Respecting privacy and upholding confidentiality: core ethical duties

Opening Vignette

Dr L, a senior physician in a tertiary hospital, encounters a distressed daughter of a critically ill patient. The patient, Mr T, has explicitly stated that he does not wish for his medical condition to be disclosed to his children. However, his daughter presses Dr L for information, citing her concerns and need to arrange financial and caregiving matters. Dr L must now navigate the ethical dilemma of balancing respect for patient privacy and professional duty of confidentiality with the need to address the family's emotional and practical concerns.

UNDERSTANDING PRIVACY AND CONFIDENTIALITY

Privacy and confidentiality are not merely regulatory obligations; they lie at the heart of the patient–physician relationship. Privacy refers broadly to an individual's right to control access to themselves and their personal information. Confidentiality refers to a physician's professional duty to safeguard patient information shared in the course of care. Together, they underpin the trust essential to the therapeutic relationship. Privacy affirms the patient's dignity and control over personal boundaries, supporting autonomy in care decisions, while confidentiality safeguards shared information, fostering openness. In this way, privacy protects patient autonomy by preserving control, while confidentiality maintains professional trust through discretion and ethical stewardship. Confidentiality reinforces autonomy by enabling patients to disclose sensitive information with the assurance that it will not be shared without consent, thereby supporting truly informed and voluntary healthcare decisions. Professionalism likewise entails more than regulatory compliance; it embodies a set of moral commitments to veracity, fidelity and confidentiality.[1] These values are enacted daily in the collaborative and trust-based relationship of therapeutic alliance, where patients entrust physicians with not only their ailments, but also their intimate narratives. The obligation to safeguard this trust underpins the fiduciary duty of care. A fiduciary relationship is one in which an individual places trust and confidence in another, who is expected to act in their best interest. In medicine, this is especially pertinent because patients are often vulnerable and dependent on physicians not only for treatment, but also for honesty, discretion and advocacy. In this regard, confidentiality is not merely an administrative bulwark; it is a moral promise embedded within the professional identity.

The Singapore Medical Council's Ethical Code and Ethical Guidelines (SMC ECEG) provide the imprimatur of ethical conduct, noting that while these rights are robust, they are not absolute and may be overridden under specific, ethically justified circumstances, such as when there is a serious risk of harm to the patient or others, or when disclosure is mandated by law.[2] These exceptions reflect the ethical principles of beneficence, non-maleficence and justice, which may at times take precedence over strict adherence to confidentiality. While privacy and confidentiality are interrelated, clinical practice more often engages the latter. Box 1 briefly outlines their conceptual distinctions to clarify how each contributes to ethical professionalism. In clinical practice, the key concern is not the theoretical distinction, but how confidentiality is upheld and, when necessary, ethically breached. This includes knowing when disclosure is justified and how to limit it to the minimum necessary while ensuring transparency in the process.

PROFESSIONAL DUTIES AND PATIENT RIGHTS

According to SMC ECEG, patients have the right to expect that all information disclosed to physicians will be held in confidence. This duty includes both passive and active obligations, such as not accessing records when not involved in care and preventing inadvertent disclosure through casual conversations or digital media use. The duty of confidentiality continues even after the patient's death, requiring continued protection of confidential information posthumously. Complementing these ethical obligations,

Box 1. Privacy and confidentiality: practical considerations for clinical practice.

Privacy	Confidentiality
Control over physical space, personal interactions and personal data	Duty to safeguard patient information disclosed during clinical care
Grounded in the patient's expectation of dignity and modesty	Grounded in the physician's ethical obligation to protect patient trust
Enforced through institutional, societal and legal norms (e.g. Computer Misuse Act, Personal Data Protection Act, etc.)	Enforced through professional codes (e.g. SMC ECEG) and legal duties
Breached by unauthorised access, observation or data collection	Breached by sharing identifiable information beyond those directly involved in care
Key in ensuring respectful interactions	Key in determining when disclosure is justified and how to do it appropriately

SMC ECEG: Singapore Medical Council's Ethical Code and Ethical Guidelines

Singapore's Healthcare Services Act, enacted in 2020 with phased implementation, outlines statutory requirements for maintaining patient confidentiality. Section 27 mandates accurate documentation of healthcare services, and Healthcare Services (General) Regulations 2021 require licensees to ensure confidentiality, integrity and security of patient health records at all times. These legal provisions reinforce that confidentiality is not merely a professional virtue, but a regulatory imperative shared at both the individual and institutional levels.

CLINICAL SITUATIONS AND COMMON PITFALLS

Common breaches in confidentiality include discussing cases in public spaces (e.g., elevators), improperly accessing celebrity records, or sharing identifiable case details during informal teaching settings or social gatherings. Confidentiality breaches in hospital settings are more frequent than often presumed.[3,4] Studies report incidents such as inappropriate elevator conversations occurring in up to 10% of journeys and one breach occurring every 62.5 h.[4,5] In one observational study, 26 of 32 patients experienced breaches in the triage/waiting area within a six-hour period.[5] The ethical responsibilities of confidentiality extend beyond routine clinical encounters. They encompass student and trainee access to patient records, the secure digital storage of medical information and the ethical handling of data used in research. The SMC ECEG emphasises that trainees and colleagues must be briefed and guided on these responsibilities, and patient identifiers must be anonymised or removed unless explicit consent is obtained.[2] In medical publishing, using black boxes for deidentification may create a false sense of confidentiality, as 55.5% of individuals are still identifiable even with facial features fully masked.[6] This highlights the need for explicit informed consent when publishing facial images. The historical misuse of patient biospecimens, such as the widely debated use of HeLa cells without consent, underscores the importance of informed consent and governance in research involving identifiable health data.[7] In addition, the recently revised 2024 Declaration of Helsinki introduces a stronger emphasis on community engagement, data sharing obligations and environmental sustainability in research ethics, marking a shift from individual-centric to broader societal responsibilities.[8]

CONFIDENTIALITY IN CASES OF ABUSE AND VULNERABILITY

Breaches of confidentiality may be ethically and legally warranted when patients are victims of abuse, coercion or neglect. In such cases, upholding confidentiality without context may perpetuate harm, while disclosure may be necessary to prevent serious injury or protect life. In situations involving intimate partner violence, physicians should first assess the immediacy and severity of risk and seek the patient's consent for any disclosure. When the patient declines consent but credible evidence of imminent harm exists, limited, proportionate disclosure to relevant authorities or protective services may be ethically justifiable. Similar considerations apply to elder abuse, particularly where patients face cognitive decline, dependency or fear. In Singapore, the Vulnerable Adults Act 2018 provides a legal framework to protect individuals aged 18 years and above who, due to mental or physical infirmity, disability or incapacity, are unable to protect themselves from abuse, neglect or self-neglect.[9] Under this Act, healthcare professionals may report such concerns without patient consent, when necessary, to safeguard the welfare of the vulnerable adult. Clinicians should adhere to trauma-informed care principles: protect privacy during interviews, avoid retraumatisation, assess the patient's capacity for decision-making, and collaborate with medical social workers or hospital-based safeguarding teams. Whether disclosure is made or withheld, detailed documentation of risk assessment, clinical reasoning and actions taken is essential. In such ethical dilemmas, clinicians should approach institutional ethics committees to guide decision-making.

EXCEPTIONS AND ETHICAL JUSTIFICATIONS

Exceptions to confidentiality arise when there is risk of serious harm to the patient or others, or when disclosure is required by law. Even in these situations, disclosure must be minimal, necessary and justifiable. Justification may be rooted in ethical principles of beneficence, non-maleficence or justice. A commonly debated example involves the potential disclosure of a patient's human immunodeficiency virus status to a sexual partner.[10] While the duty to prevent serious harm may, in rare cases, override confidentiality, such disclosure must adhere to the aforementioned principles. The initial, preferred step is to counsel the patient to voluntarily inform the at-risk partner. Physicians should thoroughly document these counselling efforts. If disclosure against the patient's wishes becomes ethically necessary due to credible, imminent risk of serious harm, it should be limited to the person at risk and be followed by contemporaneous documentation of the rationale, the steps taken and the parties informed. This process ensures that clinical decision is ethically considered and can potentially withstand legal scrutiny. Confidentiality in adolescent care presents practical and ethical challenges, especially when minors seek sensitive care such as contraception or mental health support without parental involvement. While legal constructs such as Gillick competence,[11] which recognise a minor's right to confidential care if they demonstrate sufficient maturity, originate from the UK, they are not formally established under Singapore law. However, the ethical principle underpinning it, namely the protection of adolescent autonomy and trust in healthcare relationships, continues to inform clinical practice and professional guidance

locally. The context of each situation is essential in clinical decision-making.

In the case of *SMC v Dr Soo Shuenn Chiang* [2019] SGHC 250, a memorandum containing psychiatric details was issued with instructions for the information to be handed to the patient's husband, but it was mistakenly collected by the patient's brother. The case offers critical jurisprudential clarity on the limits and obligations of medical confidentiality.[12] The High Court affirmed that, while confidentiality is a foundational ethical duty, it is not absolute. The judgement established that confidentiality may be ethically and legally breached without patient consent if three conditions are met: (a) there is a credible risk of serious self-harm, (b) disclosure is in the patient's best interests, and (c) obtaining consent is not feasible in a timely manner. Disclosure should be limited, directed to the appropriate next of kin and undertaken for therapeutic purposes. Importantly, the Court cautioned against defensive practices, emphasising that disclosure in emergencies must be swift, proportionate and contextually justified to ensure patient safety. Physicians are held to a standard of reasonable care, not perfection, in safeguarding confidential information. The Court held that the physician had fulfilled the duty by issuing clear instructions and could not be held liable for administrative lapses by clinic staff.

The landmark UK case, *ABC v St George's Healthcare NHS Trust* [2020], illustrates the ethical and legal complexities of genetic confidentiality.[13] In this case, clinicians withheld a patient's Huntington's disease diagnosis from his pregnant daughter at his request despite being aware of her potential genetic risk. The daughter subsequently gave birth before discovering that she was gene-positive. She later sued the NHS Trusts for failing to warn her, arguing that had she known of the risk, she would have pursued genetic testing and might have considered terminating the pregnancy. The Court of Appeal held that clinicians may, in certain circumstances, owe a duty to warn when foreseeable harm to others arises from inherited conditions. Although this precedent is significant, it has not yet been tested in Singapore. Clinicians facing similar dilemmas should consult senior colleagues and engage ethics committees, where appropriate, to ensure that decisions are ethically sound and professionally supported. While the validity of an ethical decision rests on its moral foundation rather than its legal defensibility, seeking legal advice can align with and support ethical practice.

REGULATORY COMPLIANCE: PERSONAL DATA PROTECTION ACT AND TELEMEDICINE

Singapore's Personal Data Protection Act (PDPA) provides the legislative framework governing the collection, use and disclosure of personal data.[14] It mandates three core principles: consent, purpose and reasonableness. Medical professionals are obliged to ensure that patient data are collected with informed consent, used only for legitimate and stated purposes and handled with appropriate safeguards. Importantly, the PDPA also outlines specific exceptions where disclosure without consent may be permissible, such as for law enforcement or public health emergencies, provided such disclosure is justifiable and minimal.

The Advisory Guidelines for the Healthcare Sector issued by Personal Data Protection Commission Singapore recommend practical steps such as obtaining consent before physical examinations, protecting patient modesty during procedures and transfers, and ensuring secure access to records.[15] Compliance extends to operational practices, such as logging off unattended computer terminals, using password protection and limiting access on a strict 'need-to-know' basis.

In the era of telemedicine, the ethical duty of confidentiality must be rigorously upheld. Physicians must be circumspect and diligent to ensure that video consultations are conducted in secure environments, and that identifiable health information transmitted via digital platforms is encrypted, securely stored and accessed only by authorised personnel. The SMC has emphasised that telemedicine consultations carry the same duty of care as in-person visits. Physicians must not let clinical judgement be constrained by teleconsultations and should recommend face-to-face consultations for physical examination, when necessary, for decision-making. Digital transformation in healthcare must not compromise the duty to protect privacy and confidentiality. Instead, it should support secure, respectful and patient-centred and person-driven care.

CONCLUSION

In everyday clinical settings, breaches of confidentiality often arise not from malice but lapses in judgement. These situations call for scrupulous vigilance. The guiding question should always be: *Is this disclosure necessary, justified and respectful of the patient's trust?* Any disclosure requires valid reasons rooted in beneficence, public interest or statutory mandate. Even then, disclosure must be limited to essential details, directed to only those with legitimate authority, and be well documented. Ultimately, upholding privacy and maintaining confidentiality are not mere regulatory requirements but fundamental professional obligations.

KEY LEARNING POINTS

1. Privacy refers to the patient's right to control access to self and personal information, while confidentiality is the physician's duty to safeguard that information.
2. Breaches in confidentiality may occur through casual conversations, digital mishandling or digital trespass.
3. The ethical duty to maintain confidentiality extends beyond the patient's death.
4. In teaching and research, steps must be taken to anonymise data and obtain explicit consent where necessary.

5. Exceptions to confidentiality should be ethically justified and limited to what is necessary to prevent harm, serve public interest and comply with legal requirements.

Closing Vignette

Dr L reflects on Mr T's preferences and informs the patient's daughter that he is unable to share details without the patient's consent. He offers to be present to support the conversation and encourage open dialogue when Mr T and his family meet. This approach safeguards trust in the profession and upholds the core ethical duties enshrined in the physician's pledge.

Acknowledgement

The author thanks A/Prof Anantham Devanand, Executive Director of SMA Centre for Medical Ethics and Professionalism, for providing valuable comments on the manuscript.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

Vishal G Shelat[1,2,3], FRCS, MA (Healthcare Ethics and Law)

[1]General Surgery, Tan Tock Seng Hospital, [2]Centre for Medical Ethics and Professionalism, Singapore Medical Association, [3]Lee Kong Chian School of Medicine, Nanyang Technological University, Singapore

Correspondence: A/Prof. Vishal G Shelat,
Associate Director, Centre for Medical Ethics and Professionalism, Singapore Medical Association, 166 Bukit Merah Central, #04-3531 Eagles Center, 150166, Singapore.
E-mail: vishal_g_shelat@ttsh.com.sg

Received: 14 Jun 2025 **Accepted:** 22 Jul 2025 **Published:** 15 Dec 2025

REFERENCES

1. Thirumoorthy T, Shelat VG. Understanding medical professionalism. Singapore Med J 2025;66:114-8.
2. Singapore Medical Council. Ethical Code and Ethical Guidelines and Handbook on Medical Ethics. Available from: https://www.smc.gov.sg/for-professionals/regulations-guidelines-circulars/ethical-code-and-ethical-guidelines-and-handbook-on-medical-ethics/. [Last accessed on 2025 Nov 21].
3. Ubel PA, Zell MM, Miller DJ, Fischer GS, Peters-Stefani D, Arnold RM. Elevator talk: Observational study of inappropriate comments in a public space. Am J Med 1995;99:190-4.
4. Vigod SN, Bell CM, Bohnen JM. Privacy of patients' information in hospital lifts: Observational study. BMJ 2003;327:1024-5.
5. Beltran-Aroca CM, Girela-Lopez E, Collazo-Chao E, Montero-Pérez-Barquero M, Muñoz-Villanueva MC. Confidentiality breaches in clinical practice: What happens in hospitals? BMC Med Ethics 2016;17:52.
6. Preston FG, Meng Y, Zheng Y, Hsuan J, Hamill KJ, McCormick AG. Informed consent in facial photograph publishing: A cross-sectional pilot study to determine the effectiveness of deidentification methods. J Empir Res Hum Res Ethics 2022;17:373-81.
7. Beskow LM. Lessons from HeLa cells: The ethics and policy of biospecimens. Annu Rev Genomics Hum Genet 2016;17:395-417.
8. Liau JYJ, Shelat VG. Evolving ethos of medical research: A retrospective analysis of the declaration of Helsinki (1964-2024). World J Methodol 2025;15:107699.
9. Vulnerable Adult Act 2018. Revised Edition 2020. Singapore Statutes Online. [Last accessed on 2025 Jun 02].
10. Stein MD, Freedberg KA, Sullivan LM, Savetsky J, Levenson SM, Hingson R, *et al*. Sexual ethics. Disclosure of HIV-positive status to partners. Arch Intern Med 1998;158:253-7.
11. Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112.
12. SMC v Dr Soo Shuenn Chiang [2019] SGHC 250. Available from: https://www.elitigation.sg/gd/s/2019_SGHC_250. [Last accessed on 2025 Nov 10].
13. ABC v St George's Healthcare NHS Trust and Ors [2020] EWCA Civ 455. Available from: https://resolution.nhs.uk/2020/04/22/case-of-note-abc-v-st-georges-university-hospital-nhs-ft-sw-london-st-georges-mental-health-nhst-and-another-high-court-28-february-2020-yip-j/. [Last accessed on 2025 Nov 10].
14. Personal Data Protection Act 2012. Revised Edition 2020. Singapore Statutes Online. Available from: https://sso.agc.gov.sg/Act/PDPA2012. [Last accessed on 2025 May 12].
15. Personal Data Protection Commission Singapore. Advisory Guidelines on the PDPA for the Healthcare Sector. Singapore: PDPC; 2021. Available from: https://www.pdpc.gov.sg/guidelines-and-consultation/2017/10/advisory-guidelines-for-the-healthcare-sector. [Last accessed on 2025 May 12].

DOI: 10.4103/singaporemedj.SMJ-2025-147 **Website:** https://journals.lww.com/SMJ

How to cite this article: Shelat VG. Respecting privacy and upholding confidentiality: core ethical duties. Singapore Med J 2025;66:685-9.

SMC CATEGORY 3B CME PROGRAMME

Online Quiz: https://www.sma.org.sg/cme-programme

Deadline for submission: 6 pm, 12 January 2026

Question: Answer True or False
1. Regarding the distinction and interrelation between privacy and confidentiality:
(a) Privacy is primarily concerned with control over access to one's personal and bodily space, whereas confidentiality pertains to the protection of shared information.
(b) Privacy is enforced mostly through professional codes such as the Singapore Medical Council's Ethical Code and Ethical Guidelines, whereas confidentiality is governed only by societal norms.
(c) Breaches of privacy may occur through unauthorised observation or data collection.
(d) Confidentiality is fundamental to professional trust and is upheld by ethical duties of veracity and fidelity.
2. Regarding situations in which breaches of confidentiality are ethically justifiable:
(a) Disclosure of a patient's human immunodeficiency virus status to a sexual partner after counselling fails and imminent risk is present.
(b) Sharing case-specific details, including patient identifiers, during informal teaching rounds without consent.
(c) Reporting suspected elder abuse under the Vulnerable Adults Act without patient consent to safeguard the patient's welfare.
(d) Accessing celebrity medical records out of professional curiosity without being involved in their care.
3. Regarding professional ethics:
(a) Physicians should not access patient records unless they are directly involved in that patient's care.
(b) Confidentiality obligations persist even after a patient's death.
(c) Disclosure of identifiable images in publications is allowed without consent if the faces are obscured using black boxes.
(d) Students and trainees must be instructed on confidentiality responsibilities, and identifiable data should be anonymised or removed unless explicit consent is given.
4. Regarding legal guidance on confidentiality:
(a) Under Singapore's Personal Data Protection Act, healthcare data can only be disclosed with consent, except where public interest or legal exceptions apply.
(b) The Court in Singapore acknowledges that in certain urgent situations involving serious self-harm, disclosure without consent may be ethically and legally justified.
(c) A legal duty to warn may arise in genetic cases of conditions when serious harm to relatives is foreseeable.
(d) The Healthcare Services Act and associated Singapore regulations require licensees to ensure confidentiality of records at all times.
5. Regarding the principles and professional obligations related to confidentiality:
(a) Utility justifies routine disclosure of sensitive data to institutional leadership if it could benefit patient care.
(b) Physicians must always assess whether disclosure is necessary, justified and respectful of patient trust.
(c) Inappropriate disclosure can occur through casual digital communication or unsecured access.
(d) Casual conversations in shared public spaces, such as elevators, can lead to unintentional but significant breaches of confidentiality.