

Introduction

Confidentiality is seen as a fundamental ethical principle in health care and a breach of confidentiality can be a reason for disciplinary action. Dilemmas around confidentiality arise when the principle of confidentiality is in possible conflict with other ethical principles such as avoiding harm to the patient or others. Issues around confidentiality may be brought to a clinical ethics committee or group in the form of individual cases or in considering hospital policies. There are also issues of confidentiality for the ethics committee itself. In this section we provide a brief overview of the ethical and legal approaches to confidentiality and then look at some specific issues that may present to ethics committees. We describe a hypothetical case to illustrate the issues that might be brought to a committee by health professionals, and then look at the duties of the committee regarding confidentiality and access to records in health care. The section concludes with some suggested further reading on the issues.

This section does not provide a comprehensive overview of the issues around confidentiality, and does not make recommendations about what an ethics committee should do. It highlights issues that a committee may wish to consider and provides some ethical and legal frameworks for approaching the subject.

Ethical considerations

Confidentiality can be considered from a number of different ethical perspectives

Respect for patient autonomy

The principle of respect for patient autonomy acknowledges the right of a patient to have control over his or her own life – and this would include the right to decide who should have access to his/her personal information. Can there be a breach of confidentiality if a patient never knows that the healthcare professional has disclosed the information? Where the basis for the duty of confidentiality is the principle of respect for autonomy any breach of confidentiality means that the patient's autonomy has not been respected, whether or not the patient is aware of the breach.

Implied promise

The health professional-patient relationship could be seen as having elements of an implied contract and this could include an implied promise that health professionals keep information about their patients confidential. It is reasonable for patients to expect that information they divulge to their doctors or other health professionals will be kept confidential. If confidentiality is subsequently breached the patient may feel that a promise has been broken. This view of confidentiality is different from that of patient autonomy because it depends on the concept of the doctor-patient relationship rather than what the patient wants or believes.

Virtue Ethics

Virtue ethics focuses on the position of the doctor rather than that of the patient (as is the case with respect for autonomy). This approach asks what a virtuous doctor would do in the particular circumstances - what issues would a virtuous doctor take into account in deciding whether or not to disclose confidential information?

Consequentialism

From a consequentialist position the question of whether it is wrong to breach confidentiality is determined by the consequences of the breach. One of the consequences of a breach of confidentiality could be that the patient will lose trust in his/her doctor, and perhaps doctors generally, resulting in him/her not accessing healthcare in the future with a detrimental effect on his/her (and others?) health. On the other hand there may be situations where there are bad consequences of not breaching confidentiality, for example third parties may be denied information which would have serious implications for their health and treatment

Professional guidance

The General Medical Council (GMC) has published guidance on confidentiality, including supplementary guidance on specific situations such as reporting concerns about patients to the DVLA or DVA. (Although they do not have the force of law, the courts do consider such guidance to have persuasive authority).

GMC: [Confidentiality: 2009](#)

‘There is a clear public good in having a confidential medical service. The fact that people are encouraged to seek advice and treatment, including for communicable diseases, benefits society as a whole as well as the individual. Confidential medical care is recognised in law as being in the public interest. However, there can also be a public interest in disclosing information: to protect individuals or society from risks of serious harm, such as serious communicable diseases or serious crime; or to enable medical research, education or other secondary uses of information that will benefit society over time.’ GMC Para 36

The GMC has interactive case scenarios to illustrate how their guidance can be applied in practice. Some scenarios related to their guidance on confidentiality are available.

[GMP in action](#)

The Nursing and Midwifery Council (NMC) has a section on confidentiality in their Code of Conduct. NMC. [The Code: Standards of conduct, performance and ethics for nurses and midwives. 2008](#)
[Confidentiality](#)

Confidentiality: NHS Code of Practice 2003.

The code is a guide to required practice for those who work within or under contract to NHS organisations - it deals with confidentiality and patients' consent to the use of their health records.

The code can be downloaded from the [Department of Health website](#)

Legal considerations

The Human Rights Act, which encompassed the European Convention on Human Rights into UK law, recognises the importance of confidentiality under Article 8 of the Convention, the right to respect for private and family life which states:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is 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.

There is a public interest in health professionals maintaining patient confidentiality - this encourages patients to fully divulge relevant information so that the healthcare professional can make a proper assessment of the patient's condition. On the other hand there may, occasionally, be circumstances where the interest in maintaining confidentiality is outweighed in the public interest (disclosure to prevent a crime, for the health interests of others etc) and this justifies disclosure of confidential patient information without consent. The health professional will have to balance these competing public interests in deciding whether or not to disclose. Assistance can be gleaned from legal cases and professional guidance (the courts do take account of these).

W v Edgell [1990] 1 ALL ER 835

The patient was a prisoner in a secure hospital following convictions for killing five people and wounding several others. He made an application to a mental health tribunal to be transferred to a regional unit. An independent psychiatrist, Dr Edgell, was asked by W's legal advisors to provide a confidential expert opinion that they hoped would show that W was no longer a danger to the public. However Dr Edgell was of the opinion that in fact W was still dangerous. W's application was withdrawn. Dr Edgell, knowing that his opinion would not be included in the patient's notes, sent a copy to the medical director of the hospital and to the Home Office.

The patient brought an action for breach of confidence.

The Court of Appeal held that the breach was justified in the public interest, on grounds of protection of the public from dangerous criminal acts. However, the Court said the risk must be 'real, immediate and serious'.

X v Y [1988] 2 ALL ER 648

A Health Authority sought an injunction to prevent a national newspaper publishing the names of two practising doctors who were receiving treatment for AIDS. The Court balanced the public interest in freedom of the press against the public interest in maintaining hospital records confidential. The Court found that lack of publication of the information would be of minimal significance since there was a wide ranging public debate about AIDS generally.

In balancing these competing interests it should be noted that disclosure should in any event only be made to a relevant party - there should be no blanket disclosure.

See also: **H (a Healthworker) v Associated Newspapers Ltd [2002] EWCA civ 195. Times, March 19, 2002** in which again the Court of Appeal reiterated the strong public interest in maintaining the confidentiality of health workers infected with HIV.

In **Axon, R (on the application of) v Secretary of State for Health & Anor [2006] EWHC 37 (Admin)** the Court addressed the issue of confidentiality in relation to minors under the age of 16 years. This case concerned disclosure of information regarding termination of pregnancy but the principle can be applied to confidentiality in other situations. The court emphasised that a young person is entitled to the same standard of confidentiality as an adult provided that they are competent. (see our commentaries pages for a summary of this case).

Statutes requiring disclosure

Some statutes require disclosure of confidential information where this would otherwise be a breach of confidentiality. These include:

Police and Criminal Evidence Act 1984

The police can access medical records for the purpose of a criminal investigation by making an application to a circuit judge.

Public Health (Control of Disease) Act 1984 and Public Health (Infectious Diseases) Regulations 1988

A doctor must notify the relevant local authority officer (usually a public health consultant) if he suspects a patient of having a notifiable disease. AIDS and HIV are not notifiable diseases.

Abortion Regulations 1991

A doctor carrying out a termination of pregnancy must notify the relevant Chief Medical Officer including giving the name and address of the woman concerned.

Births and Deaths Registration Act 1953

The doctor or midwife normally has a duty to inform the district medical officer of a birth within six hours. Stillbirths (a baby born dead after 24th week of pregnancy) must be registered. Doctors attending patients during their last illness must sign a death certificate, giving cause of death.

Road Traffic Act 1988

All citizens, including doctors, must provide the police, on request, with information (name, address), which might identify a driver alleged to have committed a traffic offence. This would not normally justify providing clinical information without the patient's consent, or a court order. A doctor may have a legal obligation to inform the DVLA if he has concerns that a patient has a medical disability that could affect his driving.

[DVLA](#)

Human Fertilisation and Embryology Act 1990

The Human Fertilisation and Embryology Authority maintains a register of individuals receiving fertility treatment.

NHS (Venereal Diseases) Regulations 1974

Allows limited disclosure of information for contact-tracing in the case of sexually transmitted diseases. Such disclosure can only be made to a doctor, or to someone working on a doctor's instruction in connection with treatment or prevention. It forbids those working in a genito-urinary clinic to inform an insurance company of a patient's sexually transmitted disease – even with the patient's consent. GP's are not routinely informed of the patient's attendance at such clinics, although the patient may request that the GP be informed.

Children Act 1989

Regulates many aspects of childcare including professionals' duties when there is suspicion of child abuse.

Prevention of Terrorism (Temporary Provisions) Act 2000

All citizens, including doctors, must inform police, as soon as possible, of any information that may help to prevent an act of terrorism, or help in apprehending or prosecuting a terrorist.

Case study

The following is a worked example of a hypothetical case study showing how ethical principles would apply to a practical problem.

Bob has attended the genito-urinary clinic at his local Trust hospital. Bob is seen by Dr Gomez who informs him that he is HIV positive. Dr Gomez counsels Bob to contact his sexual partners to inform them of his status. Bob starts a course of treatment.

For the last 18 months Bob has been in a relationship with Sue. They are expecting a baby in 2 months time. Before this relationship Bob had a series of sexual partners.

On a subsequent visit to the clinic it becomes clear to Dr Gomez that Bob has not told Sue of his HIV status. Dr Gomez is aware of the impending arrival of their baby and tells Bob that steps should be taken to assess whether Sue is HIV positive and whether the baby is at risk so that if necessary treatment may be started.

Bob adamantly refuses to tell Sue and says that if she is told without his consent then he will stop his course of treatment.

What should Dr Gomez do? Can / should he inform Sue, or Bob's GP?

Issues to consider

The principle of respect for autonomy requires that personal information should not be disclosed without consent. However, in some cases the autonomy of another person may also be at issue (in this case Sue and previous sexual partners, as well as the baby when born). Not disclosing information may limit their ability to make decisions as to treatment and lifestyle.

Although maintaining confidence in personal information may be the starting point, a balance of the benefits and harms of disclosure / non-disclosure leads to consideration of the consequences of a course of action.

In this scenario the harms of non-disclosure can be identified as:

- The risk that Sue may be HIV positive. The consequence of not providing information to enable her to be tested is that she is harmed by not knowing her HIV status and not receiving a course of treatment.
- If Sue is HIV positive and is not aware of the risk the consequences are that she will not take steps to minimise the risk of infection to the baby eg. obtaining treatment during pregnancy, baby born by caesarean section, knowing not to breastfeed, prophylactic treatment.
- If Sue did later find out that there was a risk to her and that she was not informed she may lose trust in her doctor or the healthcare system.

- Risks to Bob's former identifiable sexual partners who could be contacted and informed.

The harms of disclosure would include:

- If the clinician informs others without Bob's consent then as a consequence he may lose trust in Dr Gomez, and perhaps the medical profession in general.
- He has indicated that he will end his course of treatment thus risking relapse and severe health problems including death.
- There is also a risk that he could go on to infect future sexual partners.
- Bob may be stigmatized by others who get to know and may have problems with future employment because of discrimination

Applying ethics and law - balancing competing interests and values

It is necessary to balance the potential harms of non-disclosure with the harms that might result from disclosure without consent in breach of the duty of confidentiality.

Paragraph 53 of the GMC guidance Confidentiality(2009) states that disclosure of confidential information without the patient's consent can be justified to prevent risk of death or serious harm to a third party.

'53. Disclosure of personal information about a patient without consent may be justified in the public interest if failure to disclose may expose others to a risk of death or serious harm. You should still seek the patient's consent to disclosure if practicable and consider any reasons given for refusal.'

If Sue were to become infected with HIV she would be harmed by contracting a serious disease which if untreated is ultimately life threatening. In addition she could transmit the virus to her child again with potentially life threatening consequences.

In its supplementary guidance on confidentiality (2009) the GMC considers specifically the issue of disclosing information about serious communicable diseases. Section 8 states

'If a patient refuses to allow you to inform someone outside the healthcare team of their infection status, you must respect their wishes unless you consider that failure to disclose the information will put other healthcare workers or other patients at risk of infection. But such situations are likely to be very rare, not least because of the use of universal precautions to protect healthcare workers and patients, particularly during exposure prone procedures'

The particular risk of becoming infected from a sexually transmitted disease (or by vertical transmission from mother to child, cannot be prevented by universal precautions taken by healthcare workers. The GMC advises in these situations, where a person with a sexually transmitted disease refuses to disclose information to their sexual partner, that a doctor

may disclose information to the sexual partner 'if you have reason to believe they are at risk of infection and that the patient has not informed them or has refused to do so'. This would appear to be the case in this scenario.

A useful comparison could be made with disclosure of genetic information.

Genetic information may have great relevance for the health of relatives. Nevertheless, if the patient refuses to allow relatives to be informed confidence should be maintained unless the health interests' of family members to be given such information outweighs the duty of confidentiality.

The GMC guidance considers the disclosure of genetic and other shared information (paragraphs 67-69). Essentially the advice is to encourage patients to share information that would be relevant to a family member, for example of the knowledge could be used to receive prophylaxis or other preventative treatments. However should a patient refuse to disclose the health professional must then make a judgement based on the public interest principle described above.

BMA guidance (Human genetics: choice and responsibility 1998) states that a healthcare professional should consider the following factors in deciding whether to disclose:

- Severity of the disorder
- Level of predictability
- Action relatives could take
- Harms / benefits in giving or withholding information

What about the interests of the child to be born? In **Re C (HIV testing) [1999] 2 FLR 1004** the court considered that it was in the best interests of a baby to undergo testing for HIV (where the mother was HIV positive and had refused interventions to prevent transmission of the virus) despite the fact that the parents refused their consent. Clinicians were of the view that if the child was infected measures could be taken to manage the condition. The court said that the child had interests that were separate from those of its parents (a foetus does not have legal rights but rights do crystallize at birth).

In the case study scenario it would be necessary to consider the likelihood of HIV risk to the baby to determine whether breach of confidentiality is justified. Sue would need to be informed in order to consent to testing / treatment.

Should Bob's GP be informed? Paragraph 25 of GMC guidance Confidentiality (2009) states that,

'Most patients understand and accept that information must be shared within the healthcare team in order to provide their care.'

However, should a patient object to information being shared with another health professional then their wish should be respected unless there is a public interest

justification for disclosure. Thus, if Bob still refuses his wishes must be respected unless failure to disclose would put a health care worker or other patient at serious risk of death or serious harm. As the GMC supplementary guidance points out this is unlikely to be the case if universal precautions are followed. One situation where there may be an increased risk to a healthcare professional is if a needle stick injury has occurred. In this situation the GMC guidance advises that it may be appropriate to disclose information if this is needed for decisions about post exposure prophylaxis (Supplementary Guidance paragraph 18)

It would appear, in balancing the harm to Bob with harms to others that the harm to Bob in disclosing without his consent is outweighed by the harmful consequences of not disclosing. However health professionals working in this area may consider that more weight should be given to the loss of trust that might result from breaching confidences.

'Compelling ethical reasons exists for protecting the privacy of persons with HIV infection. An important justification for privacy resides in the principle of respect for autonomy. To respect the privacy of persons with HIV/AIDS is to respect their wishes not be observed or to have intimate information about themselves made available to others. Privacy also enhances the development of trust in the physician. One of the defining characteristics of the doctor/patient relationship involves the sharing - freely given - of private information. Failure to respect the confidentiality of patients drives patients away from HIV testing, counseling, and treatment, and discourages patients from confiding in their physicians. Healthcare facilities that treat persons with HIV argue fiercely that compelling physicians to disclose HIV infection to sexual or needle-sharing partners would mean they would lose the trust of their clients.'

Lawrence O. Gostin, JD, from the September, 1995 issue of the JIAPAC.

Reading

Beauchamp and Childress, Principles of Biomedical Ethics, Fifth Edition, Oxford University Press 2001, p 303

Hope, Savulescu and Hendrick, Medical Ethics and Law, the core curriculum, Churchill Livingstone 2008, chapter 7

Slowther A, Kleinman I. Confidentiality. In Eds Singer P, Viens A. Bioethics for Clinicians. Cambridge. Cambridge University Press. 2007 pp43-48

Symposium on Consent and Confidentiality.

Consent and confidentiality – where are the limits? An introduction, P J Lachmann. J Med Ethics 2003; 29: 2

Consent and confidentiality in genetics: whose information is it anyway?, A. Kent. J Med Ethics 2003; 29: 16 – 18

The requirements of the Data Protection Act 1998 for the processing of medical data. P. Boyd. J Med Ethics 2003; 29: 34-35

Confidentiality and the duties of care. J O'Brien, C Chantler, J Med Ethics 2003; 29: 36-40

Patient privacy and confidentiality, Jim Chalmers and Rod Muir, BMJ 2003; 326: 725-726.

Confidentiality and cognitive impairment : professional and philosophical ethics. JC Hughes and SJ Louw. Age and Ageing, 2002; 31 (2): 147 - 150

The criminalisation of HIV transmission. J Chalmers J Med Ethics 2002; 28: 160 - 163

Wife wins case against GPs who did not disclose husband's HIV status, Christopher Zinn, BMJ; 326: 1286

Sharing patient information electronically throughout the NHS, Nick Booth, BMJ 2003; 327: 114-115

New consent form designed for release of medical records, Clare Dyer, BMJ 2003; 327: 122