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## In this issue

It is commonly assumed that the basis, scope and limits of confidentiality are fairly straightforward matters, that the problems occur just on the periphery. Anthony Fisher OP disagrees. He thinks that the basis, scope and limits of confidentiality are far more complicated than is commonly assumed, but that if we get these matters right we will find the 'peripheral' problems rather less intractable.

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Dr Fisher's article is the amended text of a lecture he gave to the Post-Graduate Course in Bioethics at the University of Santo Tomas (the Catholic University of the Philippines) in Manila earlier this year. The full text will appear in the Conference Proceedings. It is a good example of bioethics at its best: we therefore decided not to shorten it to the normal length of our articles!

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## Old paradigms and new dilemmas in medical confidentiality

**Anthony Fisher OP**

How absolute is the so-called 'principle of medical or patient confidentiality'? Can a doctor, for instance, share information with professional colleagues? With researchers? With a patient's family? With state authorities? Does he need the patient's consent and if so, in what form and circumstances? Can he use such information against the patient's will to protect the patient from harming himself or others? Can he lie to protect confidentiality? Do minors and the mentally incompetent have a right to confidentiality? Our conclusions in this area will depend crucially upon the paradigm of confidentiality out of which we operate. Here I will outline four such models, before considering their implications for some recent controversies. They are: medical confidentiality as a religious duty; confidentiality as a part of professionalism; confidentiality as an example of respect for patient autonomy; and confidentiality as an aspect of friendship or community.

## A religious duty of confidentiality?

The idea of medical confidentiality has its origins in religious tradition. Those who took the Hippocratic Oath, for instance, began by swearing "by Apollo the Great Physician, and by Asclepius, Hygieia, Panacea, and all the gods and goddesses" and ended with a prayer. Medicine was seen here as a semi-priestly vocation, a mediation of divine powers over life and health, a holy covenant; and with that calling came God-given (or gods-and-goddesses-given) responsibilities which could not be abrogated by any person, whether the doctor himself, the patient, professional colleagues or the state. The Hippocratic Oath goes on to unpack some of the requirements of that sacred trust, and in doing so offers a simple but profound and perennial code of medical ethics, constituted of various promises both of care for the patient and respect for the art of healing itself. These include the promise to keep confidential and hold as unutterable anything private seen or heard in the course of treatment. I will return to that promise in a little while. My point here is to note that in the Hippocratic tradition medical confidentiality is *an expression of religious reverence and awe* before the wonder of the human person, even the sick human person, and the wonder of healing, even that haphazard healing that ordinary human beings have to offer, because both the person and the healing are somehow connected with the gods.

This ethic was inherited by the Christian healthcare tradition where it was joined to the Christian image of the Good Samaritan. From the beginning Christians have sought to continue the healing ministry of Christ and to care for the sick as an expression of the Christian virtue of *hospitality*. Monks established hospitals and hospices and welcomed sick pilgrims and neighbours. Commonly the cure of bodies and of souls overlapped, so that people went to the same monk or holy woman for both, and were offered the same treatments (such as fasting, prayer and confession, baths, purging and medicinal herbs) for both. And if the same person were hearing the sick man's confession and tending to his physical ailments, something akin to the aura of the seal of confession came to surround healthcare also.

As the law grew to recognize the privileged status of confessional communications with the clergy, it also developed parallel doctrines of privilege for doctors and lawyers in their communications with their clients. And the three professions undoubtedly influenced each other's attitude towards confidence-keeping.

Whatever of its origins in religious discretion, few people today would regard medical confidentiality as being as absolute as the confessional seal. Nonetheless, the Hippocratic thought survived that medical confidences are 'unutterable'—at least unless uttering them was absolutely essential for the care of the patient. Those who see their relationship with their patients as that between children of God, and their care as a kind of *diakonia* or sacred service, will be moved to take very seriously the dignity of their patients and their need for privacy, as well as the sacred trust with which God and the patient have entrusted the doctor. It is no light matter to break confidence with someone you regard as your own sister or brother in Christ—not only because of any hurt it causes him or her, or any harm it does to the profession, or any breach of contract, but because it introduces disunity into communion. Thus one ophthalmologist-bioethicist argues that "*medical confidentiality merits as privileged a social status as does confessional or juridical discretion*"; doctors must beware of '*cheating on confidentiality*', even to protect a patient from self-destruction area (Kottow 1994, pp. 476,478).

If the duty to protect confidential information acquired in the course of a healthcare relationship is so strict according to this tradition, can confidentiality be protected by lying? In an uncharacteristic piece of situationist or post-modernist reasoning, Ashley and O'Rourke (1997, p. 99) write:

*The meaning of any human statement must always be determined from the context in which the communication occurs. Therefore, when persons ask questions that they have no right to ask, the context renders any answer given essentially meaningless, so that it is ethically inconsequential whether that answer in a normal context would be true or*

*false. Thus health professionals who are questioned about confidential matters may, without lying or even giving a falsehood, reply in any way that protects confidentiality.*

This, with respect, is clearly wrong. That someone asks an inappropriate, even impertinent question — as relatives of patients often do — does *not* render the doctor's answer *meaningless*: the answers he gives will be more or less candid, more or less revealing, more or less deceptive, but certainly meaningful. And whether or not we think the context makes lying or deception morally permissible, it is clear that if the doctor tells a falsehood with the intention of deceiving, then he has indeed *lied*; and this is very unlikely to be 'ethically inconsequential'.

Augustine (*De mendacio; Ad Constantium contra mendacium*), Aquinas (*Summa theologiæ* IIa IIæ 110 and 111), Kant (*On the Supposed Right to Tell Lies from Benevolent Motives*), Germain Grisez (1993, pp. 294-99, 390-411) and most recently the eminent moral theologian Fausto Gomez (1998) have all argued cogently that lying is always immoral; it is an intrinsically immoral attack on the good of truth, it undermines trust in communication, and it always injures the person lied to, the community and the liar himself. Though telling the whole truth (or even saying anything at all) is sometimes inappropriate and various evasion tactics are sometimes called for, *direct lying is always wrong*.

### **Confidentiality as part of professionalism**

*Into whatever houses I may enter, I shall come only for the benefit of the sick, avoiding all injustice and other mischief, and all sexual deeds upon the bodies of women and men, free or slave. I shall keep confidential any private thing I see or hear in the course of treatment, holding such things to be unutterable...*

Thus the Hippocratic Oath delimits what interpersonal conduct is appropriate to healthcare. We note that it is not just the person's sick body which is of concern here, but his whole person, body and mind, heart and soul, in himself and in his most intimate community—all of which is fragile and vulnerable during sickness, and all of which is

subjected to unaccustomed exposure to health professionals who are relative strangers. We are moved to reflect upon the intimacy of that relationship, the potential threat it poses to family and household, privacy and modesty, reputation and self-respect, and the need for boundaries and discretion without which there would be a corrosive self-consciousness and lack of trust. (Kass 1985).

We have come a long way from the days of Hippocrates, and there are few devotees today of the Greek gods. Modern societies entrust to health professionals much of the task of healthcare not so much on the understanding that those carers will see their task as a priestly one which includes various religious duties, but on the understanding that those carers are *professionals*, people with a very particular calling, skills and ethic. The bridging notion between these two paradigms is '*vocation*', originally the idea of a divine calling but nowadays used in a more secular sense of being committed and well-suited to such a service.

What does it mean to be a 'professional'? Some social critics have suggested that this is just an imposing name for a job in which the members can stop anyone from practising except those they approve of, a form of snobbery designed to get worldly respect and exceptionally good salaries. I think this is unfair, although it includes a timely warning about the abuses of professionalisation. My own view is that 'profession' is principally an *ethical* rather than a sociological category entailing:

- ◆ a conviction on the part of the would-be professional about the importance of this service to others and his/her suitedness to it,
- ◆ the community's recognition that this service is an expression of its core values and should be provided as needed,
- ◆ immersion of the would-be professional in a particular practice which calls forth a devotion of life and character and provides appropriate knowledge, skills and ethics,
- ◆ public and professional recognition that the person has been trained and is competent to practice,
- ◆ free and public profession or acceptance of this way of life, and'

♦ (self-) regulation of professional standards by the members of the profession as a body.

These are the sorts of things which mark a professional, without which the authority we give him or her would be implausible, even unintelligible. Confidentiality fits in here. It is a necessary part of the health professional service delivery as this is understood by colleagues, professional bodies, codes of ethics and practice, and the general public. Anyone whose desire to gossip is overwhelming should take this as a sign that he does not have a vocation to this profession; if he does indeed have such a calling, he will be immersed in a culture of professional confidentiality from the beginning of his training onwards and must cultivate the habitual demonstration of its requirements; if he transgresses accepted standards of professional confidentiality he can expect to be disciplined.

Nor is confidentiality just a quirk of the health professions like wearing white has long been. It goes to the heart of how we understand what health professionals do. When we list the sorts of things that are counted as responsibilities of health professionals, confidence receiving and keeping is usually on the list. There is a strong *prima facie* duty of keeping information gained in the course of the healthcare relationship secret, and a parallel precept against breaching confidentiality. In addition there will be appropriate character traits or virtues associated with these norms and this aspect of professionalism: respectfulness, fidelity, truthfulness, discretion. Again, if a person lacks these or is unable to cultivate them he is unsuited to this profession.

The implications of this paradigm of medical confidentiality are considerable for the range of questions I outlined at the beginning. To a large extent each will be determined by what is customary in the profession; breaches of such customs and norms will be regarded as 'unprofessional'. Unlike the confidentiality-as-religious-duty model, confidentiality-as-professional-requirement will be far from absolute: where the profession judges exceptions necessary these will largely determine the scope and limits of the professional duty. This does not necessarily

reduce the matter to complete relativity, however. Because the profession has certain intrinsic and socially-given aims and norms, this issue is not only a matter of custom and etiquette: arguably if particular practices with respect to confidentiality threaten to undermine good patient care, they will be unethical however commonplace or accepted they are amongst fellow professionals.

Nonetheless the confidentiality-as-professional-requirement model does leave us with little by which to assess current standards. Ian Robinson (1991) has argued that many of the supposedly 'accepted' exceptions to the general rule of confidentiality have in fact been imposed by the medical and research establishment in their own interests and at the expense of patients. Raanan Gillon (1985) argues that however 'venerable' inherited customs regarding confidentiality are, there is an unjustifiable paternalism underlying many of the commonplace 'exceptions to the rule', such as divulging confidential information in the 'best interests' of the patient and or of society. He rightly rejects the idea that the benefits of such actions are sufficient to warrant not even trying to solicit patient consent, and proposes a direct and more or less exclusive focus on respect for autonomy.

### Confidentiality as an example of respect for patient autonomy

In one of the leading contemporary encyclopædias of bioethics, Professor M H Kottow (1994; cf. Kottow 1986) offers a strict position and Sir Douglas Black a compromise position on confidentiality. Interestingly, both have more or less the same moral starting point. Kottow (1994, p. 472) asserts that for moderns like himself

*the idea of absoluteness elicits a feeling of uneasiness, for contemporary thinking has preferred to develop views that are more contextual, perspectivistic or circumstantial. Absolute confidentiality is therefore an extemporaneous misnomer, since no social practice and no value will hold in every and all conceivable situations.*

He thus dismisses duty-bound approaches such as that of the Hippocratic tradition as 'vague and inoperant'. Black likewise starts from a semi-relativist position: there are no

moral absolutes in life, only rules of thumb at most; there are always exceptions; we ought never to say 'always' or 'never' in our ethical discourse. Both writers plumb for the liberalism of Georgetown's 'four principles of bioethics'. Kottow (pp. 474-475) then argues for confidentiality on the basis of the (rather absolutist!) claim that "what happens in each individual's private sphere is of no concern to others" and that the patient, and the patient alone, can judge how helpful to himself it will be "to unveil information or knowingly allow information to be revealed by the invasive and pervasive gaze of medicine".

It seems to me that the individualistic ideology of 'liberal' polities such as the US and its cultural colonies has infected contemporary bioethics to such an extent that for all the talk of multiple principles, virtues and sensibilities, respect for autonomy tends to trump all. This frames my third paradigm of medical confidentiality: *confidentiality as an example of showing respect for patient autonomy*. The thought here is a simple but important one: for their own reasons people turn to healthworkers for assistance from time to time, consenting to such assistance; but they do not thereby lose their autonomy; they remain rights-bearers whose autonomy must be respected by health professionals.

This is the basis of the sorts of lists of patient rights of which we commonly hear today. Amongst those lists we usually find the right to privacy, confidentiality and/or respect for personal dignity. On this account information is a kind of *intellectual property* which the patient owns and can decide to share but on the patient's own terms; it is 'lent' to the health professionals on the understanding that they will share it with no-one unless they have the prior consent of the patient. The question of the nature, scope and limits of confidentiality is thus transformed into a *question of valid consent*. Health professionals who share information about their patients without their prior consent treat them as less than autonomous beings with a right to privacy and thereby depersonalise them; they steal from them something which belongs to the patient and is only 'on loan' to the health professional on certain terms, like a library book as it were.

Of course, as elsewhere in healthcare, there are various kinds and degrees of consent. *Actual consent* is a currently operative direction or permission given on the basis of a reasonable understanding of what is involved, including all the alternatives to and possible side-effects of giving that permission, by someone who is competent and reasonably free either to consent or to refuse. There is a lot packed into that sentence. Sometimes such permission is said to be *implied* in some other direction or permission the patient has given; consent given to a particular physician to treat in modern acute care facilities is widely understood to include consent for that physician to share what he learns or is told with others in the healthcare team, at least on a 'need to know' basis. Douglas Black goes further, arguing that sometimes permission can be *presumed*, as in emergencies where it is not possible to ask the patient's permission, or where the laws of the state require that the information be divulged, or where minors or the mentally ill present and information is shared with their parents or guardians, or where it is necessary to divulge a confidence in order to save the patient from self-harm or harm to others, or where the information is divulged in a non-identifiable way for epidemiological research (Black 1994, pp. 483-487; cf. Gillon 1986). Kottow, however, denies the validity of the whole category of 'presumed consent', arguing (with some cogency) that it is so vague as to excuse almost any paternalistic interference with patient autonomy and that concepts like conditional confidentiality and presumed consent introduce an ultimately destructive element of arbitrariness and ethical unreliability into the clinical encounter, undermining confidentiality altogether (cf. Glen 1997).

Ashley and O'Rourke's solution (1997, pp. 99-100) to the question of when confidential information can be divulged is to propose that the terms of confidentiality, including any exceptions, be precisely established *in advance*, in a *written contract*, before care is delivered; then consent to information-sharing would be formally documented like consent to surgery. (cf. Carman and Britten 1995; Lorge 1989)

Whether we take Kottow's hard-line stance or the softer views of those like Black and Ashley and O'Rourke, there are difficulties with this 'private-property-and-permission' approach to confidentiality. In the first place, it is often the health professional, not the patient, who discovers the information about the patient through testing: there is no communication by the patient of some secret which she knew before the doctor and which she could have chosen to hide or to reveal on certain terms. Furthermore, few sick people fit the bill of the idealized choosing agent, deciding with contemplative composure whether they will reveal this or that to their doctors: more often the information tumbles out, in a disordered way, from a person who is afraid and willing to reveal all in order to get well. Often the patient will not understand the full implications of giving the doctor permission to divulge personal information to others. Or the patient may be immature, or unconscious, or insane, or affected by pain, drugs, compulsions, depression, intimidation and alienation by the hospital environment, to such a degree that she are not really capable of making a rational decision about whether certain information should remain confidential. Or the patient may be the subject of economic pressures or some undue influence by health professionals or her own family, whether deliberate or not. Or culture or temperament may mean she may want someone else, such as a member of her family, to make all the decisions and therefore want to give *carte blanche* to that person to be told even more that the patient herself, thereby apparently renouncing her autonomy. For example, Filipino-Australians often surprise health professionals by the degree to which the family is involved in making the decisions about their care and this more 'communitarian' approach is a far cry from the individualism that would cast all decisions about confidentiality and everything else back upon the sick person herself.

Especially troublesome for autonomy-based analyses of confidentiality are people of limited autonomy. Kottow (1994, p. 473) deals with this issue by simply recategorising the mentally incompetent as 'non-persons'; he later even declares that the deranged are 'not capable of entering a fiduciary relationship'!

Confidentiality, on this account, is only there to protect real persons, those who are fairly sane, who are capable of wanting confidentiality and contracting in and out of it. I will not rehearse here the problems with this elitist position: suffice it to say that Kottow is (mercifully) still very much out on a limb in his thinking that we owe no duties of confidentiality to children, the insane, the unconscious and the like.

This leads to a final problem with approaches to confidentiality which are grounded on respect for autonomy: they privatize information that often should be shared, whether with the healthcare team (so that they can care better or so that they can protect themselves if necessary), the patient's family (so that they too can care better but also so that they can be properly involved in the present and prepare themselves for the future), the patient's genetic relatives (in the case of hereditary conditions), their sexual partners (in the case of sexually transmitted diseases), and their community (in the case of diseases which are public health menaces). Autonomy-based accounts encourage us to view our good as entirely private and others as rivals or threats to our interests, rather than potential friends in the joint project of achieving our common good; they therefore encourage a kind of furtiveness and adversarial secrecy which is an obstacle to friendship and community, and therefore to good care.

### **Confidentiality as an aspect of friendship**

My several objections to the previous view of confidentiality suggests that I would prefer a more 'relational' or 'communitarian' model of the nature, scope and limits of confidentiality. To elaborate this I begin with the observation that most people belong to several communities and friendships, such as family, work-situation, village, nation, church. Each involves a unifying relationship with others over some period which becomes in part constitutive of the parties themselves, their identities, values and destinies. Some of our relationships are limited to co-operation in specific projects – the commitments and associations between the parties are essentially functional, rather than being sought 'for their

own sake'. Healthcare relationships, for instance, are in themselves of this limited sort: patients are not expected to communicate their deepest secrets, hopes and aspirations to their doctor or nurse unless these bear fairly directly upon their care, or unless they choose to make their health professional also their counsellor or friend. Nonetheless even here individual choices and actions gain much of their significance from being communal, and they often lead to a deeper relationship of mutual care and respect that transcends the particular goals with which this association began (*cf.* Finnis 1970; Jones 1987; MacIntyre 1988; Nussbaum 1986; Price 1989; Sherman 1991).

If the healthcare relationship is seen as a small community and potentially a friendship, then it might seem strange that confidentiality is such a feature of it. After all, as Germain Grisez (1993, p. 415) has observed, sincerity, openness and generosity in communication are what build up community, not evasiveness, secrecy and silence. Yet it is also true that intimate friendships require the kind of privacy, and trust premised on privacy, that will allow and encourage people to reveal themselves more fully than they would or rightly could to other people. Thus paradoxically both open communication and privacy are necessary for building up community and friendship. On such a view the very point of confidentiality is *not* that the other is seen as a rival or threat (as I suggested often underlies autonomy-based approaches), but rather that the other is seen as worthy of a certain intimacy, a certain kind of mutual information-sharing to the exclusion of others. Grisez (1993, p. 415) notes that certain valuable interpersonal relationships depend on trust that communications will be kept between the parties, such as sacramental confession, intimate communication between husband and wife or between friends, professional secrets, secrets children confide to parents and so on. While some of these confidences may be absolute (as in the confessional), others will be qualified, as when professional colleagues can only fulfil their professional responsibilities by collaboration. Ashley and O'Rourke (1997, p. 99) put it thus: "*Human community is based on free communication, which is impossible if confidences*

*cannot be shared. Thus health professionals have a serious obligation to maintain such confidences that protect the patient's right to privacy.*"

A community or friendship paradigm helps to explain why there is a presumption in favour of keeping confidences, including medical ones, and also why there are exceptions. Rather than consent given by autonomous strangers or rivals to each one borrowing the knowledge of another, friendship suggests that information sharing is good but that there must be limits as required by the friendship. Here the proponents of liberal approaches demonstrate a fundamental misunderstanding of autonomy. Kottow (1994, p. 475), for instance, claims that "in confiding in his doctor the patient is reshuffling his autonomy and transferring part of it"; and Black (1994, pp. 485-486) suggests that when the patient gives free informed consent to the release of health information contained in his record he "voluntarily abrogates his own autonomy". Well, whatever reshuffling, transferring and abrogating autonomy could possibly mean, self-sharing in communication or otherwise *is* an autonomous act, an *expression* of autonomy, and a potential enrichment of autonomy rather than a diminishment or compromise of it. In freely entering relationships with others we do not 'give away' something we own, our private information, our freedom: rather, our range of options is extended, our minds and hearts expanded, we are enlarged and, in the case of healthcare, we are also given things which are necessary to our exercising autonomy at all.

What, then, are the scope and limits of the presumption in favour of keeping confidences secret? Grisez (1993, p. 417) helpfully suggests applying the golden rule here. Having considered the basis of the responsibility to keep the confidence, including relevant norms, promises, laws, customs and professional expectations, and the likely effects both of keeping and of breaching the confidence, one should ask: how would I regard someone in my position breaching such a confidence were I the person to whom the confidence were owed? This exercise in moral imagination and appropriate

impartiality will help us avoid prejudice in decisions to respect or not to respect confidentiality (cf. Edgar 1994). If we view healthcare relationships as a variety of community and friendship, such a test will easily explain why health professionals ought not to gossip about their patients (or each other), nor question patients within earshot of others who need not be there, nor tell aloud private information about patients in hospital elevators or cafeterias or the other places where they might be overheard, nor leave patient records on open view for others—all of which, sad to say, are all too common (cf. Grady, Jacob and Romano 1991; Rushton and Infante 1995; Ubel *et al* 1995). A friendship model also explains why confidentiality should be observed even when the patient is not likely to be humiliated or harmed by divulging the information, as when she is unconscious or mad or too young to care; autonomy-based accounts, as we saw earlier, have great difficulties explaining this. Still less would friends contemplate passing such information to the media or other such parties. Medical friendship is careful to protect things expressly revealed in confidence but also anything of a private or degrading or potentially embarrassing nature which one discovers in the course of the relationship (cf. Parrott *et al*, 1989); it is likewise solicitous to defend the other's reputation and not only during the term of the formal healthcare relationship but thereafter, perhaps even after the patient's death.

As friendship requires that friends intervene to protect each other both from violence and from committing violence, this model of confidentiality will allow the divulging of confidential information to those who might prevent suicide or other injury; of course the health professional will first try to persuade the person to report or commit himself and get appropriate attention. Ashley and O'Rourke (1997, p. 100) extend this category further to include with those who are suicidal, patients feeding a self-destructive chemical dependency, and with those who pose a threat to others, patients determined to risk spreading some contagious disease. "The family or society," they explain, "has an obligation to prevent harm both to the patient and

*to the public because all are members of a community that exists for the good of each of its members in relation to all others... Professionals have not only the right but the duty to communicate information to those who may be able to prevent serious harm to the patient or to others."*

A communitarian approach also suggests that, generally speaking, the family or the patient's nearest and dearest will be given relevant information regarding the patient because together they form a basic community of care and respect and can only function adequately if such important matters are common knowledge; this is all the more clearly the case with respect to minors and information-giving to parents or guardians. In "Reconciling the patient's right to confidentiality and the family's need to know" Furlong and Leggatt (1996) have recently suggested that we must explore options, especially at the engagement phase, which allow for meaningful collaboration with families later on.

Likewise if healthcare is seen as a form of friendship, not only between health professional and patient, but also between the community which helps fund the care and the patient, a good case could be made for allowing patient records to be used for research purposes, as long as anonymity is carefully protected so that no trust is broken.

### **Contemporary issues regarding confidentiality**

We might now reflect briefly upon a few very current dilemmas with respect to confidentiality to see if the four paradigms analysed above might have anything to say to them. I will treat here HIV, genetic testing, information technology and statutory reporting, but there are clearly many more problem areas worthy of careful attention.

#### **HIV**

One much-asked question on confidentiality concerns whether health professionals who learn confidentially of a patient's HIV+ status may (or even should) communicate that information to other members of the healthcare team and/or to the family, and especially the sexual partner, of the patient.



A healthcare paradigm that conceives of each HIV+ patient as a child of God, and each healthcare intervention as a quasi-priestly mediation of God's healing grace, would be very reluctant to compromise a patient's privacy and the doctor's covenant. Since 'universal precautions' are supposedly universally followed and every patient is properly treated as an potential HIV carrier, it is hard to see what benefit would be gained for health professionals by any breach of that covenant. An exception might conceivably be made where a patient with an infectious and lethal disease expresses the intention of putting others at risk. This would be true, for instance, of someone with bubonic plague who intended to return to his community while still contagious; the same would be true of a person with HIV who intended to keep this information secret and continue to engage in high-risk acts with his unsuspecting sexual partner.

A professional model will look to the evolving standards of the health professions for guidance on these matters. Current standards in several countries give considerable latitude with respect to situations such as the HIV+ patient, with several medical associations asserting rights to compulsory testing, compulsory sharing of HIV test results amongst health professionals caring for a particular patient, and revelation of such information to the sexual partners of patients who refuse to share this information themselves. The rationale for all these exceptions with respect to HIV is not always clear but much of it seems to be focussed on the interests of the professionals themselves (cf. Marshall 1990).

A patient autonomy paradigm, on the other hand, would *prima facie* disallow all these supposed exceptions to the confidentiality rule. News of someone's HIV status is that person's business and no-one else's; it is up to him to decide, in his own good time and free from pressures of others, especially his healthcarers (Kottow 1994; Obade 1991). Lorge (1989) found most people surveyed expect and require of their doctors that they keep secret from insurance companies their HIV+ status. Any other view is a failure of respect for the personhood of the HIV+ patient, an infringement of his rights. Of

course an HIV+ patient might give free and informed consent to such information sharing, whether with staff or family, by contract prior to testing or by present permission, but this would require access to appropriate counselling and 'space' for thinking through the implications of such revelations. But even here we must be wary of too readily accepting permission from such a patient to divulge such sensitive information: shame, lack of self-esteem, fear and depression, poverty—all might vitiate such supposed consent.

A more 'communitarian' model of the nature, scope and limits of confidentiality would focus very immediately on the threat to trust and frankness of communication which any policy of divulging HIV results would have. Any loose talk by health professionals about this matter might also do irreparable harm to community with this particular patient; he has a right to a reputation and his healthcarers as his potential friends have a duty to help protect that reputation. On the other hand, healthcare is a team effort of several colleagues who must share with each other what they know if they are to care well; and health professionals have duties not only the patient in front of them but, to some extent, to the person's family and the broader community (cf. Marshall 1990).

Honestly applying the Golden Rule, the doctor might conclude that were he in the patient's shoes he would accept the information being shared with others on a strictly need-to-know basis, without thereby thinking himself unjustly treated or losing faith in health professionals. Doctors, like everyone else, are involved in several overlapping communities and their responsibilities to one may compete with their responsibilities to others. They might legitimately conclude that their duties in friendship to their colleagues, the sexual partner of their patient, or their society, are sufficient to warrant the risk that their patient will feel betrayed.

On the other hand, the doctor might fear that such a policy would only exacerbate the social prejudice, discrimination and alienation already suffered by homosexuals and narcotic-users, denying them that ordinary

confidentiality which others with highly embarrassing and even dangerous conditions can presume they will receive as of right. Kottow (1994, pp. 476-478) suggests that, for all their appearance of social concern, most arguments to justify 'cheating on confidentiality' with respect to HIV+ bisexuals or promiscuous carriers are really based upon a kind of as 'moral puritanism'. He observes that breaches of confidentiality with respect to such people will only serve to subtract such people from adequate care, because they will be understandably unwilling to confide in indiscreet medical practitioners. We risk establishing an underclass of people who are denied the protection of confidentiality, and this could drive those people away from health services and fracture community in the process.

Nonetheless, a patient determined to risk spreading some contagious disease must in all reason expect that others will seek to contain the risk (*cf.* Ashley and O'Rourke 1997, p. 102; Green 1995). Furthermore, the patient's sexual partner and children are not only at risk of contracting the disease; they are the ones charged with the first care for the patient, a care they cannot provide if they are 'kept in the dark' about what is wrong with him. They too will have grief and fear and much else beside to contend with sooner or later, and should be assisted to come to terms with the situation before they discover it in some less supportive situation.

Given the strong communitarian arguments both for and against divulging confidential information in these situations, Benjamin Freedman (1991) has suggested that the physician would be at liberty to disclose but is not obliged to do so. I agree: in the end this seems to me a matter of discretion and prudence in the circumstances.

### Genetic test results

It is a real possibility that genetic information about people could easily in the future become 'common property', with extended family, the health system, researchers, employers, insurers, creditors, police and the government all demanding to know the results of any genetic tests a person has or even prescribing tests which we must have (*cf.* Lorge 1989;

Wiesenthal & Wiener 1996). There is not space to consider whether each of those groups has any right to expect that confidential genetic information will be divulged to them: here I shall consider just one example.

Jean Adams (1990) tells the story of a mother who had the symptoms of Huntington's chorea and did not want her daughters to know. The doctor tried to make her realise how valuable the information could be to her daughters (in terms of seeking the best medical help, coming to terms with the likely future, deciding whether to marry or have children...), and thus tried to obtain her consent to inform them. What if the mother still refuses to consent to information-sharing in these circumstances? Adams' answer is straightforward: the well-being of the daughters and their future families must take precedence over the mother's desire for secrecy regarding her condition. But other physicians, genetic counsellors and bioethicists would think differently (*cf.* Fletcher *et al* 1990: a similar case). I am inclined to Adams' view, but I confess that I am not sure. (For a fuller discussion of these issues see: Rothstein 1997.)

### New information technologies

Another area of recent concern with respect to patient confidentiality has been the implications of computerization (e.g. Carman & Britten 1995). Obviously computerized medical records allow storage, manipulation and immediate access to vast amounts of information and therefore can be of advantage both to patient care and to institutional efficiency. But this is not without its risks to patient privacy. On the simplest level there is the problem of computer screens with patient records on open view in hospitals. Still more challenging is the fact that electronic data bases now store and centralize more and more information about us, and all sorts of people could potentially have access to this: researchers, employers, insurers, police and the government (*cf.* Gostin 1997; Wernert 1995). There is as yet little agreement on how such records should be secured and who should have access to them.

Ashley and O'Rourke (1997, p. 101) again suggest formal patient permission should be

sought before records are computerized, and then who shall have access to those records should be specifically authorized in the patient's confidentiality contract. Other writers suggest legislation is in order (e.g. Wernert 1995). I think the health professions themselves must give the lead here, developing their own principled view and strategies of implementation, after broad-based community consultation and taking sound ethical advice.

### Statutory reporting

At the beginning of this article I suggested that one of the implications of seeing healthcare as a religious vocation and health ethics as the terms of a religious covenant is that the responsibilities of that calling cannot be abrogated by the doctor himself, his patients, his colleagues or his polity. Yet in modern times governments have repeatedly intervened with legislative mandates requiring health professionals to report to some authority certain otherwise-confidential matters, such as births and deaths, child abuse and child neglect, certain infectious diseases, suspicion of crime, threat of crime, and so on. Medical records are also commonly subpoenaed in criminal or civil actions. The law of negligence now recognizes a duty of health professionals in certain circumstances to report patients with dangerous tendencies to the authorities (cf. Emson 1988; McPhedran 1996; Reamer and Schaffer 1985).

Most treatments of medical confidentiality as a professional matter accept that, if the state requires such confidence-breaking, that is the end of the matter. Yet clearly not everything that governments require of health professionals is moral: the advent of modern healthcare ethics was in fact largely a reaction to the monstrous demands made of doctors during the Nazi period which, to the eternal shame of the profession, were all too often complied with all too willingly. Autonomy-based approaches will be suspicious of mandatory reporting regimes and might even regard them as unethical (e.g. Kottow 1994); more communitarian approaches will be better disposed to such measures, as long as

the common good would clearly be best served in this way (e.g. Ashley and O'Rourke 1997, pp. 100-101). As a lawyer myself, I am wary of the tendency of lawyers and politicians to see mandatory reporting, followed up by various bureaucratic interventions, as the solution to all problems. I am all the more wary when this involves compromising important principles such as medical confidentiality and disappointed that there is so little resistance to this trend amongst health professionals themselves. What if governments were to decide that the medical records of every patient whose life-style in any way contributes to their illness, e.g. through sexual behaviour, drug-taking, drinking, smoking, diet, lack of exercise etc., have to be handed over to some government authority so that the person can be 'encouraged' to lead a healthier life-style? We should not, I think, presume that every mandatory reporting measure will in fact serve the common good or accord with sound medical ethics (cf. McConnell 1994).

### Conclusion

In the face of the enormous challenges to confidentiality in contemporary healthcare practice, current medical and nursing codes seem to me to be inadequate to the task, couched as they are in deliberately vague language of 'respecting the principle of confidentiality', 'judiciously' divulging confidential information to 'appropriate' others and 'using professional judgment' when doing so. However, as the fragmentation of the underpinnings of healthcare ethics continues apace it may be increasingly difficult to construct coherent international and national codes which are anything more than vague 'motherhood' statements. In such circumstances there will be a need for thorough discussion by professional groups, bioethics institutes and hospital staff with a view to establishing local protocols on how medical confidentiality is to be respected in the twenty-first century (cf. Fletcher 1991).

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