

Protecting the privacy of patient information is among the most honored traditions of the medical profession. On beginning medical practice, each physician who takes the Hippocratic Oath pledges that "what I may see or hear in the course of the treatment . . . in regard to the life of men, which on no account must be spread abroad, I will keep to myself, holding such things shameful to be spoken about." The philosophic underpinnings of such a statement are readily apparent. First, respect for the individual demands that his or her trust be held inviolate except for sufficient cause (namely, the potential for imminent harm to self or others). Second, such violations of trust erode patients' confidence in the medical profession, making it unlikely that they will be forthcoming with information that would be helpful to the physicians charged with their care.

For two millennia, this ideal has served the profession well. At the dawn of its third, however, modern medicine faces challenges to patient confidentiality that earlier physicians could scarcely have imagined. Technologic advances have made possible the attainment of that holy grail of information transfer, the seamless medical record. Digitizing the medical record holds great promise for basic research, cost containment, and improved patient care. A less fortuitous consequence of this process is that

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it provides unprecedented opportunities for breaches of confidentiality. Health care professionals who create medical records are not always proficient in providing mechanisms to safeguard electronic information. These opportunities are obvious with respect to information placed on the Internet, but they also exist with respect to information exchanged through less exotic technologies, such as cellular telephones and facsimile machines (Dodek and Dodek 1997).

The emergence of the concept of managed care has also forced physicians to think differently about patient confidentiality. In the managed care paradigm, patient care functions multilaterally, rather than as a dyad between patient and physician. Many members of an interdisciplinary team may view a patient's records while providing care. In addition, employees of the managed care organization not directly related to the individual's care team (such as utilization review officers) may examine the patient's medical records, in an effort to trim costs (Walker 1997). Although many physicians recognize the potential dangers in such systems, few consider themselves competent to prevent invasions of patients' privacy in an environment which is unfamiliar to them — one in which the interests of a particular patient may not be primary.

Often when confronted with such rapidly changing circumstances, we become so preoccupied by shifting data that we fail to recognize general patterns that could help us interpret those data (one remembers the forester who became lost because he focused on the trees). We have a template readily available to guide our efforts to provide protection for the confidences of patients — the Hippocratic oath and the language that has been used to articulate it. Perhaps then, our best path forward involves a step back.

The Hippocratic tradition states that to wrongly reveal patient confidences is "shameful." We have already delineated reasons that breaches of confidence can be detrimental to a patient's care. The Hippocratic formulation, however, enjoins a

moral dimension that supersedes the realm of medical outcomes. A brief examination of the language that we use to describe patient confidentiality may help us understand why. The word "confidentiality" derives from the Scottish verb "confide," which entered the English language before 1455 (Barnhart 1995). Based on the Latin *confidere*, to "confide" implies having "full, complete trust." The later form "confidant" denotes a "close friend or intimate."

Our conception of privacy is similarly endowed with a rich connotative history. The English *privat* signified a matter that was "distinctive" or set "apart." The Latin *privatus* invoked that which was "apart from the public life, belonging to an individual." This concept drew from the Latin word for individual, *privus*, the word that forms the root of our phrase for private communication, "privileged information."

We often speak of breaking confidence as "disclosing" such information. The English "closure" (1390) originally meant "an encircling barrier or fence." It derives from the Latin *clausum*, a "closed space" or closet, a "private room for study or prayer." Only in this arcane context can we truly comprehend the sanctity of the trust patients place in physicians when they reveal to them details of their personal lives. At their origins, medicine and religion intertwine; physicians served as shamans, helping to unburden the soul, long before they served as scientists, helping to heal the body. Although contemporary society emphasizes the latter role, there are many patients for whom physicians — or other health care providers — continue to function as secular priests. These patients present to their providers, not simply to receive biomedical alterations, but to find what Martin Buber called "confirmation of [their] being" through "genuine dialogue" (1965, 85).

It is in the tensions between physician as confidant, physician as scientist, and physician as business person that the current controversies concerning patient confidentiality are centered. The challenges to confidentiality posed by new

methods of information transfer are technological problems that admit to technological solutions. The entrance of third-party interests into the physician-patient relationship, however, raises philosophic questions that are not so easily dispatched. As we have seen, the Hippocratic oath holds that the information exchanged between a patient and a physician is to remain private, unless it "must be spread abroad."

In the case of imminent harm to the patient or others, it is clear that such information must indeed be disseminated. What is not clear is whether confidentiality should be breached if doing so offers only the *prospect of benefit* to others, as is the case with utilization review committees. In light of the special relationship that exists between patients and their physicians, a formidable argument can be proffered that it should not, without the patient's explicit and informed consent. If patients' trust is to remain inviolate, it must be protected vigorously, even at the price of losing lesser potential benefits.

William Pitt (1741) observed that "confidence is a plant of slow growth." The tree of patients' confidence in their physicians has for twenty-five centuries been nourished by the understanding that patients could rely on their caregivers to keep private information private — set apart from the

general discourse. Of late, numerous axes have been ground, which threaten to sever the roots of that confidence. If physicians do not act, individually and collectively, to ensure that confidentiality is protected, they may find themselves no longer privy to the inner lives of their patients — an outcome that would be "shameful" indeed.

References

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