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Several years ago there was a flurry of interest and activity among university faculty and undergraduates who were concerned about the inclusion of extra-academic information on transcripts. That a transcript itself was available, e.g., to prospective employers,only by permission of its putative owner (that is, the student) was little comfort if the document conveyed disciplinary or other information incidental to academic performance. This problem was resolved in many universities by separating academic from other student records.

Dr. Smith, a professor of Moral Theology at Duke University, is a frequent contributor to Linacre. *His article examines the subtleties and intricacies which arise from the question "who is entitled to know what from whom?"*

In the 1970's sickle cell disease became a national health concern of enormous proportions, federal budgeting for programs increased dramatically, and several states adopted legislation which requires screening for the disease. Despite the apparent and obvious benefits which derive from heightened concern for both carriers and affected patients, some persons have protested that employment and insurance eligibility have been affected by their having been identified as heterozygous asymptomatic carriers and that public programs for mandatory

screening constitute an invasion of privacy.

The proposal, in the 1960's, to create a unified national data system met insurmountable (at least then!) objections from many sectors of the general public. Now something similar—though clearly more modest—is being proposed (in some instances already rudimentarily operative) for computer-based medical records. But because of the evident risks to "medical privacy" both physicians and patients are concerned about the security needs for such a system and whether the present level of privacy for sensitive medical data, or protection of privileged medical communications, can be guaranteed.

Conflicting Loyalties

Most people have by now seen enough of "Marcus Welby, M.D." and "Medical Center" to know that professional secrecy is rather more complicated than the proverbial coathanger. And many others of us have first-hand awareness of the problems associated with privileged information from our experience in examination rooms or confessionals. But the problem of confidentiality is not unique to physicians or priests, or professors or programmers — it is genuinely problematic for every situation, professional or not, in which one has access to another's personal affairs which would otherwise remain private.

The nub of the problem has fundamentally to do with conflicting loyalties — both of which, it can be argued, are relatively appropriate but neither of which, it can also be argued, is either always or universally overriding of the other. At stake, in matters of professional secrecy, are not only debated protocols which fit professional identity and function but an enormously complex web of inter-professional and interpersonal relationships as well. "Who is entitled to know what from whom?" is one way to formulate the question; but underlying the apparent simplicity of that query are many other subtle and intricate puzzles. Among these are "what do you know?" and "whose information is it?" and "are we ever or always obligated to tell less than we know?" and "what are we to do when the interests and needs of a private individual appear to conflict with, or perhaps threaten, the larger public welfare?"

One of my physician friends, who has had extensive experience in genetics counseling, is convinced that there are some situations in which telling the whole truth will result in more harm than good; and he has cited two cases in support of his view. In one case, a child's genetic disorder opens the possibility of nonpaternity — i.e., the husband's genotype indicates the he *may* not be the child's father. In the other case, a four-year-old child had multiple congenital malformations and there was a question of possible chromosome etiology. On

examination the child was found to be a 45,X/46,XY sexual mosaic. Because the mother had already undergone considerable psychic trauma — from the belief that her child was being punished for something which she had done — the physician decided that it would be more than the woman could bear to tell her that the child had a sex chromosome abnormality in addition to congenital malformations — which included mental retardation, clubfoot, and a heart defect.

"The Whole Truth"

Both of these cases have to do not so much with protecting information which was obtained under a pledge of confidentiality but with denying access to information which was sought by diagnosis. Perhaps more importantly for our purposes, here, both these cases raise the questions, "what do you know?" and "whose information is it?" It is clear that in neither instance does the physician have "the whole truth" — that is, he cannot claim evidentiary certainty in the first case that the husband is not the father; nor can he, in the second case, establish reasonable grounds for heightened maternal guilt since he knows that the child's being a sexual mosaic has nothing to do with inheritance or risk of recurrence. Is the physician then obligated to tell what he does know? Barring the patient's — in these cases, the parents of minor patients — incompetence to receive the information, I cannot imagine (apart from a misplaced paternalism) what warrants would be appropriate for withholding that knowledge; and this is particularly compelling if the evident answer to "whose information is it?" is "the patient's."

Moreover, since moral responsibility depends in large measure upon freedom to act upon alternative choices, knowledge of facts and options is critical for setting the boundaries of that freedom. I know that ignorance is no excuse of the law; but that is not the case with moral accountability. We certainly assess the moral responsibility of persons in terms of what they do, and by that interest signify that consequences of actions are an essential ingredient in the decision-making process; but we are also concerned for the reasons persons act, for the intentions which inform discreet choices, because we are aware that (except in frivolous choices) why a decision is taken is quite as morally significant as what was decided and how that decision was acted out. Intention, method, and consequence are the basic rubrics for interpreting and judging the moral worth of moral choices apprehended in their entirety. Thus to deprive persons of information appropriate to their choice-making is *de facto* to limit their freedom to elect from among knowledgable alternatives, and in turn to moderate commensurately their accountability for choices and actions. Beyond that, however, the moral web extends to

those who deliberately deprive or withhold that information; and they become ineluctably implicated in the process. Sometimes the judicial process takes account of a plaintiff's "ignorance" when this has been professionally denied, and sometimes the judicial process provides remedy through indemnification or other penalties; but it is more probable, because the issue is so difficult to prove, that most people simply live out their lives in whatever bliss or hardship attends that ignorance.

The Right to Privacy vs. The Right to Know

Occasionally benign neglect backfires. I learned recently of a case in which, during the course of a routine physical examination, the physician found that a female patient had a positive serology and positive smear for gonococcus. The patient did not come with that complaint, nor did she intend to tell the physician about her sexual contacts or that she had contracted the disease; but by the very nature of the tests, all this was communicated. That her husband was asymptomatic and that this infection is contracted only by venereal contact would appear to be sufficient grounds for a charge of adultery; and that, as it happened, was precisely what the husband did charge when he learned of his wife's infection and subsequently sued for divorce.

Did the physician, upon positive diagnosis of gonorrhea, have any obligations to inform the husband? (There may be questions of obligation to a larger public — e.g., the public health authorities — but those can be bracketed just now in order to focus on the physician's obligation vis-a-vis the wife's right to privacy and the husband's right to know.) With the wife's consent, the physician is not only free but arguably obliged to tell the husband; without the wife's consent, however, the obligations of the physician is clouded by the competing interests of the two parties for whom he might be mediator. This seems to me clearly a case which dramatizes the ambiguity of professional secrecy since to tell the husband would violate the confidential information conveyed (however unintentionally) by the wife, while failing to tell the husband would expose him to risk of infection and disease.

Getting straight about where the priorities lie might free one to alternative considerations; and if the physician and the patient could discuss the possibilities and problems of a case like this with less regard for profesional confidentiality, and more sensitivity and concern for what the wife's attitudes and conduct signified about her marriage, the crux of the issue could be exposed. That the wife has a positive diagnosis of gonorrhea does not exhaust (or even precisely identify) the complete etiology of this infection; indeed that positive diagnosis may itself be only symptomatic of a

more insidious and farther reaching malaise which infects her marriage. The practice of quarantine for contagious disease would appear to grant the principle that the right to privacy is vincible when public health or welfare is jeopardized by it.

Historically, professional secrecy has been essentially a matter of protecting the right to privacy; but the professional is, of course, potentially if not actually an intermediary with respect to the information which has been entrusted to him. Despite an occasional demurrer, my experience is that there is general consensus that these confidences belong, in the first immediacy, to the patient (or client or parishoner) whose prerogative it is to share or withhold confidential information. There are surely instances in which, because of the mutuality between a professional and a person seeking his services, the professional's own self-interest is sometimes at risk; but it is precisely out of the priority of the client's well-being — which was the precondition for establishing a confidential relationship — that the client's superior moral claim is sustained.

In some cases this is straightforward enough; but most patients present themselves as parties to other relationships — spouse, parent, child — and those bonds cannot be either callously rejected or carelessly neglected by physicians or pastors or attorneys who suppose that the unilateral relationship between themselves and their client is the only one of consequence. It is ahistorical to act on that predicate, and depersonalizing to everybody concerned. I know that it complicates matters; but is it true — for example, in the case of the gonorrheal wife — that the doctor-patient relationship is *ex hypothesi* enlarged to include the husband? I tend to think so if the wife and husband understand themselves to be married to each other, since it is the totality of this action — its etiology, communicability, and the rest — within the context of marriage that constitutes the basic desideratum for exposure or secrecy. The "principle of totality" was formulated with respect to the bodily integrity of individuals; but I wonder whether — especially with regard to marriage and family, if not the general public — it might also have applicability to other forms of organic wholeness.

The Public Interest

The nexus of the issue lies then in assessing the relative tolerances between private and public interests, and in defining as precisely as we can the relational networks which mark the boundaries of those interests. Although the scales are ordinarily heavily weighted in favor of protecting individuals in the disclosure of confidential information, there is a legitimate public interest which sometimes intervenes. That interest has customarily been acknowledged when there is prob-

able cause of criminal activity, either prospective or retrospective, or when evidence is required by legal proceedings. So the extent to which the state can legally intrude into confidential relationships, while it varies from state to state according to the definition of "privilege" and the discretion of judges, is prescribed by law. But I mean to raise a rather more subtle question — which sometimes, to be sure, finds its way into the courts — about the moral obligations, which transcend the limits of law, of persons in their several relationships.

Attorneys are protected by "privilege" from being required to disclose incriminating information which was given in confidence by a client; but attorneys are obligated to disclose information about crimes committed in their presence or crimes which they may know to be planned for the future. Similar provisions for differentiating "privilege" from "privacy" are provided in other circumstances, e.g., restraints for requiring testimony from spouses. And just now the nation is beset by the complexities of "executive privilege" and the enormous implications of this concept, and its execution, for national (to say nothing of constitutional) interests. But professional and personal relationships, most of us like to believe, are at most only tangentially amenable to juridical models of contracts and checks-and-balances; and at this level it may be more appropriate to talk of trust and fairness and honesty than of statutes or judicial processes or criminal penalties.

Indeed, it is arguable — and compellingly arguable in view of past experience — that judicial encroachment into professional secrets is counter-productive unless instrusions remain clearly exceptionable to the general rule *not* to expose professional confidences. Functional counter-productivity is already illustrated by fear of subpoena which prompts some physicians either to write incomplete records or to compose the record in ways that are self-consciously designed to be ambiguous or imprecise. The primary intention of this artifice is to protect the physician from unwilling testimony and the patient from coerced exposure of medical records. But by this behavior, and despite all the arguments in defense of it, the physician places himself above the law. It is only another way — not principally unlike withholding medical information from a patient — in which professional is at its best incestuous and at its worst solipsistic.

The promise of professional secrecy is that it will protect confidences and guard privacies from frivolous and capricious inquiries. In the measure to which this is accomplished, free and trustful relationships can establish the context for professional service. The peril of professional secrecy is not that we will tell less than we know, because all of us know more than we can tell, but the temptation to tell less than we can tell.