take responsibility for their own lives. This may require steps on your part to neutralize coercive forces and guard against unduly influencing the patient yourself.

4 Confidentiality

Confidentiality is extremely important to patients and has historically been regarded with great respect by health care professionals. In this section, you will explore the values and ethical principles behind the principle of confidentiality. Why does it matter so much to patients? What values does it promote, and what is the source of its importance? The answer may help one decide when the principle has reached its limit so that information about a patient should be revealed.

4.1 The Importance of Confidentiality

"Why should people be so concerned about confidentiality? If they have done nothing wrong, they should have nothing to hide. And, if they have done something wrong, perhaps we should not assist them in hiding it."

This expresses a common sentiment about confidentiality. Some of the cases in this section involve people who do have something shameful or some sort of wrongdoing to hide, and these may confirm this attitude toward confidentiality.

However, there are reasons for privacy that do not necessarily involve shame or wrongdoing, and it is these that provide the background for the principle of confidentiality. Every society has a sphere of life kept shrouded in secrecy, a private realm. The content of this realm may differ from culture to culture (and from person to person within a culture). Some cultures may not be particularly "up-tight" about nudity but will have other areas of life about which they are as reticent and discreet as our society is about nudity. For example, another domain of secrecy in our culture is money. Ask someone his annual income or net worth, and you are likely to be met with elaborate evasion instead of a straight answer. Of course, some do not share this reticence but may be secretive about some other issues, e.g., political leanings or religious attitudes, about which others, in turn, may be more open.

We would guess that you have some secrets yourself. Stop and think about it briefly. Use the following questions to guide you.

1. Would you be troubled if your mind suddenly became an "open book," i.e., such that everyone could tell exactly what you were thinking at any moment?

2. Identify three things about yourself you have never told anyone. (CAUTION: Do NOT write these down! Somebody might discover your list, which could be embarrassing.)
3. Think of three things you have told someone about yourself that you would be disappointed to find he had made public. (If you can think of nothing in this category initially, put it this way: suppose everyone you had talked with in the last month were to rent advertising billboards and post on them everything you had told them about yourself.)

4. Think of three things you have told a physician about yourself, or that she has discovered about you, that you would not want made public, e.g., on an advertising billboard.

Theories abound about why privacy is so important to us. One value theorist claims that the right to privacy is a property right. As people are possessive about things they own, so they are possessive about their person and information about themselves [Thomson (1975); see replies by Scanlon (1975) and James Rachels (1975) in the same issue].

Harvard Law School Professor Charles Fried (1970, Chapter 9) claims that the importance of privacy stems from its role as “currency” or “capital” by which people establish and maintain relationships of intimacy with others. One does not customarily share intimate information with casual acquaintances. It would be an affront, for example, to turn to the stranger sitting next to you on a bus and ask questions about the person’s sex life or financial status. It would also be an affront to you for the stranger to begin telling you details about these things without being asked. By doing this, the person 1) makes the presumptuous assumption that you care about these intimate aspects of his life, and 2) he implicitly imposes upon you obligations of reacting sensitively to this information and exercising discretion with regard to it.

In contrast to the reserve expected toward strangers, one is expected to reveal intimate information to friends; the level of sharing varies directly with the closeness of the relationship. One who refused to reveal her salary to her spouse would be justly criticized, as would one who refused to reveal information about his political affiliation to a friend of long standing whom he proclaims to be his best friend.

According to Fried, the harm done when confidences are violated is that it becomes impossible to regulate these degrees of intimacy. If everyone knows everything about you, there is no information left with which to establish close relationships.

Some authors go further than Fried and maintain that a sense of privacy is essential to being a person: “If anyone else could know all that I am thinking or perceive all that I am feeling except in the form I choose to filter and reveal what I am and how I see myself . . . I might cease to have as complete a sense of myself as a distinct and separate person as I have now” (Wasserstrom 1981, 113; cf. Reiman 1976). This is, of course, highly speculative, but it underscores the extreme importance of confidentiality.
4.2 The Need for Confidentiality in Medicine

The reason confidentiality becomes an issue in the health care setting is because of the degree of intimacy necessary to provide health care. Physical examination and treatment of patients requires an intimacy of access to their bodies that may be greater than they allow to anyone else in their life. (Today’s media attention to sexual openness may be deceptive. Keep in mind that many still conduct their sexual activities under the covers and with the lights off, and even their sexual partners may never have observed them in the bright lights or the state of undress characteristic of the medical examining room.) Medical examination and procedures involve touching of the body in ways that may be more intimate than people allow any other person to do to them.

Furthermore, a medical history involves intimate information. Aside from the obvious elements of sexual history or symptoms of the genitourinary system, even information regarding aches and pains in other body systems is not usually shared in detail with others. The diagnostic label established as a result of the examination, as well as the details of the treatment regimen, are further items many patients handle with discretion and share with few, if any, acquaintances.

Attention to the psychosocial dimensions of illness brings up other intimate issues. The physician who explores the family dynamics and personal adjustments of patients will tread in areas that may not have been shared by the patient with anyone else. Hence there is plenty of material to be confidential about in the health care setting.

4.3 Confidentiality in Medicine

The principle of confidentiality is one of the oldest and most firmly held doctrines of professional ethics. Consider this list of statements of this principle from various professional codes and related documents:

1. *Oath of Hippocrates (Greece, fourth century B.C.):* "Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret."

2. *Advice to a Physician—Haly Abbas (Persian Code, tenth century A.D.):* "A physician should respect confidences and protect the patient’s secrets. In protecting a patient’s secrets, he must be more insistent than the patient himself."

3. *Five Commandments and Ten Requirements (China, 1617):* "The secret diseases of female patients should be examined with a right attitude, and should not be revealed to anybody, not even to the physician’s own wife."
4. **Code of Ethics—American Medical Association (1847):** "Secrecy and delicacy, when required by peculiar circumstances, should be strictly observed; and the familiar and confidential intercourse to which physicians are admitted in their professional visits, should be used with discretion, and with the most scrupulous regard to fidelity and honor. The obligation of secrecy extends beyond the period of professional services—none of the privacies of personal and domestic life, no infirmity of disposition or flaw of character observed during professional attendance, should ever be divulged by him except when he is imperatively required to do so. The force and necessity of this obligation are indeed so great, that professional men have, under certain circumstances, been protected in their observance of secrecy by courts of justice." (Chapter I, Article I, Section 2)

5. **Principles of Medical Ethics—American Medical Association (1957):** "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community." (Section 9)

6. **Principles of Medical Ethics—American Medical Association (1980):** "A physician . . . shall safeguard patient confidences within the constraints of the law." (Section 4)

7. **American College of Physicians Ethics Manual (1984):** "The physician must keep secret all that he knows about the patient and release no information without the patient’s consent, unless required by law or unless resulting harm to others outweighs his duty to the patient."

8. **International Code of Medical Ethics—World Medical Association (1949):** "A doctor owes to his patients absolute secrecy on all which has been confided to him or which he knows because of the confidence entrusted to him."

9. **Code for Nurses—American Nurses Association (1950):** "The nurse safeguards the client’s right to privacy by judiciously protecting information of a confidential nature." (Section 2)

10. **Patient’s Bill of Rights—American Hospital Association (1972):** "The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present." (Section 5) "The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential." (Section 6)

There are significant variations in content between the statements on confidentiality cited above. The principle from China (3) especially stresses the
observance of confidentiality within the physician’s family, but it severely limits
the scope of information protected. The Persian code (2) appears the strongest of
them all, demanding paternalistic refusals to reveal information even when the
patient authorizes its release. Both the World Medical Association Principles (8)
and the Hippocratic Oath (1) allow no exceptions to a rule of protecting
information.

A comparison of changes over the years in statements by the American Medical
Association reveals a progressive strengthening of the principle of confidentiality.
In the 1847 Code of Ethics (4), breaches of confidence were permitted whenever
"imperatively required," leaving pretty wide latitude. By 1957 (5) grounds for
revealing information had been narrowed (or at least more firmly specified) to
include only three circumstances: (a) when the physician is required by law to
reveal information; (b) when revelation "becomes necessary in order to protect the
welfare of the individual," and (c) when "it becomes necessary in order to protect
the welfare of . . . the community." In the 1980 AMA statement (6), the latter
two indications for revealing confidential information are omitted. Thus the only
ground for breaching confidentiality is when required to do so by law—as, for
example, in mandatory reporting laws regarding suspected child abuse, com-
municable diseases, etc. The American College of Physicians Ethics manual (7) is
closer to the 1957 AMA position.

4.4 Confidentiality and the Law

Society (through law) exhibits an ambivalent attitude toward medical con-
fidentiality.26 On one hand, the patient’s right to confidentiality is supported
legally in several states by having breaches of confidentiality grounds for sus-
pension or revocation of a medical license. Stronger legal support for this right is
supplied in many (but not all) states by provisions classifying physician-patient
communications as "privileged," meaning that they cannot be introduced as
testimony in judicial or administrative proceedings without permission of the
patient.

Conversely, all states also have statutes requiring physicians to breach con-
fidentiality by reporting specific medical conditions to the authorities. Failure to
supply such information is also a ground for suspension or revocation of medical
license. The list of conditions covered by mandatory reporting laws is extensive.
Among those for which such reporting is required in one or more states are the
following:

— indications of child abuse
— gunshot wounds
— indications of "foul play"
— criminal actions

26. For a review of the legal issues, see Annas et al. (1981, 170–192) and Fiscina (1982, Chapters 4
and 8).
— contagious, infectious, or communicable diseases (usually those contained on a specified list)
— abortions
— births out of wedlock
— diseases or congenital deformities in newborns
— any psychiatric diagnosis, especially those posing a danger to others
— death
— Medicare, Medicaid, OSHA reports.

4.5 Cases

Many physicians allow the principle of confidentiality and loyalty to their patients to override legal reporting requirements in some circumstances. Thus many physicians treat patients and any acknowledged “contacts” for venereal disease without reporting the incident to the public health authorities as required by the letter of the law. Do you think this practice is justified? Consider the following case as an example.

4.5.1 “Please Don’t Ruin My Marriage!”

Joan Wentaway is a 40-year-old businesswoman. She and her husband Stone (who is 43) have been your patients for quite a few years; you know them well.

You were surprised three days ago when Joan came to see you for a routine pelvic exam. She had a small amount of purulent cervical discharge, so you took a GC culture that came back positive this morning.

At today’s follow-up appointment, you explain to Joan that laboratory tests confirm that she has gonorrhea, and you administer 4.8 million units of penicillin G, IM. You then explain that state law requires that you report all cases of gonorrhea to the Health Department. You point out that her husband needs to come in for the same treatment you have just given her.

With considerable emotion, Joan begs you not to report her disease either to the Health Department or her husband. “I know exactly where I got this,” she explains, “I picked up a prostitute a couple of weeks ago when I was in Atlanta for a business convention. I haven’t had sex with Stone, or with anyone else, since, so I haven’t spread the disease. If you tell Stone about this, he will walk out on me, I know. And if you report me to the Health Department, Stone will find out. A neighbor of ours works at the Health Department handling these reports, and he’ll go straight home and tell Stone all about it. I swear, I have never done anything like this before. What rotten luck! One ‘fling’ and I get VD! Please don’t ruin my marriage by telling Stone.”

What should you do? Should you tell Stone? Should you report the case to the Health Department? Consider the following options:

1. Insist that Joan tell her husband and bring him in for treatment.
2. Same as 1 plus threaten that unless her husband has called for an appointment
within 48 hours, you will contact him and tell him yourself.

3. Insist that she bring her husband in for treatment but agree to go along with a fictional explanation for the need for him to receive this treatment, if Joan can come up with some plausible fiction.

4. Call Stone on the spot and tell him yourself, while Joan is still in the room.

5. Call the Health Department on the spot, while Joan is still in the room.

6. Call Stone and/or the Health Department as soon as Joan has left your office.

7. Promise Joan that you will not report her either to Stone or to the Health Department. Keep your promise.

8. Other (specify): __________________________________________________________________________

Choice 6 may be tempting because it minimizes the immediate hassle, but in our view it is among the least satisfactory of the options (although it is certainly legally defensible). Joan is likely to be extremely upset later when she discovers that the information was revealed. Thus the net hassle is likely to be greater here than for the other options. More importantly, on ethical grounds, she surely has a moral right to be informed in advance if this is going to be done so she can prepare for Stone's reaction. This is essential if you hope to preserve trust in your relationship with her.

A. Telling the Health Department  The law mandates reporting cases of venereal disease to the Health Department or other health officer. The AMA Principles of Medical Ethics demand reporting information when "required to do so by law."

However, this does not settle the issue on moral grounds. One may always decide, on ethical grounds, to disobey the law and professional codes if there are compelling moral reasons to do so. And it is not irrelevant to this case to recognize that (1) many health departments are too concerned with more serious venereal diseases, such as syphilis, to be upset by failures to report gonorrhea, or to do much follow-up with this disease when it is reported, and (2) the practitioner may be more effective in eliciting information about and treating contacts than the public health authorities.

The primary losses if the case is not reported are (1) the distortion of public health data about the incidence of the disease and (2) the loss of any chance the public health authorities have to locate the prostitute and treat the source case for this infection. Both of these goals might be achieved while still preserving confidentiality by reporting the case to the health department anonymously or assigning an alias for the patient, while handling treatment and follow-up yourself.

Of course, taking matters into one's own hands in this way is risky. Society has vested authority for these matters in the health agency, and there may be penalties for the practitioner who does not acknowledge this authority.
**B. Telling Stone** The question of whether to tell Stone is more immediately related to issues of personal welfare. If Stone has been exposed to the disease and goes without treatment, the consequences for his health could be serious.

How much weight do these consequences carry compared to Joan’s right to confidentiality? Clearly they would have to have considerable weight to provide a justification for overriding Joan’s right.

In general, rights require strong countervailing considerations in order to be overridden. Otherwise, rights would not be worth much. If, for example, my right to free speech held only until others felt it is better that I not be heard, then my right would be limited and my reason for prizing it is reduced. I don’t need the support of a right to say things no one objects to hearing. I need to appeal to the right to speak when I want to say things some may prefer not to hear. The courts have acknowledged this by ruling that the right to free speech is overridden only in those rare and extreme situations in which the speaking poses a “clear and present danger” to others or the social order. (The classic example is yelling “Fire!” in a crowded theater.)

Is the danger of untreated gonorrhea sufficiently serious to justify breaching Joan’s right to confidentiality? Let us isolate the point by constructing a hypothetical proposition that varies in some respects from the case at hand. Suppose (for purposes of this argument) we knew that Stone had been exposed by Joan and had contracted the disease. Suppose the only way to get him in for treatment is to breach Joan’s right to confidentiality. Is the need for treatment sufficiently serious to justify this breach? Most people would agree that it is. In addition, that Stone is also your patient may add weight to your duty to prevent his suffering the effects of untreated disease when you are in a position to prevent it from happening.

On the other hand, you may find yourself inclined to tell Stone because of a desire (or a sense of obligation) toward this patient/friend/fellow-male (if you are male) to inform him of his wife’s infidelity. This inclination should not enter into your deliberations. This consideration does not fall within the physician-patient relationship, and thus (even if it might be relevant in other decision contexts) it ought not intrude into clinical decisions.

The next question may be whether you believe Joan’s insistence that Stone has not been exposed to the disease. We have said that if Stone were exposed, he ought to be treated, even if arranging treatment requires violating confidentiality. Is your degree of confidence in her report sufficient to warrant a decision not to offer treatment to Stone? (NOTE: In making this judgment, try to avoid extraneous factors, such as the inclination to make sure he knows what a “bad girl” his wife has been, or assumptions based upon your own sexual practices or standards.)

If you are sufficiently skeptical of Joan’s report to conclude that Stone must be treated, then you must determine the best means to get him in for treatment. Four alternatives are suggested in options 1–4. List the advantages and disadvantages of each. List the moral principles involved in each choice. Which do you think the
best approach and why? Choose one of the options and formulate your reasons for favoring it before you go to the next section.

C. Reconsiderations  Now that you have made a decision in this case, think it through further. A decision, once carried out, rarely ends a matter. Future events may lead you to reflect on the choice you made. Find the choice you made from the following list and consider the information presented. Would you stick with your original decision?

1. If you have chosen not to tell Stone, what if he came in a day or two later with dysuria and a profuse, purulent urethral discharge?

2. If you have chosen not to report this case to the Health Department, what if a Public Health officer telephoned you a week later and asked whether you had ever treated Joan for gonorrhea, explaining that someone had reported her as their contact.

3. If you have chosen to tell Stone, how would you feel if (1) his GC culture came back negative and (2) he instituted divorce proceedings against Joan immediately?

4. If you have insisted that Joan tell her husband, how would you feel if you read in the paper the next day that Joan committed suicide immediately after leaving your office?

5. If you chose to go along with option 3, how would you respond to Stone if he asked you point-blank what this treatment was for? What would you say if he asked, "This is for VD, isn’t it?"

Now that you have begun to formulate a policy for dealing with cases of this sort, test it further by applying it to the following situation.

4.5.2 “Please Don’t Tell my Parents!”

On the appointment book, the patient is listed as “Alice Avender—camp physical.” Her record reveals that she is 15 years old.

At the end of the routine camp physical, Alice requests a prescription for birth control pills and asks that her parents not be informed of this request. She says she plans to pay for the prescription and any related office visits herself, so her parents will not have to know. (She has a part-time job at a fast-food restaurant; her earnings, with the allowance she receives from her parents, will be more than enough to pay these expenses.)

Alice explains she has read “all about” alternative methods of birth control and has decided she prefers the pill. She volunteers to return for periodic examinations as often as is advisable while she is on contraceptives. Alice’s desire for secrecy is surprising in view of her parents’ attitudes. More than once, during general

27. Some of the general principles involved in these later events are discussed in Appendix I, Section 2.1.3: "Responsibility for Consequences."
discussions of teenage sexuality, Alice’s parents have been mentioned as prime examples of parents who champion openness with teenage children about sex. Although they are not sure that teenagers are mature enough to handle intimate relationships, they think that after adequate parental counseling, young people should make these decisions for themselves.

In contrast, Alice reports that her mother told her a few months previously, “If you want to mess around with sex, I guess I can’t stop you. Just do two things for me: Be sure that you are protected, and don’t let me, or especially your father, hear anything about it.”

The application of the confidentiality principle to minors has not been firmly established. Parents are generally considered to have a right to medical information concerning their children. Few physicians would think of asking patients under legal age for permission to discuss their illnesses and problems with their parents. They would feel free to disclose information to the parents as a matter of course. However, this policy may be based on factors extraneous to the case at hand. First, in most instances parents are paying the bills for the minor’s care; it can be argued that they have a right to know precisely for what they are paying (a line of argument to be challenged in connection with a later case). Secondly, most of these cases involve medical matters less intimate in nature than the illustrative case. Issues of birth control and abortion have been singled out in recent decisions of the United States Supreme Court for special protection under the constitutional right of privacy, and this protection might apply to the medical sphere. It should be noted, however, that the Supreme Court appears to be weakening this protection, especially with regard to abortion, in some recent opinions.

Two issues are central to this situation; both indicate that it would best serve the interests of the family as a unit for the parents to be informed. The first issue concerns truth, honesty, and trust. Secrets are ultimately destructive in these situations, as they are in any intimate relationship. If Alice continues to be sexually active and hides it from her parents, a chronic erosion of their relationship could develop. In contrast, the truth may generate an acute crisis in the family. However, as long as caring and trust remain, there is potential for overcoming the crisis, resulting in the growth of all parties individually and a strengthening of the family unit.

The second issue central to this situation is autonomy. A prime goal of any medical interaction is to support, restore, and enhance autonomy. The physician (particularly the family physician) must consider the autonomy of both Alice and her parents—and even the autonomy of the family as a unit.

To enter into collusion with Alice as she requests can be interpreted as supporting her autonomy, but parental and corporate family autonomy would be eroded in the process. In contrast, were the parents informed of Alice’s sexual activity, the family disagreement could eventually resolve itself in a way that enhances the autonomy of all parties. The vigorous family discussions that undoubtedly would follow this disclosure would require each party to express views on the issue more carefully than
would be necessary for individual thought about the matter. This process could lead to a creative but disciplined autonomy for the teen-ager and her parents, which differs significantly from (and in our judgment is far superior to) the passive and random autonomy they each appear to express at present. Alice and her parents may recognize (and value) a role for the parents as competent advisers. Because these values exist in the family unit, the family physician is obligated to make a concerted effort to see that Alice's parents are informed.

However, the physician's obligation to ensure that the parents are informed varies with the degree of his relationship with them. If he does not know the parents at all, or if they are merely social acquaintances, then Alice's right to confidentiality outweighs any duty the physician might have to the parents. (One might still urge Alice to talk the matter over with her parents, but it would not be justifiable to inform them without her consent.)

One mechanism for bringing this information to the attention of the parents is to prescribe the pill under a mild ruse, e.g., saying it is to achieve menstrual regularity. Knowing their daughter is on the pill is bound to start the parents thinking about the possibility of sexual activity on her part.

If the parents are also the physician's patients (and particularly in the specialty of family practice, where the family as a whole is the fundamental unit of care), the obligation to see that the parents are informed is considerably stronger. However, even here unilaterally informing her parents would undermine the physician's trust relationship with Alice. Thus we propose a strategy of strongly urging Alice to inform her parents, offering to be present and assist the family in dealing with the short-term impact of this announcement, and offering supportive counseling to all parties over the long term.28

**Note On Law** This case raises two issues about the relationship between legal requirements and moral decisions. The Department of Health and Human Services proposed in 1982 an administrative regulation that required informing the parents of any minor provided with birth control by a clinic receiving federal funds. Many health professionals wrote protesting this proposal, arguing that it would increase teen-age pregnancies and that this was far more dangerous in medical terms than the use of contraceptives by teen-agers. Some who protested agreed with our suggestion that it is morally right to inform the parents in some cases. However, it is one thing to hold that this is a moral requirement and quite another to enact a legal reporting requirement. The former allows for professional discretion in deciding when the obligation applies and the best approach to meeting it, whereas the latter would significantly diminish these domains of individual professional discretion. The AMA Principles would require physicians to abide by this regulation were it adopted, whereas a moral decision might require civil dis-

28. For details of the strategy we propose, see Eaddy and Graber, (1982).
obedience by refusing to notify the parents in cases where the physician is convinced that this would not be constructive.

The *American College of Physicians Ethics Manual* (American College of Physicians 1984, 132), explicitly allows for civil disobedience in the face of a court order: "If the physician thinks that his commitment to the patient's welfare overrides his duty to obey a court order, he may ethically refuse to give to the courts information not released by the patient but must be prepared to accept the legal consequences."

4.5.3 "Please Don't Tell My Family!" In this case, taken from Melvin P. Levine and colleagues (1977, 205), the physician is a nephrologist or transplant surgeon.

A five-year-old girl has been a patient in a medical center for three years because of progressive renal failure secondary to glomerulonephritis. She had been on chronic renal dialysis, and the possibility of a renal transplantation was considered. The effectiveness of this procedure in her case was questionable. On the other hand, it was the feeling of the professional staff that there was a clear possibility that a transplanted kidney would not undergo the same disease process.

After discussion with the parents, it was decided to proceed with plans for transplantation. Tissue typing was performed on the patient; it was noted that she would be difficult to match. Two siblings, age two and four, were thought to be too young to serve as donors. The girl's mother turned out not to be histocompatible.

The father, however, was found to be quite compatible with his daughter. He underwent an arteriogram, and it was discovered that he had anatomically favorable circulation for transplantation. The nephrologist met alone with the father and gave him these results. He informed the father that the prognosis for his daughter was quite uncertain.

After some thought, the girl's father decided that he did not wish to donate a kidney to his daughter. He admitted he did not have the courage and that in view of the uncertain prognosis, the very slight possibility of a cadaver kidney, and the degree of suffering his daughter had already sustained, he would prefer not to donate.

The father asked the physician to tell everyone else in the family that he was not histocompatible. He was afraid that if they knew the truth, they would accuse him of allowing his daughter to die. He felt that this would "wreck the family."

The physician felt very uncomfortable about this request. However, he agreed to tell the man's wife that "for medical reasons" the father should not donate a kidney.

In what ways is this case different from Case 4.5.2? How would your solution here differ? Give this some thought before you read the explanation in the following section.
Here again a key issue is exchange of information within the family. However, one difference is that the physician is being asked not merely to refrain from reporting information to the man’s family, but to participate actively in misleading them about the outcome of the tests. Clearly mere confidentiality would not accomplish the man’s purposes. Suppose the physician were to say to the family, “I cannot tell you the results of the tests. He will have to tell you himself.” One can imagine the pressure that would be put on the man to reveal the results. Thus he requests the physician’s assistance to avoid this kind of pressure, assistance that goes well beyond protection of confidentiality.

The patient requests that the physician lie about the results of the tissue tests. This course of action is inadvisable. A direct lie, if discovered, will undermine the trust relationship between the physician and the family much more than would evasion of the truth. The phrase “for medical reasons” can be construed to cover the truth, that the father’s fear of donation might be regarded as pathological.

Does this seem a semantic quibble to you? Do you feel there is no moral difference between a direct lie and an evasion that, while not strictly false, may be no less misleading? Before you dismiss this distinction, think about how it would apply in a whole range of situations. In particular, think of the case in which you would regard the distinction as most likely to be justified. Only if it is never justified in any situation can it be said that the distinction lacks moral significance. On the other hand, if it is justified in some situations, reasons have to be offered for not considering it significant in other circumstances.29

If the choice is seen as a one-moment, all-or-nothing matter, i.e., between preserving the man’s confidentiality at this moment and breaching it, then it would be difficult to defend the physician’s action. Important as the man’s right to confidentiality may be, it does not outweigh the child’s right to life, and although there are some doubts about the prospects for success of the transplant, they do not seem serious enough to justify foregoing this life-saving possibility.

However, the best approach may be to protect the man’s confidentiality right now, and then continue to help him deal with his reluctance to donate a kidney to his daughter. This approach takes confidentiality to be justified as a means to an ultimate goal.

There are at least two goals to which confidentiality might be subordinated in this way: either (1) persuading the father to agree to donate, or (2) allowing the father to work through his immediate emotional reaction and reach a considered decision. The difference between these goals would show up at a later stage if, after further counseling, the father still refused to donate. One pursuing the former goal would seriously consider breaching confidentiality at that point, whereas one who held the latter goal would be inclined to accept the father’s decision, as long as he was convinced it was a considered decision.

29. For further discussion of distinctions of this sort, see discussion of “Half-Truths” (Section 2.3.1.B) and Appendix I, Section 2.1.1: “Side-Constraints.”
4.5.4 "Please Don’t Tell Anybody!" This case is adapted from Barbara Tate (1977, 21–22).

A young unmarried woman was admitted to the hospital with excessive uterine bleeding, which she explained was connected with her monthly period. She stated that this had occurred several times over the course of the past year and was of great concern to her.

A medical student (who is currently on an externship rotation with the private practice gynecologist treating this patient) established a good rapport with her, perhaps partly because the student was close to the patient’s own age, whereas the physician was significantly older.

On the day after admission, the student was chatting with her when she said: "You would keep anything I told you secret, wouldn’t you?" After the student’s assurance that confidentiality would be preserved, she confided that she had been certain she was pregnant and took some medication that she had been told would bring about an abortion. She insisted she does not want anyone, not even the physician-mentor, to know about this.

What should the medical student do? What would you do? Consider the following options:

1. "Promise anything." Promise her that you will keep the information confidential, then tell the doctor the whole story (but ask him not to let the patient know that you told him).
2. Promise that you will keep the information confidential and do not tell anybody, not even the doctor.
3. Promise you will keep the information confidential, then tell the doctor only "There’s more to this case than she has told you, but I cannot tell you the details," leaving it to him to get the whole story from her in his own way.
4. Promise only that you will not take the initiative to tell the doctor, but explain that you will have to answer truthfully if he asks you whether you learned anything relevant in your conversations with her. Then honor this promise.
5. Refuse to promise to protect her secret. Explain that proper treatment cannot be carried out unless the doctor knows all the relevant facts about the patient, and thus you must tell the doctor the whole story.
6. Refuse to promise to protect her secret. Encourage her to tell the doctor the whole story, explaining that proper treatment cannot be carried out unless the doctor knows all the relevant facts about the patient.
7. Change the subject. Comment on the pretty flowers someone sent to her and try to forget the whole episode ever happened.
8. Other (specify): _______________________________________

The first mistake was to agree to an unqualified promise of confidentiality as the patient prepared to reveal the information. It may have seemed innocuous enough at the time, but soon it became clear that her conception of the scope of
confidentiality was significantly wider than the medical student had in mind when he offered the assurance. What she wanted is what we call "secrecy," i.e., that information be kept entirely to oneself and not shared with anyone else. We argue below, however, that this is different from the way confidentiality works in the medical setting.

It would probably have been wise for the student to have qualified any assurance of confidentiality: "Of course, I will have to share information with the physician who is caring for you, but the care team will not tell anyone else." (Of course, one result of responding in this way might be that she would not reveal the information in question to the medical student. That may be the price that has to be paid for the difference between confidentiality and secrecy.)

But the promise was made, and now the question is what to do about it. This situation might not have arisen had more attention been paid to its consequences and ethical implications before it was made, but it must be dealt with in ethical terms now that it has reached that stage.

A general issue raised by this case is the exchange of information among the various health care professionals treating the patient. Present practice sets few, if any, limits on exchange of information among professionals. The patient's chart is open to a wide variety of hospital personnel. One physician counted the persons in his metropolitan teaching hospital who had access to the hospital record of a particular patient. He reports:

I was amazed to learn that at least 25 and possibly as many as 100 health professionals and administrative personnel at our university hospital had access to the patient's record and that all of them had a legitimate need, indeed a professional responsibility, to open and use that chart. These persons included 6 attending physicians (the primary physician, the surgeon, the pulmonary consultant, and others); 12 house officers (medical, surgical, intensive-care unit, and "covering" house staff); 20 nursing personnel (on three shifts); 6 respiratory therapists; 3 nutritionists; 2 clinical pharmacists; 15 students (from medicine, nursing, respiratory therapy, and clinical pharmacy); 4 unit secretaries; 4 hospital financial officers; and 4 chart reviewers (utilization review, quality assurance review, tissue review, and insurance auditor). (Siegl er 1982, 1519)

The author concludes that "medical confidentiality, as it has traditionally been understood by patients and doctors, no longer exists. This ancient medical principle, . . . has become old, worn-out, and useless; it is a decrepit concept" (Siegl er 1982, 1518).

We do not share completely this negative assessment. Confidentiality is meaningful in today's complex health care structure when its nature and scope are properly understood.

The heart of the agreement to preserve confidentiality is found in the physician-patient relationship as a component of the therapeutic bond comprising the doctor-patient relationship or DPR (as discussed in Section 1.2.4.B.3). The
patient controls the scope and content of this principle, having the option to select any information for protection under the principle of confidentiality. The physician has no grounds for judgment about what is to be confidential except his or her reading of what is sensitive to a given patient. From this principle it follows that students, who are in the process of acquiring clinical skills, are well advised to treat all information as confidential until they become proficient in determining what each patient regards as sensitive.

There are four cases in which information about patients is shared with other professionals.

A. Communication with Other Caregivers The primary physician enlists other professionals to assist in the care of the patient, and their role in care makes it necessary for them to become familiar with the facts of the case. Those in Siegler's list above fall into this category. Information about the patient is deposited in the hospital record to make it available to these individuals. This is the key difference between confidentiality and secrecy. Keeping information "secret" means that it is not shared with anyone. "Confidentiality," in contrast, means sharing information with others directly involved in the patient's care.

This may include a large number of individuals, as Siegler's list indicates. Protection of the patient's privacy results from the circumspect behavior of these individuals. They should be aware that (1) they have the right to access only those charts and that information within a chart that is directly relevant to their care-giving function, and (2) the pledge of confidentiality made to the patient by physicians makes it wrong for them to reveal any information learned from the chart (or from their own interactions with the patient) outside the bounds of the health care team.

Formal procedural safeguards might be devised to enforce some aspects of these rules of decorum, i.e., to prevent hospital employees other than those directly involved in the patient's care from having access to the chart. However, these could never be "fail safe," and they involve a greater loss (by impeding communication between those with a need to exchange information) than the gain to be achieved. There is no substitute for morally sensitive behavior by the individuals involved.

B. Teaching The second occasion for sharing information in the clinical setting is for purposes of teaching. This is bounded by safeguards in several ways, including (1) obtaining informed consent of the patient before introducing students into his or her care, (2) impressing upon the students the importance of discretion with regard to information gained about patients, and (3) admitting into this role only those students who, even at this stage of their skills, can be of benefit to the patient. The last is why introduction to clinical practice is delayed in health professions training programs until students have mastered requisite preliminary skills.
C. Peer Review  A third occasion for sharing information is peer review, to be distinguished from (A) above. Although these reviews protect and improve the care of the individual patient, they also protect the hospital and thus cannot be brought entirely under the rubric of providing care. Explicit patient consent should be sought for access to the chart for this purpose. This might be included with other forms filled out by the patient upon admission, but it ought to be specifically described.

D. "Shop Talk"  Professionals often share information about patients among themselves in an informal, often anecdotal form. This "shop talk" is similar to that between other intellectuals as a means of enhancing scientific creativity. To communicate the reasoning behind diagnosis and treatment of a specific case to another professional clarifies one's thinking, prompts the listener to useful intellectual exercise, and promulgates information about disease entities, therapies, etc. Compared to a formal consultation, this sort of exchange is much less structured, and the listener is not committed to share responsibility for the decision reached. The patient's privacy is safeguarded in these discussions by keeping the identity of the patient anonymous. Outsiders sometimes criticize health professionals for referring to patients, for example, as "the gall bladder in [room] '46"; but this sort of reference confers anonymity and thereby preserves confidentiality.

Returning to the particulars of Case 4.5.4., the key value conflict is between the principle of promise keeping on the one hand and the patient's health needs on the other. The student made a serious mistake in getting embroiled in what the patient regarded as a promise of absolute secrecy. This promise cannot be sustained, given the student's standing in the clinical setting and the health needs of the patient. The student's position in the setting is ancillary to that of the physician-mentor, and thus the physician-mentor must be given the information. To attempt to persuade the patient to reveal the information herself might be best; if this fails, though, the student has no recourse but to inform the physician. Hence, option 6 is recommended as the initial approach, followed (if necessary) by option 5.

4.5.5 "Please Don't Tell My Ex-Husband!!"

Ms. Meda Mystake is a 31-year-old woman who has been a patient of yours for about ten years. Her marriage to Roland Doughe ended in divorce six months ago. At that time Meda brought a copy of the court decree to you and pointed out the provision in which Roland had agreed to pay "all medical expenses" for Meda for one year following the date of the divorce. You told your business manager to bill all charges to Roland for the one-year period.

A month ago Meda came to your office again. Laboratory tests confirmed your clinical impression that she is pregnant. When you informed her of these findings, she volunteered that the baby's father is a man she has been living with since shortly following the divorce.
You indicated on the chart that Meda should be scheduled for the standard pattern of prenatal visits. As most physicians nowadays, you charge a flat fee for prenatal visits, delivery, and postnatal care. In your case, the fee is $650.

Today, Roland Doughe is on the phone, irate. The business manager tried to handle the situation, but Roland insisted on talking with you. "I demand to know what sort of treatment is being given to my ex-wife that amounts to $650," he says angrily. "Your office staff refused to tell me anything about it. They said that I must ask Meda about it, but I have asked her, and she won't discuss it. I have a right to know what I am paying for. How do I know you aren't overcharging me?"

What should you tell Roland?

This is another situation that could have been avoided. For the physician to get embroiled in this situation was a mistake. When Ms. Mystake came in with the court order, the physician would have been advised to refuse to take part in this arrangement. It should have been possible for her and her ex-husband to work out an arrangement independently for handling his payment of these expenses—for example, by having her pay the physician and then sending copies of the receipts to her ex-husband for collection.

There is little basis for violating her confidentiality by revealing to Roland the details about this bill. Other third-party payers may demand to know what they are paying for, but the physician must obtain a release from the patient before complying with this request; surely the same applies here.

Roland might have a special claim to information here because a substantial portion of the blanket charge covers the delivery of the baby, but this will occur after the one-year period for which he had promised to pay medical expenses. If this were brought to the attention of a court (as Roland would be likely to do if he knew these facts), the court might release him from responsibility for a pro-rated portion of the bill corresponding to the delivery charge. Hence, it might be unjust to expect him to pay the entire bill. The questions remaining are

1. Is the injustice involved here sufficiently serious to justify a breach of confidentiality?
2. Is relieving Roland of this injustice the responsibility of the physician and his or her staff?
3. Meda is clearly not being "fair" or "just" to her ex-husband, but must the physician intervene to rectify this wrong?

Clearly some harm to others is sufficiently serious to justify breaching confidentiality. If you determine that a certain patient is at risk for a myocardial infarction or seizures and his occupation is such that he will jeopardize lives if such an event occurs (e.g., a bus driver, a commercial pilot), you have an obligation to urge him to inform his employer of this condition and to request relief from duties with direct impact on public safety. If the patient does not notify his employer, you have a moral duty to inform the employer despite his protests.
The difficult issue here is to balance the degree of risk with the impact the patient is likely to have on public safety, and thereby to determine when to override confidentiality. A person at risk for an MI might injure others if one occurs while he is driving a private automobile. Should physicians, then, notify the state bureau of licenses of every patient with this diagnosis? If this risk is insufficient for abridging confidentiality, should the authorities be notified of all those who drive a good deal more than the average (e.g., traveling salesmen), on the grounds that the chances of an MI occurring under conditions that could be harmful to others is increased? If this is seen as excessively cautious, then where is the line to be drawn between this situation and the airline pilot responsible for several hundred passengers? These are issues of balancing competing obligations: the principle of confidentiality on one hand, and the duty to protect society from harm on the other. There are no easy formulas for resolving these questions. They depend on weighing normative factors in each individual case.

4.6 President’s Commission Recommendations

The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983, 37–38) has issued guidelines dealing with aspects of confidentiality:

1. Respect for patients’ legitimate expectations of privacy is an important part of ethical health care practices, as well as the foundation on which a relationship of mutual trust and benefit can be built between patient and professional.

2. Health care institutions and providers are urged to educate the public about their expectations and practices on private medical matters.

   —In particular, patients need to be better informed about the scope of confidentiality and to be given the opportunity to give waivers for specific information rather than blanket waivers.

   —Specific warnings should be made if disclosures of patient information are anticipated without prior consent.

3. Instances of unconsented disclosures are to be regarded as exceptions to the general norm of confidentiality and require special justification, such as an important public purpose.

4. When information is provided based upon a general consent by a patient (for example, permission for a hospital to send records to a third-party payer), no more information should be disclosed than is necessary for the function to be performed by the third party.

   —Efforts should be made to permit patients to review for accuracy any records to be disclosed.

   —Third-party recipients of confidential information are encouraged to find economical methods of notifying patients whose records they are requesting or when they plan to pass along individually identifiable information to other persons or organizations.
4.7 Review Exercises

1. Is privacy a right or a value? What difference does this distinction make to a) the scope, b) the stringency, and c) the justification of a principle of confidentiality?

2. Design a statement on confidentiality for one of the purposes indicated below. Develop the rationale, in the way you would present it to an administrative committee as part of a proposal that the statement be adopted as official policy, for (1) having such a statement and (2) the specifics of your statement.
   a. A statement for patients, to be included in the admissions forms for a hospital.
   b. A statement for hospital employees, to be included in an employees handbook.
   c. A statement for medical students, to be included in a student handbook.

3. Describe a range of cases involving the decision to breach confidentiality; on the basis of your response to these, develop a principle to determine when confidentiality should be violated.

5 Conclusion

In this chapter, you have explored central issues in the physician-patient relationship. In the next chapter, you will examine some theoretical resources, from both professional ethics and general ethics, that will assist you in examining these issues more thoroughly.

References

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Further Reading

General Features

Patient’s own account of his unconventional self-treatment for ankylosing spondylitis.
Account of the course of an illness, told by both the patient (Lesher) and the physician (Halberstam).
Parents’ account of the course of illness of their hemophiliac son.
Therapeutic Relationship
I. History of the Relationship (Entralgo PL)
II. Sociohistorical Perspective (Bloom SW)
III. Contemporary Sociological Analysis (Mechanic D)
IV. Contemporary Medical Perspective (Cassell EJ)
Reflections by a former cancer patient on the emotional impact of a diagnosis of cancer, as compared with the rather glamorized image of tuberculosis in the nineteenth century.

Information Exchange

Abrams, Buckner: Medical Ethics, Section II.C, 1983.
Truth-Telling
I. Attitudes (Veatch RM)
II. Ethical Aspects (Bok S)

Placebos


Informed Consent

Miller LJ: Informed consent. JAMA 244: 2100–2103 (Part I); 2347–2350 (Part II); 2556–2558 (Part III); 2661–2662 (Part IV), 1980.

Confidentiality

5.03 Communications Media: Press Relations
5.04 Communications Media: Standards of Professional Responsibility
5.05 Confidentiality
5.06 Confidentiality: Attorney-Physician Relation

Informed Consent in Human Research
I. Social Aspects (Gray BH)
II. Ethical and Legal Aspects (Lebacqz K, Levine RJ)
Informed Consent in Mental Health (Burt RA)
Informed Consent in the Therapeutic Relationship
I. Clinical Aspects (Cassell EJ)
II. Legal and Ethical Aspects (Katz J)
Right to Refuse Medical Care (Capron AM)

5.07 Confidentiality: Computers
5.08 Confidentiality: Insurance Company Representative
5.09 Confidentiality: Physicians in Industry
7.01 Records of Physicians: Availability of Information to other Physicians
7.02 Records of Physicians: Information and Patients
Privacy (Greenawalt K)
Confidentiality (Winslade WJ)