Confidentiality: a modified value

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Author's abstract

In its original expression as a medical value confidentiality may have been absolute; this concept has become eroded by patient consent, legal actions and change in the climate of public opinion. In particular requirements arising out of legal statutes and common law judgements have greatly modified the confidentiality of the doctor-patient relationship in societies deriving their law from English origins. Despite this, confidentiality remains a value which the physician must strive to preserve. He cannot however do this without considering its effect upon possible innocent third parties.

Confidentiality

The value of confidentiality is formally accorded great weight in medicine. It appears in the Hippocratic Oath, usually translated in some such form as 'Whatsoever I see or hear in the course of my practice, or outside my practice in social intercourse, that ought never to be published abroad, I will not divulge, but consider such things to be holy secrets', and it recurs in contemporary codes of ethics; that of the Canadian Medical Association (CMA), for example, states, 'An ethical physician will keep in confidence information derived from his patient, or from a colleague regarding a patient, and will divulge it only with the permission of the patient except when the law requires him to do so' (1). In the contemporary medical ethics of Western societies primacy is accorded to autonomy, to the right of the patient to dispose of his or her own body according to personal wishes. Various rights devolve from this and confidentiality is one of them; the right to autonomy includes the right to privacy. The patient, disclosing all freely to the physician, has the right to have the privacy of this information respected by the confidentiality afforded to it.

In its original form the value is modified only by the phrase 'that ought never to be published abroad'. This implies that there might be matters which a physician learned as a part of his practice, which ought to or

could be published, but we have no idea what these might have been. The near-absolute nature of the oath presumably was in part because the doctor-patient relationship was a simple one; there did not exist the many groups of co-diagnosticians and therapists that we have now. Another reason could be that public values which might conflict with individual confidentiality, such as the recognition of infectious disease, were not then appreciated. It seems in that society there were probably exceptions to apparently absolute rules accepted by common usage, and not regarded as needing the minute and specific definition of our own, somewhat casuistic time.

Whether or not the early statement was in fact as absolute as it appears to be, society has by degrees modified it and the obligation of confidentiality upon the physician has become greatly eroded. The CMA statement in part demonstrates this. The first and most obvious exception to absolute confidentiality is when the patient consents to its modification; this might be thought to be self-evident and redundant, except that few patients have any concept of what is involved. Upon admission into hospital in North America it is virtually mandatory that each patient sign a general consent form permitting all hospital personnel to perform their usual duties. The fact that this is so general and non-specific as to be virtually meaningless in law, if invoked as evidence of consent, does not alter the situation to which the patient has apparently consented. One effect of this general consent, unappreciated by most patients, is to breach confidentiality insofar as this is deemed necessary by the 'health care team'. The usual criterion applied is the 'need to know', and communication of any information concerning a patient should be limited to the amount and nature of the information necessary for another member of the team to carry out diagnosis or treatment; what is unappreciated by the patient is the extent, number and ramifications of the individuals and groups involved. Whatever the 'need to know' confidentiality is diluted by dissemination of information to the extent that the concept is virtually meaningless within the health care team. The chance of patient information being disseminated outside the health care team increases with the size of that team, and with the freedom of information regarding a

Key words

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patient within the hospital environment; it is, or was, notoriously easy for any person willing to wear a white coat, fabricate a badge and carry a clip-board to gain access to virtually any patient information within a hospital. I add the *caveat* 'was' because there is recently an enhanced awareness of this risk, and increased precautions within the hospital.

A patient may give specific consent to release of information in a specific context, most commonly a legal situation involving a claim for insurance or litigation for alleged negligence. This appears to be a defined and comprehensible situation, as opposed to the general and largely uncomprehended 'consent' to dissemination of information within a hospital.

The second overriding exception to confidentiality is a legal requirement that it be breached, thus exempting the physician from the obligation. Again, a patient who voluntarily enters into an insurance claim, or a lawsuit for negligence, can legitimately be presumed to have comprehended the necessity for breach of confidentiality, and made in his or her own mind an informed decision on the likely loss/benefit equation of such breach. Apart from this, there is in Canadian law no absolute privilege for confidentiality of medical information, which is accessible for adequate reason to any court of competent jurisdiction. However, there is a much wider range of situations in which medical information on a patient may legally be demanded, as a general principle, when the right to individual confidentiality is determined to be less than the 'Need-to-know' for the public good. In these situations, in which society has made a judgement weighing one set of rights against another, a legal obligation is placed upon the physician to breach confidentiality. Furthermore, the necessity to do this may not be known specifically to the patient before he or she gives information to the physician; the patient may know only the general situation which may arise, as the obligation to disclose will depend upon the nature of the information communicated in the doctor-patient relationship. In making reference to statutes I have used the legislation of Canada and the Province of Saskatchewan as the most accessible to me, but similar provisions are found, with minor variations, in Britain and those countries deriving their legal systems from British/English roots. In many of the countries of continental Western Europe the value of confidentiality is rated more highly and is specifically protected in codes of civil law, with penalties for its breach.

The first type of situation in which such legally mandated breach of confidentiality becomes obligatory upon the physician, is communicable disease (2). For some such diseases, the risk to the remainder of society is considered to outweigh the right to individual confidentiality. The obligation upon the physician may be permissive or compulsory; it may be that he is protected *if* he communicates the information, or more commonly that he *must* do so and may be punished if he does not. The possible consequences to

the patient are not limited to loss of confidentiality; they include, in many statutes, possible loss of liberty by enforced confinement and possible enforced treatment or immunisation. Contemporary society appears to accept this limitation of confidentiality with two main exceptions. The first and less common is when an individual has an ethical objection to a type of treatment or prevention which may be compulsory by law; to vaccination or immunisation, for instance. The situation becomes more complex when this objection is extended to minor children. Occasionally this may give rise to an attempt to preserve confidentiality which involves evasion of the legal requirement to inform. Much more frequent, and much more important, is the situation arising when communication of the information is likely to lead to serious disadvantage for the patient in society. The archetype of this was the lady known as 'Typhoid Mary' (3) who, when her condition as a carrier of typhoid fever was known, became unemployable in her occupation of cook. On several occasions she escaped from surveillance and because her carrier state was compounded by lack of personal hygiene, succeeded in infecting several employers. With modern therapy the necessity to segregate or confine patients with such 'traditional' diseases has been much reduced, but the legal capacity to do so remains. It was invoked in Britain recently to confine, briefly, a patient with AIDS (4).

Until very recently, the major group of diseases in which there was resistance to legally required reporting, because of resulting disadvantage to the patient, was the 'traditional' group of sexually transmitted bacterial diseases. Estimates have been made that perhaps only 10 per cent of known cases were reported, because of this disadvantage. On occasions physicians were placed in a dilemma of whether to inform spouses or other sexual contacts of a patient, outside the legal requirements. Some precedents have suggested that a physician who divulges such information (5) may be protected, but in general it is safer to leave the responsibility to the public health authority.

This situation has been compounded, and brought into sharper focus, by the current epidemic of AIDS, a disease which is compulsorily reportable in some but not all jurisdictions. This disease is most commonly communicated, in our society, by male homosexual intercourse. There are widely divergent opinions in society about this practice, ranging from those who consider it a sin and ethically unacceptable in any circumstances, to those who regard it as a common and ethically acceptable variant of sexual activity. AIDS is also most probably incurable, though this may change quite soon with rapidly increasing knowledge of the disease. It appears that AIDS is not a very communicable disease except for sexual intercourse, or the more rare situation of transfer of infected blood, but the stigma attached to the diagnosis and fear of infection have on occasion produced situations of near-hysteria in persons in contact with patients, including

health care workers. Legislation has been proposed which would seriously limit the normal freedom of AIDS patients (6, 7) and AIDS patients have been constrained by pre-existing legislation. This has given added emphasis to the maintenance of confidentiality of this diagnosis, extending sometimes to the refusal of physicians to use it in hospital charts. As there are special populations of health care workers who may be at increased risk of contracting AIDS from exposure at their work, particularly laboratory technologists, this has given rise to an apparent conflict of rights; the right of the patient to have his diagnosis kept confidential, and the right of the worker to be informed of a possible hazard to his/her health arising out of work.

An analogous conflict of rights has previously been defined specifically in relation to psychiatric patients who as a result of their disease make threats of attack against groups or individuals. In such an instance it is necessary for the therapist to evaluate the relative good, or the risk, of breaching the confidentiality of the patient against the possible harm extending to death of a third party. He may have to consider the possibility of legal liability, should he not inform a potential victim and the patient carry out the threat of attack (8).

Other statutes have breached the principle of individual confidentiality in what is presumed to be an overriding public interest. These extend to a legal duty upon the physician to report a condition which may make the patient a hazard as the driver of an automobile (9) or the pilot of an aircraft (10); under these very broad conditions, society as represented by the legislative body has decided that the risk to potential victims outweighs the disadvantage to the patient. Under another statute, it is the responsibility of the physician to report the case of a child whom he suspects is being abused (11), and if this is done without malice, the physician is immune from legal action, such as for breach of confidentiality. Here again society has weighed the potential damage to one individual, virtually defenceless, against the privacy and freedom from investigation of another.

The enactment of such statutes has removed situations of agonising moral difficulty, and the necessity for some judgements, from the domain of the physician. Despite Kottow's (12) brisk statement to the contrary, most physicians were not single-minded in their commitment to individual confidentiality; if they knew their patient with hypertension was a commercial pilot they could not glibly evade their responsibility to the potential passengers with the justification that it was the company that was negligent, for not demanding adequate medical examination.

The erosion of confidentiality by the process of law, as in the examples above, involves both statute and common law, statutory requirements to inform, and common law precedents where the physician must presume that, were he to be in an analogous situation, society would find him liable. But however the bedrock is eroded the principle of confidentiality, be it

diminished and battered, does still remain and the physician will continue to find himself in situations of apparent conflict, most commonly involving the possibility of breaching confidentiality to protect an 'innocent other'. In a recent article Kottow (12) has argued for confidentiality as an absolute requirement in medicine and for a 'robust and relentless position in favour of exceptionless confidentiality'. He sets aside the statutory requirements of reporting with the statement, 'If public interest demands a catalogue of situations where the physician would be under obligation to inform, medicine becomes subject to political design'. Kottow is writing from the Federal Republic of Germany, with whose statutes I am not familiar, but it seems likely that they do include those analogous to infectious diseases acts at the very least. He is quite correct in believing that compulsory reporting under law could be perverted for political purposes and by this means doctors be recruited into the information system of an ethically unacceptable regime: to guard against this we have only our individual and corporate professional awareness and courage, but to deny mandatory reporting of diseases significant for public health, because of this possibility, is surely hyperacuity of danger. An agreement to submit to the rule of law is not to submit to all, or unjust laws; it was the defence of Eichmann that he merely obeyed legally given orders. It must be the responsibility of physicians as individuals and as organised bodies to advise governments on the legitimate grounds for breach of medical confidentiality; society in general, and organisations of physicians in particular, have accepted the statutory requirements outlined above. From the practical point of view, it is far more difficult to control the proliferation of medical liability arising out of common law judgements, and it is from them that much of the delicate balancing act arises, between responsibility for confidentiality on the one hand, and for its breaching when someone is threatened on the other.

The opinions of society on this issue are hard to estimate, because under our system there is minimal input from ordinary citizens into legal processes. Society's acquiescence to the erosion of confidentiality by statutory requirements for reporting can be assumed because there has been no general public opposition to their extension. The awareness of judgements under the Common Law is much less even than that of statutory enactments. Also, from time to time there appear in the news media, accounts of the public appearance of confidential documents; a bundle of medical records falls off a truck and blows around the street, or some similar occurrence. The lack of comment on such accidents, other than by special interest groups, seems to signal a public apathy and lack of concern. The medical licensing and disciplinary bodies find a very small proportion of the cases currently coming before them arise from breach of confidentiality. Awareness of confidentiality of medical records, or its breach, is virtually confined to

the small minority of situations when such a breach incurs a significant disadvantage to the patient. In general, health care workers are much more sensitive to confidentiality than their patients. Some of this sensitivity undoubtedly stems from fear of litigation, and it is ironic that the person who finds it most difficult to gain access to the medical record is the patient to whom it pertains.

Statutory requirements for breach of confidentiality and common law judgements tending in the same direction, have not removed the necessity for the physician to remain acutely aware of the general requirement, nor that of judgement when breach seems necessary in situations not covered by the law. The judgement in such situations will for most physicians be situational and not the absolute position advocated by Kottow. In the instance cited above, the apparent conflict of rights between the confidentiality of the AIDS patient and the safety of the laboratory staff handling his specimens, may be satisfied by some understood but non-specific term such as 'Hazardous specimen' applied to the labelling of material from him. In this designation can be grouped all specimens known to be hazardous to laboratory staff, such as those from known or suspected cases of hepatitis or tuberculosis. The confidentiality of the specific diagnosis is preserved in part by its inclusion in a non-specific group and the 'innocent others' at particular risk are protected. Situations have arisen and will arise with AIDS, when public reaction is based more upon hysteria and fear than on scientific fact and sensible appreciation of risk, and the balance will here be on the preservation of confidentiality. The limitation of confidentiality by law has not removed from the physician the obligation to preserve it; it has limited the situations in which his judgement must be determining, and removed from him the risk when society has decided in favour of breaching the obligation. As a frequent airline passenger, I had rather accept the reduction of confidentiality for pilots, as a factor in my own safety; I have a derived responsibility that society deals fairly with those pilots from whom it exacts this peculiar obligation. As a frequent driver and a pathologist, I am more concerned with the alcoholic, the psychopath, and the individual who expresses his excessive machismo through his driving, than I am with the much less dangerous arteriosclerotic or sufferer from epilepsy, and if society should devise a way of diminishing my danger without disproportionately limiting their freedom I shall be the first to applaud. In a complex global society the

'innocent other' is at risk from chemical pollution, and from radiation, from sources beyond his knowledge and control, and is the more entitled to protection from them because of his innocence. In judging the relative damages by breach of confidentiality, I cannot dismiss the innocent other so easily as Kottow does; both the damage done to the patient by the breach, and the damage saved to the other(s) are quantitatively imponderable, but that should not prevent the physician assessing the value to be given to each of them.

Confidentiality is a value; like most others, I cannot consider it an absolute value. The protection of statute does not absolve the physician from the active preservation of confidentiality in his practice and its rare breach when he considers it warranted. He may be fortified by the knowledge that contemporary society places an increasing weight upon the rights of the 'innocent other', and has tended to strike a more equal balance between these and the 'exceptionless confidentiality' of Kottow.

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