

Point of view

A vote for no confidence

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Author's abstract

This paper considers the justifications for adhering to a principle of confidentiality within medical practice. These are found to derive chiefly from respect for individual autonomy, the doctor/patient contract, and social utility.

It is suggested that these will benefit more certainly if secrecy is rejected and the principle of confidentiality is removed from the area of health care.

Recent contributors to this journal on the subject of confidentiality have left us with an apparently insoluble problem. Kottow persuades us that, once offered, a duty to preserve a patient's confidentiality is 'an exceptionless and absolute commitment' (1). Emson, however, is just as convincing when arguing that such an absolute commitment cannot be followed because 'contemporary society places an increased weight upon the rights of the "innocent other"' (2). A solution to this dilemma is afforded by closer examination of the *a priori* assumption made by the above writers. Both accept without question the necessity for secrecy within the medical model. I suggest that doctors need not accept information in confidence. If it is accepted that confidences are unnecessary, it alters our considerations about whether the keeping of them is imperative, or even possible.

Medical confidentiality

There are three main reasons commonly given for not handing on information given by patients to their medical carers. These derive from respect for medical codes of practice, a hypothetical contract of confidentiality, and utility or the benefit of society as a whole. Let us consider each of these in turn.

Medical ethical codes stress the keeping of secrets. The Hippocratic Oath states: 'Whatsoever I shall see or hear in the course of my profession, as well as outside my profession with my intercourse with men, if it be what should not be published abroad, I shall never divulge, holding such things to be holy secrets' (3).

However, doctors no longer take this oath, and few respect other sections of it such as those demanding no lithotomies or abortions be performed. Codes are only as strong as the assumptions on which they are based. Use of these as a reason for keeping secrets may show lack of consideration of the true issues involved.

It has been suggested that there is an implicit contract between doctors and their patients which involves acceptance of all communications as confidential. Such a contract is left undefined. It is supposed that patients expect their confidences to be respected – but they are rarely asked if this is the case. The Younger Report states: 'Any contact with the complex medical machinery of today implies acquiescence in some degree of extended confidence' (4). Here a contradicting assumption is also left unquestioned. Research into the expectations of patients and the actions of doctors in this field is badly needed. If a contract exists it needs further clarification. Perhaps patients only expect their secrets to be kept when this is compatible with their best care, or with their families' happiness, or with the smooth running of society. At present we cannot be certain of the truth in this matter.

Whatever present expectations are, they need not be considered immutable. The responsibilities of doctors in their professional capacity, and the doctor/patient contract are not unchanging. If they appear to hinder the development of the principles for which they were formed, they should be discarded or modified. The present incomplete respect for confidentiality in practice suggests that this is our position.

The most powerful argument for not communicating secrets is that of the overall benefits deriving from such a practice. It is generally believed that patient confidentiality is a basic requirement for effective medical care. Francis writes: 'Privacy is integral to the doctor/patient relationship. Without it the trust which a doctor requires to elucidate the problems of his patients would not be given' (5). Parkes also feels confidentiality is fundamental to the caring relationship. 'The patient looks to his doctor for two essential qualities: one is medical skill; the other is absolute discretion.' 'No doctor can practise successfully unless his patients have complete confidence....in the confidentiality of all that they tell

Key words

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him' (6). What is being suggested here is that trust is necessary for the doctor/patient relationship to survive, and that confidentiality is necessary for adequate trust. I have no wish to argue with the first supposition. Surely, however, confidentiality is not a necessary component unless it has been promised. If no confidence is expected the patient can decide whether or not his illness would merit loss of privacy. He can trust the doctor as far as his medical skills are concerned. If, on the other hand, absolute confidence is expected but not given (as is possible with current medical practice (7)), trust will be harmed and the doctor/patient relationship will suffer. It is clear that an agreed degree of confidentiality is required for trust, and therefore for the success of the therapeutic relationship. This is not an argument for total confidentiality; if appropriate, the parties involved might agree to no confidentiality.

It may be claimed that lack of secrecy will deter some people from revealing facts concerning their health or lack of it, and that these people will therefore suffer the effects of disease unnecessarily. I should like to suggest that such a risk is acceptable, since their health is being sacrificed in a good cause – that of their individual autonomy. The loss of confidentiality might result in an increase in hidden illness, but the certain benefits would be a generalised increase in the level of personal autonomy experienced by all. Although some doctors might find this difficult to accept, it would seem that ill-health may be a reasonable price to pay for the maintenance of autonomy. In this system the patient retains the choice.

Discarding the pretence of non-communication would result in increased respect for personal privacy and autonomy from which the principle of confidentiality was originally developed.

Confidentiality

In order to accept the plausibility of this position we need to examine why it is accepted that individuals need to have secrets and why they might need to share them with others.

The word confidentiality derives from two latin roots: *con* – completeness, and *fidere* – to trust (8). To confide is to trust wholly, to impart knowledge with reliance on secrecy. A confidence is a secret communication. This analysis reveals two questions. Firstly, what are secrets, and why, and by what right do we have them? Secondly, need these secrets ever be communicated?

Having secrets

The right of an individual to have secrets is concerned with the notion of privacy. It derives from 'the right to be let alone'. This principle is frequently stated and not explored further. The Younger Report on Privacy (4) merely states that such a right is recognised by most people and assumes, presumably, that such a majority view has moral relevance within a democracy. For our purposes, however, we need to establish the right more

conclusively.

Arthur L Caplan claims that privacy is a basic, universal, human need, essential to a personal sense of identity, and therefore superior to other rights (9). This idea is echoed by Bok when she writes: 'In seeking some control over secrecy and openness, and the power that makes it possible, human beings attempt to guard and to promote not only their autonomy but ultimately their society and society itself' (10).

These suggestions appear to found the right to privacy on firm ground. People are not free to act as they wish if their secrets are not respected. Denying secrets will limit individual freedom. Such liberty should be part of our individual rights to autonomy. The breaking of a confidence will immediately result in some diminution in that person's autonomy – in his/her control over his/her own life. (Although the breaking of a confidence constitutes, in itself, an offence against autonomy, it may be that an attempt can be made to justify such an offence if it is committed with the ultimate intention of increasing individual autonomy. In this case, although an offence occurs, the *consequence* may be greater autonomy (11).) If the right to have control over our secrets derives from our rights to liberty and autonomy, which in turn descend from the respect of the person and life itself, it must be taken seriously (12).

Sharing secrets

The above discussion contains a contradiction. Secrets are respected in order to allow individuals the liberty of forming relationships. However, secrets must be shared for any relationship to form. Just as one accepts some loss of autonomy on joining a society, so one might be expected to accept loss of privacy over health matters when accepting medical care provided by society. One cannot maintain absolute control over one's personal details and communicate with others. There is no reason why our private information should concern our lifestyles or health. If people's secrets in the field of health were removed, other areas of their life or thoughts could become the matters relevant to privacy. Although personal identity may be necessary for individual freedom and the workings of society, the content of such identity may not have to be medical. It is necessary for society to decide of what the bounds of confidentiality ought or ought not to consist. A decision within society to define the limits of confidentiality would not abuse personal privacy if the bounds were universally accepted.

Conclusion

It would seem that taking the principle of confidentiality away from its role in health care would be most effective in preserving the ideals on which it was originally founded. The doctor would give no pretence to the keeping of any secrets – which would leave the patient absolute guardian of his/her own personal privacy and autonomy. Trust in the doctor/patient relationship should benefit rather than suffer.

Any resulting decrease in the overall health of the individual will be a personal decision and is justified by the increase in autonomy and honesty within society.

That doctors would no longer be tied to a principle of confidentiality does not imply that all they learn should be broadcast widely. Just as we avoid gossip in our private lives, so idle discussion of patients' personal information, or the giving of personal details to the media for monetary gain should be shunned. Such actions would be blameworthy because they are impolite and unkind, even where high moral principles are not involved. However, this will be a matter of professional etiquette rather than ethics.

The advantages of my suggestion are obvious. Individual autonomy will be afforded greater respect and will be less frequently harmed by breaches of trust than it is at present. Doctors will no longer face a dilemma when considering cases where they feel personal information about a patient requires action. A final advantage, less tangible but no less valuable, will be a general increase in openness in our society.

It is evident that acceptance of the principle of non-confidentiality of information revealed to medical practitioners would increase personal privacy and personal autonomy. Whether we ought or ought not to break confidences within the medical sphere is no longer decided by the doctor, but becomes a conscious moral decision made by society. Society must choose. I propose a vote for no confidence.

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(continued from page 178)