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Confidentiality in Medicine—A Decrepit Concept

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Medical confidentiality, as it has traditionally been understood by patients and doctors, no longer exists. This ancient medical principle, which has been included in every physician’s oath and code of ethics since Hippocratic times, has become old, worn-out, and useless; it is a decrepit concept. Efforts to preserve it appear doomed to failure and often give rise to more problems than solutions. Psychiatrists have tacitly acknowledged the impossibility of ensuring the confidentiality of medical records by choosing to establish a separate, more secret record. The following case illustrates how the confidentiality principle is compromised systematically in the course of routine medical care.

A patient of mine with mild chronic obstructive pulmonary disease was transferred from the surgical intensive-care unit to a surgical nursing floor two days after an elective cholecystectomy. On the day of transfer, the patient saw a respiratory therapist writing in his medical chart (the therapist was recording the results of an arterial blood gas analysis) and became concerned about the confidentiality of his hospital records. The patient threatened to leave the hospital prematurely unless I could guarantee that the confidentiality of his hospital record would be respected.

This patient’s complaint prompted me to enumerate the number of persons who had both access to his hospital record and a reason to examine it. I was amazed to learn that at least 25 and possibly as many as 100 health professionals and administrative personnel at our university hospital had access to the patient’s record and that all of them had a legitimate need, indeed a professional responsibility, to open and use that chart. These persons included 6 attending physicians (the primary physician, the surgeon, the pulmonary consultant, and others); 12 house officers (medical, surgical, intensive-care unit, and “covering” house staff); 20 nursing personnel (on three shifts); 6 respiratory therapists; 3 nutritionists; 2 clinical pharmacists; 15 students (from medicine, nursing, respiratory therapy, and clinical pharmacy); 4 unit secretaries; 4 hospital financial officers; and 4 chart reviewers (utilization review, quality assurance review, tissue review, and insurance auditor). It is of interest that this patient’s problem was straightforward, and he therefore did not require many other technical and support services that the modern hospital provides. For example, he did not need multiple consultants and fellows, such specialized procedures as dialysis, or social workers, chaplains, physical therapists,occupational therapists, and the like.

Upon completing my survey I reported to the patient that I estimated that at least 75 health professionals

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and hospital personnel had access to his medical record. I suggested to the patient that these people were all involved in providing or supporting his health care services. They were, I assured him, working for him. Despite my reassurances the patient was obviously distressed and retorted, “I always believed that medical confidentiality was part of a doctor’s code of ethics. Perhaps you should tell me just what you mean by ‘confidentiality!’”

TWO ASPECTS OF MEDICAL CONFIDENTIALITY

CONFIDENTIALITY AND THIRD-PARTY INTERESTS

Previous discussions of medical confidentiality usually have focused on the tension between a physician’s responsibility to keep information divulged by patients secret and a physician’s legal and moral duty, on occasion, to reveal such confidences to third parties, such as families, employers, public-health authorities, or police authorities. In all these instances, the central question relates to the stringency of the physician’s obligation to maintain patient confidentiality when the health, well-being, and safety of identifiable others or of society in general would be threatened by a failure to reveal information about the patient. The tension in such cases is between the good of the patient and the good of others.

CONFIDENTIALITY AND THE PATIENT’S INTEREST

As the example above illustrates, further challenges to confidentiality arise because the patient’s personal interest in maintaining confidentiality comes into conflict with his personal interest in receiving the best possible health care. Modern high-technology health care is available principally in hospitals (often, teaching hospitals), requires many trained and specialized workers (a “health-care team”), and is very costly. The existence of such teams means that information that previously had been held in confidence by an individual physician will now necessarily be disseminated to many members of the team. Furthermore, since health-care teams are expensive and few patients can afford to pay such costs directly, it becomes essential to grant access to the patient’s medical record to persons who are responsible for obtaining third-party payment. These persons include chart reviewers, financial officers, insurance auditors, and quality-of-care assessors. Finally, as medicine expands from a narrow, disease-based model to a model that encompasses psychological, social, and economic problems, not only will the size of the health-care team and medical costs increase, but more sensitive information (such as one’s personal habits and financial condition) will now be included in the medical record and will no longer be confidential.

The point I wish to establish is that hospital medicine, the rise of health-care teams, the existence of third-party insurance programs, and the expanding limits of medicine will appear to be responses to the wishes of people for better and more comprehensive medical care. But each of these developments necessarily modifies our traditional understanding of medical confidentiality.

THE ROLE OF CONFIDENTIALITY IN MEDICINE

Confidentiality serves a dual purpose in medicine. In the first place, it acknowledges respect for the patient’s sense of individuality and privacy. The patient’s most personal physical and psychological secrets are kept confidential in order to decrease a sense of shame and vulnerability. Secondly, confidentiality is important in improving the patient’s health care—a basic goal of medicine. The promise of confidentiality permits people to trust (i.e., have confidence) that information revealed to a physician in the course of a medical encounter will not be disseminated further. In this way patients are encouraged to communicate honestly and forthrightly with their doctors. This bond of trust between patient and doctor is vitally important both in the diagnostic process (which relies on an accurate history) and subsequently in the treatment phase, which often depends as much on the patient’s trust in the physician as it does on medications and surgery. These two important functions of confidentiality are as important now as they were in the past. They will not be supplanted entirely either by improvements in medical technology or by recent changes in relations between some patients and doctors toward a rights-based, consumerist model.

POSSIBLE SOLUTIONS TO THE CONFIDENTIALITY PROBLEM

First of all, in all nontaxing institutions and in nontaxing institutions medical encounters—that is, in the millions of doctor–patient encounters that take place in physician’s offices, where more privacy can be preserved—meticulous care should be taken to guarantee that patients’ medical and personal information will be kept confidential.

Secondly, in such settings as hospitals or large-scale group practices, where many persons have opportunities to examine the medical record, we should aim to provide access only to those who have “a need to know.”
know." This could be accomplished through such administrative changes as dividing the entire record into several sections—for example, a medical and financial section—and permitting only health professionals access to the medical information.

The approach favored by many psychiatrists—that of keeping a psychiatric record separate from the general medical record—is an understandable strategy but one that is not entirely satisfactory and that should not be generalized. The keeping of separate psychiatric records implies that psychiatry and medicine are different undertakings and thus drives deeper the wedge between them and between physical and psychological illness. Furthermore, it is often vitally important for internists or surgeons to know that a patient is being seen by a psychiatrist or is taking a particular medication. When separate records are kept, this information may not be available. Finally, if generalized, the practice of keeping a separate psychiatric record could lead to the unacceptable consequence of having a separate record for each type of medical problem.

Patients should be informed about what is meant by "medical confidentiality." We should establish the distinction between information about the patient that generally will be kept confidential regardless of the interest of third parties and information that will be exchanged among members of the health-care team in order to provide care for the patient. Patients should be made aware of the large number of persons in the modern hospital who require access to the medical record in order to serve the patient’s medical and financial interests.

Finally, at some point most patients should have an opportunity to review their medical record and to make informed choices about whether their entire record is to be available to everyone or whether certain portions of the record are privileged and should be accessible only to their principal physician or to others designated explicitly by the patient. This approach would rely on traditional informed-consent procedural standards and might permit the patient to balance the personal value of medical confidentiality against the personal value of high-technology, team health care. There is no reason that the same procedure should not be used with psychiatric records instead of the arbitrary system now employed, in which everything related to psychiatry is kept secret.

AFTERTHOUGHT: CONFIDENTIALITY AND INDECENCY
There is one additional aspect of confidentiality that is rarely included in discussions of the subject. I am referring here to the wanton, often inadvertent, but unavoidable exchanges of confidential information that occur frequently in hospital rooms, elevators, cafeterias, doctors' offices, and at cocktail parties. Of course, as more people have access to medical information about the patient the potential for this irresponsible abuse of confidentiality increases geometrically.

Such mundane breaches of confidentiality are probably of greater concern to most patients than the broader issues of whether their medical records may be entered into a computerized data bank or whether a respiratory therapist is reviewing the results of an arterial blood gas determination. Somehow, privacy is violated and a sense of shame is heightened when intimate secrets are revealed to people one knows or is close to—friends, neighbors, acquaintances, or hospital roommates—rather than when they are disclosed to an anonymous bureaucrat sitting at a computer terminal in a distant city or to a health professional who is acting in an official capacity.

I suspect that the principles of medical confidentiality, particularly those reflected in most medical codes of ethics, were designed principally to prevent just this sort of embarrassing personal indiscretion rather than to maintain (for social, political, or economic reasons) the absolute secrecy of doctor-patient communications. In this regard, it is worth noting that Percival's Code of Medical Ethics (1803) includes the following admonition: "Patients should be interrogated concerning their complaint in a tone of voice which cannot be overheard." To the medical profession frequently neglect these simple courtesies.

CONCLUSION
The principle of medical confidentiality described in medical codes of ethics and still believed in by patients no longer exists. In this respect, it is a decrepit concept. Rather than perpetuate the myth of confidentiality and invest energy vainly to preserve it, the public and the profession would be better served if they devoted their attention to determining which aspects of the original principle of confidentiality are worth retaining. Efforts could then be directed to salvaging those.