NOTES ON CONFIDENTIALITY AND DISCLOSURE IN A DIVERSE WORLD

‘Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.’

—Hippocratic Oath

Confidentiality is central to the trust between doctors and their patients and a fundamental aspect of medical practice. Some have suggested that information shared between a patient and their doctor is sacrosanct, and not to be divulged under any circumstances. Without assurances about confidentiality, people may be reluctant to seek medical attention, conceal embarrassing facts or not give doctors the information they need in order to provide good care. Furthermore, without the protection of confidentiality, patients may be subjected to discrimination from employers, insurance companies, their families and society. However, confidentiality is not an absolute concept. The interpretation and application of the principles of confidentiality and disclosure may be influenced by cultural values. Practice often varies between individual- and family-based societies. We briefly discuss UK guidance, and reflect upon views about confidentiality and disclosure in other cultural contexts.

Confidentiality and disclosure in the UK

There is a legal as well as a moral duty on doctors in the UK to respect confidentiality of their patients. In the case of Hunter v. Mann, it was ruled that ‘the doctor is under a duty not to disclose, without the consent of the patient, information which he, the doctor, has gained from his professional capacity’. The applicability of Article 8 of the European Convention of Human Rights to the concept of confidentiality can be gleaned in Z v. Finland, where the European Court of Human Rights held that ‘the protection of personal data, not least medical data, is of fundamental importance to a person’s enjoyment of his or her right to respect for private and family life’. The UK General Medical Council has comprehensively outlined a doctor’s duty to respect patient confidentiality. Failure to follow this guidance (which doctors in India may find a useful read too, since much of it discusses common sense issues and addresses many ethical dilemmas in the form of case studies) may put a doctor’s registration at risk. Breaches of confidentiality in some cases may be unintentional, for example, discussing identifiable information about patients where they can be overheard, or on an internet chat forum, or simply leaving medical records where they can be seen by others. It is the doctor’s responsibility to avoid such accidental breaches of confidentiality. Confidentiality may only be broken without consent in certain cases when required by law, or justified in the public interest. An example of a statutory requirement for disclosure may involve notification of a known or suspected case of certain infectious diseases. In exceptional cases where patients withhold consent and the public interest outweighs the patient’s interest, the doctor may disclose the information without consent. These circumstances may include situations where failure to disclose may expose others to a risk of death or serious harm. In our experience, these rare occurrences have included situations when a specific threat has been made, where children are at risk, and where someone continues driving despite a medical advice not to. Such situations bring important legal and ethical dilemmas and decisions are best made with legal advice and documented discussions with professional peers. However, in many circumstances, patients may consent to disclosure even if their consent is not required, and such a discussion could be considered if practical and safe.

Although family and relatives are often consulted in the UK with regard to treatment, no information is usually disclosed without the express wish of a patient. In the case of individuals who are unable to make their own healthcare decisions, the family’s perceptions as to the wishes of the patients are gauged within the framework of ‘best interest’ meetings where relevant professionals, family members, carers and/or advocates of the patient discuss the issues at hand, and come to a consensus whether the treatment/intervention being offered may be in the best interest of the patient.

Please don’t tell him/her

However, it has been argued that ‘it is erroneous to assume that the precepts of western bioethics, such as autonomy, are universally accepted. Serious ethical issues can arise from fundamental contradictions between biomedical perspectives and the norms and values of other cultural groups’. In many cultures, including India, relatives may play a more central role in healthcare decisions. Here, the family construct is dominant and the western concepts of individualism, autonomy and self-determination play a less important role irrespective of the patient’s capacity to make decisions. This difference may become more acute in the case of the terminally or seriously ill patients, or the elderly and other vulnerable groups. Disclosure of diagnostic or prognostic medical information to relatives but not to the patient is a frequently encountered scenario in such cultures. Numerous reasons have been forwarded for this trend—the fear of causing distress to the patients being a common one. The attitude and norms of protecting the patient from difficult news may be unnecessary, and there is little evidence supporting that such disclosure harms patients. On the contrary, there is considerable evidence indicating that patients benefit from knowing about their diagnosis and prognosis. Open and honest communication of the facts may be considered not only good clinical practice but a right to which each patient is entitled. Furthermore, such communication may result in positive effects on patient compliance and health outcomes. It allows the patients to prepare for all eventualities including death, and make plans in terms of their affairs. The creation of effective communication skills both for ‘truth telling’ to the patients and also for persuading the relatives to permit honest disclosure has been suggested. Such training may now be available early in medical education in high-income countries, but may need to be developed and enhanced elsewhere.

Of course, many patients may prefer their loved ones to be fully involved in their healthcare decisions and all that may be required on the part of the doctor is to ask. In case of a condition that may lead to a patient losing capacity, advanced decisions about who
they would like their healthcare information to be shared with may also be respected by law. In our view, a crucial point worth remembering is that honest communication with patients by placing them at the centre of decision-making, and valuing their wishes with respect to their information is unlikely to ever go wrong, whatever the cultural context.

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