treatment is effective. It is also worth noting that none of the abovementioned conditions are eliminated by circumcision. The most that can possibly be said is that it offers some degree (often slight) of risk reduction in the circumcised.

Medical circumcision policy and practice in Anglophone countries

As medical justifications for routine infant circumcision have been steadily overturned, medical organisations in Anglophone countries (the only countries with a history of medicalised non-therapeutic or preventive circumcision) formulated policies that withheld endorsement of routine circumcision of infants, and accordingly the rates dropped considerably in all but the USA. The UK stopped coverage of circumcision via the National Health Service in 1949 because of lack of evidence of benefit,¹² and the American Academy of Paediatrics (AAP) stopped endorsement of routine circumcision in 1971, citing no valid indications.¹³ An AAP statement in 1989 elaborated on risks and benefits,¹⁴ and in its most recent policy statement in 1999 the AAP reaffirmed that routine circumcision was not recommended.¹⁵

Until recently infant male circumcision has been on the decline, as parents in developed countries began increasingly to perceive that genital surgery on non-consenting subjects was not only unnecessary, but also inhumane and out of step with an evolved human rights culture. Circumcision appeared to be going the way of other outdated practices such as corporal and capital punishment and less humane slaughtering and animal sacrifice practices. In the USA, UK and Israel, small but increasing numbers of Jews oppose the practice as antiquated, and refuse to have it done to their infants, despite its religious and cultural significance.¹⁶⁻¹⁹

The evidence for HIV prevention

Before the implementation of properly designed randomised control trials (RCTs), the authoritative Cochrane Review of recent studies on the subject found 'insufficient evidence to support an interventional effect of male circumcision on HIV acquisition in heterosexual men'.²⁰ Results of observational studies were conflicting and no strong association was observed. However, results of recent RCTs²¹⁻²³ examining the

effect of adult male circumcision on the risk of HIV infection have once again led to renewed medical justifications and calls for circumcision.²⁴⁻²⁷ There have been calls for mass circumcision campaigns, even though these might be impractical in many circumstances. Although some commentators have been careful to emphasise that circumcision has only been shown to reduce the risk, many lay people are beginning to believe that circumcision can prevent (in the sense of eliminate) the risk.

Recent RCTs have shown that over a maximum period of 24 months of observation post circumcision, a man's risk of contracting HIV is reduced by between 60% (see South African study²¹) and 53% and 51% (see Kenyan²² and Ugandan²³ studies) respectively. Garenne²⁸ has pointed out that a 60% reduction in the risk of infection is similar to the effectiveness of the rhythm method of contraception, which reduces fecundity by around 50% without protecting women against pregnancy.

A circumcised man cannot hope for full immunity to HIV; the best he can hope for is perhaps a longer period of time and/or a greater number of sexual encounters before he becomes infected as a consequence of his reduced risk. The problem is that if people are led to believe that circumcision is actually 'protective' in the sense of conferring full immunity, this could be seriously counterproductive, resulting in behavioural disinhibition in circumcised men and their abandonment of other preventive methods.

At the population level there is no notable correlation between circumcision and HIV status. In Europe, where few men are circumcised, HIV prevalence is the lowest in the world. In the USA, where most men are circumcised, HIV prevalence is highest in the developed world. In Ethiopia, despite the universal practice of circumcision, the number of HIV cases increased from 0% in 1984 to 7.4% in 1997.²⁹ In the Eastern Cape, where most men are circumcised, the prevalence rate is not meaningfully lower than in KwaZulu-Natal (KZN), where most men are not circumcised. The pandemic in the former province appears merely to be lagging behind that in KZN.²⁸

While these findings are not incompatible with evidence from trials showing that circumcision reduces the risk of HIV transmission, they demonstrate that there are far more important factors affecting HIV spread than the absence of circumcision. Actuarial modelling showing the impact that mass circumcision might have in South Africa provides an estimate of a modest 9% reduction in the incidence of HIV cases over the next 10 years³⁰ (an average risk reduction of less than 1% a year).

Unbalanced circumcision advocacy

The current zeal and naïve enthusiasm for promoting circumcision as an AIDS prevention tool show lack of regard for the limited degree of benefit likely. Potential harms include disinhibition and surgical complications like infection and worse at the individual level, and increased costs and strain on



thinly stretched health services and the opportunity cost of de-emphasising other crucial health services at the societal level. Recent research has shown that HIV infection is about three times more likely as a result of the circumcision procedure itself in three African settings (Kenya, Lesotho and Tanzania).³¹ One should also not lose sight of the ethical issues of circumcising non-consenting infants.

Cultural double standards

It is also useful to ask ourselves how consistent attitudes are in relation to preventive surgery. Hypothetically, imagine that female circumcision had also been shown to have a similar 'protective' effect. Would we be any more likely to promote it? Would women be lining up for it, and would young parents, eager to do the best for their children, request it for their daughters? If female circumcision was medicalised in a similar way to male circumcision, it could be made safer and less damaging. Nevertheless, that sort of argument does not convince.

Although it is not deemed ethically possible to study female circumcision by means of a RCT, a large Tanzanian study, which controlled for confounding variables, found that this practice reduced HIV transmission.³² Biologically the explanation for this is probably the same as for male circumcision.

The downplaying of these facts in the media is a powerful reflection of Western cultural attitudes. We have already decided that female circumcision is an appalling human rights violation and so do not even flirt with the idea of using it as an HIV prevention tool. Similar arguments apply to mastectomy in teenage girls, even though this would be effective to prevent breast cancer in later life. The difference with male circumcision is that it is still tolerated in Western and other parts of the world, rendering it politically acceptable. This has tended to lower ethical barriers to recommending male circumcision as an HIV/AIDS preventive measure.

Caution and more research are needed

More research is needed into integrated HIV/AIDS management that examines the long-term preventive effects of circumcision. Research should focus on the duration of sexual activity in men (as with the rhythm method of contraception over the reproductive years of women), the impact on female risk of acquiring HIV, and on the issue of disinhibition in circumcised men. The impact on women is a key issue, and recent research in Uganda shows that female partners of circumcised men appear twice as likely to contract HIV,³³ while South African research shows that of the principal group at risk for HIV infection – 15-24-year-olds – a massive 90% of those newly infected were women.³⁴ In summary, the evidence for preventive benefit

of male circumcision is rather modest and does not warrant heroic policies or practices.

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