Confidentiality in medical practice

John Saunders

Abstract

A patient's personal information can only be disclosed to those involved in their care if consent to such disclosure is given. This consent normally extends implicitly beyond medical staff to other professionals who may also be involved in care. It also commonly includes administrative, secretarial and managerial staff as well as healthcare professionals. This constitutes the duty of confidentiality. In certain specified circumstances, a patient's otherwise confidential information may be disclosed without consent to allow benefits to particular others. The legal position is complex, and while doctors should be familiar with most routine situations (e.g. reporting of certain infectious diseases), advice should always be sought if doubt exists.

Keywords Confidentiality; data protection; disclosure; General Medical Council guidance

Key points

- Confidentiality is grounded in a doctrine of respect for people
- Confidentiality is implicit in the doctor–patient relationship
- Special justification is required for the non-consensual disclosure of confidential information and relates to the rights or interests of others
- Confidentiality should be maintained after the patient's death

'Whatever, in the course of my practice, I may see or hear (even when not invited), whatever I may happen to obtain knowledge of, if it be not proper to repeat it, I will keep sacred and secret within my own breast.' So runs the Hippocratic Oath (https://en.wikipedia.org/wiki/Hippocratic_Oath), emphasizing the antiquity of this principle in medicine, yet even the Oath appears to be less than absolute: 'if it be not proper to repeat it'. Is confidentiality in medical practice an absolute obligation or may this principle be compromised on occasions? When is it 'proper to repeat it'?

The Hippocratic Oath remains widely quoted even if infrequently sworn, although some medical graduation ceremonies have substituted what amounts to a modern version, such as the Declaration of Geneva. One difficulty with the Hippocratic Oath is, of course, its prohibition of abortion, widely practised by doctors in many (and probably most) countries.

The Declaration of Geneva was first adopted by the World Medical Association (WMA) in 1948 and revised most recently in 2017. The WMA appends statements on termination of pregnancy – 'Medically-indicated termination of pregnancy refers only to interruption of pregnancy due to health reasons, in accordance with principles of evidence-based medicine and good clinical practice. This Declaration does not include or imply any views on termination of pregnancy carried out for any reason other than medical indication'[1] – and on euthanasia and assisted suicide – 'The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide'.[2] The Declaration of Geneva also contains an explicit commitment to confidentiality: 'I will respect the secrets that are confided in me, even after the patient has died'.[3]

Confidentiality is grounded in a doctrine of respect for persons, a moral obligation to the patient – another expression of taking autonomy seriously. It is further grounded consequentially in a consideration of outcomes, which are beneficial in the overwhelming majority of cases. Without the patient's secrets being kept, information will not be disclosed to the doctor, with resulting adverse outcomes.

To those ethical justifications we can add legal support in a mixture of both statute and case (common) law: the prevention of disclosure of personal information without consent is supported by the concept of a right to privacy, based in turn on Article 8 of the European Convention on Human Rights, given effect in the UK in the 1998 Human Rights Act. The 2019 updated Guide on Article 8 of the Convention is available online. (The Convention, incidentally, comes from the Council of Europe, which has no connection with the European Union.) Personally controlling the information we disclose (or permit others to disclose) about ourselves serves to calibrate the degrees of intimacy we share with others and promote a sense of identity protective of our interests.

Without confidentiality, then, information would not be divulged by the patient to the doctor. This is true in many walks of life. Journalists want to protect their sources, priests will protect (absolutely in their case) the secrets of the confessional, bankers will not publish your financial details, intelligence services function in a web of confidentiality and disclosure. All these examples and many more pose questions about the boundaries of openness and trust, the demands of society against the rights of individuals. There are legitimate and continuing debates about all this. But the fundamental principle in medical practice is that confidentiality is implicit in the doctor–patient relationship. Disclosure of information requires special justification. In healthcare, non-disclosure is the default position.

Healthcare requires teamwork, and patients should understand that sharing information is routine practice. This includes sharing information with those administering the service as well as those directly providing it. But disclosure can be restricted by the patient for any reason or none. An audience at a clinical

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'grand rounds' meeting is not involved in a patient's care and the patient's identity should not therefore be disclosed. X-rays should have names removed, but anonymization alone may be an inadequate protection against deductive disclosure. Describing a case as 'a 22-year-old Olympic medallist from Somewhereville who presented with …' does not maintain confidentiality at Somewhereville General Hospital. The Information Commissioner's Office (ICO) anonymization code of practice may be found on the ICO website (www.ico.org.uk). Best practice is to ensure the patient's consent even for anonymous presentation, a standard now routine in medical journals.

Patients' spouses, relatives, partners and friends have no right to confidential information without the patient's consent. But disclosing information may be best practice where a reasonable assumption can be made that the patient would have wished this although lacking capacity — let us say, disclosing details to a spouse after a patient is admitted unconscious with a stroke. It should otherwise be routine to seek and not assume the patient's consent when talking to spouses, relatives, etc. given the complexity of so many social relationships. It may also be necessary to proactively warn an informant that, while you may be grateful for information they wish to give you, you cannot disclose information in return.

Confidence can only be broken if there is a stronger duty to do so than maintain it in a particular situation. This is rare and whether it concerns the UK Driver and Vehicle Licensing Agency, employers, law enforcement agencies or others, further advice from a professional body should be sought, as noted below.

Obligations of confidentiality do not end with the death of the patient. The published disclosures made by Lord Moran, Winston Churchill's personal doctor, for example, caused a storm of controversy despite claims of legitimate public interest. As already noted, all codes of practice, from Hippocrates to that of the UK's General Medical Council (GMC), the WMA, etc. express clear prohibitions on breaking the maintenance of confidentiality towards the dead. The GMC now gives specific advice when surviving relatives want access to medical details. (Posthumous rights and respect are, incidentally, also relevant considerations in organ retrieval.)

Despite this unanimity of advice, the basis for this prohibition is not often explored. There is something odd in asserting that the dead can be harmed, that they have interests or that their reputations should be respected. Are not the dead beyond harm or benefit? Thus, 'without awareness, expectation, belief, desire, aim and purpose, a being can have no interests; without interests, he cannot be benefited; without the capacity to be a beneficiary, he can have no rights.'[3] It may be that justification could be argued in some interpretation of a social contract, or that a 'person's good or harm may be wider than his subjective experience and longer than his biological life.' Space prevents detailed discussion and interested readers are directed to the Further Reading list.

The ethical justification for non-consensual disclosure usually relates to the rights and interests of others. As Hume wrote, 'All our obligations to do good to society seem to imply something reciprocal. I receive the benefits of society, and therefore ought to promote its interest.'[4,5] Our information is not exclusively ours, but may be disclosed under strict circumstances where others or a wider society have an interest. Our records may not even be disclosed to *us* if it involves revealing informants or interested third parties (*their* confidentiality requires protection too). Information may be required by law, in connection with litigation, for public health purposes, for the protection of third parties, for audit, for genetic reasons and for research.

In these varying situations judgements may be required about how much is disclosed, what regulatory bodies may need to be approached and whether a patient should be informed that their information is being disclosed. In a criminal case, for example, there may be sound reasons why the patient should not be informed. Again, in general, express consent should be the default position if information is to be disclosed for reasons other than personal care or local clinical audit. Disclosures should be limited to what is necessary and either anonymized or coded, if compatible with the purposes of disclosure.

Laws regulating the disclosure of information by or to healthcare professionals or providers have developed over many years in a complex web of case law and statute. In some situations, there may be continuing legal uncertainty — the details of various applications of the Data Protection Act, for example, have not been exhaustively tested in the courts, upon whom the final interpretation rests. There may also be subtle legal differences in the constituent countries of the UK.

In situations of difficulty, doctors should seek further advice. The medical defence societies — the Medical Defence Union, the Medical Protection Society and the Medical and Dental Protection Society of Scotland — provide telephone helpline services for if the problem is beyond the expertise of a more knowledgeable local authority. Membership of a defence body is strongly recommended for all doctors (see www.bma.org.uk/support-at-work/life-and-work-in-the-uk/doctors-new-to-the-uk/medical-defence-and-indemnity).

The complexity of possible situations has led the GMC to issue short supplementary guidance covering the reporting of concerns about driving, knife and gunshot wounds, child protection issues, risks of communicable diseases, information disclosure for insurance or employment, responding to press criticism and educational and training purposes among others. These represent the working-out in practice of the underlying ethical principles, including their translation into statute or common law. It is a key function of the GMC to turn those principles into professional standards against which doctors can be regulated, and by which good medical practice can be ensured. Both the British Medical Association (www.bma.org.uk/advice/employment/ethics/medical-ethics-today) and the GMC (www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality) offer authoritative and clearly written advice on their websites that can be consulted with confidence. ◆

KEY REFERENCES

1 World Medical Association. Reykjavik 2018. https://www.wma.net/policies-post/wma-declaration-on-therapeutic-abortion (accessed 24 May 2024).

2 World Medical Association. Tbilisi 2019. https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide (accessed 23 May 2024).

3 World Medical Association. WMA declaration of Geneva. https://www.wma.net/policies-post/wma-declaration-of-geneva/ (accessed 23 May 2024).

4 Feinberg J. The rights of animals and unborn generations. In: Blackstone W, ed. Philosophy and environmental crisis. Athens: University of Georgia Press, 1974; 43–68.
5 Hume D. Of suicide. In: Singer P, ed. Applied ethics. Oxford: OUP, 1986; 19–28.

FURTHER READING

British Medical Association. Medical ethics today – the BMA's handbook of ethics and law. 3rd edn. London: Wiley-Blackwell, 2012. This includes a chapter on confidentiality with free online access for BMA members. It is full of possible situations well beyond the scope or space of this article – audit, research, domestic, child and elder abuse, crime, sexual disease transmission, guns and knives, courts, regulatory bodies, capacity, social care, etc. If you study the NHS, GMC and BMA guidance, you will need no more for daily practice unless you are interested to explore, for example:.

On posthumous respect: Partridge E. Posthumous interest and posthumous respect. *Ethics* 1981; **91**: 243–264.

On trust: Saunders J. Trust and mistrust between patients and doctors. In: Edwards S, Schramme T, eds. Handbook of a philosophy of medicine. Hamburg: Springer, 2015: 487–502.

http://bmj.com/about-bmj/resources-authors/forms-policies-and-checklists/patient/confidentiality

With the changing legal regulations since 2016, the Department of Health has published more detailed guidance in new Supplementary Guidance on Public Interest Disclosures. It is available online at http://dh.gov.uk/publications

General Medical Council. Confidentiality: additional resources: situations doctors may find hard to deal with. London: GMC, 2017.

These booklets are also available online. They cover all common situations, and the parent booklet contains a short legal annex. All doctors should be familiar with this guidance and it could be the subject of questions in medical examinations such as MRCP.

General Medical Council. Confidentiality: good practice in handling patient information. London: GMC, 2017.

UK Government. Confidentiality: NHS code of practice. 2003, https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice

UK Government. Confidentiality: NHS supplementary guidance on public interest disclosures. 2003, https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice

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