

Confidentiality

Confidentiality is an important principle in medical ethics, but one that may be overridden in some circumstances.



Unlike some other principles in contemporary bioethics, such as principles of (patient) autonomy and (doctors') truth-telling, the principle of confidentiality has been recognised since ancient times to be essential to the professional ethics of medical practitioners. As important as this principle is, however, it has limits. There are some occasions when it is outweighed by competing moral considerations. Determining when this is so is often difficult. There is no simple formula that can be applied to establish when confidentiality ought to be breached. However, if we understand the values on which the principle of confidentiality is based, we are better equipped to assess whether the principle ought to be sacrificed in a given circumstance.

UNDERLYING VALUES

Confidentiality's value is not intrinsic but rather instrumental. That is to say, the value of confidentiality is derivative from the other values it advances. We can distinguish four such values: autonomy, privacy, promise-keeping and utility (or welfare).

Autonomy

Autonomous beings are those that are capable of controlling their own lives. They are beings that can deliberate and, in the absence of any external restrictions, act on their deliberations. Healthy adult humans typically are, in this sense, autonomous (to varying degrees). Given that they are autonomous in this way, they have an interest in having this autonomy respected. Confidentiality protects the autonomy of patients by allowing them to control information about themselves. This is particularly important given the often sensitive and personal nature of the information that medical practitioners can acquire, and the damaging ways in which such information could be used.

Privacy

Although privacy, like confidentiality, can foster a person's autonomy, people also tend to value privacy independently of concerns about autonomy. Feelings of shame and vulnerability lead people to value their privacy. Confidentiality obviously fosters privacy by preventing the spread of privileged information that would violate privacy.

Promise-keeping

Given that doctors undertake to preserve confidentiality, the importance of confidentiality is also based on the value of promise-keeping. Sometimes the promise to keep information in confidence is explicit, but it is often implicit. Patients know that doctors have duties of confidentiality and have often taken oaths to affirm those duties. Patients consult doctors in this knowledge and often without securing explicit promises from the doctors directly to them. The professional norms of preserving confidentiality are so widespread that patients can reasonably assume their doctors to have implicitly promised to keep confidence.

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MAIN TOPIC

Utility

Confidentiality in medicine greatly enhances utility by leading to improved health care, both of the individual patient and of society. If patients had no assurance that doctors would respect confidentiality, they would be more reluctant to consult doctors. The upshot of this would be that many more people would suffer and even die than is the case where people feel more comfortable consulting doctors. An individual's health is therefore improved. Public health is also improved, both by iterating the individual benefits and by avoiding the exponential ill-effects of undiagnosed contagious diseases.

MORAL LIMITS

One obvious condition that would justify divulging confidential information is the consent of the person to whom the duty of confidentiality is owed. Where such consent is given, private information is conveyed but the duty of confidentiality is not breached. This is because the patient, in giving the consent, waives the right to confidentiality. Typically, the consent to convey private medical information is limited: the patient grants a medical practitioner permission to provide specific information to a specific person or group of people.

The dilemmas of preserving confidentiality arise in those situations in which there is no consent to disclose. These dilemmas, at least in their most difficult forms, arise where the principle of confidentiality conflicts with a principle of harm prevention. It is helpful to consider separately two categories of harm prevention:

- the prevention of harm to people other than the person to whom the duty of confidentiality is owed

- the prevention of harm to the very person to whom the duty of confidentiality is owed.

We might call the former 'harm to others' and the latter 'harm to the patient'.

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Harm to others

The others may be one or many. For example, preserving confidentiality about a patient's HIV-positive status may pose a threat to one other person (the spouse) if the patient is in a faithful monogamous relationship, or many other people (various potential sexual partners) if the patient is promiscuous.

In such situations, the patient's interest in autonomy, privacy and promise-keeping obviously persists. However, the moral weight of these interests is limited. The value of one person's autonomy, for example, is bounded by the value of others' autonomy. My right to lead my life as I please cannot extend to limiting your autonomy (beyond the limitation on your freedom to interfere with me). Privacy and promise-keeping too have their limits. Thus, if any one of these three values — autonomy, privacy or promise-keeping — were pitted against serious harm to others, the prevention of harm would certainly prevail. Although they have greater strength together, they would still be outweighed by sufficiently serious harms to others.

One way in which confidentiality dilemmas can become difficult is if it is unclear whether the harm is sufficiently weighty. Although a significant threat to life may defeat the other values, it is less clear whether more remote threats of this kind, or significant threats of lesser harms, are strong enough.

A second and more common way in which confidentiality dilemmas become vexing is seen if we examine the fourth underlying value — utility. Where confidentiality does not conflict with the prevention of harm, all considerations of utility usually support the preserving of confidentiality. In cases of conflict, the usual utility of keeping confidence (outlined above) must be balanced against the disutility of doing so — the harm to others. In other words, we are caught on the horns of a utility dilemma — sacrifice the long-term utility of keeping confidentiality for the short-term gain of preventing harm, or preserve the long-term gain at the cost of not preventing the more immediate harm. The fact is that most of the long-term benefits can be preserved if breaches are sufficiently few. However, the erosion of these benefits is incremental with each breach, and their loss can thus creep up imperceptibly.

Harm to the patient

Sometimes the person whom one seeks to protect from harm is the very patient to whom the duty of confidentiality is owed. Consider, for example, a patient who does not want his diagnosis made known to a spouse or parent even though the spouse's or parent's knowledge of the diagnosis could greatly benefit the patient. Or consider a patient whom a doctor finds to have been abused, but who does not want the doctor to make this known to other people, even though such a disclosure could

prevent more such abuse. Where the patient's autonomy is intact, overriding that autonomy in the name of benefiting the patient is an unwarranted form of paternalism and is unjustified (although attempting to persuade the patient about the importance of disclosure would be appropriate).

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Autonomous agents have the capacity to decide for themselves whether their welfare is best served by breaches of confidentiality. Thus violating confidentiality to prevent harm to the patient to whom confidentiality is owed can be acceptable only where the patient's capacity for autonomy is sufficiently compromised or absent. In that case, the autonomy is no longer a value or, in the case of limited autonomy, a sufficiently strong value underlying the preservation of confidentiality. The other three underlying values do remain intact. As the patient cannot assess their relative value, a guardian or proxy-decision maker must make that determination on the patient's behalf. Privacy and promise-keeping considerations will typically weigh less heavily for the incompetent, and especially for those who were never competent. Although they may have greater weight for members of the patient's family, they will be outweighed in the same conditions under which a patient's interest in privacy or

promise-keeping is defeated by the prevention of harm to others.

HOW TO BREACH

Because breaching confidentiality (without consent) always has some cost, it should be avoided if possible. Thus the preferred first course of action should be to persuade the patient (or patient's guardian) of the moral importance of disclosing the relevant information. Some medical practitioners are reluctant to bring moral pressure to bear on patients to consent to disclosure. Such concern is sometimes well-founded where disclosure is the greater of the evils. However, where it has been determined that breaching confidentiality may be required, it is obviously preferable to obtain patient consent for the disclosure. At least in such circumstances moral pressure in eliciting consent is entirely apt.

One ought to break confidence in the least damaging way consistent with the required goal of preventing harm.

Sometimes, but relatively rarely, consent is not forthcoming, and a breach of confidentiality is necessary. In such conditions, one principle should govern the breach. This is the principle of minimising the costs of the breach. That is to say, one ought to break confidence in the least damaging way consistent with the required goal of preventing harm. On this principle, one would be required to disclose the least information and to the fewest people necessary to attain the goal. One ought usually also to

provide advance warning to the patient (or patient's guardian where the patient is non-autonomous) of one's plan to break confidentiality. Very often one will find that at this point, a patient will decide that given the doctor's intent, the patient would rather disclose the information himself, perhaps with the assistance of the doctor. Where the patient does not relent, he or she will at least have the opportunity to minimise the costs to himself in other ways.

THREATS TO CONFIDENTIALITY

Although the real dilemmas of whether to breach confidentiality often interest doctors, there are highly suspect assaults on confidentiality that receive very little attention. The most obvious of these is indiscretion. Some doctors are scrupulous in exercising discretion, but others are not. Many talk about patients in corridors, elevators and other public spaces. They leave confidential documents lying around. They sometimes fail to delete personally identifying details when presenting cases at academic meetings. They talk with their spouses or gratuitously with colleagues not involved in a particular patient's care. Just mentioning that somebody is one's patient can constitute a breach of confidentiality. Imagine a psychiatrist, for example, making it known that a particular person is his patient. Another form of indiscretion is poor control over patient files. Consider, for example, a private doctor who, upon retirement or sale of a practice, transfers all his patients' files to another doctor without the patients' consent. Patients, particularly in the private sector, should be entitled to choose which doctors have access to their medical records.

MAIN TOPIC

Less well-recognised by many doctors is the threat that large hospitals and medical teams pose to confidentiality. Where a patient is cared for by a single doctor, perhaps with an occasional referral to a specialist, few people have access to information about the patient. In large hospitals and medical teams, dozens of people may be involved in a patient's care and hundreds of people might have access to a medical file. The problem is sometimes exacerbated when medical files are stored electronically. Not only is private information more widely known when so many people have access to it, but the risk of further information leakage is also greater. Institutional safeguards, such as limiting access to medical files, and clinical and clerical staff awareness about the importance of confidentiality are necessary to limit the damage that large medical teams do to confidentiality.

Very few people would willingly disclose private medical information to insurance companies if they did not fear the alternative of being medically uninsured.

Private health insurance is another threat to confidentiality. This is because of the danger that asymmetrical knowledge would pose to a private health insurance scheme.

If patients had medical information about themselves that was not disclosed to private insurers, high-risk people would self-select into insurance schemes and low-risk people would opt out. The upshot of this would be the eventual collapse of the insurance scheme. If insurers and insured both have access to the information then this problem is avoided, but it is avoided at the cost of confidentiality. Very few people would willingly disclose private medical information to insurance companies if they did not fear the alternative of being medically uninsured. The disclosures, in effect, are coerced by circumstance. Notice that this dilemma between insurance failure and loss of confidentiality could be avoided by the community-rating of risks characteristic of public health insurance. As everyone is automatically insured by such a system, there is no need for the insurers to have private information about the insured in order to insure them. Asymmetrical knowledge therefore does not threaten public insurance.

CONCLUSION

Confidentiality is an important principle in medical practice. However, it is not an absolute principle. There are circumstances where it may be breached, typically to prevent serious harm. Where the principle is indeed outweighed by countervailing considerations, its sacrifice is regrettable but justified. Where confidentiality is sacrificed in the absence of competing values — as it is in cases of indiscretion, for example — the breach of confidence is not only regrettable but also unjustified.

FURTHER READING

- Bok S. *Secrets: On the Ethics of Concealment and Revelation*. New York: Vintage Books, 1984: 116-135.
- Siegler M. Confidentiality in medicine — a decrepit concept. *N Engl J Med* 1982; **307**(24): 518-521.
- Winslade WJ. Confidentiality. In: Reich WT, ed. *Encyclopedia of Bioethics*. New York: Macmillan, 1995: 451-459.

IN A NUTSHELL

- Confidentiality is an important but non-absolute principle of medical ethics.
- The moral value of confidentiality is derivative from four underlying values: autonomy, privacy, promise-keeping and utility (or welfare).
- Where patients consent to information being divulged, there is no breach of confidentiality.
- The dilemmas of whether to breach confidentiality arise when this principle conflicts with the principle of harm-prevention.
- The harm one seeks to prevent may be either to people other than the patient or to the patient to whom the duty of confidentiality is owed. In the latter case it can be justified only where the patient is not autonomous.
- Where confidentiality must be breached, it should be done by minimising the moral costs of the breach.
- Threats to confidentiality include: indiscretion, large hospitals and medical teams and private health insurance schemes.