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ARTICLES

HUMAN NEED AND THE RIGHT OF PATIENTS TO PRIVACY

*Len Doyal**

Few commentators have done more than Ian Kennedy to highlight the centrality of the concept of autonomy for medical law and ethics. Over many years and with great flair and unremitting consistency, he has defended the right of competent patients to exercise final control over medical decisions about themselves. Having no truck with attempts to conflate moral with clinical judgment, he has dramatized the dangers of paternalism within medicine.¹ Kennedy has also criticized the conservatism of those judges who are unwilling to challenge professional vested interests and thereby reinforce such paternalism.²

Yet, despite the value of Kennedy's championship of the moral importance of autonomy within the patient-clinician relationship, there remains a puzzling silence within his work. He appears to regard respect for autonomy as a moral given, but gives little justification for this.³ Moral intuition, therefore, becomes the only foundation of his ethico-legal arguments. This is hardly surprising. Much of Kennedy's work is concerned explicitly with medico-legal issues rather than the articulation of the philosophical foundations for his moral beliefs. However, these foundations are important. Without them, and in the face of conflicts between

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This Article retains British spelling and citation form in many places.

1. Ian Kennedy, *Decisions, Decisions . . .*, in *THE UNMASKING OF MEDICINE* 76-98 (London: Allen & Unwin, 1981).

2. Ian Kennedy, *The Patient on the Clapham Omnibus*, in *TREAT ME RIGHT, ESSAYS IN MEDICAL LAW AND ETHICS* 175-212 (Oxford: Clarendon Press, 1988).

3. Ian Kennedy, *Consent to Treatment: The Capable Person*, in *DOCTORS, PATIENTS AND THE LAW* 44, 44-46 (Oxford: Blackwell Scientific Publications, C. Dyer ed., 1992).

clinicians' intuitions about the same moral questions, we risk being thrown back into the very professional arbitrariness from which Kennedy has done so much to extricate us.

Nothing better illustrates this problem in medicine than the literature on privacy. Few doubt the centrality of confidentiality to the success of the clinical encounter. The principle of confidentiality has been repeatedly endorsed by the medical profession throughout its history. At the same time, however, this emphasis on the privacy of patients has been qualified consistently whenever it is perceived to be in conflict with other public interests deemed more important. In the face of such conflict, the information which passes between clinician and patient can lose its otherwise privileged status. Indeed, there are some circumstances where clinicians are required by law to breach confidentiality.⁴

Though such breaches of confidence are common practice, we need to ask whether there is any moral justification for overriding the right of patients to privacy in this way, and if so, how we should decide when to apply these justifications. Moral intuition does not suffice since, again, individuals do not always agree. This paper will clarify these issues by explaining: why respect for autonomy is a basic human right; why respect for the confidentiality of the clinical relationship is an extension of this right; why privacy conceived as a right morally derives from imputed duties of good citizenship; and, why these duties are incompatible with some, but not all, harms to other recognized citizens. The paper will conclude with a brief analysis of some implications of these arguments for our understanding of relevant law within the United Kingdom and the United States. Throughout, specific references to law will primarily pertain to the former.

I. IS THERE A RIGHT TO PRIVACY WITHIN THE CLINICAL RELATIONSHIP?

All regulatory and advisory institutions concerned with professional standards in medicine generally endorse the principle of confidentiality. For example, in its guidance to doctors, the General Medical Council ("GMC") in the United Kingdom states: "Patients have a right to expect that you will not pass on any personal information which you learn in the course of your professional duties, unless they agree."⁵ The British Medi-

4. IAN KENNEDY & ANDREW GRUBB, *MEDICAL LAW: TEXT WITH MATERIALS* 644-71 (1994).

5. GENERAL MEDICAL COUNCIL, *Confidentiality 2* (London: GMC, 1995).

cal Association concurs: "Privacy is a fundamental right which allows individuals to decide the manner and extent to which information about themselves is shared with others."⁶ The American Medical Association confirms the same moral principle: "physicians shall respect the rights of patients . . . and shall safeguard patient confidences within the constraints of the law," as do other professional organizations whose members are involved in clinical work.⁷

Legally, the source of the obligation of clinicians to maintain confidentiality is less clear in Britain than the United States, although there is no doubt that the duty exists. Unlike the United States, privacy is not a recognized legal right in Britain.⁸ Further, since patients under the National Health Service have no enforceable contract with their clinicians, there is no related remedy available for breach of confidentiality.⁹ Section 8 of The European Convention of Human Rights states that: "Everyone has the right to respect for his private and family life his home and correspondence" so that in theory an application can be made to the European Court of Human Rights.¹⁰ However, the Convention makes no explicit reference to the right to confidentiality as regards clinical care.

Theoretically, a clinician who breaches a patient's confidence may be deemed negligent since there is a recognized duty of care to maintain confidentiality. If significant harm results from a breach of confidence, then a claim for damages may arise. However, the more likely legal remedy in Britain is in equity through an action for breach of confidence per se.¹¹ The relevant case law involves injunctions to prevent information from being made public, rather than claims for financial compensation for harm. There is widespread agreement among commentators in Britain that in principle, the illegality of a breach of confidentiality should be

6. ETHICS, SCIENCE AND INFORMATION DIVISION, BRITISH MEDICAL ASSOCIATION, *MEDICAL ETHICS TODAY: ITS PRACTICE AND PHILOSOPHY* 36 (London: BMJ Publishing, 1993).

7. Bernard Friedland, *Physician-Patient Confidentiality: Time to Re-examine a Venerable Concept in Light of Contemporary Society and Advances in Medicine*, 15 J. LEGAL MED. 249, 256-57 (1994) (citing AMERICAN MEDICAL ASSOCIATION, *PRINCIPLES OF MEDICAL ETHICS* IV (rev. ed. 1981)).

8. RAYMOND WACKS, *PRIVACY AND PRESS FREEDOM* 1-20 (London: Blackstone, 1995).

9. JONATHAN MONTGOMERY, *HEALTH CARE LAW* 250-54 (Oxford: Oxford University Press, 1997).

10. JEAN MCHALE ET AL., *HEALTH CARE LAW: TEXT, CASES AND MATERIALS* 439 (London: Sweet and Maxwell, 1997) (citing section eight European Convention of Human Rights).

11. MONTGOMERY, *supra* note 9, at 250-53.

understood in these terms. In practice, however, because of legal difficulties pertaining to the calculation of damages and the costs of litigation, the most easily available remedy for patients remains professional rather than legal censure.¹²

Philosophical justifications for the moral importance of clinical confidentiality usually fall into two categories. First, as regards the patient-clinician relationship, it is argued that the aggregate utilitarian consequences of breaching confidentiality otherwise outweigh the benefits, understanding "benefit" to be some subjective measure of utility (e.g., happiness, preference, desire). The success of the clinical relationship will depend on trust: the willingness of patients to respond honestly to any questions pertaining to their diagnosis and treatment and to follow prescribed treatment plans. High benefits in utilitarian terms will not accrue if the trust of patients is compromised by fear that an embarrassing breach of confidence may occur.¹³

Despite the fact that professional lip service is sometimes paid to such utilitarian justifications, they face serious difficulties. On the one hand, it is unclear how the relative subjective benefits of maintaining confidentiality are supposed to be measured. For example, different individuals respond to embarrassment in a range of ways: which ones should we select as our standard measure? This dilemma goes to the heart of the problem faced by judges in determining financial awards for damages pertaining to a breach of confidence. On the other hand, the aggregate pleasure derived from, or preference expressed for, revealing confidential information about a patient—a well known celebrity, for example—might far exceed any discomfort caused to the patient. Yet, professional and regulatory codes do not allow utilitarian calculation of this kind. Therefore, it is implicit in such codes that much more is required to justify a breach of confidentiality than high levels of aggregate pleasure or preference. Rather, accepted codes endorse the view that there is something intrinsically wrong about such breaches.

This endorsement derives from the second justification customarily used for protecting confidentiality: the belief that patients have the moral right to the protection of their privacy. As we have seen, such codes make explicit reference to rights in which individuals are believed to have claims on others who must or should honor them, with the former's rights

12. MARGARET BRAZIER, *MEDICINE, PATIENTS AND THE LAW* 48 (Harmondsworth: Penguin, 1992).

13. TOM L. BEACHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 421-24 (4th ed., New York: Oxford University Press, 1994).

always trumping the preferences of the latter's.¹⁴ If we believe in one's strict right to confidentiality in these terms, it follows that others should be denied access to the medical secrets of patients, without their consent. However, accepting that rights trump preferences brings us no closer to explaining why the confidentiality of patients should be taken so seriously in this way.

In an interesting commentary on medical confidentiality and legal practice, Jean McHale explicitly links the right of the patient to confidentiality to that of the citizen to privacy: "The right to privacy relates to the right of the individual to control access to his own personal information . . . [and] . . . applies to all personal information It is confidential information which is especially worthy of protection."¹⁵ Quite so, and Kennedy certainly agrees.¹⁶ But again, one asks, why? McHale rightly endorses the views of a number of philosophers who have emphasized the importance of privacy for the development and expression of individual autonomy.¹⁷ Yet, like Kennedy, she provides no moral justification for so doing. Instead, she refers to her "declared . . . preferred alternative" to do so.¹⁸ No clear guide is provided as to what should be argued if others have different preferences.

We require a more coherent moral justification for taking the general right to privacy seriously, as well as the specific right of patients to the confidentiality of their communication with clinicians. Without it, there seems little to choose between the intuitions and preferences of its defenders and those (e.g., some journalists) who would justify their opposite position in similar terms.

II. HUMAN NEED AND THE MORAL IMPORTANCE OF PRIVACY

Why do we regard privacy itself as so important? Returning to moral intuition, privacy certainly does feel as if it should ordinarily be respected; that it is of intrinsic moral importance. One way of synthesizing the many arguments which have been put forward in support of this position is to determine the extent to which privacy can be said to be a human

14. RONALD DWORIN, *TAKING RIGHTS SERIOUSLY*, at v-xv (London: Duckworth, 1981).

15. JEAN V. MCHALE, *MEDICAL CONFIDENTIALITY AND LEGAL PRIVILEGE* 56 (London: Routledge, 1994).

16. Ian Kennedy, *The Doctor, the Pill and the Fifteen Year Old Girl*, in *TREAT ME RIGHT, ESSAYS IN MEDICAL LAW AND ETHICS* 52-118 (Oxford: Clarendon, 1988).

17. MCHALE, *supra* note 15, at 54-56.

18. *Id.* at 69.

need, like nutrition, as opposed to a preference or desire, like hamburgers. If human needs are themselves of moral significance, then the same will apply to privacy and to clinical confidentiality if they can also be shown to be needs.

What are basic human needs? To answer this question, we must first ask another: is there anything that all humans in all cultures have an objective interest in achieving, irrespective of any other cultural differences? The answer is that all have an interest in attaining the capacity for potentially successful social participation. Such participation is crucial. Through it we develop our manual and mental skills, i.e., the specific abilities and associated social roles which constitute the means by which we identify ourselves and others as individuals. Our potential to flourish as humans will depend on the evolution and sustained reinforcement of these abilities and roles. If our potential for successful social participation is artificially reduced, we will be disabled both as the persons we now are and the persons we may wish to become. We will be objectively harmed, irrespective of our culture.¹⁹

Universal and objective basic human needs can, therefore, be defined as those general abilities that individuals must acquire if they are not to be so harmed. The capacity for successful social participation is proportional in individuals to the degree of satisfaction of two variables: physical survival/health and autonomy. The ways in which death and sustained physical illness can disable social participation are clear. Individual autonomy can be placed in the same category, if by "autonomy" we mean the degree to which individuals possess enough understanding, emotional confidence, and social opportunity to formulate aims and beliefs, which they then employ to interact with others. If they possess only low levels of these attributes, and thereby low levels of autonomy, then as is the case with poor physical health, their ability to flourish within their culture will be fundamentally disabled.²⁰

This argument linking basic human needs to survival/physical health and autonomy is highly abstract, producing what is sometimes called a "thin" theory of need.²¹ To make our theory more substantial ("thicker"), it must be linked empirically to the further concrete needs which must always be satisfied if survival/physical health and autonomy

19. LEN DOYAL & IAN GOUGH, *A THEORY OF HUMAN NEED* 49-75 (London: Macmillan, 1991).

20. *Id.*

21. Kate Soper, *The Thick and Thin of Human Needing*, in *NEW APPROACHES TO WELFARE THEORY* 69-84 (Aldershot: Edward Elgar, G. Drover & P. Kerans eds., 1993).

are to be achieved. Let us think of these “intermediate needs” as those properties of goods, services, activities, and relationships that enhance physical health and human autonomy in all cultures. Elsewhere, Ian Gough and this author have argued that there are eleven such intermediate needs: nutritional food and clean water, protective clothing, a non-hazardous work environment, a non-hazardous physical environment, appropriate health care, security in childhood, significant primary relationships, physical security, economic security, appropriate education, and safe birth control and child-bearing.²²

Aside from safe birth control and childbearing, which are of course sex-specific, these intermediate needs are universal in that they must be met for individuals everywhere—if their potential for successful social participation and human flourishing is to be optimized. Safe birth control and childbearing are needs in the same sense for one-half of the world’s population. However, there is no cultural monopoly on how such intermediate needs should be satisfied.

Having now defined intermediate needs, one can show that privacy should also be regarded as a need in this sense. It is another universal characteristic, the satisfaction of which is especially important in the fostering of individual autonomy, in the same way in which, say, appropriate education can be said to be. The link between privacy and control over access of information already has been mentioned; now, the definition is broadened. Privacy includes individual control over access to certain activities, especially those deemed personal or intimate, and to information associated with such activities.²³

This definition captures much of what we ordinarily refer to as privacy. For example, it sums up the concern that patients have for the privacy of the clinical consultation, that diarists have for the privacy of their journals, that lovers have for the privacy of their bedroom, that people in business have for the privacy of their contractual negotiations, and that we all have for the privacy of our weird and wonderful fantasies. There is a clear link between such examples of privacy and the understanding, emotional confidence, and social opportunities required—the autonomy required—to interact with others in ways which we and they deem successful. Each of these is taken in turn.

Privacy is an essential element in realizing the potential of individuals

22. DOYAL & GOUGH, *supra* note 19, at 155-59.

23. Julie Inness, *Information, Access, or Intimate Decisions About One’s Actions? The Content of Privacy*, 5 PUB. AFF. Q. 227-42 (1991).

for successful social participation. Without it, they cannot learn the relevant cognitive and emotional skills, nor be initiated into the nuances of the different rules, which constitute the normative and legal fabric of their social lives. Privacy is important for this process because the acquisition of understanding—education in the broadest sense—requires the ability to make mistakes without censure, the opportunity to practice without embarrassment.²⁴

When we move on to emotional confidence, the role of privacy, and the supportive relationships of intimacy making it possible, become even clearer. It is through significant primary relationships that we seek support for our weaknesses and failures, as well as celebrations of whatever successes we achieve. Within these relationships, we can explore, develop, and improve those emotional aspects of our personalities that if displayed publicly might undermine our potential for successful social interaction in the future.²⁵ When such intimacy is lacking, especially in childhood, the result can be emotional disability. Equally, when important intimate relations are lost, along with the particular types of privacy that they offered, disabling depression can often follow.²⁶

Social opportunity is the third determinant of the level of autonomy which individuals display in social participation. It has both positive and negative dimensions, corresponding to what has been described as positive and negative freedom.²⁷ The former entails freedom from interference by others; the latter freedom to act on the basis of personal beliefs and goals and the practical resources to do so. Our social opportunity for autonomous action will obviously be constrained in ways that are personally damaging if others, including government, do not respect our privacy as a form of negative freedom.²⁸ Positive freedom, on the other hand, requires specific goods and services without which specific goals cannot be pursued. For example, we may be left alone to further our education in our own way, and this is morally important. Yet more education will only be a practical possibility if we have the resources to obtain it.

The same point applies to privacy as a form of positive freedom. When

24. Jeffery Johnson, *A Theory of the Nature and Value of Privacy*, 6 PUB. AFF. Q. 271-88 (1992).

25. See Charles Fried, *Privacy: A Moral Analysis*, in PHILOSOPHICAL DIMENSIONS OF PRIVACY 203-22 (New York: Cambridge University Press, F. D. Schoeman ed., 1984).

26. GEORGE W. BROWN & TIRRIL HARRIS, *SOCIAL ORIGINS OF DEPRESSION* 173-79 (London: Tavistock Press, 1978).

27. Isaiah Berlin, *Two Concepts of Liberty*, in *FOUR ESSAYS ON LIBERTY* 118 (Oxford: Oxford University Press, 1969).

28. Jeffery Johnson, *Privacy, Liberty and Integrity*, 3 PUB. AFF. Q. 15-33 (1989).

we think positively about the importance of personal control over access to certain types of information and other aspects of personal activity, it is almost always with reference to the things that we have an interest in doing in private. Yet the degree to which we are in a position to enjoy and benefit from our privacy will usually depend on much more than simply being left alone. For example, elderly people without surviving relatives, financial resources, and decent housing may have a great deal of privacy in that no one cares to intrude in their personal lives. However, this is simply another way of saying that they may be alone and lonely. Thus, there is nothing valuable about privacy in itself unless the individuals concerned have something they want to do in private as well as the practical means to achieve it. This in turn will depend on the degree to which intermediate needs other than privacy have been satisfied (e.g., basic education, and physical and economic security).

It follows that a reciprocal relationship exists between the levels of autonomy that an individual possesses and the degree to which her intermediate need for privacy has been satisfied. Although our autonomy is enhanced by the degree of privacy in our lives, the amount of privacy we command, and the impact which it has on the quality of our lives, depends on the autonomy which we bring to enjoying that privacy. In short, the more autonomy we exercise in our lives, the more we will benefit from privacy, and the more we benefit from privacy, the more autonomy we will possess.

This close link between autonomy and privacy explains why breaches of privacy are about much more than just intrusion, embarrassment, unwanted publicity, or loss of earnings, which in law are damages associated with violations of privacy.²⁹ Even if no harm can be demonstrated in any of these respects, an individual's potential for successful social participation can still be damaged if privacy is abused. For example, sustained breaches of privacy may undermine confidence and lead to abnormal levels of anxiety and depression. Hence, the significance of the disabled social participation resulting from loss of privacy cannot for many aspects of an individual's life be captured by or reduced to the harms associated with the usual legal remedies.³⁰

Further, if someone records and makes public a particularly intimate

29. William Prosser, *PRIVACY [A LEGAL ANALYSIS]*, in *PHILOSOPHICAL DIMENSIONS OF PRIVACY* 107 (New York: Cambridge University Press, F. D. Schoeman ed., 1984).

30. See Edward Bloustein, *Privacy as an Aspect of Human Dignity: An Answer to Dean Prosser*, in *PHILOSOPHICAL DIMENSIONS OF PRIVACY* 156-202 (New York: Cambridge University Press, F. D. Schoeman ed., 1984).

moment between two individuals, one may not be subject to immediate ridicule or be financially disadvantaged. Indeed, one's friends and the public may gather round in support and one's popularity may even increase. However, it is impossible to predict how events such as these may affect one's social participation if they are revealed at some later date. There is no way of guaranteeing that one's autonomy will not be restricted by others in ways about which one is unaware and in which one has a significant interest.

Breach of privacy should, therefore, be regarded as constituting a harm in itself for which legal remedy should be available.³¹ Conceptualizing privacy as an intermediate need which must be satisfied for the basic need for autonomy to be satisfied helps to make this clear. If we morally value autonomy because of its role in enabling individuals to avoid harm throughout their lives, then we must do the same for privacy to the degree that it enables them to develop and sustain that autonomy.

Finally, arguments demonstrating the importance of privacy for human flourishing also explain its particular significance for relationships between patients and their clinicians. We have noted that the success of these relations depends on the willingness of patients for clinicians to touch them, and to discuss the details of their symptoms and their personal lives, in ways that would not normally be allowed except with an intimate partner. Equally, in learning to cope with suspected or real illness, patients also require a setting where they can unburden their anxieties, fears, and fantasies without the fear of public exposure. The belief by patients that their privacy will be protected, that they will remain in control of any information thus communicated to their clinicians, optimises the opportunity for such self-reflection and enhances autonomy in the face of illness and medical treatment. Patients and clinicians may not be friends, and should not be lovers. As regards privacy, however, the normative structure of their relationship is much the same.

III. PRIVACY AS A HUMAN RIGHT

One may accept the argument that privacy is an intermediate need essential to the achievement of requisite levels of autonomy. Yet, that does not explain why individuals have a general right to privacy and a specific right to confidentiality within the clinical relationship. As any of the forty million American citizens with inadequate access to health care will confirm, the recognition of a need does not entail that everyone will agree on

31. MONTGOMERY, *supra* note 9, at 252.

the right to its satisfaction.³² Indeed, some well known moral philosophers argue that no individual or government should be able to force others to be charitable, even in the face of the most extreme need.³³ Why should the situation be any different in relation to the recognition of privacy as a human need?

We have outlined why some utilitarian arguments do not provide a satisfactory answer. There may be circumstances when breaches of privacy may well create more rather than less subjective utility. The fact that we reject at least some of these as morally inappropriate suggests that we must look elsewhere for an explanation of why we should regard privacy and clinical confidentiality as constituting claims which all humans are entitled to make on others. The same point applies to attempts to ground the right to clinical confidentiality on moral intuition. Like calculations of utility, these too may conflict. Can the gulf between the need for privacy and the right to it be bridged in some other way?

Consider the following argument. Cultures are bound together by visions of "the good" which are equated with a variety of moral duties. It is our conformity with specific sets of such duties which identifies us as good citizens of particular cultures. Depending on the cultural importance of the particular duties linked to the type of "goodness" in question, conformity will be reinforced by legal and/or moral censure. For example, all cultures have moral codes concerning the responsibilities that parents or those with parental responsibilities have for the informal or formal education of children in their charge. Parents or guardians are expected to do their best to conform to these codes, and penalties will be enforced if they do not carry out their duties.

Yet to say that someone "ought" to do something implies that they "can" do it. If we believe that others should do their best to do what is right, to be a good citizen in terms of the duties believed to define membership of our culture, then it follows that they must have the physical and mental abilities and the social opportunities to do so. This point applies equally to our moral expectations of ourselves and of others to us. We cannot realize our potential as good citizens if we are physically and mentally disabled in ways that are potentially correctable, but are not corrected. This is true of all cultures, regardless of whether or not they

32. Ronald Dworkin, *Will Clinton's Plan Be Fair?*, *NEW YORK REVIEW OF BOOKS*, Jan. 13, 1994, at 20.

33. RAYMOND PLANT ET AL., *POLITICAL PHILOSOPHY AND SOCIAL WELFARE* (London: Routledge, 1980).

employ the specific concept of "citizenship," and of all individuals who morally identify with them.

It follows that if we wish to impute moral duties on others, then we must accept that others have a right to the appropriate need satisfaction required to enable them to do their best to do their duty, to be the good citizens we wish them to be. To ask less of them would imply that we are not serious about our moral beliefs regarding good citizenship. The same applies to the expectations of others as regards us. If they wish us to carry out those duties which they morally endorse to the best of our ability, then they must respect our right to the need satisfaction this requires. In either case, optimal levels of good citizenship will only be achieved if citizens themselves are helped to achieve optimal levels of physical health and autonomy, our two basic human needs. Returning to our earlier example, if we really do believe that parents have a moral responsibility for the education of their children, we also have a duty to help them to acquire the necessary intermediate need satisfaction to enable them to do so, including the intermediate need of privacy for the reasons already outlined.

The same argument can be made with respect to the privacy of patients. If the therapeutic enterprise is to work, patients themselves must do their best to cooperate with the diagnostic process and to follow treatment plans when they are appropriately prescribed.³⁴ But unless they believe that they will have control over potentially embarrassing information about themselves, they are unlikely to fulfill these obligations, since they will not trust their clinicians sufficiently to do so. Indeed, they may even endanger their own health and that of others by not seeking help in the future. Hence, if clinicians wish their patients to be mature and responsible citizens, they should respect their right to privacy, i.e., their confidentiality. Any alternative picture lacks consistency.

Thus, it is philosophical reasoning about the relationship between needs, rights, and duties that ultimately dictates the moral importance of the patients' right to confidentiality, not the calculation of utility or the exercise of moral intuition.

IV. PRIVACY AND CLINICAL CONFIDENTIALITY AS QUALIFIED RIGHTS

At this point, however, both utilitarians and moral intuitionists may object. On the face of it, the argument linking expectations of good citi-

34. Donald A. Redeimeier et al., *Understanding Patients' Decisions: Cognitive and Emotional Perspectives*, 271 *JAMA* 72-76 (1993).

zanship to the right to high levels of basic need satisfaction is universal in character. Yet this does not seem to apply to privacy, especially with respect to the confidentiality of the clinical relationship. It is widely accepted that there are extraordinary circumstances where the right to confidentiality should be professionally and legally qualified.³⁵ In one way or another, these qualifications concern conflicts between the interests of the patient and other individuals, or the general public.

In the context of professional ethics in the United Kingdom, the GMC states that “[d]isclosures may be necessary in the public interest”³⁶ Similarly, legal provisions exist for acceptable breaches of confidence in the case of information about notifiable diseases, dangerous drivers, or suspected terrorists.³⁷ Arguments about the public interest are also in the background of disclosures ordered by a court, in relation to attempts to detect or to prevent crime, or to facilitate the fairness of the judicial process.³⁸ Thus, breaches of clinical confidentiality are professionally and legally regarded as acceptable when the right of patients to exercise control over information about their diagnosis and treatment might lead to the significant harm of others. How can such exceptions to the principle of respect for privacy be morally justified?

Utilitarians will regard such conflicts as confirmation of the necessity of linking moral judgement to the maximization of aggregate subjective utility, e.g., if more happiness will be generated through ignoring confidentiality in the public interest, then so be it. For utilitarians, rights are at best a fiction which people should be encouraged to believe because of the beneficial consequences of doing so. If the benefits concerning aggregate happiness of doing otherwise outweigh the deficits, then there can be no moral reason for respecting rights. With regard to medicine, such arguments might appear to have exerted much influence. Professional codes of ethics concerning confidentiality regularly justify breaches of confidence in circumstances identified with the public interest. Important recent cases in English law do the same, reiterating the view that since patients have no legal right to privacy, their entitlements, such as they are, derive primarily from the public interest inherent in sick individuals submitting themselves for treatment.³⁹

Whether or not these arguments should be viewed as utilitarian, how-

35. MCHALE, *supra* note 15, at 71-98.

36. GENERAL MEDICAL COUNCIL, *supra* note 5, at 8.

37. KENNEDY & GRUBB, *supra* note 4, at 644-71.

38. MCHALE, *supra* note 15, at 57-70.

39. *W v. Egdell*, 1 All ER 835, 847-49 (1990).

ever, depends upon how one defines the public interest. If breaches of confidence are defended with reference to increases in aggregate happiness or preference, then this reasoning will certainly qualify as utilitarian. However, we have already seen that utilitarianism is flawed by the lack of any objective measure for comparing subjective utility. The majority of the public may well be made happier than would otherwise be the case if private information about specific patients is revealed to them. However, the medical profession and the courts reject the legitimacy of disclosure on the grounds of promoting greater subjective utility. The only basis for their rejection must, therefore, be an objective rather than subjective definition of harm, one linked to conceptions of disability similar to those which we have identified with the non-satisfaction of the basic needs for survival/physical health and autonomy.

The implementation of such an objective measure might lead to the non-utilitarian consequence of the preferences of the majority being discounted. It follows, for example, that despite frequent claims to the contrary, the public has no professional or legal right to information about the HIV status of clinicians simply because they are seropositive. The risks of objective harm to members of the public through not being told of their doctors' status are deemed to be less than those of infected clinicians whose confidentiality is breached, however strongly and widespread feelings may be to the contrary.⁴⁰

Similar arguments can be applied to the belief that moral judgements about the boundaries of clinical confidentiality should be decided on the basis of moral intuition. Some clinicians, for example, are intuitively convinced that patients should be tested for HIV in order to protect health care teams who treat them. Others intuitively oppose this view.⁴¹

But haven't we now reached a dead-end? Approaches to understanding the importance of confidentiality, which are not rights-based, lack coherence. Yet we seem no closer to providing an account of how the right to privacy can be reconciled with the obvious need to protect the public from objective harm. Indeed, McHale is skeptical of any successful philosophical resolution to this tension, claiming instead that: "Ethical analysis assists us to identify questions of concern. But philosophy provides us with the tools for reasoning and not with the answers to the questions of

40. Len Doyal, *Good Ethical Practice in the Dental Treatment of Patients with HIV/AIDS*, in *ORAL DISEASES* 3, Suppl 1:214-20 (1997).

41. Ronald Bayer, *AIDS, Public Health and Civil Liberties*, in *AIDS AND ETHICS* 26-49 (New York: Columbia University Press, F. G. Reamer ed., 1991).

practical importance which assail us. It is for us to make the choice."⁴² If we leave it at that, however, there can be no more incentive to recommend McHale's choice of moral options than anyone else's. Moral issues become matters for a vote (back to utilitarianism) or the application of power. Both are dangerous positions in a decade when we have seen majorities engage in genocide against minorities. Can philosophy offer a better alternative?

V. THE LIMITS OF THE RIGHT TO PRIVACY

We have seen that the moral right to privacy goes hand-in-hand with reciprocal expectations of good citizenship. However, the existence of this right does not entail its unlimited application. The right to privacy follows not from the fact that it is an intermediate human need, but from the fact that individuals will not be as able to live up to the moral expectations of others unless their privacy is respected. We cannot, therefore, defend the privacy right while simultaneously inflicting objective harm on others. For it is precisely the avoidance of this disabling kind of harm that provides the moral justification for taking the right to privacy seriously.

To allow others to be harmed through respect for my right to privacy would be inconsistent with my presumed commitment to the universality of my own moral values about their obligations, including their obligations not to harm me. For they would not be able to live up to those values and responsibilities as well as they otherwise might. It is true that were they harmed by me, they might not be as able to harm me—depending on the type of harm I inflict. However, it will equally be the case that they will also be unable positively to achieve any of the other moral goals which I associate with their and my good citizenship. The same applies to their harming me in the exercise of their right to privacy. My ability to continue to do my duty in their moral terms would also suffer as a result. Therefore, respect for privacy and the potential for moral worthiness go hand-in-hand so long as such respect does not undermine this potential through the generation of other types of objective harm.

For this reason, respect for the rights of patients stops at the point that it poses a threat to the survival/physical health of others. Reason, not utilitarian calculation, dictates that if a patient insists that his privacy is to be respected in the face of such a threat, he is ignoring the right of others not to be harmed. In the name of expediency, he is rejecting the possibil-

42. McHALE, *supra* note 15, at 70.

ity of others doing what he professes to believe to be right, as well as they might. He contradicts himself and in the process effectively rejects whatever moral beliefs to which he may otherwise have expressed a commitment. If we really believe in the moral correctness of specific goals then consistency dictates that we want others to be able to do their best to achieve them. Otherwise, we cannot believe that what we endorse as moral goodness is that good after all!

VI. OTHER CONSEQUENCES OF THESE ARGUMENTS

I have argued that privacy inside and outside medicine is a basic human right. It follows that the law in the United Kingdom should move in the direction of that in the United States. That is, it should be modified to provide specific remedies for failures to respect this right. These changes should recognize that it is the intrusion of privacy itself that harms the individual rather than any embarrassment or financial loss associated with it. As with battery, it is the breach of the individual's autonomy per se which may constitute the only harm for which legal remedy is sought.⁴³

In the context of medicine, this means that in the absence of convincing evidence that respect for clinical confidentiality poses a threat to others, any breach of that respect should be actionable as a violation of privacy per se.⁴⁴ If an action were successfully brought on these grounds, then exemplary damages should be awarded since clinicians have a special responsibility in this connection. Likewise, information gained from patients during a clinical consultation should be considered legally privileged. Clinicians should be asked to reveal this information only when serious harm is posed to others. Such harm would include any unfairness that might result in legal proceedings if disclosure were refused. It is doubtful whether legal innovation to achieve these aims will come from within Britain or through the jurisdiction of the European courts.

It follows from arguments developed herein that the risk of serious harm to others may indeed trump the rights of individuals to privacy. However, it does not follow that the risks of objective harm to patients themselves will trump their right to respect from others. The right to privacy derives from its status as one of the intermediate needs; it must be satisfied to meet the basic need for autonomy. The priority of autonomy over privacy in this sense will be forgotten if the confidentiality of pa-

43. Roger Crisp, *Medical Negligence, Assault, Informed Consent and Autonomy*, 17 *J.L. & Soc'y*, 79-81 (1990).

44. McHALE, *supra* note 15, at 109.

tients is sacrificed in order to protect them, as opposed to others, from harm.

The GMC says the following about competent patients:

Rarely you may judge that seeking consent to the disclosure of confidential information would be damaging to the patient, but that the disclosure would be in the patient's best interests. For example, you may judge that it would be in a patient's interests that a close relative should know about the patient's terminal condition, but that the patient would be seriously harmed by the information. In such circumstances information may be disclosed without consent.⁴⁵

The history of medicine is littered with potentially damaging paternalism of this kind. Regulatory bodies should dissuade clinicians from breaching their patients' trust, rather than encouraging them to violate the principle of clinical confidentiality whenever they deem it appropriate. Surely, it is better to suggest that clinicians develop the communication skills necessary to communicate bad news with a minimum of distress both to patients and themselves, while also remembering that sorrow is a natural and rational response to bad news. Because the statement by the GMC quoted above is inconsistent with the right to privacy, it can be regarded as an invitation to harm patients rather than to act in their best interests. If, for example, patients are deceived in the way the GMC suggests, they may be made unable to interact with others toward the end of their lives in ways that they may have otherwise wished. The GMC statement conflates clinical and moral judgment in precisely the ways that Ian Kennedy has so classically and powerfully argued against.⁴⁶

One must, however, be cautious in defence of the moral importance of the confidentiality of the patient-clinician relationship. Appeals to regard privacy as a fundamental human right will ring hollow to those who lack the intellectual, emotional, social, or material wherewithal to demand rights claims of any real significance in their lives. This injury would be compounded if, in the name of respecting the right of privacy, we turn our backs on violations of other human rights occurring in circumstances inappropriately regarded as private by others. If one's right to privacy stops when it threatens seriously to harm others, the "others" in question consist of everyone who might be negatively affected, including family members, friends and anyone else with whom one may be regarded as having a private relationship.

45. GENERAL MEDICAL COUNCIL, *supra* note 5, at 6.

46. See Kennedy, *supra* note 1.

Some commentators have rightly condemned the way in which moral arguments for privacy have been used to justify non-intervention by the state to protect women from their violent husbands.⁴⁷ The phrase “a man’s home is his castle” sums up the problem and the refusal of some police to deal adequately with domestic violence because it is a “private affair” provides a clear illustration. However, the moral right to privacy is linked to, and circumscribed by, the basic needs of each individual, rather than the collective interests of the family. It has been argued that respect for privacy loses its moral force when it leads to the objective harm of others. Hence a proper formulation of the privacy right cannot lead to the legitimation of the abuse of women in the name of protecting the family. Indeed, it is unclear what critics of the right to privacy would put in its place in order to protect the very individuals they wish to defend.⁴⁸ The fact that a moral concept can be abused does not necessitate such abuse.

It also follows from the arguments outlined herein that individuals should be prevented from harming others through the exercise of their ordinary right to privacy. And, when prevention fails, punishment must be imposed. For such legal constraints to have effect, it is crucial for the state to be seen to have a legitimate role in limiting personal privacy in situations where others are placed at risk. The practical problems of deciding where to draw the boundaries of such state intervention and how to control abuses of state authority are important considerations. But such concerns must not obscure the state’s right to intervene when necessary.

Thus far, nothing has been said about two especially contentious areas of the law relating to privacy: abortion and the right of patients to control the circumstances of their own death. In the United States, the legal right to abortion in *Roe v. Wade* was based on the constitutional right to privacy.⁴⁹ It follows from the general arguments herein, that this is a poor defence and it is one which has also been attacked by other commentators.⁵⁰ Once it is recognized that the state does have a legitimate interest in violating the privacy of some in order to protect the lives and health of

47. Nancy S. Jecker, *Privacy Beliefs and the Violent Family: Extending the Ethical Argument for Physician Intervention*, 269 JAMA 777 (1993).

48. Catherine MacKinnon, *Feminism, Marxism, Method, and the State: Toward Feminist Jurisprudence*, 8 SIGNS: J. OF WOMEN IN CULTURE AND SOC’Y 635-58 (1983).

49. *Roe v. Wade*, 410 U.S. 113 (1973).

50. Thomas Halper, *Privacy and Autonomy: From Warren and Brandeis to Roe and Cruzan*, 21 J. OF MED. AND PHIL. 121-35 (1996).

others, then the right to abortion is not guaranteed. Like it or not, many people believe that, morally, abortion precisely constitutes an attack on the life and the right to life of the fetus.

The fact that the legal right to abortion has been conceptualized as one guaranteed by privacy has in fact aided the success of the anti-abortion lobby. It would have been much more difficult for those who oppose a woman's right to choose if *Roe v. Wade* had given abortion the status of a right linked to the intermediate need for reproductive choice itself,⁵¹ which along with privacy, is a necessary condition for meeting the basic need of autonomy.⁵² The importance of reproductive freedom as such would then have become the primary justification behind this and other related legal judgments.

Legal reasoning should evolve so that denial of access to abortion for women is focused directly on the objective harm which would accrue to them should their right to choose be denied. The moral issue at stake would no longer entail a comparison of the rights of women with those of their fetus. In the United Kingdom, the legal justification for a woman's right to choose abortion reflects such reasoning and rejects any grounding in privacy.⁵³ It should continue to do so, despite other arguments advanced in general support of the legal right to privacy. The future evolution of law in the United States should follow suit.

Similar arguments apply to the claim that the right to refuse life-sustaining treatments is legally grounded in the right to privacy, either directly or indirectly through living wills or through the substituted judgements of legal proxies. There can be no more dramatic nor direct exercise of individual autonomy than the attempt to determine the circumstances of one's own death. Privacy is, again, an intermediate need whose satisfaction derives its moral legitimacy from its relationship to the satisfaction of the basic need of individual autonomy. Therefore, whatever "right to die" we have should be directly linked to the exercise of our own autonomy, rather than our right to privacy as a proxy for autonomy.⁵⁴ There is, of course, a reciprocal relationship between autonomy and privacy that we have already outlined: the former is strength-

51. PATRICIA BOLING, *PRIVACY AND THE POLITICS OF INTIMATE LIFE* 85-90 (Ithaca: Cornell University Press, 1996).

52. *Id.*

53. J. K. MASON & R. A. McCALL SMITH, *LAW AND MEDICAL ETHICS* 98-116 (London: Butterworths, 1994).

54. Halper, *supra* note 50.

ened by the latter and vice versa. However, this does not mean that they should be treated as indistinguishable.

As regards competent persons, their "right to die" should be understood as an extension of the right to exercise autonomy in making an informed choice about which medical treatments are or are not administered to preserve life. It is the exercise of control over specific circumstances of their administration—who is present, who knows, who knows what—that should be identified with claims of privacy. Respect for the autonomy and the privacy of incompetent individuals who, while competent, expressed a legally binding choice about their treatment (leaving open what this might mean in practice) should be thought of in the same terms.

Decisions about the non-provision or withdrawal of treatment of permanently incompetent individuals who have not expressed such a choice clearly cannot be based on the right to privacy or autonomy. They will never be able to make claims associated with rights of either kind. The problem then becomes when it can justifiably be argued in law that the person involved no longer has any interest in life and that to maintain it artificially would be both cruel and disrespectful. There are no simple answers and the argument will continue (as it will about abortion), especially against the background of the duty of the state to keep citizens from harm.⁵⁵

VII. CONCLUSION

This paper attempts to explain the moral importance of the confidentiality of the clinical relationship by linking it to the basic need for autonomy and the intermediate need for privacy. The moral claim patients make that their confidentiality should be respected flows from the general obligation of others to help them to satisfy their need for both. Unless this is done, the capacity of patients to conform to patterns of good citizenship—as patients—which are expected of others, will be compromised.

The moral boundaries of the right to privacy, including clinical confidentiality, have also been drawn through the same pattern of reasoning. Inside or outside of the clinical relationship, the exercise of this right has been shown to be incompatible with causing harm to others, because to do so is inconsistent with the very same arguments which give rise to the

55. Carl E. Schneider, *Cruzan and the Constitutionalization of American Life*, 17 J. OF MED. AND PHIL., 589-604 (1992).

right to privacy itself. As a result of these arguments, certain changes in law within the United Kingdom and in the professional advice currently offered to British doctors by the GMC are necessary. These arguments also have implications regarding some aspects of law in the United States.

Throughout, the discussion has attempted to convey the degree to which patients can be harmed by breaches of their confidence. It is just as important for doctors to respect the autonomy of their patients as it is for them to protect their life and health. This sentiment should be philosophically grounded on reason and not utilitarian calculation or moral intuition. In doing so, such arguments are consistent with and reinforce much of Ian Kennedy's own work.

