

BMJ

A crisis of confidence

Daniel K Sokol

BMJ 2008;336;639-
doi:10.1136/bmj.39521.625486.59

Updated information and services can be found at:
<http://bmj.com/cgi/content/full/336/7645/639>

These include:

Rapid responses

5 rapid responses have been posted to this article, which you can access for free at:

<http://bmj.com/cgi/content/full/336/7645/639#responses>

You can respond to this article at:

<http://bmj.com/cgi/eletter-submit/336/7645/639>

Email alerting service

Receive free email alerts when new articles cite this article - sign up in the box at the top left of the article

Notes

To order reprints follow the "Request Permissions" link in the navigation box

To subscribe to *BMJ* go to:

<http://resources.bmj.com/bmj/subscribers>

ETHICS MAN Daniel K Sokol

A crisis of confidence

With regards to confidentiality, there is a discrepancy between what appears on the pages of professional medical guidance and what occurs at the coalface

A patient is admitted to your ward. In your first encounter with the patient, do you explain that their personal details will be shared with other members of the medical team? Do you point out that this helps the team provide safer and more effective care, but that they none the less have the right to refuse? If not, you are flouting the guidance of both the General Medical Council (GMC) and the BMA.

You should make sure that patients are aware that personal information about them will be shared within the healthcare team, unless they object, and of the reasons for this (see the GMC's publication *Confidentiality* (April 2004)). It is important that patients are made aware that information about them will be shared and with whom it will be shared, and of their right to refuse (BMA Ethics Department. *Medical Ethics Today: The BMA's Handbook of Ethics and Law*. Second edition, 2004).

And if we want patients to be really informed about confidentiality, should hospital doctors and general practitioners tell patients at the outset that there are limits to clinicians' obligation to keep secrets? After all, some patients may believe that doctors are committed to absolute confidentiality, like Roman Catholic priests at confession. Hence a general practitioner might start the consultation: "Hello, I'm Dr Jones. I don't yet know the reason for your visit, but I must tell you something first. I shall respect your confidences, but if doing so is likely to put yourself or others at risk of serious harm, then I might need to violate your confidentiality, even if you object."

With this disclaimer, patients' decisions to disclose would be more fully informed, but how tedious and time consuming for the doctors. They would have to brief each new patient about the limits of confidentiality, even though the likelihood of reaching these limits is minute. It might also dissuade some patients from disclosing

certain information that they would otherwise have shared, increasing the risk of medical harm to themselves or others.

With regards to confidentiality, there is a discrepancy between what appears on the pages of professional medical guidance and what occurs at the coalface. They cannot both be right. Either the guidance is so implausibly stringent or impractical that it cannot be followed, or clinicians need to change their practice to avoid the daily violations of the principle of confidentiality. I favour the former: the guidance needs to change.

There should be a presumption that patients are willing to have their medical details shared within the medical team. In the hospital environment, patients can see that they are not treated by one or two professionals, as in times past, but by a whole healthcare team. They can see different people consulting their notes. Popular medical dramas on television clearly show the plural nature of medical care. A patient with an iota of common sense, let alone the hypothetical "reasonable person," knows that the healthcare team cannot function properly without sharing information. In short, patients are well aware that medical staff involved in their care can access their records. In requiring that patients be told explicitly of the information sharing, the reasoning behind it, and their right to refuse, the current guidance is excessive and unnecessary. It is noteworthy that the American Medical Association does not advocate such a stringent approach: "Consent to use and share information for the direct therapeutic benefit of a patient may generally be presumed when the patient presents for care" (www.ama-assn.org/ama/pub/category/3742.html#quest1).

Several years ago, following a sports injury, I was admitted to hospital for a scan. A few days later, a friend working in a different part of the hospital reassured me that my scan looked fine. "How," I thought to myself, "did he



“Confidentiality is a cornerstone of the doctor-patient relationship, but concern for confidentiality can be taken too far”

have access to this?" The scope of the presumed consent does not extend beyond the inner circle of the healthcare team. Although I expected intra-team sharing, I certainly did not anticipate that any clinician working in the hospital could peruse my electronic records. Beyond the inner circle, a more explicit form of consent is required.

As for the super honest general practitioner who discloses the limits of confidentiality to each new patient, I compare this with a restaurant magician warning a spectator that the corner of the card he is about to toss in the air might land in his eye. The chances are so slim and so disproportional to the prominence of the warning that it distorts rather than clarifies reality. It may be appropriate to disclose the limits of confidentiality to particular types of higher risk patients, perhaps those dependent on certain drugs, but not to all patients. It is a mistake to think that more information invariably leads to greater patient autonomy. Sometimes, through causing panic, distress, or muddled thinking, it can reduce patients' ability to make informed, well reasoned decisions.

I hold in high regard the ethical guidelines of the BMA and GMC. On occasion, the guidelines may recommend practices quite divorced from clinical reality. In such cases, it behoves the medical community to consider the reasons for this discrepancy and to decide whether the guidance or the practice needs to change. At times, clinicians' ethical ignorance or sloppiness is the explanation. Sometimes, it is the guidelines themselves that must be modified. Confidentiality is a cornerstone of the doctor-patient relationship, but concern for confidentiality can be taken too far. In this area of clinical practice, the guidelines are distinctly unhelpful. **Daniel K Sokol is lecturer in medical ethics and law, St George's, University of London**
daniel.sokol@talk21.com