Medical confidentiality: an intransigent and absolute obligation

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Author’s abstract
Clinicians’ work depends on sincere and complete disclosures from their patients; they honour this candidness by confidentially safeguarding the information received. Breaching confidentiality causes harms that are not commensurable with the possible benefits gained. Limitations or exceptions put on confidentiality would destroy it, for the confider would become suspicious and un-co-operative, the confidant would become untrustworthy and the whole climate of the clinical encounter would suffer irreversible erosion. Exercising breaches of confidence on grounds of superior moral values introduces arbitrariness and ethical unreliability into the medical context. Physicians who breach the agreement of confidentiality are being unfair, thus opening the way for, and becoming vulnerable to, the morally obtuse conduct of others. Confidentiality should not be seen as the cosy but dispensable atmosphere of clinical settings; rather, it constitutes a guarantee of fairness in medical actions. Possible perils that might accrue to society are no greater than those accepted when granting inviolable custody of information to priests, lawyers and bankers. To jeopardise the integrity of confidential medical relationships is too high a price to pay for the hypothetical benefits this might bring to the prevailing social order.

The contemporary expansion of ethics in general and medical ethics in particular harbours the danger of increasing scholasticism to the point where not even pressing practical problems are being offered workable solutions. People involved in health care may end up by distrusting the discipline of ethics, thus increasing the improbability of agreement between pragmatists and analysts (1). Even traditionally straightforward practices, such as confidentiality, have been subject to extensive review and analysis which have proved incapable of offering committed stances or unequivocal guidelines for action (2, 3). In an effort to illustrate that more stringency is desirable and possible, the status of confidentiality as an exceptionless or absolute commitment is here defended. It should be stated at the outset that I share general scepticism about absolute ethical propositions (4), and that confidentiality is here not defended as an inviolable moral value – a position that would be self-defeating – but as an interpersonal communications strategy that ceases to function unless strictly adhered to. Confidentiality is a brittle arrangement that disintegrates if misdirected in pursuance of other goals and, since it is a necessary component of medical practice, care should be taken to safeguard its integrity.

Defining confidentiality
The following definition of confidentiality is used:

situation is confidential when information revealing that harmful acts have been or possibly will be performed is consciously or voluntarily passed from one rationally competent person (confider) to another (confidant) in the understanding that this information shall not be further disclosed without the confider’s explicit consent. The harm alluded to may be physical, but moral damage alone may also be the subject matter of a confidential exchange. When this sort of communication occurs in a medical setting it constitutes medical confidentiality.

What is at issue in confidentiality conflicts?
The main ethical controversy around confidentiality concerns the assessment of whether more harm is done by occasionally breaching confidentiality or by always respecting it regardless of the consequences. As long as the physician gathers private information, that is information that only concerns the confider and harbours no element of past or potential harm, confidentiality will concern exclusively the patient and any disclosure would be nothing but a malicious or at the very least gratuitous act of the physician, of little or no moral significance. It seems redundant to discuss other instances of confidentiality than those involving either the possibility of impending harm or testimonial of past injury, for these are the fundamental cases where dilemmas arise and a breach of confidence must seek justification.

Breaching is defended on the ground that the harm announced in the confidence is severe and can possibly
only be averted by the confidant’s disclosure (5, 6, 7). Exceptionless confidentiality, on the other hand, is upheld by the idea that breaching will relentlessly harm the confidant, subjecting her or him to precautionary investigations and constraints of some sort, perhaps even with unavoidable defamatory consequences. The harm purportedly averted is merely potential and all the less likely to occur, the more exorbitant and posteroberous the threatener’s claims are. After all, excessively vicious menaces may well be uttered by psychotics who are rationally incompetent and therefore not protected by a pledge to confidentiality they can neither honour nor demand. Furthermore, the practice of confidentiality is in itself damaged by breaching because its trustworthiness is disqualified. Ultimately, degrees and probability of harm are so difficult to assess (8), that they will hardly deliver an intersubjectively acceptable argument for or against confidentiality, except for one: breaching confidentiality can not be a significant and enduring contribution against harmful actions, for these are no more than potential, whereas the damages caused to the confidant, to the practice of confidentiality and to the honesty of clinical relationships are unavoidable.

Perhaps less elusive is the conflict of rights – and their correlative obligations – which ensue in confidential situations. Confidentiality is an agreement bound by the principle of fairness (9); it gives the confider the right to expect discretion whereas the confidant has the right to hear the truth, but also the obligation to ensure guardianship of the information received. It could be argued against this right that past victims might be vindicated or potential ones helped by divulging confidential information that seems critical, and that these victims also have a right, namely to vindication or protection. In order for the victim’s right to prevail, the confider must involuntarily forfeit his or her right to secrecy, which the confidant will forcefully violate by divulging information against the confider’s will. This forfeiture of the confider’s right can only occur subsequently to the confider’s disclosure, for it is triggered by the contents of the confider’s disclosure. To avoid the risk of losing the right to secrecy, confidants would have to confide falsely or not at all, a strategy that would erode their legitimate and initially granted right to be impuniby outspoken, distort or reduce confidentiality to lies and irrelevancies, and destroy both the confidant’s right to hear the truth and the institution of confidentiality.

Medical confidentiality

Physicians would appear to be under the prima facie obligation to respect the right to secrecy, but also to abide by the right of potential victims to be protected. In cases involving moral conflict they must necessarily override one of these rights. Infringing certain rights for the sake of other rights may be justifiable, but it leaves a sediment of negative feelings of regret, shame or guilt (10, 11). It is an unhealthy and paralyzing notion to know that the relationship one enters into with patients may unexpectedly turn into a situation of conflict, infringement of rights, and guilt. This guilt may be compounded by the awareness that breaching relates to a family of dubious practices that misuse information obtained by resorting to deception or even duress. Of course, confidentiality is enacting in the unfettered environment of medical encounters, but its breaching infringes the rights of the confiders, harms them, and abrades confidentiality as an institution, all this in the name of elusive values and hard-to-specify protective and vindicative functions.

In the case where a physician believes the patient’s exorbitant threats and alerts the police, a morally questionable principle becomes involved. The patient has sought the clinical encounter and proffered information on the understanding that this is necessary for an efficient therapy and also that the relationship with the physician is protected by a mantle of confidentiality. Confidence is offered and accepted in medical acts, and known to be an indispensable component of the clinical encounter, thus enticing the patient to deliver unbiased, unfiltered, uncensored and sincerely presented information (12).

Consequently, it appears contradictory and perversive first to offer confidentiality as an enticement to sincerity, only subsequently to breach it because the information elicited is so terrible it cannot remain unpublicised. Confidence is understood as an unconditional offer, otherwise it would not be accepted, and it appears profoundly unfair to disown the initial conditions once the act of confiding has occurred.

Should one decide to introduce exception clauses, it would only be fair to promulgate them beforehand, allowing every potential confider to know what to expect. But officially sanctioned exceptions would have the undesirable side-effect of creating a second-class kind of medicine for those cases where the patient considers it too risky to assume confidentiality. The communication between patient and physician would in these cases be hampered and would thus render the patient’s medical care less than optimal.

Gathering confidential material

The covenant of confidentiality only obtains if information is voluntarily and consciously given. No question of confidence arises unless the relationship involves rational, conscious and free individuals. But subtleties arise in the medical context when incriminating information reaches the physician unintentionally. Does this information fall within the confidence pact in virtue of being part of the clinical encounter? Or does it obey independent rules because it occurred marginally to the intended doctor/patient relationship?

During the clinical encounter a perspicacious physician may find tell-tale signs of matters the patient did not intend to disclose (skin blemishes perhaps caused by alcohol excess, suspiciously pin-point
pupils, injection marks). This involuntary information transfer might not seem at first to fall under any confidentiality agreement according to the above presented definition. Nevertheless, it is the product of a conscious interaction between patient and physician. In consulting a doctor, a person implicitly accepts the risk of surrendering more information than intended but at the same time understands herself or himself to be under the protection of confidentiality. Information fortuitously gained within the freely chosen association of the clinical encounter is to be considered confidential and treated in the same way as information voluntarily disclosed by the patient. Everything that happens in the interpersonal relationship of a clinical encounter is confidential.

**Are there exceptions to confidentiality?**

Exceptions to unrelenting confidentiality (6) have been invoked for the sake of the confider (paternalistic breaching in general and medical consultations as a special case thereof), in the name of potentially endangered innocent others, in the name of institutional or public interests, and less explicitly, in cases where the confider is potentially in danger.

**Confidentiality throughout time**

Confidants may consider the potential harm of divulging information they have had in custody eventually to diffuse after the confider's death, so that a posthumous revelation will not be injurious. The contrary position that harm after death is possible is too weak to support obligations to the dead (13). A more convincing approach suggests that posthumous disclosures may be harmful to surviving persons. If the death of a famous politician should prompt a physician to uncover his knowledge about the deceased's homosexual inclination, still living patients of the same physician might register with distaste and fear the possibility that private information about them could eventually be disclosed after they died. This suspicion may well be unsettling and therefore harmful to them, especially if they happen to believe in some form of 'after-life', the quality of which would be polluted by indiscretions occurring after their biological death. Also to be considered are the negative effects a disparaging disclosure might have upon surviving family members as well as groups of individuals with whom the deceased had a commonality of interests. Death does not cancel the obligation of confidentiality which remains of import to all survivors within the radius of interests of the deceased.

**Paternalistic breaching**

A commonly suggested exemption to confidentiality is that some patients' interests might be better served by physicians' indiscretion (14). Harming confidants for their own purported good is like forcing therapeutic decisions on patients for the sake of their health care. Such stern paternalism has nothing to recommend it for it is generally agreed that autonomous individuals are not to be compelled into undergoing medical procedures they have explicitly rejected. If rationally competent patients refuse a medical procedure that would do them good, the physician is not authorised to insist, let alone proceed. Rationally competent individuals are allowed to take decisions against their own interests and this does not make them irrational as some have misleadingly suggested (15). Why, then, should confidentiality function differently? If patients wish certain knowledge to be kept confidential even if this course of action injures their own interests, they are entitled to do so and no one, not even the physician, has the right to breach confidentiality in the name of patients' welfare.

**Medical consultations**

Multi-professional care seems to offer plausible alibis to breach confidentiality for the sake of the confider (16). It has been argued that patients negotiate confidentiality with their primary care physician and that if additional professionals are involved in the patient's care they are to report to the confidant and physician. This position is discarded by those who believe that patients, in as much as their autonomy is respected, are to re-negotiate – or count upon confidentiality with every physician involved. Such a line of thought has much to recommend it since every physician/patient encounter may unveil unidirectional information which the patient is willing to discuss in a certain setting but is reluctant to have brought to the attention of the primary-care physician. Consultations and other expansions of a medical care programme do not serve as an excuse to exchange information about patients against their will. If they did, they would be supporting double morality and possibly double quality medicine, where primary health care would have a paternalistic format embedded in trust and confidence whilst secondary and tertiary services would operate in a contractual setting. This would not be acceptable, it being preferable that each act of confidence be equally and non-transmittably entrenched in all medical encounters.

**Harm to innocent others**

Another major exception invoked against absolute confidentiality concerns the aversion of damage to uninvolved and innocent third parties. These are the oft-quoted cases of the doctor telling the bride that her fiancé is homosexual, or calling the wife because he is treating the husband for venereal disease. Escalating examples include informing authorities about a confider's intention to kill someone, as well as encounters with terrorists at large.

This postulated exemption to confidentiality is self-defeating. Firstly, if physicians become known as confidence-violators, problem-ridden patients will try to lie, accommodate facts to their advantage or, if this...
does not work, avoid physicians altogether (17). Physicians would then be unable to give optimal advice or treatment to the detriment of both the reluctant patients and their threatened environment. It is better to treat and advise the slyphilitic husband without informing the wife than not have him come at all for fear of undesired revelations.

Physicians who believe themselves in possession of information that must be disclosed in order to safeguard public interests are contemplating preventive action against the putative malefactor. Like all preventive policies, breaching confidentiality is difficult to analyse in terms of costs/benefits: is the danger real, potential or fictitious? what preventive measure will appear justified? how much harm may these measures cause before they lose justification? Since physicians will rarely be instrumental in deciding or carrying out preventive actions, they have no way of knowing in advance whether taking the risk of honouring confidentiality will eventually prove more or less harmful than breaching it.

If physicians play it safe and commit frequent breaches of confidentiality they will unleash overreacting preventive programmes, at the same time progressively losing credibility as reliable informers. On the other hand, should they remain critical and carefully decide each case on its own merits, they will be equally suspect and unreliable informers, for their conscientiousness and judgement might well deviate from what other authorities, notably the police, consider adequate.

In apparently more delicate cases it could be argued that physicians might subject their co-operation with the authorities to some conditions in order to defuse the dramatic moment. They may suggest that violence be refrained from, that their own intervention be kept secret, that the preventive action be discreet. But certainly, if physicians accept that their confidential relationship with patients is conditional, they must consequently expect authorities to handle their own role as informants in a similarly unpredictable and contingent way. Physicians who breach confidentiality cannot expect to be protected by it just because they have exchanged the confidant for the confider role. Physicians who are known to take confidentiality as a prima facie value cannot demand that the authorities they are serving by disclosing information should honour their request for discretion. For similar reasons they must expect some patients to become increasingly inconsiderate or even vicious. By breaking confidentiality, physicians are helping sustain a language of dishonesty and they cannot expect violence-prone patients to refrain from blackmailing, threatening or otherwise molesting them. As a physician, I would be most unsettled if it became a matter of policy that my colleagues violated confidentiality for the public good, for it would leave me defenceless when confronted with a public offender. No amount of promising would help, since physicians would already have a reputation as unpredictable violators of agreements.

Who should control the policy of confidentiality in medicine anyhow? If public interest demands a catalogue of situations where the physician would be under obligation to inform, medicine becomes subaltern to political design and starts down a treacherous path. Should one prefer to leave the management of confidentiality to the physician’s conscience and moral judgement, public interest would not be relying on a consistent and trustworthy source of information. Fear of either political misuse or personal arbitrariness should make us wary of opening the doors of confidentiality for the sake of public interest.

What about possible conflicts between the frailties of public figures and the purported interests of society? National leaders from time to time suffer from disabilities due to old age and the question is raised whether the attending medical team are under an obligation to publish full-fledged clinical reports. It must again be brought to mind that the medical team have been commissioned not to safeguard the public interest but to care for the health of this individual who happens to be influential. Consequently, the medical team’s duties remain in the clinical realm, not in the political arena. Furthermore, if the leader in question were in such a precarious situation as to constitute a public danger, his political mismanagement would become obvious to other individuals more qualified to take public decisions and would not require the physicians to play the role of enlightening figures. Observers of the political scene have preferred to suggest constitutional amendments and political measures to cope with this problem, being aware that cajoling physicians out of their commitment to confidentiality is no solution (18).

**Competing claims to confidential material**

This issue refers to conflicts arising from individual interests colliding with those of groups or institutions. It differs from those previously discussed in that here physicians do not necessarily engage in active disclosure but restrict themselves to a one-sided co-operation. The emphasis here is not so much on harm being prevented – although this also plays a major role – but on conflicting parties claiming the physician’s loyalty.

Company doctors doing routine examinations of employees are under obligation to report even disparaging findings, for their duty is to the commissioning company. By failing to report an epileptic bus driver or a hypertensive pilot, the doctor is deceiving the company and hindering its efforts to secure safe transportation. If, on the contrary, the same bus driver or pilot goes to the private office of a doctor unconnected with his employer, there would be no excuse for unauthorisedly reporting any findings to the company, for the physician is now being commissioned by the individual, not by the institution,
to perform a medical act under the mantle of confidentiality. If this results in the bus driver continuing to work under precarious conditions it means that the company has not established an efficient medical service to check its drivers and is negligent. Physicians are to declare themselves explicitly and unmistakably loyal to those who engage their services for, again, the legitimate claim to confidentiality lies in the act of entering an agreement, not in the contents of the confided material.

Not even these competing claims of loyalty can be settled unless a robust and relentless position in favour of exceptionless confidentiality is upheld. If a physician owes loyalty to an institution, he has no right to misuse the confidence of his employer in order to honour any personal desire for confidentiality. Conversely, when physicians are committed to the confidential situations that arise in their consulting rooms, they lack the right to infringe this agreement to the benefit of other interests.

**Does risk to the confidant justify breaching?**

The situation could arise where the patient’s revelations contain threats of harm or disclosure of damage already done directly to the confidant physician, his or her family members or their interests. Can the physician disclaim the obligation to confidentiality in the name of self-defence? If physicians were morally allowed to breach confidentiality in defence of their own interests it would mean accepting the principle that one can inflict harm upon others for self-interested reasons. It has already been stated that in disclosing confidential information there is no adequate way of comparing amounts of harm inflicted with harm prevented, so it might well occur that a person brought about severe harm to others in an effort to avert a fairly trivial or improbable harm to her or his own interests, comparable to killing a burglar who is running away with some property – perhaps no more than a loaf of bread. Since an unbiased view can hardly be expected from someone who believes his interests to be in jeopardy, legal systems do not tolerate self-administered justice and condemn, albeit with leniency, injuring others in the face of putative menace to self-interests. Physicians may not safeguard their own interests by mishandling patients, so why should they be allowed to cause harm by breaching confidentiality only because they believe or fear their interests to be imperilled?

Although imaginary situations can be concocted that make it awkward to insist on not breaching, the basic attitude should still be to respect confidentiality to the utmost. Admittedly, if the patient’s disclosure implies impending harm to the confidant, the moral obligation to the confidential relationship is weakened in its core, but this admission requires a double qualification: firstly, such situations are highly improbable and therefore of little paradigmatic interest; secondly, even if they should obtain, breaching confidentiality should be used as a last, certainly not first, resort to resolve the conflict, precisely because there is no suasive justification for employing confidentiality as a weapon to avert harm.

**Concluding remarks**

Confidentiality is a widely recognised implicit warranty of fairness in clinical situations and thus constitutes a technically and morally essential element of efficient medical care. If breaches of confidentiality occur, they do so necessarily after the communication and therefore retroactively introduce unfairness into the clinical encounter. A situation that is potentially, even if only occasionally, unfair can no longer be described as fair, especially if breaching occurs unpredictably. All possible exceptions to an attitude of unrelenting confidentiality lead to morally untenable situations where harm avoided or harm inflicted is incomensurable, and rights preserved are less convincing than rights eroded. Confidentiality collapses unless strictly adhered to, for even occasional, exceptional or otherwise limited leaks are sufficient to discredit confidentiality into inefficiency.

The clinical encounter is consistently described as a confidential relationship. If this statement is adhered to, there can be no room for violation without making the initial statement untrue. Nor can the description be qualified – ‘usually confidential’ – or made into conditional – ‘confidential unless’ – statement, for these half-hearted commitments are, from the confider’s point of view, as worthless as no guarantee of confidentiality at all. Confidentiality cannot but be, factually and morally, an all or none proposition. It might perhaps be easier to present a plausible defence of conditional confidentiality, but the ethical atmosphere of the clinical encounter, the autonomy of patients and the sovereignty of the medical profession are all better served by making confidentiality an unexceptionable element of medicine.

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**References**

nurses are concerned with their patients as people and not merely as cases of disease or potential disease. The moral objectives of nurses and doctors are surely the same—only the perspectives are different.

The obvious danger if nurses fail to keep distinct the three components of their developing concern with professional ethics is that patients will suffer as, in the name of nursing ethics, they are used as shuttlecocks in an increasingly bitter interprofessional battle about the occupational status of nursing (6, 7). That is an outcome which all who are concerned with the welfare of patients would surely wish to avoid.

### References


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3. For a brief differentiation between these two concepts of professional ethics see: Anonymous. Two concepts of medical ethics [editorial]. *Journal of medical ethics* 1985; 11: 3.


(See also *Case conference* page 151.)