THE MEDICO-LEGAL SIGNIFICANCE OF ANAMNESIS IN CONTEMPORARY MEDICAL PRACTICE*

Abstract
Throughout the history of mankind, in all climes and all creeds, it is a universally acclaimed fact that from him to whom much is given, much is expected. So, it is with the medical practitioner. The responsibilities on the shoulders of the medical practitioners are enormous, but so also is the degree of trust and reference vested in them. The medical practitioner historically had been revered and maybe, a little feared too. The hands of the healer were seen as extensions of some supernatural power. In fact, it has been said in some quarters that very early medicine was of course a matter of mystery; there being no apparent natural reason why disease struck one person rather than another; the answer had to be found in the supernatural, and supernatural powers being sparingly distributed, healing became a prerogative of a few whose power depended largely on the ignorance of the others.[1]The above being the case, each encounter on health grounds with a medical doctor right from antiquity till date has always been expected with awe, to some extent freight, and also with trust. It therefore behooves the medical doctor to understand that there is no margin for error and/or misbehaviour particularly on the first encounter in course of which the anamnesis is taken. This work has been a humble attempt to remind both medical doctors and lawyers of this important responsibility, since observation has shown that same has steadily been on the decline.

Keywords: Medicine, Law, Anamnesis, Contemporary Medical Practice

1. Introduction

The intrinsic and incontrovertible significance of anamnesis in contemporary medical practice is rooted in its peculiarity in affording the patient and the medical doctor the very first avenue for professional interaction.
In course such an intercourse a contractual agreement of fiducial bent is originated by the parties concerned. The human person being triune in nature (the physical body, the soul, and the spirit), it is self evident that the complexity of the burden before the medical doctor is enormous. Since one has no second chance to make a first impression, the doctor's approach to such an enormously complex problem often either boosts or destroys the confidence reposed in him by the patient. Anamnesis is the collection of medical history from patient by the doctor. It is a process quite akin to still waters, silent and simple on the surface, but deep and often destructive underneath the calmness and simplicity. The care of the patients begins with the development of a personal relationship between the patient and the doctor. In the absence of a sense of trust and confidence on the part of the patient, the effectiveness of most therapeutic measures is diminished. In most instances, when there is confidence in the doctor, reassurance is the best treatment and is all that is needed. Likewise, in most cases which do not lend themselves to easy solutions or for which no effective treatment is available a feeling on the part of the patient that the physician is doing all that is possible is one of the most important therapeutic measures that can be provided.[2] The first and most crucial step towards the inculcation of such a high degree of confidence in the doctor is often initiated through proper conduct in anamnesis.

Tact, sympathy and understanding are expected of the physician, for the patient is no mere collection of symptoms, signs, disordered functions, damaged organs and disturbed emotions. He is human, fearful and hopeful, seeking relief, help and reassurance. To the physician and to the anthropologist nothing human is strange or repulsive.[3] The misanthrope may become a smart diagnostician of organic diseases, but he can scarely hope to succeed as a physician.[4] The true physician has a Shakespearean breadth of interest in the wise and the foolish, the proud and the humble, the stoic hero and the winning rogue. He cares for people.[5] In light of the above, it maybe trite to emphasize that physicians need to approach the patients not as 'cases' or a disease, but as individuals whose problems all too often transcend the complaints which bring them to the doctor.[6] The first step to such a

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[1] Michael Davies, Textbook on Medical Law, 2nd edition Blackstone Press Ltd, 1998.
[2.] Robert G. Petersdorf; Raymond D. Adams, Eugene Braunwaled Eral: *Harrison's Principles of Inter Medicine* .10th edition Mc Graw – Hill Book Company 1983.
[3] Ibid
[4] ibid
[5] ibid
[6] ibid

relationship is taken during the process of history taking. Vital clinical information is derived from conversation with the patient.

Anamnesis (history taking) is not simply question-and-answers session. It is a dialogue. The physician must listen with care to what the patient is saying. He must interpret what the patient is trying to say, and he must be attuned to what the patient does not say – topics and issues the patient avoids. The principal complaint which patients make about modern scientific medicine is the failure of physicians to communicate with them adequately. A physician should recognize this and be aware that his conversation with the patient can accomplish a great deal of good. He should also realize that uncovered or misinterpreted conversation can result in great, even irreparable harm to the patient.[7]

2. Obtaining the History

The synonym for medical history is anamnesis or case history. Anamnesis is from the Greek words – '*ana*'- and – '*mnesis*', '*Ana*'-open and '*mnesis*' – memory. Anamnesis of a patient is information gained by a physician by asking specific questions either of the patient, or of other people who know the person and can give suitable information, with the aim of obtaining information useful in formulating a diagnosis and providing medical care to the patient.[8] The medically relevant complaints reported by the patient or others, familiar with the patient, are referred to as symptoms in contrast with signs which are ascertained by direct examination on the part of the medical personnel.[9] Most health encounters will result in some sort of history being taken. Information obtained from history taking together with the physical examination enables the physician and other health professionals to form a diagnosis and treatment plan.[10] History taking involves several distinct elements. One aspect involves the elicitation of straight forward factual information for example, 'is there a hypertensive patient in your family?' A second aspect involves branching to the other questions depending on the patient's response to an earlier question. Here one sees the difference between the expert and the novice. For example, when asked whether or not he has headaches, the patient may reply 'occasionally'. The novice may simply record 'occasional headaches' but the more experienced clinician will want to explore further the nature of these headaches – are they caused by emotional tension, hypertension, sinusitis or other causes. He will ask questions in an attempt to distinguish between these possibilities. The skilled physician will analyze historical data while acquiring them. He will act on the analysis in order to ask other questions that develop the data further.[11]

The physician is also further supposed to be interested in that aspect which relates to the rich and relatively unstructured information about the patient's complaint, the history of his present illness or so-called history of presenting complaint.

Obtaining this information requires flexibility, analysis, interpretation, assessment of nuances and non-verbal communication. Taking of history is not an isolated circumscribed procedure. Much information could be gathered from the habitus of the patient-does the patient sit erect during the conversation, does he lean forwards clutching the midsection of his abdomen? Does he moan and groan or salivale involuntarily (ptyalism) in course of the discussion therefore spitting all the time? How did the patient walk into the consulting room? His gait- did he shuffle or limp into the room? Was he aided? These are veritable sources of vital (-non verbal) communication to the physician.

3. The Physician's Mien

The process of anamnesis or history taking is the physician's first introduction to the patient. It is normally the physician's first psycho-somatic interaction with the patient. It is therefore of vital importance that this relationship gets off to a good start and the success or failure of the procedure would depend to a large extent on the following:

- How comfortable the patient in made, both physically and mentally. A few moments spent in friendly conversation will allow the patient to settle down before proceeding to the business at hand.[12]

-The physician should be properly and politely introduced to the patient making the physicians role in the patient's care quite understood by the patient.

-The informed consent of the patient to be interviewed in the presence of a chaperon should be sought and obtained. It is important that the medico legal significance of the position be made clear to the patient.

[7] A. McGehee Harrey et al, *The Principles and Practical of Medicine*, 20th Edition 1980 Appleton-century-crofts. New York. 1980.
[8] Https;//en.m.wikipedia.org/wiki/medical-history. Visited 28/05/2020.
[9] ibid
[10] ibid
[11] A. McGehee Harrey.. et al eupra).
[12] ibid

-The patient must be reassured that he has a warm and understanding, indeed a compassionate listener and adequate time in which to tell his whole story. He must be made to understand that the physician's whole attention is focused on him, without any distracting concerns or commitments. The atmosphere should be one of thoughtful conversation, not the dictation of a diary.[13]
-Meaningful questions cannot be asked without understanding the general nature of the patient's problem. Therefore, at the outset afford the patient enough time to express in his own terms, without interruption his basic reasons for visiting the physician.
-The patient may have forgotten some details of his past history; he should be reassured and not scolded or blamed. This is of particular importance when talking to elderly patients who may feel inadequate and embarrassed by their difficulties with memory.
-The patient should be encouraged to use his own words and to avoid any jargons or terminologies that he may have picked up elsewhere and thinks fashionable or trending. He should be discouraged from reciting diagnosis and/or interpretations from other health care establishments or personnel.
-The patient should never be made to feel inadequate, drab, dull or distraught. Questions should be so couched as not to embarrass or intimidate the patient.
-In spite of the above, the patient's narrative should not be allowed to bog down in needless details or drift into irrelevancies. The reminder must be gentle, compassionate but firm.
The sequence in which the history is obtained is dictated by the specific circumstances. If the patient is severely ill, infirm or emotionally upset, it is wise to inquire about the present illness before reviewing the past health and family history. Since the patient is most interested in his current problem, this sequence which begins with his present illness is generally preferable.[14]

4. Starting Point
It is of extreme importance to gently guide the patient as to when to start his narration. To this effect, it is of vital importance that one must be certain that the patient actually starts his narration from the beginning of the illness. Patients are known to often date the outset of their illness by some dramatic events, or events of particular significance, forgetting to tell the events which led up to it. These are frequently highly significant. Thus the insidious onset of fatigue and mild weight loss may give important insight into the nature of an acute upper abdominal pain, which started six months later. The physician must push the patient's recall back to the earliest beginning of his illness. It may be important and helpful to ascertain whether or not the patient's health was entirely normal before the particular dramatic symptom began. Reference to a date or season may be helpful in prompting a recollection. For example, the patient's state of health before the Christmas, New year etc.

5. Significance of Details
Some medical authorities have been of the opinion that patients sometimes tell small details about their illness, which are disregarded by the physician because at that time, they do not seem pertinent to the rest of the story. For example, a patient insisted that he got chills, fever and jaundice each time he took a cathartic and only then. This detail did not make much sense and was ignored. Search for the usual cause of intermittent fever were unrevealing until the patient was given a cathartic and subsequently had a high temperature, chills and jaundice. He was later found to have diverticulitis of the colon with abscess formation. Cathartics precipited acute episode by showering his liver with septic emboli.[15] Above is a clear justification of Robert Hutchison when he intoned 'listen to the patient because he is telling you the diagnosis'[16]. The implication of the statement is to the effect that even the minutest detail of a history given by the patent must be properly noted and taken into consideration when analyzing the whole history for within such a minute detail may be embedded the all-important diagnosis.

6. The Issue of Bias
A medical history collecting physician with a biased or fixated mindset could very easily constitute a tragedy to the patient and to clinical medicine. As 'he who comes to equity must come with clean hands', a physician embarking on anamnesis collection must proceed with an open mind. The collection of medical history is full of surprises. Such surprises when landed by an experienced physician could be exhilarating and reassuring but in the hands of a novice could spell doom. In taking medical history, the physician must weigh and analyze the information as it is being acquired. The information and the testing of hypothesis as to what may be the cause of the patient's illness is a major element in the gathering of meaningful information. The physician must discipline himself. However, to avoid bias, he must not disregard or ignore information that does not fit with a current hypothesis that he has under consideration. Furthermore, he should not ask leading questions in a manner that

[13] ibid
[14] ibid
[15] ibid
[16] Michael Glynn & William Drake, *Hutchinson Clinical Methods: An Integrated Approach to Clinical Practice*, 23rd edition. Sauners eiserier 2012 Edinburgh., New York London.

makes it difficult for the patient to disagree. He should not mislead the patient. The history should be an unbiased statement of all the facts presented by the patient.[17] It is advisable that physicians be critical in accepting certain expressions from the patients. Physicians should not uncritically accept such expressions as arthritis, eczema, pneumonia or indigestion from the patient. An episode of pneumonia, as expressed by the patient, may in reality have been a pulmonary infarction, or indigestion may have been coronary insufficiency.[18] The physician is to utilise the opportunity to acquire the details and the information, but should bring his professional background into use, in interpreting the facts. He should not simply record the diagnosis according to the patient, or the patient's own diagnosis. Physicians should strive in course of history taking, not to be biased by another physician's diagnosis. Conservative skepticism is a desirable trait. Such major symptoms as fever, weight loss, haemoptysis, macrohaematuria, haematemesis, black stools, chills, convulsion and lapse of consciousness, which often herald serious underlying disease should be cautiously evaluated and proper clinical explanations to them sought and obtained, for therein lies the hallmark of appropriate diagnostic utilization of the proceeds of anamnesis.

Patients are to be encouraged to quantify their symptoms in simple terms. For instance, a patient who has diarrhea should be able to tell the physician in simple terms, how many times the bowel was voided within the past night, sputum could be quantitatively expressed in teaspoons, tablespoons or teacups; dyspnoe in flight of stairs, and orthopnoe in number of pillows required for comfort in sleeping. Quantification of the symptomatic manifestations helps the physician in the determination of the significance of the symptom and therefore in proper diagnosis, after all the ultimate aim of a good history taking is to help the physician arrive at an accurate diagnosis since '*qui bene diagnoscit bene curat'* he who accurately diagnoses, heals effectively. The world is a global village. Dramatic improvements in the information superhighway and means of transportation has shrunken the world the implication here is that one can hardly think about medical history of a patient, without taking into consideration environmental factor particularly where there has been a recent change in environment and also the influence of drugs as in medication and prescription drugs. It is the responsibility of the physician to elicit from the patient whether or not the patient's illness is associated with alterations in the patient's environment. In effect has there been any recent change of environment by the patient? This should include such facts as whether or not the patient had gone on a picnic in the country, to the city, or has had an unusual contact with nature. The patient should be able to inform the physician also of any recent unusual contact with pets and also in case any of the patient's relatives had such contact, the physician should be told. Drugs are of particular significance. If possible, the physician should list all the drugs the patient may have been taking with appropriate dates on which they were administered. Any untoward or adverse reactions the patient may have had must be described, and any effect, if any, they may have had on the manifestations of the present illness indicated. It must be stated that it is often difficult to obtain an accurate history of drug usage, even when a drug reaction is suspected. Patients often regard as drugs only those medications that are expensive, prescribed or given by injection. They must be made to understand that among drugs are pills, tablets, capsules and liquid medication. Other common overlooked but often important agents include laxatives, sedatives, tonics, vitamins birth control pills and some remedies for menstrual cramps.

7. The Physician:

The fact can never be over emphasized, that inadequate communication or poor communication between the physician and the patient is an important cause of the rising frequency of malpractice suits in developed countries and Nigeria may not be an exception. The physician who is hurried in his explanations is often assumed to be hurried in his judgments. Failure to understand and cope with a patient's unrealistic expectations can lead to disappointment, anger, and litigation even when the outcome is as good as could be reasonably expected.[19] Hasty dismissal of realistic patient concerns by hearty and unwarranted reassurances can lead to the development of unrealistic expectations. Physicians must be aware of the nature of the psychological relationship which usually exists between a patient and his doctor. The patient goes to a doctor because he expects to trust and believe in him. Many authors have branded this belief and trust as amazingly uncritical and naïve, but this author humbly requests to differ. The high esteem and reverence in which the society holds the medical doctor (one of the noble professions) warrants this degree of trust. After all, '*omnum disciplinarium medicina nobilissima est*' – of all professions medical practice is the most noble. This is a pronouncement by the ancient sages. What a physician says is often regarded as infallible, even though the patient may actually know very little about the physician's qualifications.

[17] A. McGenee Harrey et al Op cit
[18] ibid.
[19] A Mcghee et al op cit.

In spite of the above, circumstances abound, where patients have been known to lack confidence and trust in a physician, over aspects that are unrelated to professional competence. For example, the physician's attire, or demeanor may not fit with the patient's expectations of how a physician should dress or act. Such physicians do create problems for themselves, the profession and their hospital, in establishing this mutual trust which is of inestimable value in medical practice. At the termination or conclusion of the interaction between the doctor and the patient, the doctor benefits much by asking the patient in an unhurried way, 'is there anything more you want to tell me?... about anything at all'. The patient should be made to understand that the physician hopes the patient would regard the hospital office as a place in which he can feel free to discuss fully any and all matters which may be of concern to him. The patient must be made to realize that the physician, and indeed the health care delivery establishment are reliable, trustworthy and desirable custodians of his healthcare records.

8. Computer-Assisted History Taking

Computer – assisted history taking systems have been available since the 1960s.[20] However, their use remains variable across healthcare delivery systems.[21] In Nigeria, computer – assisted history taking system has not yet been put into popular practice, but the prospects are there. One advantage of using computerized systems as an Auxiliary or even primary source of medically related information, as observed in some countries, is that patients may be less susceptible social desirability bias.[22] For example, patients may be more likely to report that they have engaged in unhealthy lifestyle behaviors. Another advantage of using computerized system is that they allow easy and high-fidelity portability to a patient's electronic medical record. Moreover, this system saves money and paper.[23]

Computer – assisted history taking systems are not devoid of disadvantages. Among such disadvantages are:

1. They cannot detect non-verbal communication which may be useful for elucidating anxieties and treatment plans.
2. Another disadvantage is that people may feel less comfortable communicating with a computer as opposed to a human. In a sexual history – taking setting in Australia using a computer-assisted self interview, 51% of people were very comfortable with it, 35% were comfortable with it and 14% were either uncomfortable or very uncomfortable with it.24

As it stands, the evidence for or against computer-assisted history taking systems is sparse. For example, as of 2011, there were no randomized central trials comparing computer-assisted versus traditional oral-and-hand written family history taking methods.[25]

9. The Legal Aspect

One of the most glaring repercussions of a faulty medical history is its propensity to occasion misdiagnosis which is a prelude to wrong management. It will be recalled that '*qui bene diagnostit bene curat*' – he who diagnosis accurately, heals effectively. Misdiagnosis and its resultant maltreatment could be actionable. It has been stated that 'provided he has executed reasonable skill and care, a doctor cannot be held negligent for a mistake in diagnosis or treatment'.[26] The classic authority for this is Lord Clyde who, when Lord President, stated 'In the realm of diagnosis and treatment, there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge, than others would have shown'.[27] The principle remains but the test – the standard of the ordinary skilled man exercising and professing to have that special skill [28]– is now different. It is clear that while an error in clinical judgment need not necessarily be negligence, it can be so if it is reached in a manner falling below the test standard.[29]

[20] J. G. Mayne, W. Weksel & R. N. Sholts, 'Toward automating the medical history' *Mayo Clinic Proceedings* 43 (1): 1-25, 1968.

[21] Cash-cubson, Lucinda, Pappas et al, 'Computer-assisted versus oral-and-written history taking… *Cochrane Database of systematic Reviews car, Josip* (2012).

[22] Ibid

[23] Ibid

[24] R. L. Tideman, M. Y. Chen & M. K. Ditts et al; 'A randomized controlled trial comparing computer-assisted with face-to-face sexual history taking in a clinical setting' *Sexually Transmitted Infections*. 83 (1): 52-6. (2006).

[25] Y. Pappas, W. Igor; J. Car, et al; 'Computer-assisted versus oral-and-written family history taking for identifying people with elevated risk of type 2 diabetes mellitus'. In J. Car (ed), *Cochrane Database of Systematic Reviews,* pp. CD 008489.

[26] J.K Mason, *Forensic Medicine for Lawyers,* 2nd Edition ELBS 1988.

[27] In *Hunter v Hanley* 1995 L.T 213 at P.217.

[28] *Chin Keow v Government of Malaysia* (1967) 1 W.L.R 13

[29] *Whitehouse v Jordan* (1981) 1 ALL. E.R,267 per Lord Ed Mundovaries at D.276.

From the fore-going, it is self evident that any misdiagnosis and subsequent mismanagement of disease conditions, occasioned by unprofessionally taken or untaken medical history is actionable in torts. It has been stated that the physician must inculcate in the consciousness of the patient, the reality that the healthcare delivery establishment and the doctors are reliable and trustworthy repositories of his healthcare records. This situation arises from the already stated fiduciary relationship between the doctor and the patient, and therefore transcends ordinary tenets of professional ethics. Embedded therein are rules of law. The doctor is obliged, not only by conscience and ethics to maintain a strict sense of confidentiality as far as the patient history is concerned; he is bound by law to so do. Even in the absence of a specific concentrated duty to keep a patient confidence, the common law puts the doctor under a duty to respect the confidence of his patient.

The legal underpinning is located in the fact that doctor - patient relationship is essentially characterized as one of a fiduciary nature. The obligation is supplemented by legislation in some jurisdictions.[30] It has been suggested that the scope of duty covers information received directly, and extends to those received indirectly in so far as they are received in the doctor's character as a patient's doctor.[31] Thus, while the duty surely covers information and observation of the patient, it extends to information received from third party in circumstances where the third party gives the information knowing of the existence of the doctor-patient relationship. Once information is received in his character as the patient's doctor, it is immaterial whether it is gotten from a professional colleague or from a non-doctor. Both are undistinguishable. The duty of confidentiality applies to both.[32] Whether the duty will extend to cases where the third party is unaware of the doctor-patient relation remains controversial. In A-G v Guardian Newspapers Ltd. (2),[33] the English court of Appeal subscribed to the proposition that there is public interest in the legal enforcement and protection of confidences received in a circumstance of confidentiality. Flowing from this it can be argued that since a doctor receives information almost always in these circumstances he ought to come under an obligation to confidence.[34] The patient trusts that information about his person will be kept secret unless he permits a disclosure. It means in effect, that confidentiality turns around how the patient perceives the trust held by the doctor. That being the case, it is the circumstance in which the doctor receives the information and not the knowledge of the information of his status that ought to determine whether a duty does exist or not.[35] That point was implicitly recognized by Lord Goff when he stated: 'a duty of confidence arises when confidential information comes to the knowledge of a person (the confidant) in circumstances where he has notice or is held to have agreed, that the information is confidential, with the effect that it would be just in all circumstance that he should be protected from disclosing the information to others'.[36]

Right from the days of Hippocrates, up to the present day, doctors have bound themselves not to divulge professional secrets. A doctor ought to keep silent as to anything he sees or hears while visiting or treating a patient, which is improper to divulge.[37] The basis for this was well summarized by Lord Riddle when he said:' A doctor, being in fiduciary capacity, must preserve his patients' confidence unless relieved from obligation by some Lawful for excuse of legal compulsion, the patients consent, the performance of a moral or social duty, or the protection of the doctors interest. A doctor shares with other citizens the duty to assist in the detection and arrest of a person who has committed a serious crime. Everyone recognizes the necessity and importance of medical confidence. But we must recognize also that the rules regarding them exist for the welfare of the community and not for the aggrandizement or conveniences of a particular class. We must recognize also that they must be modified to meet the inevitable changes that occur in the necessities of various generations.[38]

Unfortunately, quite a good number of medical practitioners in Nigeria are gleefully oblivious of the fact that a breach of confidentiality as far as the patients are concerned is actionable. The healthcare consumption populace is also not any better informed. The high esteem in which the medical personnel are held, coupled with widespread poverty and illiteracy make the populace ignorant of their moral and legal rights as far as patient doctor confidentiality is concerned. It is reassuring, that as the level of education slowly increases in Nigeria, awareness is rising, and some patients are beginning to ask questions with some even beginning to dare contemplate litigation. For a patient to succeed in an action for a breach of confidence, the patient must prove the following:

1- That the information in the circumstances given or received was meant to be treated as confidential.

[30] F. O. Emiri, *Medical Law and Ethics in Nigeria,* Malthonsc Press Ltd, Lagos 2012.
[31] Francis Gurry, *Breach of Confidence* (1985) cited in Kennedy and Grubb, *Medical Law*, 2nd Ed, London Butterworth 1994 at p637-a639.
[32] Kennedy and Grubb. Op. Cit. at p.639 -410
[33] Emiri Supra. 32. (1988) 3 All Er 545, (1990) 1 AC 109.
[34] Emiri op at
[35] Ibid
[36] *AG. V Guardian Newspaper* (No 2) (1988) 3 ALL ER 545 at 658
[37] Emiri, Op Cit.
[38] Lord Riddle, *Medico-Legal Problem*, London, Lewis & co Ltd 1929.

2- That the obligation to keep the information confidential was breached by the doctor.
3- That the patient suffered some legal injuries as a result of the breach, or occasioned by the breach.

According to Emiri, the fundamental nature of the obligation is responsible for its inclusion as part of the provision for secondary legislation on doctors on ethics in Nigeria.[39] This author humbly aligns totally with the erudite professor. The remedy for the breach is either intra disciplinary (intra professional) or extra professional.
In Intra professional remedy, an aggrieved party may make a case before the council, which through its investigative panel and tribunal may sanction the doctor if found guilty. Such sanctions may include a temporary loss of the right to practice medicine through suspension of the certificate for any period of time, or a total ban of the medical doctor from practicing medicine in Nigeria (in this case the doctor's name may be struck out from the register of medical practitioners in Nigeria). Extra professional remedy is sought by way of civil action for damages. Breach of confidence is criminalized in some jurisdictions is Belgium and France.[40]

10. Scope of, and Exceptions to, the Rule

In course of this work, clarifications had been sought by some medical practitioners, healthcare delivery establishments, and healthcare consumers as to whether or not there are exceptions to the rule and the scope of the rule. Desirable and laudable as the rule is, one is compelled to admit that it cannot be absolute, and the fundamental obligation must make way for the interest of the society. In effect it must be subject to any modifications that are in overriding interest of the society. It is noteworthy that the Declaration of Geneva modifies the strict stance of the hypocratic oath, that the physician shall keep secret information rather it states 'I will respect the secrets which are confided in me'. One has but to concur with the considered submission of the erudite Professor Emiri that the phrase 'respect' makes less sacrosanct the doctor's obligation as against the wording of the hypocratic oath. –'to keep secret'. [41] It is now a settled fact and trite law that the obligation is qualified. This is in line with the opinions of certain medical experts, case law and legislation.[42] Thus: (1) confidentiality is not breached by private discussion with colleagues in puissance of treatment but this may require the consent of the patient, which may be waived by the patient. This notwithstanding, a doctor may be required by law to make a disclosure in which case no breach of confidentiality would be said to occur.
2. In a group practice, where common filing is used, the doctor may disclose certain medical aspects of what he discussed with the patient without breaching the duty of confidentiality.
3. Limited information to some outside agencies may be permissible for purposes of statistics accounting, data processing or other legitimate information.
4. If a patient is treated by other doctors, in the course of treatment, it would be expected that doctors would exchange information about the patient for purposes connected with further treatment or research.
5. A doctor may also reveal confidences and secrets if he is required to present same before a court or tribunal, for example if he has to defend himself or others against accusation of wrongful conduct.
6. On certain occasions, a doctor may receive information about how dangerous a patient could be to the society, under such circumstances the doctor would be expected to use good professional judgment to determine whether or not the need exists to inform the appropriate quarters.
7. Epidemiologically speaking, some types of information obtained from patients would necessarily have to be relayed to the necessary organs of government to avoid the outbreak of pandemics or epidemics.

11. Conclusion

It is accepted as a principle, that the patient, in confiding in the medical practitioner, should expect that confidence to be sustained. The moral obligation is clear and extends, save in exceptional circumstances, to include the rights of maturing children to secrecy in relation to their parents. It would be difficult today, to claim that a person aged less than 18 was not protected from such disclosure [43] and in some sections of society the critical age might even be placed lower. Parental rights are not, however, to be highly undermined and decisions in such cases must rest with the individual doctor, aided by his protection society. Legally, the doctrine of medical confidentiality is founded on the law of contract and of equity. The fact that some qualification exists has been recognized for a long time, the classical reference being Lord Riddell,[44] who, describing the necessity and importance of medical confidence was of the opinion that. 'We must recognize also that rules regarding them exist for the welfare of the community. We must recognize also that they must be modified to meet these inevitable changes that occur in the necessities of various generations'.[45] Finally, it must be stated that the practice of medicine in its broadcast sense,

[39] Rules of professional conduct for Medical and Dental practitioners in Nigeria, made pursuant to the 1988 Act.
[40] France: Art 378 of panel code; Belgium Art 458 of panel code.
[41] Emiri. Supra
[42] Ibid
[43] See *Gillick v West Norfolk and Wisbech AHA and the DHSS* (1888) 3 WLR 830 H.L.
[44] *Medico - Legal Problems* (1929) London. Lewis
[45] J.K, Mason, *Forensic Medicine* for *Lawyers.* Op Cit.

includes the whole relationship of the physician with his patient. The foundation of this relationship begins with a healthy interaction between the patient and the doctor during the collection of anamnesis i.e. Medical history. The treatment of disease may be entirely impersonal but the care of the patient must be completely personal. This personal relationship could be made or marred by the impression made on the patient in course of his first contact with the doctor – collection of anamnesis (taking of medical history) – for truly, there is no second chance, to make a first impression, and the first impression is made during the patients first interaction with the doctor – collection of the medical history.