Ethical, professional, and legal obligations in clinical practice: a series of discussion topics for postgraduate medical education

Topic 4: confidentiality

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This is the fourth discussion topic in a series of five dealing with ethical, professional and legal obligations of clinical practice. Junior doctors tend to lack confidence in these subjects, and thus I organised a series of informal discussions in our surgical unit on which these discussion articles are based. The sessions were prepared with reference to non-academic literature readily available from the General Medical Council (GMC) and the medical defence organisations. While our unit dealt with these issues from a surgical perspective, the obligations of clinical practice apply to all practitioners and the series could be easily modified for other clinical specialties.

Confidentiality is a primary ethical and professional duty for doctors, and most employment contracts stipulate it. There is, however, much less case law about this topic compared with matters of consent. There are certain instances where disclosure is obligatory by statute law.

The principle of confidentiality is comparable in practice to that of consent. Respect for autonomy is paramount and any disclosure must be authorised by the patient.¹ If an adult patient is not legally competent then disclosure should be made on the basis of best interests.^{1,2} Junior doctors are particularly likely to be asked for information since it is they who spend most time on the ward and so they ought to be aware of their obligations.

Keeping the patient informed

A doctor should keep a patient informed about the progress of his/her management and involve him/her in decisions. The patient's right to know is not absolute in law²; if the disclosure of information would certainly be detrimental to the physical or mental health of the patient, then it may be withheld. However in practice if a patient asks a specific question the doctor usually ought to answer it honestly.

Disclosure to relatives and carers

Neither group has any automatic right to information about an adult patient. Disclosure should be with the spoken consent of the patient.² Of course once a good rapport is established the more mundane details of a patient's management may be disclosed with consent implied, but more serious issues should always be presented to the patient first. If the patient is in a confusional state, acute or chronic, then disclosure should be in the

patient's perceived best interests once the good faith of the relative or carer is established.²

Disclosure to other healthcare workers

It is common and necessary practice to share information about a patient in the course of management—for example, requesting a consultation or investigation. In such cases the consent of the patient is assumed. It is good practice to point out to the patient that the general practitioner will be informed of any diagnosis on discharge, if not before, according to local policy.

Children

Normally parents reasonably expect to be kept abreast of their child's management. The same definition of parental responsibility applies here as it does in terms of consent. Married parents share parental responsibility; an unmarried mother has an immediate parental responsibility but the father has rights and responsibility only by mother's permission or court order under the Children Act 1989.² For older children the Gillick principle applies. This is more of a problem in general practice or gynaecology than in general surgery.

Accidental disclosure

Beware of casual discussion as anecdote: much embarrassment has occurred as result of injudicious chat in the canteen when it transpires that a relative is sitting at the next table. Another important practical point concerns the assessment of a teenage girl with abdominal or pelvic pain. Make sure that parents are well out of range and not just sitting on the other side of a curtain when you take a sexual history. If parents are in earshot you may either get a misleading answer or parents may hear confidences which your patient did not wish heard.

HIV positive patients

The general principle of confidentiality applies, although extra prudence is required given the sensitivities surrounding this diagnosis.² Theatre lists or other prominent forms should not bear notice of HIV status. Cautions regarding sharps should instead be communicated in person to all those involved. HIV positive patients should be fully counselled and advised of the good sense of informing their sexual partners. Very occasionally a patient may

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forbid disclosure to a partner. The GMC considers this a possible justification for disclosure without consent where there is a *serious and identifiable risk to a specific individual who if not so informed would be at risk of infection*. Of course this must not be contemplated until it has been considered by senior doctors with legal advice.

Case 1

You are treating an elderly man with an incurable malignancy. He is alert, orientated, and fully informed of his diagnosis. A son appears for the first time just as the patient is about to go home and asks you in private how long the old man has got left. What do you tell him?

- You must discuss disclosure with the patient himself before counselling the son. In this case you have no rapport with the son and you do not know what kind of relationship son and father have.

Case 2

A 14 year old girl with lower abdominal pain and a late period has two positive pregnancy tests. She admits she has been having unprotected sex but demands that her parents not be told of the pregnancy. Her mother appears and wants to know what's going on. What do you tell her?

- If the girl is Gillick competent then she has a right of confidentiality. However it is nearly always better that the girl tells her parents, and she should be counselled accordingly.

With thanks to Mr C Weir FRCS and Mr I Stirling FRCS, Craigavon General Hospital.

- 1 General Medical Council. *Confidentiality* London: GMC, 1995.
- 2 Medical Defence Union. *Confidentiality*. London: MDU, 1997.