Legal reviews

This is another paper in a series of reviews dealing with legal aspects of surgical practice. We have asked several distinguished authors, expert in their field, to contribute to this series. Our aim is to provide up-to-date guidance for surgeons in potentially difficult areas of their practice and academic work, whilst at the same time re-affirming the legal boundaries within which they work.

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Confidence and conflicts of duty in surgery

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ABSTRACT

This paper offers an exploration of the right to confidentiality, considering the moral importance of private information. It is shown that the legitimate value that individuals derive from confidentiality stems from the public interest. It is re-assuring, therefore, that public interest arguments must be made to justify breaches of confidentiality. The General Medical Council's guidance gives very high importance to duties to maintain confidences, but also rightly acknowledges that, at times, there are more important duties that must be met. Nevertheless, this potential conflict of obligations may place the surgeon in difficult clinical situations, and examples of these are described, together with suggestions for resolution.

KEYWORDS

Confidentiality – Conflict of duty

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The publication of the General Medical Council's (GMC) new guidance on confidentiality offers the chance for a timely reflection on the moral underpinnings to a duty of confidentiality.¹ In the same way that consent can allow clinicians to touch a patient in the course of treatment, consent can also allow clinicians to disclose information that is otherwise confidential. Thus confidentiality and bodily integrity are two obvious manifestations of our autonomy, and the key to making interferences with both of these legitimate, from the clinician's perspective, is consent.

When read alongside the GMC's guidance on consent,² the new guidance provides exhaustive advice on obtaining lawful disclosure of personal information.

The importance of confidentiality

Well-known ethical principles and associated maxims are commonplace throughout healthcare. Their familiarity melts into a received wisdom. We know, for example, that we must do no harm, respect autonomy, and uphold

patients' rights. Key amongst the important principles is confidentiality, which has attained a quasi-sacred status that commentators can date all the way back to Hippocrates:³

And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.

As with other ethically grounded principles, there is a danger that we too easily take for granted the goodness of this concept.⁴ It is salutary, therefore, to engage critically with confidentiality to understand whether, why, and to what extent we should protect it.

Thompson suggests that confidentiality comprises three values: privacy, confidence, and secrecy. The importance of privacy is logically entailed by any system that includes private individuals, and rights of privacy carry into the doctor-patient relationship. Thompson cites three reasons for this: (i) the patient's inherent vulnerability; (ii) privacy inherent to the very nature of a consultation; and (iii) the need for 'reciprocal confidence' if intimate information is to be shared. The value of confidence comes from the beneficial therapeutic effect it inspires, and the support it gives to the 'contractual relationship' between doctor and patient. Added to this is a wider confidence that the public must have in the medical profession. Finally, secrecy relates to the doctor's possession of specialist knowledge and the best way to impart this knowledge to the patient (if at all) given individual idiosyncrasies.⁵

It seems that two layers of argument are of particular interest to an evaluation of the importance of confidentiality in healthcare. The first appears pragmatic, though clearly rests upon value-based concerns about individual welfare and the public good. Without a credibly confidential relationship, healthcare will be vastly sub-optimal, with patients unwilling to disclose personal matters that they would not wish to be widely known. The second layer of argument is more philosophical: what is privacy, and are there any principled reasons why privacy should be protected?

Few support 'absolute' moral principles that must be respected at any cost. We cannot, for example, be beholden unqualifiedly to patient autonomy. Equally, it would be difficult to claim that morality always demands that confidentiality be maintained, although it has been argued that any breach of medical confidentiality undermines medical practice and so is never justifiable.⁶ If we move away from such an extreme view of the importance of confidentiality, and accept that healthcare professionals have a relationship both with their patients and society more widely, the view that confidentiality is nonetheless very important for both practical and principled reasons can still hold. In addition, it gives a presumption that there must be justification if

patient confidentiality is to be breached.⁷ Practical arguments linked to effective healthcare are easily understood. Consideration is needed, however, of the purported right to privacy that would be linked to a right to confidentiality: why and how should such a right exist? What harm obtains, or interest is disrespected, when confidentiality is flouted?

Autonomy, privacy, and confidentiality

It is clear that there is overlap between autonomy, privacy, and confidentiality, and that the arguments that support one can also support the others. However, the three are usefully distinguished as follows. Autonomy relates to self-government broadly conceived. What is conducive to good self-government (what is 'good for autonomy') depends on many factors. Sometimes it involves a person being burdened with information, sometimes in protecting a person from an 'information overload'. Sometimes good self-government requires many choices to be available; sometimes autonomy only permits one rational choice. Privacy refers to information about us that warrants a special type of protection because of its personal nature. Privacy need not connote secrecy: we may share private information with others. And this is where confidentiality claims importance: a right to confidentiality exists where a person has a claim that another may not share private information.⁸ Again, this need not mean absolute secrecy. If a patient tells his doctor something in confidence, he may be happy for her to share that information with other healthcare professionals who are caring for him. However, the information does not become public by mere virtue of his disclosure.

The surgeon who is confronted with a patient who, in seeking treatment, reveals that his sight is too poor, or whose seizures are insufficiently controlled, to drive is thus confronted with a common dilemma. The patient has inadvertently revealed information that the DVLA would regard as precluding him driving on public roads. Ideally, the patient will accept the surgeon's advice to disclose the situation to the DVLA, and adhere to the Authority's instructions. If the patient is resolute in refusing to do this, and continues to drive, the surgeon is obliged to inform the DVLA, whilst informing the patient that he is doing so.⁹

A New Zealand case of a bus driver with three-vessel coronary disease illustrates the narrow distinction between breaching a patient's confidentiality in the public interest, as opposed to revealing matters that the public might be interested in.¹⁰ His doctor, who had disclosed the fact that the patient had undergone triple bypass surgery to the relevant authorities, had also disclosed the supposed danger to the passengers. His disclosure to the authorities was accepted as consistent with the public interest; however, he was found guilty of breaching confidentiality with his disclosure to the public.

Is privacy sacred?

Generally, rights can be said to protect our interests or our legitimate autonomy.¹⁴ When someone asserts a right, he seeks to demarcate a matter of sufficient importance that others have a duty either to meet his claim (a right to necessary medical care imposes a duty on the state to provide it), or not to interfere with his exercise of a liberty (a right to drink alcohol imposes a duty on others not to stop people from doing so). When someone asserts a right to confidentiality, he asserts a duty on those with knowledge not to share it.

This is exemplified by the patient with a cancer, perhaps colorectal or genital, who regards her condition as humiliating. Irrespective of the benefit that her relatives might derive from the knowledge of her cancer, and its details, she is resolute that her information should be kept confidential. If we are to be convinced that our duty to her is compelling, we need to know what interest it serves, or why it is entailed by an aspect of her autonomy.

Scanlon¹² suggests that whilst invasions of privacy vary, there is a 'common foundation' to the diverse matters that may constitute an invasion of privacy. An interest based on this foundation would demonstrate privacy's special source as the grounding of a right. Scanlon¹⁵ suggests that:

The interests to which an account of privacy must refer ... include, in addition to specific interests in not being seen, overheard, *etc.*, broader interests in having a zone of privacy in which we can carry out our activities without the necessity of being continually alert for possible observers, listeners, *etc.*

Rachels¹⁴ also believes there is a special interest that derives from privacy itself:

[T]he value of privacy [is] based on the idea that there is a close connection between our ability to control who has access to us and to information about us, and our ability to create and maintain different sorts of social relationships with different people.

Thus, a special interest can be seen to attach itself to privacy. By parallel reasoning, maintaining confidentiality when private information has been given in confidence provides the basis of a right.

From this general discussion, we can observe that there is a strong interest for each of us in sustaining privacy. This is as applicable to surgeons as it is to their patients. An HIV-positive dental surgeon was attempting to prevent a national newspaper from revealing his speciality, the health authority for which he worked, or the approximate time of his seroconversion.¹⁵ In considering the injunction that he sought to prevent publication, the court recognised the strong public interest in maintaining the confidentiality of health workers with HIV, since it was important that they were not deterred from reporting this to their employers.

On the other hand, to constrain the paper from identifying him as a dentist would inhibit a legitimate public debate over the ability or otherwise of HIV-positive dentists to continue in practice. The injunction against naming the dentist or his employing authority was upheld.

Where we provide personal information in confidence, we can legitimately expect that confidence be maintained. This enables us to live fulfilling lives without concern about intrusion into our affairs. Furthermore, we have seen that in the healthcare context, this general rule is of particular salience: not only is health-related information considered to be 'axiomatically private';¹⁶ there are also good, consequence-based reasons for having a system in which patients expect confidentiality. Within marriage, each spouse retains this right. A husband has no more right to information about his wife's abortion than he has a right to veto it.¹⁷ Fifty years ago, at least one judge had no doubt that a surgeon should, in addition to obtaining the wife's consent, 'approach the spouse in order to satisfy himself as to consent' when considering sterilising a married woman.¹⁸ The dictum seems anachronistic now, although was equally applicable to vasectomy at the time.

Confidentiality promotes accurate consultations and, thereby, optimises the prospect of the best health outcomes. However, there are limits to this. Any right is qualified by all other rights. Sometimes, the interest supporting a right to confidentiality must bow to a greater interest supporting other rights.

Conflicts of duty, and confidentiality in surgery

Surgeons are presented with an apparent dilemma when there is a choice between protecting an individual's confidence and honouring another interest. As a starting point, the common law establishes that threat of physical violence to a third person can justify a breach of a patient's confidentiality.¹⁹ In this case, a psychiatrist's disclosure of the risk of serious harm to the public that could flow from the release of his patient from his secure unit was considered by the court to be legitimate. This is echoed in Article 8(1) of the European Convention on Human Rights (ECHR), which guarantees individuals' right to respect for private and family life, but contains the following qualification in Article 8(2):

There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

It is well known that the law provides relatively little guidance on the question of when breaching confidence is

acceptable, let alone required. In a Californian case,²⁰ a young girl acquired HIV through a blood transfusion. Neither she nor her parents were told. Later, she inadvertently infected her boyfriend, who received damages from the surgeon because he failed to inform the girl of her propensity to infect others. Academic lawyers recognise that it is not clear how this case would have been dealt with in the UK, illustrating the degree of uncertainty that exists.²¹

More explicit legal protection of privacy is provided by the influence of the *Human Rights Act 1998*, which introduces Article 8 into English law.²² Although ultimately it is the law that offers authority to the boundaries of acceptable and unacceptable breaches of confidence, in a medical context, enforcement generally resides with the GMC, and judges will look to GMC guidance when developing legal rules.²³

The principal guidelines²⁴ reflect well the ethical considerations outlined above. There is an emphasis on taking the approach least likely to offend against a right to confidentiality. For example, inform patients when there is a need to share information, anonymise data where this will suffice, seek express consent for disclosure, and keep disclosures to a minimum.²⁵ It is incumbent, too, when disclosing confidential information to others within the surgical team, to ensure that they recognise its confidential nature.²⁶ On disclosure in the public interest, it says:

37. Personal information may ... be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential. You must weigh the harms that are likely to arise from non-disclosure of information against the possible harm, both to the patient and to the overall trust between doctors and patients, arising from the release of that information.

Practitioners' discretion to adjudge the public interest leaves them vulnerable to the GMC, and ultimately the courts, but the guidance does suggest various avenues for consultation where there is doubt.²⁷ Confidentiality's great importance is found in limits to a minimum of non-consensual disclosure of information: disclosure must be necessary, and likely to achieve its purpose. Consent must be unobtainable or, though withheld, still subservient to something more pressing in the public interest.

One of the most relevant contemporary conflicts between patient and public interests is in the field of violent crime, as the GMC instructs that surgeons should inform the police quickly, when a person with a gunshot or knife wound presents for treatment.²⁸ The reason for this is primarily one of safety, to prevent a further attack either on the patient, or others in the vicinity of the hospital or original site of wounding. As a quite separate matter, we are

advised, by the second stage of this guidance, to judge whether further disclosure of personal information, including the identity of the patient, is justified in the public interest. This is deemed a clinical judgement, and is greatly helped by the GMC's guidance, which all surgeons should read. There is no obligation to provide personal information about the patient to the police during their initial contact, although, if clinically appropriate, the patient may be both able and willing to provide permission for disclosure, which obviously simplifies the situation. In the absence of consent, if the police have grounds to believe that confidential information is vital to their investigation, they may approach a judge or the presiding officer of a court, for an order to obtain information within the medical record; this order must be complied with. Additionally, there are some statutes, including the *Terrorism Act 2000*,²⁹ which compel all citizens, including doctors, to disclose information to the police.

Conclusions

This paper has considered the moral underpinnings to a concern for confidentiality, and their practical application. Respecting patients' privacy helps ensure that they disclose personal information accurately, and thus receive optimal healthcare. When assessing the value of maintaining confidentiality, furthermore, it is important to consider the wider effects of a breach: the integrity of public healthcare requires that society generally has faith in healthcare professionals' respect for confidentiality. There are good reasons to recognise an interest in privacy; sufficiently strong reasons to support a right to confidentiality. Nevertheless, sometimes there will be countervailing interests. By seeing that the common good underpins both legitimate claims to keeping and setting aside confidentiality, we see a positive way forward. Apparent conflicts of duty are usefully dealt with through a 'balancing exercise'. But, it is helpful to remember that, ultimately, there is appeal to one bedrock of legitimacy – the public interest. At the level of principle, this means that, whilst breaching a patient's confidentiality feels intuitively wrong, it may be justified without contradiction, incoherence, or disregard of legitimate claims. In practical terms, this may lead to proportionate disclosures on the basis of an obligation, placed on surgeons both by the law and the GMC, such as in the example of knife crime. The proper and most expedient way of resolving the issue of confidentiality is to obtain the consent of the patient, or others who may be empowered to provide it. When this is impossible, and the clinical need for disclosure remains, advice should be sought from the local Clinical Ethics Committee.

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