

Privacy Matters

THE BASICS

The spirit and soul of the entire medical profession is founded on **four fundamental doctor patient ethical principles:** Non-maleficence, beneficence, (patient) autonomy and justice. On these four pillars, we stand or fall.

Patient confidentiality, an issue that gathers more prominence as the years pass by, is an important component of patient autonomy. The relevant section from our very own SMC Physician's Pledge reads:

"I solemnly pledge to respect the secrets which are confided in me."

It tells us that, more than patient confidentiality, is the issue of **privacy**. In many developed countries, there are more laws passed about privacy than confidentiality. Here are some simple definitions of words many often use, but often are unable to define succinctly.

Privacy is the right of an individual to control disclosure of his or her medical information.

Confidentiality is the understanding that medical information will only be disclosed to authorised users at time of need.

Security includes the processes and mechanisms used to control the disclosure of information.

These definitions, or different expressions of them, can be found in any textbook on medical ethics. Confidentiality as such is a corollary of privacy. The SMC Physician's Pledge says as much: "respect the secrets which are confided in me", which puts the initiator and controller of information with the patient. The patient must first confide before doctors can maintain confidentiality, that is, the patient determines his or her extent of privacy, surrenders some privacy to the doctor who is cleared to know (confidant) and who also maintains confidentiality. A practical problem is that it is high impossible in the dynamic interaction of a doctor-patient consultation to determine exactly what is "secret" and what is not. So erring on the safe side and rightly so, doctors usually treat everything confided by the patient as "secret".

EMR: THREAT AND OPPORTUNITY

There is a lot of talk about medical records being digitalised and shared between caregivers. There is also a lot of talk about how to maintain patient confidentiality, the setting of standards for patient confidentiality, and the measures that need to be put in place to maintain these standards (that is,



security measures). These are all genuine concerns made even more pressing in the Age of the Electronic Medical Record (EMR), and now the EMRX (EMR Exchange). However, the more relevant issue is that of standards for privacy.

At present, there are practically no established standards for patient privacy on a nationwide basis. The closest thing we have is something on patient confidentiality under the Private Hospitals and Medical Clinics (PHMC) Regulations,

which states in Paragraph 12(1), "Records": "Every licensee of a private hospital, medical clinic or healthcare establishment shall keep and maintain proper medical records..." Intrinsic to this statement is that it is the statutory obligation of the licensee to maintain the integrity of the medical records within the licensed healthcare establishment. A licensed healthcare establishment under the PHMC Act is defined by a physical address; a location. The Act really does not specifically allow for sharing of records between different licensed healthcare establishments in different locations without patient consent. Privacy is assumed to be maintained as long as the patient information remains within the healthcare establishment, even if the establishment can be a huge one with thousands of employees. But as we can see, it falls short of what is prescribed above: "authorised users at time of need", which infers specific persons with a temporally limited access based on need.

On the other hand, only doctors are allowed to use the EMRX and not other caregivers. Does that mean privacy is more relaxed for doctors and not other caregivers?

WHEN PRIVACY IS KNOWINGLY COMPROMISED

There are, however, sometimes when privacy has to be sacrificed for the greater good. This is usually empowered through a deliberate act of legislation in which the elected representatives of the People decide on behalf of the electorate to surrender the privacy rights of the individual. The list of diseases under the First Schedule of the Infectious Diseases Act, whereby doctors have to report on their patients to the relevant authorities, is one such instance whereby society in general has agreed to and surrendered the right of the individual to privacy once he or she contracts a disease listed under the Schedule.

But such surrender of privacy rights on a nationwide basis are few and far in between. A commoner form of surrender of privacy rights is that at the individual level, usually linked to payment for medical services by a third party; the commonest being that of Medisave and Medishield usage. Every time a patient opts to pay by Medisave or Medishield, he is asked to sign a Medisave use form, in which he agrees that for the purposes of using these payment methods, he surrenders his privacy in terms of hospitalisation information to CPF Board. The same principles apply to private medical insurance companies that inevitably demand the policyholder to empower the company to obtain medical reports from the healthcare provider.

Privacy is also sometimes diminished when, in the interests of the patient and the duty of care owed by the physician, medical referrals are made. A physician in a hospital does not really have to obtain written consent from the patient, whose problem he feels is best dealt with by another doctor, when he makes a referral.

EMRX – A WATERSHED IN MEDICAL ETHICS

All these have worked well in the past and they really are examples of exclusion. The current modus operandi is that control and rights of privacy now reside with the patient on a case-by-case basis, that is, autonomy, because frankly, the patient decides what to tell each doctor he meets, and at the time he so desires. Each doctor as such may have a very different picture of the same patient. The same doctor may also have a very different picture of this one patient as time goes on and the doctor-patient relationship develops with the patient revealing more and more of oneself to the doctor. Trust is inversely proportional to the need for privacy. Trust needs time and that is why a family doctor of 20 years knows more about the patient than the episodic specialist.

As doctors, we had all long yearned for the day when at the click of a button, we would be able to obtain the information on what was done for the patient at another hospital or clinic. This is now possible with the EMRX. EMRX will undoubtedly greatly increase efficiency and patient safety, with less missed drug allergies, drug interactions, adverse effects, duplication, and so on. This is in line with our creed of beneficence. However, the right to privacy is also a cornerstone of the principle of patient autonomy. The need to balance the two principles of autonomy and beneficence is made more pressing with the great potential afforded by electronic medical records and EMRX.

The current EMRX model is a watershed event in local medical ethics. Duty of care is given as adequate reason for supplanting expressed consent with implied consent. The fact that a patient turns up and that the physician owes this person duty of care is sufficient empowerment for the physician to use EMRX without obtaining expressed consent from the patient. However, where does duty of care end and expressed consent begin? Does duty of care extend to

workmen compensation consultations or preparation of medical-legal reports for the Singapore Medical Council, lawyers and police? The person is still your patient, but the context of the interaction may not have any duty of care component. Do our doctors know the differences and traps therein? Sadly, lawyers probably know this better.

The majority of Singaporeans (also known as heartlanders) will undoubtedly sacrifice privacy for convenience. But there will be some who will not (probably the vocal cosmopolitans). Frankly, there will always be some of us who do not want our hand surgeon to know we have piles, or our colorectal surgeons to know we have trigger finger. And then, there are those who do not mind the family doctor knowing both conditions, as well as those who consult three GPs and do not want all three to know either condition. We should not pre-judge and say one is more right than the other, or that one is more difficult than the average Singaporean.

Incidentally, some of the public sector doctors I met recently did not even know that one could opt out of EMRX. They may well be one of the ignorant few. Anyway, can one make an informed consent without knowing the opt-out option? Can there be implied consent without informed consent? It would be interesting to know the results of a one-day surprise exit-survey on patients in all our government hospitals on their knowledge of EMRX and the option to opt out of EMRX. Perhaps the Ministry of Health or the SMA can separately or jointly fund such a survey and see the awareness levels of our patients (and maybe even staff).

BACK TO THE BASICS

We started this discussion with “Basics”. We will now end by getting back to the basics. Let us not talk about EMR, patient confidentiality and medical record security first, and therefore put the cart before the horse. It is almost like defining who can qualify to be Singapore Permanent Residents, Employment Pass and Work Permit Holders, Social Visitors and so on (Confidentiality), without first knowing where are Singapore’s borders and what qualifies a person to be a Singaporean Citizen (Privacy). Worse, talking about security is like discussing where we should put our immigration officers and CIQ (Customs, Immigration and Quarantine) facilities to keep unwanted persons out without knowing where the borders of Singapore are.

We neither want the medical equivalents of illegal visitors nor a CIQ built in Bishan, or worse, accidentally, in a neighbouring country. After all, autonomy is just the individual’s equivalent of sovereignty. The time is ripe for some national standards for patient privacy. These standards should lie somewhere in the middle: one that facilitates continuity of care between different healthcare providers so that patients benefit, and one that addresses some of the major privacy concerns of the more discerning patient.

And then, only when we have figured out issues of privacy and confidentiality, can we begin to tackle issues of implied consent, expressed consent and informed consent. ■