
The Physician's Role in Protecting Confidentiality — A Consideration of the Implications of AIDS

by Sharon Lee

While aspects of physician-patient confidentiality can become challenging legally, the maintenance of confidentiality is foremost an ethical issue. Using HIV disease as the parable that illuminates some of the darker corners of medical practice, this article examines the limits of patient confidentiality. These limits may appear to be sharply drawn, but they are often rendered fuzzy along the edges of substantive cases. Readers comments on the cases are invited.

The duty of physicians to maintain confidentiality has roots in the ancient association of clergy and medicine. In many ancient cultures, priests were healers; and spiritual infirmities corresponded to physical manifestations of disease. Confession of one's sins or failings of the soul has been, at least since the Middle Ages, a confidential matter between priests and penitents. Likewise, the diagnosis of illness or failings of the body was — and is — confidential between physicians and patients.

Yet confidentiality in medical contexts, once considered sacrosanct in theory and in accord with various oaths of the medical professions, is under siege. In modern reality, information communicated between physicians and patients is often shared with third parties. To a practicing physician and student of ethics, the concept of confidentiality appears to have eroded in an age characterized by instant communication and an increasingly litigious atmosphere. At the extremes, confidentiality encompasses ethical obligations to patients and to certain third parties and legal responsibilities to both. Nevertheless, we have a duty to protect patient information from unwarranted disclosure and a responsibility to protect other parties at risk.

The ethical prescripts differ significantly from the legal proscripts for determining the limits of

confidentiality. A physician's ethic of patient confidentiality is not protected by law to the degree often assumed. Laws preserving confidentiality between priest and penitent or attorney and client are essentially inviolate. The legal shield that protects the physician-patient relationship is not that secure. Federal rules of evidence allow medical records to be opened without regard for issues of privacy or confidentiality. On the other hand, we know of legal cases in which damages for inappropriate release of patient information have been awarded. While aspects of physician-patient confidentiality become challenging legally, the maintenance of confidentiality is foremost an ethical issue. This paper examines the ethical limits of patient confidentiality.

Initially, the limits of confidentiality may appear sharply drawn. On closer inspection, the concept is rendered fuzzy along the edges of substantive cases. At times, a balance must be sought between ethically conflicting claims to information, including the physical safety and well-being of other parties, the protection of property and assets, and privacy issues.

I have chosen HIV disease as the parable from which to examine these issues because my practice includes familiarity with specific illustrative examples. HIV is a disease that is particularly suited to elucidate several of the ethical and moral

perimeters of modern medicine. Issues such as duty to serve patients despite the potential for harm to oneself, medical cost and payment responsibilities, and reproductive rights have been re-ignited by concerns exemplified by AIDS. Various aspects of this disease and community responses to it illuminate some of the darker corners of medical practice. One such corner is that bounded on one side by a physician's duty to protect patient confidentiality and on the other by the sometimes equally powerful duty to protect third parties by suppressing or disclosing otherwise confidential facts, particularly as the information concerns a deadly contagious disease.

Information about HIV

HIV infection is a communicable disease that is almost always fatal and for which there is no cure. It is not possible to temper the consequences of decisions that may result in disease transmission or harm to a third party. The possibility of using after-the-fact treatments to "fix" an undesirable consequence is ruled out by attributes of the infection.

The risk of HIV transmission is significant only in settings of intimate sexual contact or possible direct contact with blood. A single sexual encounter, transfusion, or needle stick may result in transmission. Casual contact including eating food prepared by an infected individual, or having one's hair cut by an infected person does not promote transmission.

Universal precautions are established infection control measures recommended by the Centers for Disease Control and other public health agencies and which, if successfully used, prevent HIV transmission. These precautions include specific recommendations to protect health care workers from potential occupational exposure to body fluids containing HIV. The precautions are to be universally applied to all patients regardless of HIV status.

Testing an individual for HIV requires signed informed consent except for inmates in correctional institutions and military personnel. The significance of maternal to infant transmission of

HIV has prompted some health care workers to urge mandatory testing of all pregnant women for HIV. A mother who takes anti-HIV medications during her pregnancy and gives the medication to her child for the first few weeks after delivery can reduce the likelihood of transmission to her infant from over 25 percent to 8 percent or less.

Consider the following local cases

1. A doctor providing medical care to a family sees a husband who acknowledges that he has participated in homosexual behavior. The husband, Mr. Jones, reports that he is no longer interested in a sexual relationship with his wife, and that they have legally separated. His HIV test is positive. Ms. Jones confides that she is trying to win back her husband and has in fact tried to seduce him in an attempt to pull him home. The doctor encourages the husband to disclose his disease status to the wife. He refuses stating he is worried he will be disadvantaged in the upcoming custody battle. The wife refuses to be tested for HIV, stating she believes she has no risk factors, having been monogamous with her husband. What is the doctor's obligation to Mr. and Ms. Jones?
2. An HIV infected mother, Ms. Brown, is in the seventh month of pregnancy, but refuses to take anti-HIV medications because she does not want her family to find the medicine and learn of her infection. She states that she has disclosed her disease to only one sister and wishes to conceal it from other family members. Ms. Brown's family is very tight-knit. Does the physician's obligation to her prohibit discussing her case with her sister or other family members to encourage compliance? What of the doctor's responsibilities to the infant?
3. A pregnant woman, Ms. Davis, is admitted to the delivery unit at a community hospital. She has tested positive for HIV and is taking medication to control the virus. Her physician has been helping the hospital educate its health care providers about universal precautions for several months and notifies

the Labor and Delivery Staff that an infected patient will likely be on the unit in the next few weeks. These health care workers are presumed to know about and use universal precautions; however, at the time Ms. Davis is admitted, physicians were legally prohibited from unnecessarily disclosing a patient's HIV status to others.

The physician encouraged Ms. Davis to inform hospital personnel of her status. The patient disclosed that she was HIV infected and taking specific anti-HIV medication to the admitting nurse. The nurse documented the medication information. In conversations with the physician, the nurse indicated awareness of the patient's status, but the doctor did not request that the information be placed on the chart. What was the primary physician's ethical obligation to Ms. Davis and the other health care workers?

4. Mr. Smith, a cook at a local restaurant sustained a severe thumb laceration while preparing food. After his recovery, he requests a release note to go back to work. His employer's release for work form includes a space for diagnosis. Is the physician obligated to include the HIV diagnosis on the form?

Some clashes between patient autonomy and other ethical principles merely whisper; others thunder. HIV cases are instances of the latter.

5. Mr. Johnson, a patient with end-stage HIV and complications of cancer and pneumonia, dies at the local hospital. Ms. Johnson, the patient's wife pleads that she will lose her home if the doctor includes HIV on the death certificate because the family's mortgage insurance specifically excludes benefits related to HIV. What is the doctor's obligation to Mr. Johnson's family? to the third-party insurer? to the state?

These five cases and the doctors' actual decisions involve ethical underpinnings. The five cases differ in their potential for harm — from illness and death to loss of assets — and each represents a conflict of claims between individuals or groups. In each case, however, the physician's actions are, or should be, guided by principles identified in biomedical ethical analysis.

Ethical Principles

The most instructive principles of bioethics are beneficence and autonomy. These concepts often form the two poles of medical ethics debates.

Beneficence

While beneficence and nonmaleficence are sometimes presented as two principles, their separation may be arbitrary in cases where beneficence toward one individual is arguably maleficence toward another. Thus the question becomes, which individual is deemed more deserving of beneficence? Or perhaps, which harm is determined the lesser harm? Often the more prominent issue is whether beneficence and the distinct ethical principle of autonomy can coincide.

Autonomy

Privacy issues may be viewed as issues of autonomy, which certainly include a patient's control of his or her medical record. But autonomy is also a clanging cymbal used by some physicians to justify relinquishing responsibilities toward patients and at times toward third parties. Some clashes between patient autonomy and other ethical principles merely whisper; others thunder. HIV cases are instances of the latter.

Discussion — the risk of transmission

1. In Mr. and Ms. Jones's case, protection of the husband's secret is clearly arguable on grounds of privacy and patient autonomy. It may also be argued as beneficent toward him. However, if the outcome includes Ms. Jones's acquisition of the disease rather than the information, maleficence toward her becomes a reality. Which possibility carries the greatest weight? Does it depend on whether the husband is believed when he swears he will

not have sex with his wife? If under the influence of alcohol, or in some other extenuating circumstance Mr. Jones does transmit the virus to Ms. Jones, would the doctor's decision not to disclose her husband's medical condition to her be ethically supportable?

The issue of protecting third parties from the possibility of endangerment was illustrated in the Tarasoff debate and legal decisions of 1974. In that case, a psychiatrist had reason to believe that a patient was planning to harm an identifiable individual. Which ethical notion should prevail? Should the third party be protected or should we protect the patient's confidence in the privacy of the physician-patient relationship? Which value trumps: beneficence toward the third party or patient autonomy regarding loss of privacy.

What of Ms. Jones's refusal to be tested? She may already have HIV and could be missing treatment or potentially exposing others in her ignorance. Using beneficence arguments, is her interest best served by telling her of her husband's disease? Should she be informed of her specific risk and persuaded to undergo testing? Does the situation warrant surreptitious testing? Should informed consent be waived in Ms. Jones's own best interest?

2. Ms. Brown's case also involves protection of a patient's secret from her family, but in this case, the family members are not themselves at risk. However, the woman's infant is put at great risk by her mother's refusal to accept treatment. Should the physician enlist Ms. Brown's sister to persuade the mother to take medication? Does the doctor have an obligation to the infant to reveal the mother's status to others so that she can be persuaded to protect her child? What if Ms. Brown chooses not to take medications because she does not believe they are effective, or believes the treatment to be harmful? Can the physician disclose her disease to compel her compliance?

What about after the delivery? Disclosure of the infant's status incidentally reveals the mother's status. Should the baby be placed in foster care after delivery so that therapy can be initiated if the mother still refuses to treat the baby? What about later in the child's life? At what point is it the physician's duty to notify child protective services to secure treatment for the child?

Should pregnant women be tested without their consent? What about those who test positive? Should they be required to take the protective medication? How can compliance be mandated?

Is harm to a third party only ethically consequential if the party is thought to be physically at risk? Or are there times at which risks to property may also be relevant in determining the propriety of breaching confidentiality?

3. The case involving Ms. Davis raises the issue of disclosure to medical personnel at a time when there were legal prohibitions against prominently displaying a patient's HIV status. Although the patient told the admitting nurse, that nurse did not pass the information along to other personnel on the unit, and Ms. Davis's primary physician did not order placement of the diagnosis on her chart. The doctor had, however, pressed the hospital and especially the labor and delivery unit to comply with universal precaution guidelines. What was the doctor's obligation to other personnel who may have been working with Ms. Davis? What of emergency care? In the event of a precipitous delivery, should a good samaritan physician or nurse have the information? Should the

primary doctor rely on health workers compliance with infection control guidelines or does the doctor have a responsibility to disclose HIV medical data to all potential care givers?

Discussion — Protecting Other Entities

Is harm to a third party only ethically consequential if the party is thought to be physically at risk? Or are there times at which risks to property may also be relevant in determining the propriety of breaching confidentiality?

4. The question of what to reveal to an employer is exemplified in Mr. Smith's case. Many employers request diagnoses on return-to-work releases. Is it ethical to comply with this request? At times, a patient may be at risk of losing his or her job if the form is not completed, but also at risk of disclosing certain conditions such as AIDS. Do physicians have an ethical obligation to shield patients from revelation of diagnoses to employers? If so, should that shielding apply at all times, or only in cases where there are significant diagnoses, for example, of contagious conditions, such as AIDS?

5. Mr. Johnson's case does not represent any personal exposure of the infected individual who has died. Rather, it concerns the bereaved family who will certainly lose their home if the physician completes the death certificate in its entirety and includes a list of contributing factors in addition to the primary cause of death. Does the physician's ethical duty include "the whole truth" or only the partial truth? Can Mr. Johnson's AIDS diagnosis be omitted?

What Do You Think?

Each of the dilemmas presented here are taken from actual cases that have occurred in Kansas City, Kansas. The "rest of the story" has been omitted purposefully the better to engage our readers in ethical argument. We, the author and editor, invite your responses, which may be as formal or informal as you wish. How would you handle the confidentiality issues that are represented in one or more of these cases? What do you think?

Please send your comments to "Letters to the Editor": Midwest Bioethics Center, 1021-1025 Jefferson Street, Kansas City, Missouri 64105-1329. E-mail: <bioethic@midbio.org> Fax: (816) 221-2002