

Indiscretion and other threats to confidentiality

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Confidentiality is a central principle of medical ethics. The most common breaches of this principle are not the rare cases in which the principle is overridden by other considerations. Instead, confidentiality is most often breached when it clearly should be respected. In this paper I outline these threats to confidentiality, the most frequent and disturbing of which is indiscretion in its many forms.

It is ironic that the greatest threats to medical confidentiality are those that elicit the least discussion. Confidentiality is widely recognised as a central principle of ethical medical practice. It is crucial for patient autonomy and privacy.¹ It incentivises people to seek the medical help they need (or at least removes one disincentive).² It is therefore not surprising that medical students and new doctors are required to take an oath of confidentiality, and that they have been required to do so for a very long time. The principle of confidentiality has an ancient pedigree and was one of the principles enshrined in the Hippocratic Oath.

Despite its importance, the principle may sometimes be overridden, albeit in rare circumstances. Much discussion about confidentiality concerns those exceptional circumstances and is focused on the conditions under which a health care professional may permissibly break confidence.³ Yet, for all the handwringing about such cases, the principle is threatened most often not by breaches where it is unclear whether confidentiality should be preserved – instead, the most common and alarming threats to confidentiality are in cases where it is (or should be) manifestly obvious that confidentiality should be preserved.

These common breaches of confidentiality are of many and varied kinds. I propose to outline a number of them here. Some will immediately be recognised as wrongful violations of medical confidentiality. The purpose of mentioning these will be to serve as a reminder of how often doctors and allied health care professionals do what they know they should not do. Other breaches of confidentiality, even when attention is drawn to them, are often not recognised as wrong. This is partly because of how deeply they are ingrained in current medical practice. Doctors often fail to recognise just to what degree some common practices violate confidentiality. In such cases it is important to gain some distance from conventional practice and to see these violations for what they are. Not all of the problems I shall outline can be resolved easily, but recognition of the problem is the first step.

Indiscretion

The major threat to confidentiality is indiscretion, which manifests in a variety of ways. The most egregious are cases where doctors gratuitously divulge information to those to whom disclosures should not be made. Consider, for example, the young woman who consulted a doctor.⁴ The patient's mother saw the doctor's wife socially a few days later. In the course of their conversation, the doctor's wife relayed information disclosed by the *patient* to the doctor during the consultation. While such cases are not rare,

still more common are cases in which doctors mention a patient by name in casual conversation and say what condition he or she has. Such doctors might never dream of divulging what they take to be intimate information, but the obligation of confidentiality extends to information, including a patient's disease, that the doctor may not regard as sensitive. This is because the patient may regard it as sensitive. Even the mere mention that somebody is one's patient might be a breach of confidentiality. If, for example, a psychiatrist remarked casually that a named person was a patient of his, it would thereby be disclosed that that person was seeing a psychiatrist, which itself would be a breach of confidentiality. Even in the case of less sensitive specialties, there may be good reasons why a patient might not want it known that he or she was seeing a specific doctor. In such cases, the disclosure that that person is one's patient would be an unnecessary breach of confidentiality.

These bad habits start early. I am regularly struck by how often medical students, even when they have been taught about confidentiality, will begin an ethics case presentation by stating the name of the patient. While medical education may sometimes require medical students to identify a patient to members of a medical team, students are often not trained by their medical educators to discern the difference between such cases and others, where mentioning the patient's name is gratuitous. Indeed, their teachers sometimes set a poor example. For example, I once attended an open academic seminar about intersex. The speaker, a paediatrician, was discussing the details of specific cases, and showed slides of the ambiguous genitalia of some previous patients, whom he mentioned by name.

Even when doctors do not mention a patient by name, they sometimes talk about a patient (in a non-medical context) in sufficient detail that it is possible to identify the patient. This too is both unnecessary and inappropriate.

Even in the course of medical communications, health professionals are regularly oblivious to the access others have to the confidential information they share. For example, doctors can be overheard talking about patients in the corridors and elevators of hospitals.⁵ In at least some South African hospitals patient files are *still* left at the foot of a patient's bed, where any visitor or other transient, not to mention medical personnel unconnected with the patient's care, can gain ready access to confidential information, perhaps while the patient is sleeping or unconscious. I have known cases of doctors faxing medical reports to non-secure fax machines, where they can and have been read by those other than the intended recipient. Recently, on my way out of a hospital

after talking to one department about confidentiality, I found a pile of stickers for patient folders lying on a table in a public corridor. These stickers included patients' names and dates of birth. The names of patients in a hospital, and information such as their dates of birth, should be kept confidential. Leaving this sort of information lying around shows a sloppy disregard for confidentiality.

Disregard for confidentiality is often more egregious when health care professionals conduct medical interviews or consultations in public or semi-public circumstances. In one case a middle-aged woman visiting a pharmacy was obviously trying to describe her condition in hushed tones to the pharmacist and his female assistant. The pharmacist was overheard by another customer in the pharmacy as he repeated the client's answers and brashly questioned and commented: 'When last did you mess yourself?', 'Are you leaking?', 'Are you wetting yourself?', and 'You may have an infection.'

In another case, a doctor sat down next to a young male patient in the waiting room and started asking questions about his condition, within earshot of other patients.

Or consider the case of a young woman who was having her medical history taken by a specialist in private consulting rooms. On about three occasions the nurse entered unannounced to ask or tell the doctor something – often about another patient! When the nurse was not talking, the medical history continued in her presence. While it might be argued that the nurse as a health care professional was part of the team to which the confidential disclosure was made, this is not obviously so, particularly under the circumstances. The patient is making disclosures to the doctor. The nurse entering and leaving may be perceived as a transient interloper in the confidential consultation, and this may be disconcerting to the patient. References to other patients also inspire no confidence that the content of the consultation will not be shared similarly casually with subsequent patients.

The reception offices, waiting rooms and consultation rooms of medical practices and departments raise a number of challenges to confidentiality. The public nature of reception and waiting rooms presents a problem. All those waiting can recognise all others as patients. Consider, for example, finding your boss in the same psychiatrist's waiting room where you are awaiting your appointment. You might not want your boss to know you are seeing a psychiatrist, and he might not want you to know that he is. The same might be true in the offices of cosmetic surgeons, gynaecologists, oncologists, or any of a number of other specialities. Confidentiality is breached by the very architecture of the waiting room. These problems could be minimised if reception and waiting rooms were designed differently. Indeed, I have heard of one sexologist (in Israel) who had patients enter through one door and exit through another.

Making appointments also raises problems. A (potential) patient calls the practice and attempts to make an appointment. The receptionist then repeats the patient's name aloud, in the presence of those seated in the waiting room, as she records it in the appointment book. Another common occurrence is that of calling out a patient's name in a waiting room, thereby enabling other waiting patients who might not have recognised the patient to identify her by name. In one case of which I was advised, a patient was being wheeled through a radiological waiting room. He was called by his

full name, thereby identifying him to everybody in the room. The trolley was then stopped at the counter for him to sign another form before being wheeled into the procedure room.

Another common problem is that lists of patients or patients' folders are often left on a receptionist's counter or on the doctor's desk in the consulting room, where other patients can clearly see who else is scheduled to see the doctor. (If the doctor or receptionist leaves the room, curious patients could even sneak a peak at the contents of such folders.)

Sometimes doctors also take (non-emergency) calls about one patient while they are in the midst of a consultation with another. In such cases, like that of the interrupting nurse mentioned before, the doctor not only diverts his attention from the patient in the room, but may also breach confidentiality by speaking to or about one patient in the presence of another.⁶ I have sometimes called a doctor about a patient and made it clear to the receptionist that I only want to talk to the doctor if he is not busy with a patient. Receptionists typically interpret this as reluctance to disturb the doctor rather than reluctance to talk about one patient in the presence of another, so put one through to the doctor anyway.

This raises another important point. Receptionists, clerks and others who have access to confidential medical information are often not themselves medical professionals. They have never even been inducted into the professional requirements of confidentiality, limited and ineffective though these often are even for medical practitioners. Nor have these clerical staff members typically taken any oath of confidentiality. This highlights the importance of sensitising such staff to issues of confidentiality.

Medical certificates regularly over-disclose. Very often all a medical certificate need state is that a patient was unfit for work on a specific day, yet doctors often state the ailment without permission of the patient. Even when the patient then presents the certificate to the employer, this may only be because of the costs of not doing so. More sensitive doctors would ask patients whether the nature of the medical condition needs to be listed or whether it could safely be excluded. (It must be conceded, however, that one downside of this is that unscrupulous doctors can hide behind non-disclosure when they inappropriately certify unfitness. Because they do not need to certify the condition, their certificates are less transparent and therefore less accountable.)

It is not uncommon for doctors selling a medical practice to transfer all the practice's medical files to the practitioner purchasing the practice. The problem with this, however, is that the patient entered into a confidential relationship with one doctor, and sensitive information is then transferred to another doctor, not originally part of the health care team, without the patient's permission. There may be good reasons why the patient would not want the information conveyed to specific other doctors. Those who are suitably punctilious about confidentiality should therefore seek the consent of patients before their files are transferred. Where patients cannot be contacted, perhaps because a long time has elapsed since the consultation, the files should either be destroyed or retained for a while longer by the original doctor.

Other threats to confidentiality

The foregoing are all instances of indiscretion of one kind or another. However, not all threats to confidentiality fall primarily in this

category. There are a number of others that are also worth mentioning. Although these are cases where the primary threat lies not in indiscretion, they are often exacerbated by it.

Large hospitals and medical teams present important problems. It has become the case that very many people can be involved in the care of a single patient. Patient care could be compromised without some sharing of confidential information. To that extent the broadening of the pool of those with access to this information is ethically unavoidable.⁷ However, that does not mean that confidentiality standards could not be improved. Patient consent for the sharing of information within clearly delineated limits could be sought. As indicated earlier, patient folders could be kept in a secure place rather than at the foot of a patient's bed. Access by orderlies and porters to patient folders could be removed.⁸

Electronic databases present both problems and opportunities. On the positive side, they provide a mechanism for only authorised access to sensitive information. However, it is worrying that they potentially extend the access. People authorised to access some information on a system might illegitimately access other information too.⁹ This suggests that the controls put on access should enable access only to the information that person is authorised to see. Given the risk of people hacking into electronic databases, sophisticated security protection is also necessary.

Private medical insurance poses another major threat to confidentiality. For private health insurance schemes to remain financially viable, insurers must have the same information that scheme members have about themselves. Without that information, those at higher risk would be more inclined to insure themselves or to insure themselves more. Because those at higher risk cost more, medical insurance schemes could not survive without knowing the risks of those they insure. The problem, however, is that those wanting to be insured are consequently coerced into making disclosures they might not really want to make, for otherwise they will lose out on much-needed medical care. Moreover, these disclosures are often made to insurance brokers and insurance scheme administrators, who may have taken no oath of confidentiality and may often be insensitive to the importance of confidentiality. The best way around this is public health insurance, as this works on the basis of overall community risk. Such schemes do not need to know information about specific people who are insured. However, insofar as private health insurance schemes persist, there are various safeguards that could be introduced to minimise the problems. Essential clerical staff could be sensitised to confidentiality issues and be required to take an oath of confidentiality. Insurance brokers could be removed from the loop of sensitive information.

Practical constraints

The most egregious violations of confidentiality to which I have referred will widely be recognised to be wrong. However some people, especially health care professionals, will say that practical considerations preclude the purest adherence to the principle of confidentiality in other situations. While I have acknowledged such practical constraints and indicated that they may sometimes allow more disclosure than would be ideal, it is likely that many of those appealing to practical considerations do so too readily. They attempt to excuse, on practical grounds, too many violations of confidentiality. We therefore need to have some sense of when practical considerations do and when they do not allow departures from the ideal.

Consider first an example of genuinely unavoidable sharing of confidential information. I noted above that the phenomenon of large medical teams makes it inevitable that more people will have access to information about a patient. Since there is a value in such large teams, and they are also often a necessity, such sharing of information is genuinely unavoidable and also defensible in some circumstances. However, even then there are ethical limits on disclosures. Leaving patient folders at the foot of the bed rather than at a nurses' station, for example, is not unavoidable. Indeed there are places where this is exactly what is done. It may be more convenient to leave the files at the foot of a bed, but convenience is not an excuse. There are lots of convenient things we may not do. In other words, ethical constraints are often inconvenient, but that does not mean that these constraints either are unwarranted or may be overridden on account of the inconvenience.

In a resource-poor environment large wards may be unavoidable. A consequence of this is that history taking and other conversations with a patient in close proximity to other patients may also be unavoidable. This inevitably poses a threat to confidentiality. Nevertheless, sensitive doctors can sometimes take action to minimise that threat. For example, except when speaking to patients who are hard of hearing, they could speak softly rather than at full volume. (Receptionists could employ the same technique when they repeat the names of patients who call in to make an appointment.)

In other cases the appeal to practical constraints is just the product of lazy and unimaginative thinking. Things are done a certain way and people cannot imagine doing them any other way. Consider the practice of calling out the names of patients in a waiting room to announce that the doctor is ready to see them. This is not unavoidable. With a little imagination alternatives could be found. In small waiting rooms where the receptionist knows the patients, she or the doctor could approach the relevant patient and, without mentioning the name, indicate that the doctor is ready to see him or her. In larger settings, patients could be issued with a number that could be displayed on a screen when it is time for them to see the doctor. Some might suggest that this is too impersonal, but that objection is unconvincing. We already encounter similar systems in other contexts where confidentiality is either not important or less important. If the encounter with the doctor himself is a caring one the use of an impersonal system of getting the patient from waiting room to consulting room need not offend, especially if it is (or becomes) known that the purpose of the system is to preserve confidentiality.

Some of the structural issues to which I referred earlier may make some breaches of confidentiality unavoidable in the short term. However, this does not mean that the status quo is desirable. Where structural arrangements could alleviate the problem and are feasible, foresight and effective planning can lead to their being implemented in the medium to long term. In such cases one cannot perpetually appeal to the structural issues without preventing the structural problems when suitable opportunities to reconfigure arise.

Conclusion

Not everybody values his or her own privacy equally. Some people put very little store on it. This fact is not incompatible with the principle of confidentiality. This is because the principle of confi-

Confidentiality allows the patient to decide whether information is made available to others. Those who do not mind disclosing their own medical information to others, or even prefer such disclosure, are at liberty to disclose or to permit others to do so. Health care professionals, however, may not assume that a patient is indifferent or prefers disclosure. The presumption is that confidentiality will be preserved – and vigorously so. This presumption is overridden when the patient gives permission for confidential information to be conveyed to others (and, more rarely, in select other circumstances).

It is alarming then that confidentiality is so often breached. Matters could be still worse, of course. Health care professionals could have *no* regard for confidentiality. Fortunately that is not the case. Most doctors are at least partially respectful of the principle of confidentiality. That, however, is not grounds for satisfaction. Instead, we should be focused on the extent to which current practice falls short of what should and can be achieved. To do this, doctors and other health care professionals need to become more attentive to the myriad ways in which confidentiality can be and is compromised.

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References

1. Privacy and confidentiality, although related, are not identical. Confidentiality is one way of protecting privacy. For more on the relationship between confidentiality and privacy see Huw W S Francis, 'Of gossips, eavesdroppers, and peeping toms', *J Med Ethics* 1982;8:134-143.
2. For more on the value of confidentiality and the conditions under which breaches may be considered, see David Benatar, 'Confidentiality', *CME* 2003;21(1):11-14.
3. See, for example, 'Please don't tell!', commentaries by Leonard Fleck and Marcia Angel, *Hastings Center Report* 1991;21(6):39-40.
4. Each case that I cite is from a reliable informant. I checked all the facts in making notes of the case. The final description was then sent to the informant to check. For obvious reasons the identities of informants are not disclosed.
5. Ubel PA, Zell MM, Miller DJ, Fisher GS, Peters-Stefani D, Arnold R. Elevator talk: Observational study of inappropriate comments in a public sphere. *Am J Med* 1995;99:190-194.
6. It is not only telephonic conversations *about* patients that pose a threat to confidentiality. Conversations that are ostensibly *with* a patient can also threaten confidentiality if the doctor is not sure that the caller is indeed the patient rather than somebody merely pretending to be the patient. In response to this danger, some have suggested the use of passwords to verify that the caller is indeed the patient. (See Sokol DK, Car J, 'Patient confidentiality and telephone consultations: time for a password', *J Med Ethics* 2006;32:688-689.)
7. The large number of people who have legitimate access to a patient's medical records in a large hospital has led one author to suggest that medical confidentiality may now be a decrepit concept, at least within that context. (See Mark Siegler, 'Confidentiality in medicine: A decrepit concept', *N Engl J Med* 1982; 307:1518-1521.) However, he too thinks that some features of confidentiality can be rescued even within the large hospital setting.
8. One author has suggested, at least with regard to outpatients, that patients be allowed to keep their own medical records as a way of protecting the confidentiality of those records. (See Vernon Coleman, 'Why patients should keep their own records', *J Med Ethics* 1984;10:27-28.) However, this arrangement might result in the loss of medical records, with a resultant threat to the quality of patient care.
9. Ornstein C. Just 'nosy,' says figure in medical data scandal. *Los Angeles Times*, 9 April 2008. <http://articles.latimes.com/2008/apr/09/local/me-ucla9> (accessed 6 September 2010.)