Journal of medical ethics, 1984, **1**, 3–4

Editorial

Medical confidentiality

In this issue of the journal an erstwhile family doctor indicates his concern that standards of medical confidentiality are slipping – a concern shared by previous contributors (1,2). Yet in America a physician has called medical confidentiality a 'decrepit concept' (3): Mrs Thatcher's last government tried (unsuccessfully) to legislate for police to have access to doctors' files; and Mrs Gillick and her supporters clearly believe that doctors are excessively concerned with confidentiality, at least in regard to young girls wanting oral contraception. Can any sense be made of what may appear to be a somewhat chaotic jumble of attitudes to confidentiality?

The first requirement is to decide what is meant by the term. The next is to decide whether confidentiality is valuable in itself and if so why, and if not, why it is valuable, (to promote which valuable objective). Next it is important to decide whether or not the principle of confidentiality is an absolute requirement in medical ethics. Finally some analysis is needed concerning the relationship of this principle to other moral requirements. Clearly justice can not be done to such a programme here – but a sketch of a skeleton of such an analysis may be useful.

Essentially confidentiality is respect for people's secrets. Thus there is no transgression of confidentiality where information is not regarded as secret. However, in the context of medical ethics the patient may well consider *all* information concerning his or her interaction with the doctor as secret, including the fact that the consultation has occurred at all (consider venereological and psychiatric consultations for examples). But why should the doctor feel morally obliged to keep his patients' secrets? To reply that this is because he explicitly or implicitly undertakes to do so, while true, is inadequate; why should the doctor promise in the first place to respect his patients' secrets?

Perhaps the commonest justification is utilitarian: people's happiness, the general good, is maximised if doctors do promise to keep their patients' secrets, and then keep their promises. If on the contrary doctors were not known to maintain their patients' confidences, then either patients would withhold 'delicate' but potentially important information (and thus probably receive worse medical treatment) or they would provide the information and feel exceedingly anxious at the prospect of their secrets being revealed.

Such consequentialist reasoning would probably be accepted by many deontologists as well as by utilitarians – but for the former such a justification would not be *adequate*. Thus deontologists are in addition likely to invoke the principle of respect for autonomy (4) or respect for privacy (5) seen as a fundamental moral requirement (6,7).

Medical confidentiality, then, cannot readily be seen as a moral end in itself – but it *is* readily defended by utilitarians and deontologists alike as a means to some morally desirable end, whether this is the general welfare, respect for autonomy or respect for privacy.

Is the principle of confidentiality to be regarded as absolute, to be honoured invariably whatever the circumstances? Despite occasional professional references to the need for 'absolute discretion' (8) it is clear that medical confidentiality has never been widely considered to be an absolute principle, though always a very important one, to be transgressed only in exceptional circumstances. The Hippocratic Oath itself suggests the existence of such exceptional circumstances and the British Medical Association code of ethics (9) lists five exceptions. The first is when the patient gives consent to disclosure. Strictly speaking this is *not* an exception to the principle of confidentiality since where consent has been given no transgression of confidentiality occurs. The second is where 'it is undesirable on medical grounds to seek a patient's consent, but it is in the patient's own interest that confidentiality should be broken'; the third is when the doctor's 'overriding duty to society' justifies transgression of confidentiality. The fourth is where the information is required for approved medical research; and the fifth is when the information 'is required by due legal process'. Broad as these exceptions already are, they fail to mention perhaps the commonest infraction of strict secrecy, notably the sharing of information about their patients not only between different members of the medical profession but also between different members of the 'health care team' – receptionists, nurses, secretaries, record-keepers, physiotherapists, radiologists, social workers, psychologists, chaplains and perhaps even teachers, police, and assorted voluntary workers. Dr Siegler was

'astonished to learn that at least 25 and possibly as many as 100 health professionals and administrative personnel at our university hospital had access to the patient's record and that all of them had a legitimate need, indeed a professional responsibility, to open and use that chart' (3).

Clearly then the principle of confidentiality is not an absolute one in medical practice (and indeed the very notion of absolute moral principles, at least of more than one absolute moral principle, produces considerable theoretical difficulties for cases of possible conflict). How then is confidentiality to be reconciled with other moral principles?

As the examples of exceptions indicate, the main principles with which it is considered to conflict are those of beneficence and non-maleficence – the moral requirements to help others, and to do no harm to others. In some of the cases it is the patient himself who is to be benefited or at least not harmed – notably when confidences are shared with other members of the medical team for the patient's benefit; and when it is 'undesirable on medical grounds to seek a patient's consent but it is in the patient's own interest that confidentiality be broken', often by speaking frankly to members of the patient's family. In these types of cases it is in principle at least often possible to avoid the dilemma by making arrangements for the patient to give his permission for confidentiality to be transgressed in his own interest – for example by explaining who is likely to have access to his files and then giving him the option of agreeing or not. Most patients are likely to agree to something that is clearly in their own interests.

Obviously such a straightforward approach cannot be used where it is deemed medically undesirable to obtain such consent – but in the context at least of the dying or otherwise seriously ill patient this is a form of paternalism which is increasingly rejected within the medical profession. The problem is, of course, that while some patients definitely do prefer not to be told grave news, and explicitly or implicitly accept that their doctors will discuss such news with their relatives instead, other patients undoubtedly do not. Where a competent patient does not wish others – even his family – to be given medical information about him without his prior consent then it may clearly be doubted if it is 'in the patient's own interest' that confidentiality should be broken. Sorting out which patients would and which would not allow their doctors to take such action, without actually asking them, is to say the least a difficult task, though many experienced practitioners are probably quite skilled at doing this. However, they might be assisted in such assessments if patients had previously been asked about their attitudes to such issues – perhaps when they first came to the hospital (as at present they are questioned about their religion) or when they first consulted the general practitioner.

Mrs Gillick's problem – oral contraception for under 16s – is not so straightforward, for with children the question must always arise: is this patient sufficiently autonomous for the principle of respect for autonomy to apply? Suffice it to note here that this difficult question is not answered by mere discovery of the child's chronological age.

In the case of using patients' records for research purposes the moral dilemmas are – at least in principle – resolvable by asking the patient routinely for permission in advance to use their records in *bona fide* medical research.

No easy resolution of the dilemmas – even in principle – can be obtained when the duty of confidentiality conflicts with duties to others than the patient. The doctor's 'overriding duty to society' and 'due legal process' may both require the transgression of confidentiality in the interests of promoting the benefit of, or preventing harm to, others, whether these others are members of the patient's family or of society more generally. Utilitarians have an advantage in principle in such dilemmas – they must always aim towards that action which maximises general welfare: but in practice they must generally choose between competing intuitive moral principles just as deontologists in principle as well as in practice must choose. Where either group draw their moral lines – how much benefit, or prevention of harm, to others they believe will in the particular case justify their transgression of the principle of confidentiality – will vary from person to person. The best that may reasonably be required is that doctors and other health-care workers regard the traditional principle of medical confidentiality as making a very strong moral claim upon them, against which competing moral claims must be very carefully scrutinised.

References

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