

Privacy and Confidentiality

The right to privacy constitutes the basis for many of the individual rights possessed by patients. This is in part because the right to privacy has many applications. Indeed, privacy is a major concern in bioethics. There are a number of reasons, which we will examine in this chapter, why health-care professionals ought to respect patient privacy. The scope of privacy includes not disclosing protected health information and respecting the physical privacy of the patient. Physical privacy involves limitations on the viewing and touching of a patient's body by the patient's primary health-care providers—that is, the patient's physicians and nurses—or by other hospital officials. Keeping observation and touching to the minimum required by medical need is morally required of health-care providers. Others who provide services such as blood draws and x-rays are similarly required to respect the privacy of the patient.

Health-care providers have a moral responsibility to ensure, as far as is feasible, that visitors, other patients, non-health-care employees, and other health-care professionals do not violate the patient's privacy. Living up to this requirement is difficult, partly because health-care providers become accustomed to providing information about a patient, to other health-care providers, through writing on a patient's chart, and in communicating with a patient's family.

Privacy may seem like an ordinary notion, yet philosophers have debated not only what privacy involves but also how to support the moral obligation to respect it. In this chapter we examine privacy from both a philosophical and a legal point of view. We then turn to a focused discussion of the related concept of confidentiality, which is the obligation not to disseminate patients' private information without their permission.

PRIVACY

The American Medical Association Code of Medical Ethics underscores the requirements of privacy: “Physicians must seek to protect patient privacy in all of its forms, including (1) physical, which focuses on individuals and their personal spaces, (2) informational, which involves specific personal data, (3) decisional, which focuses on personal choices, and (4) associational, which refers to family or other intimate relations.”¹

Dictionary definitions of privacy frequently center on not being disturbed by others and being free from public attention. Philosophers similarly tend to view privacy in a negative way, centering on not receiving the attention of others. Going beyond this negative aspect of privacy, philosophers often think of privacy as involving control: the ability to determine who has access to us. Privacy establishes a sphere around which we control access to information about ourselves. To make this definition work, we need to think of “information” in a very broad way, so that it includes things like information about how we learn, play, spend our time, and relate to other people, as well as our finances, our hobbies, our habits, and even our appearance. Privacy may be violated by, for example, observing a person’s bank account or seeing someone taking care of personal hygiene. Privacy may be violated by gaining information about a person, for example, the fact that the person routinely takes blood pressure medications or has Type II diabetes.

The information that a person wants to control depends on the individual. One person may want others to know that she has heart disease, while another may not. Furthermore, a person might want some people to have personal information and others not to have the same information. And while a key feature of privacy is control, it is difficult to control all the information we want to, and sometimes it might not be appropriate or even possible to control some information. For instance, it is difficult to control access to the way we look, walk or talk. Once we are in public, these things are in plain sight; people have a right to make such observations, as much as someone might not want that attention. When I walk down a crowded sidewalk, it is best to observe people coming toward me. When I check out of a store, I have no obligation to look away from the cashier; in fact, to do so may be viewed as rude. Even if cashiers would prefer that people not look at them, control of the gaze of another is often not a legal or moral right, at least in typical circumstances.

1 AMA Code of Medical Ethics, Section 5.059. The AMA Code of Medical Ethics is available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>.

There are at least two types of privacy, which are distinct but related. The first type (which we will call **privacy of information**) is the right to privacy regarding one's personal information. Individuals generally have a right to determine whether and to what extent information that is highly personal is disclosed to third parties or entities. This aspect of privacy forms the basis for the rules relating to confidentiality, which is discussed in detail later in this chapter.

The second type of privacy (which we call **privacy of conduct**) relates to one's right to engage in conduct of one's own choosing. That is, adult individuals in general have the right to make decisions regarding their conduct, assuming such conduct does not harm others or seriously interfere with the same rights possessed by others. This type of privacy can also be seen as a form of personal autonomy or freedom.

Privacy of conduct has been described as the right to be "let alone." In a medical context, however, the patient may wish to engage in conduct that requires the assistance and not merely the permission of the health-care provider. For example, in cases in which the patient wishes to forego lifesaving medical treatment, the patient may desire to be supported with palliative care and not abandoned. And decisions regarding procreation, such as the decision to abort a fetus, may require the active assistance of the health-care provider. Consequently, privacy of conduct is essentially related to several medical issues, such as the refusal of life-saving treatment, and choices regarding reproduction. These issues are discussed in detail in Chapters Six and Ten, respectively.

Though privacy of information and privacy of conduct may seem distinct, they are related. For example, if medical information regarding an individual indicates that he is infected with a serious and contagious disease, that information may not be considered confidential. Its disclosure to a public entity may result in quarantine, i.e., a constraint on the patient's privacy of conduct.

Privacy of information often enhances privacy of conduct. A person doing something he would be embarrassed about if others knew, for example, watching pornography, might only do it if it could be kept private. Suppose Jim loves to play classical guitar, but does so poorly. He might play only in private, and he might not play if he knew others could witness his playing. Suppose Sally adopts an extremely conservative investment strategy, never taking any chances with her money. She knows that all of her friends would think that a foolish approach; if others knew about her investments, she might change to a less desired investment plan just so that others would not think of her as foolish. Mrs. Jones might want her adult children not to know how much money she has for fear that they would put pressure on her to spend her money on them instead of on herself. It is easy to cite examples of personal behavior that a person would find more difficult to accomplish if the behavior

were not kept private. The point is that privacy often allows us to better control our behavior.

Another form of control involves intimate relationships. Some philosophers believe that privacy is important mainly because it allows us to pursue relationships in the way we want. This is often true: if a young married couple cannot keep their intimate relationships private, let's say because they live in crowded quarters, then that may interfere with their actions. If someone wants to confide personal information to a friend, perhaps to gain sympathy or to get advice, and that information is not kept private, then the person would be inhibited in providing the information.

Privacy as a Moral Rule

People want privacy for many different reasons. Someone may not want anyone to know that they watch three sporting events a week. This desire to keep others from knowing their watching habits might not have anything to do with establishing relationships; instead, it might be that the person is embarrassed to spend so much time on something that others might consider unimportant. Or the person might simply believe that what they do is no one's business. This might not be an issue of control but instead simply a basic desire.

If the only purpose of privacy is control over information and conduct, then privacy might be exclusively justified in terms of personal autonomy. This is a Kantian value that many philosophers find compelling. Beauchamp and Childress consider autonomy to be the primary moral justification of privacy. They claim that "rights of privacy are valid claims against unauthorized access that have their basis in the right to authorize or decline access. These rights are justified by rights of autonomous choice..."¹ If by "primary ... justification" they mean one that is often used, maybe typically used, then we would agree that this is an important justification. However, if by primary justification they mean that other justifications flow from it, we would disagree.

First of all, respect for autonomy requires that the person involved actually be capable of autonomous choice. Privacy is a very broad moral requirement, partly because it extends to people who are not autonomous. A young child who is not autonomous has a right to privacy in many circumstances. Even a dead body is often thought to bear a right to privacy. For example, unneeded inspection of a human corpse due, for example, to curiosity, should be considered a violation of privacy. A demented adult not capable of basic reasoning has lost autonomy but not a right to privacy, at least not in a pervasive way. Also, privacy may be violated in ways that a

1 Beauchamp and Childress, *Principles of Biomedical Ethics*, 5th ed., p. 296.

person knows nothing about. A person may have his or her information taken electronically without knowing about it. If it becomes known, the person may not object to this acquisition of information, and so while their privacy may have been violated, it is not clear that their autonomy has been interfered with. While we point to these exceptions to privacy as based on autonomy, it is true that a Kantian respect for autonomy is an important way to justify many claims to privacy.

A more basic argument might be that violating privacy is disrespectful. One of Kant's principles claims that a person never should be treated merely as a means but always as an end in herself or himself; to do otherwise is to disrespect the person. For Kant, the importance of respect for persons depends on human agency; but a broader interpretation of Kant's principle might state that we should respect all humans, including infants and those with dementia. By such an extension, privacy might be more broadly justified as respectful, and the invasion of privacy as disrespectful. Of course, privacy may be overridden by other values such as public safety and national security, but even then its violation needs to be justified.

On the other hand, perhaps there is no basic moral rule requiring the protection of privacy. A rule theorist might try to support the introduction of such a rule by claiming that all rational people would want it, or that it is intuitively obvious after careful consideration that such a rule is morally appropriate. But given the possible negative consequences of privacy, and, for example, some feminists' rejection of it as a basic right, it is doubtful that there is such a basic moral rule. Indeed, some philosophers reject a basic privacy rule because they believe that privacy may protect actions that are hostile to women, such as abusive relationships. Furthermore, privacy may be valued differently by people in different cultures, with some cultures less concerned about control over one's personal situation. In some cultures, keeping information from patients' parents or spouses, for example, may not be considered important. In fact, the violation of such privacy might be considered morally mandatory.

Typically, the right to privacy may be waived. A person might decide to allow others to witness personal behavior, and this is often morally and legally acceptable. Of course, some things routinely done in private are not allowed, legally or morally, in public. For example, public nudity is usually prohibited. Nevertheless, it is typically the case that the person who owns the right to privacy can waive that right. Some other rights cannot be waived. For example, the right not to be physically harmed may not be waived in some circumstances: a person might not have a moral right to allow another person to kill him or her, for example.

Utilitarian Justifications for Privacy

Regardless of why people value it, privacy may be a unique right, defended by rule-utilitarian calculations. Recall that rule utilitarianism involves judging whether having a strict moral rule, one without exceptions, adds more utility, or happiness, than not having the rule. It may seem as though having a rule supporting privacy in general would produce happiness, since most people value their privacy and would find life difficult without it. One problem with such a rule is that privacy is often thought to be overridden by other considerations. In the law, for example, a person suspected of criminal activity or terrorism might be the subject of phone recording. Later in this chapter, when we discuss health-care confidentiality, a type of privacy, we will learn that a patient seeking mental care may not have a right to confidentiality if he or she makes a credible threat against a specific person. The threat may need to be shared with the appropriate officials, perhaps law-enforcement officers. As discussed in Chapter Seven, both nurses and other health-care workers have responsibilities to report suspected child abuse, and this may involve violations of privacy. Cases such as these make it appear that although a general rule supporting the right to privacy maximizes utility, there are important exceptions to the rule.

An act utilitarian considers each situation on its own merits. Is this a situation in which respecting privacy would promote more good than harm? If the answer is yes, then privacy would be morally supported, according to the utilitarian. If not, then privacy would not be supported. When we discussed such consequentialist calculations, we noted that they involve problems. It does not seem proper to disrespect a person's privacy for the amusement of others. Such a violation would be likely to promote more sadness than happiness; after all, some cases of privacy violations cause great embarrassment and can even lead to suicide. Therefore, the act utilitarian is committed to endorsing a violation of privacy whenever doing so promotes, on balance, more good than harm.

It might seem that, typically, privacy in health-care situations does not have negative consequences. But this isn't always true. For example, easy access to medical records might promote good health even if it abuses confidentiality. A researcher with such access might be able to use the information to identify health risks. Yet we do not allow such research access without special protections. Another example in which privacy might have negative consequences involves family situations, where a patient keeps important information from relatives. This might interfere with a family's ability to help the patient, or it might fail to protect the family from risk. If information is concealed about a genetic disease, family members might not be able to reduce their risk of getting that disease.

Covert Surveillance

Let's consider a case of the violation of privacy in a hospital, and then reason about it using moral principles. We know that surveillance is a common part of life. If we shop in a large store, it is likely that we are being recorded in a more or less covert way. This is legally acceptable. However, it would seem as though secret video recording of activities in a hospital room, perhaps including the lavatory, should be prohibited.

Privacy in a hospital room is inconsistent with covert surveillance. A patient would be rightfully outraged if this happened. But we know that sometimes privacy is traded for other values. Consider Munchausen syndrome by proxy (MSbP), which is also labeled pediatric symptom falsification, factitious disorder by proxy, and pediatric condition falsification. This occurs when a child's primary caregiver, often the child's mother, deliberately and surreptitiously induces an illness in the child. This might be accomplished by poisoning a child, perhaps using laxatives or even salt. Infections may be caused by applying fecal matter to wounds. In 2008, 21-year-old mother Amber Brewington was accused of attempting to murder her son after a nurse discovered that she was injecting him with a salt-water solution.¹ Physicians sometimes suspect that a child's symptoms are caused by the child's caregiver, but this is often difficult to know. For example, treatment may be ineffective, or symptoms might be reported by the caregiver that are not apparent to the physician. Given a reasonable suspicion of MSbP, is it morally and legally permissible for a hospital to employ covert surveillance?

Morally speaking, the burden of proof is on those advocating covert surveillance. That is, there must be very good reasons in order to justify such a gross invasion of privacy. A utilitarian would weigh the pros and cons of covert surveillance, understanding that the violation of privacy tends to have bad consequences. In fact, a utilitarian may be so convinced that bad consequences flow from such actions that he or she would place a heavy burden on those proposing covert surveillance. However, a child's life may be at stake, or least the child may endure significant pain if MSbP is not caught. Furthermore, the stress on health-care providers caused by treating unexplained and recurring sickness would also need to be taken into account, as well as the impact on family members and the economic cost to society. A utilitarian might admit that there are situations that do call for covert surveillance but would consider other options that might themselves produce greater good.

¹ See "Mom Guilty of Poisoning Baby Boy with Salt in Pittsburgh," WPXI.com, July 24, 2008, <http://www.wpxi.com/news/news/mom-guilty-of-poisoning-baby-boy-with-salt-in-pitt/nGkYB/>.

A rule theorist would require further justifications for covert surveillance, not merely a balance of good done over harm caused. First of all, there must be no reasonable alternatives to covert surveillance. Second, the suspicion must be based on very solid reasons, making it highly likely that the caregiver is causing the sickness. The symptoms caused must be serious. Also, a rule theorist might insist that surveillance be done in a way that is consistent with local law.

We may also wonder whether other methods can be used to determine, with a reasonable likelihood, whether a caregiver is causing an illness. For example, on separation from the caregiver the child's symptoms may decrease. This is the approach that has been used by a family court in New York, which takes into account all available evidence in determining whether a caregiver is responsible.¹ If the court's approach is effective, it is difficult to justify covert surveillance.²

In 2000, a study by David E. Hall et al. examined whether covert surveillance was necessary to detect cases of MSBP. The conclusion was that covert surveillance was required to make a definitive determination in 53 per cent of the 41 cases examined.³ Partly because the authors claim it is extremely difficult to establish such abuse, video surveillance, they say, should be employed by all large hospitals. Furthermore, the authors claim that covert surveillance can protect the innocent. In considering ethical concerns, the authors offer a consequentialist argument, stating that the beneficial aspects of covert surveillance, possibly including saving lives, outweighs the violation of privacy. They add that privacy is reduced in a hospital, in effect claiming that covert surveillance is not as intrusive in an environment already involving constrained privacy. One could, of course, make the argument that the additional intrusion is even more offensive when in other ways privacy gives way to medical need. Finally, the authors make the claim that children cannot consent to an invasion of privacy, so violation of their privacy is permissible without consent.

A hospital using covert surveillance should seek legal advice to ensure that it is not illegal to do so. A hospital ethics committee, in advising about the use of covert surveillance, should not suggest a path of action that is illegal in the local community. It may be that hospitals can satisfy legal constraints, perhaps involving illegal

1 See M.T. Flannery, "First Do No Harm: The Use of Covert Video Surveillance to Detect Munchausen Syndrome by Proxy—An Unethical Means of 'Preventing' Child Abuse," *University of Michigan Journal of Law Reform* 32 (1998): 105–94.

2 For a victim's account see M. Bryk and P.T. Siegel, "My Mother Caused My Illness: The Story of a Survivor of Munchausen by Proxy Syndrome," *Pediatrics* 100.1 (1997): 1–7.

3 D.E. Hall, L. Eubanks, S. Meyyazhagan, R.D. Kenney, and S.C. Johnson, "Evaluation of Covert Video Surveillance in the Diagnosis of Munchausen Syndrome by Proxy: Lessons from 41 Cases," *Pediatrics* 105.6 (2000): 1305–12.

searches, by visible signs indicating the use of covert monitoring. However, whether this is so should be determined by appropriate legal counsel.

The Legal Right to Privacy

THE RIGHT TO PRIVACY OF CONDUCT

The right to privacy was not recognized under the United States Constitution until the decision in *Griswold v. Connecticut*.¹ In this case, the US Supreme Court held that a Connecticut statute that rendered illegal the dissemination of contraceptives was unconstitutional. The Court held that the statute violated the constitutional right to privacy in that it interfered with one of the “most profound and intimate decisions a married couple can make,” that is, whether or not to conceive a child. The term “privacy,” however, does not appear in the Constitution. Nonetheless, the Court held that a right to personal privacy is implied by other aspects of the Constitution. In particular, the Court held that a limited right to personal privacy is implied by the contents of other Amendments in the Bill of Rights.

The right established in *Griswold* specifically applied to decisions made by married couples regarding the use of contraception. The Court therefore established a right to reproductive autonomy, at least for married individuals. *Griswold* did not, however, establish a right to privacy on the part of unmarried individuals. In 1972, the right to privacy regarding decisions about the use of contraception was extended to unmarried individuals in *Eisenstadt v. Baird*.² In that case, the Court held that a statute prohibiting the dissemination of contraceptives interfered with the “right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.” The decision in *Eisenstadt* was based upon the equal-protection clause of the Fourteenth Amendment. The Court held that married and unmarried individuals should be treated alike. The right to reproductive autonomy, established in *Griswold* and extended to unmarried individuals in *Eisenstadt*, was the basis for the subsequent opinion in *Roe v. Wade*,³ which established the right to have an abortion. The decision in *Roe* will be discussed in more detail in Chapter Ten.

Broadly speaking, the decisions in *Griswold*, *Eisenstadt*, and *Roe* involved the right to privacy of conduct in connection with medical treatment. The dissemination of contraceptive devices or drugs in the early 1960s implicated the involvement

1 *Griswold v. Connecticut*, 381 U.S. 479 (1965).

2 *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

3 *Roe v. Wade*, 410 U.S. 959 (1973).

Box 8.1: Excerpt from *Griswold v. Connecticut*

Various guarantees create zones of privacy. The right of association contained in the penumbra of the First Amendment is one, as we have seen. The Third Amendment in its prohibition against the quartering of soldiers “in any house” in time of peace without the consent of the owner is another facet of that privacy. The Fourth Amendment explicitly affirms the “right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures.” The Fifth Amendment in its Self-Incrimination Clause enables the citizen to create a zone of privacy which government may not force him to surrender to his detriment. The Ninth Amendment provides: “The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.”

The Fourth and Fifth Amendments were described in *Boyd v. United States*, as protection against all governmental invasions “of the sanctity of a man’s home and the privacies of life.” We recently referred in *Mapp v. Ohio* to the Fourth Amendment as creating a “right to privacy, no less important than any other right carefully and particularly reserved to the people.”

... The present case, then, concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees. And it concerns a law which, in forbidding the use of contraceptives rather than regulating their manufacture or sale, seeks to achieve its goals by means having a maximum destructive impact upon that relationship. Such a law cannot stand in light of the familiar principle, so often applied by this Court, that a “governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.” *NAACP v. Alabama*. Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship.

Source: *Griswold v. Connecticut*, 381 U.S. 479 (1965).

of health-care providers, at least to the extent that the purchaser of the device would have received information regarding its use from one of them. The decision to have an abortion, moreover, involves the health-care provider to an even greater extent in that it requires not only the obligation to obtain informed consent but also the performance of an invasive medical procedure.

The right to privacy of conduct as established in *Griswold*, *Eisenstadt*, and *Roe* formed the basis for the right to refuse lifesaving medical treatment in certain circumstances. In the 1975 case *In re Quinlan*, the New Jersey Supreme Court held that the right to privacy was “broad enough to encompass a patient’s decision to decline

Box 8.2: Excerpt from *Whalen v. Roe*

Appellees contend that the statute invades a constitutionally protected “zone of privacy.” The cases sometimes characterized as protecting “privacy” have in fact involved at least two different kinds of interests. One is the individual interest in avoiding disclosure of personal matters, and another is the interest in independence in making certain kinds of important decisions. Appellees argue that both of these interests are impaired by this statute. The mere existence in readily available form of the information about patients’ use of Schedule II drugs creates a genuine concern that the information will become publicly known and that it will adversely affect their reputations. This concern makes some patients reluctant to use, and some doctors reluctant to prescribe, such drugs even when their use is medically indicated. It follows, they argue, that the making of decisions about matters vital to the care of their health is inevitably affected by the statute. Thus, the statute threatens to impair both their interest in the nondisclosure of private information and also their interest in making important decisions independently.

Source: *Whalen v. Roe*, 429 U.S. 589 (1976).

medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman’s decision to terminate pregnancy under certain conditions.” The *Quinlan* decision thus extended the right to privacy regarding medical decisions beyond the context of decisions regarding procreation to medical decisions in general.

THE RIGHT TO PRIVACY OF INFORMATION

Subsequent to the articulation of the right to privacy of conduct in making intimate choices, the US Supreme Court broadened the legal scope of the concept to include the “interest in avoiding disclosure of personal matters.” In the 1977 case *Whalen v. Roe*, the Court held in certain circumstances that public dissemination of personal information could threaten confidentiality and autonomy.

CONFIDENTIALITY

The Physician–Patient Relationship

The above discussion indicates that we do in fact have a moral and legal right to privacy in general, and this right must be upheld by health-care practitioners. Issues of privacy of information in health care most frequently arise in the context of

confidentiality: the obligation not to disseminate patients' private information without their permission. This issue is the focus of the remainder of this chapter.

The concept of confidentiality is essentially relational. It implies the existence of a relationship during the course of which private information is disclosed to another, usually a professional such as a health-care provider or an attorney. When a patient discloses confidential information, or otherwise allows the health-care provider to discover it through medical testing, the patient expects that the information will remain confidential. Professionals are obligated to preserve confidential information to the extent permitted by good practice and the law. This aspect of confidentiality is reflected in the fact that while anyone may be liable for invading a person's privacy, only individuals in possession of information derived from the confidential relationship have a duty to maintain its confidentiality.

Although it is reasonable to maintain that information disclosed to a health-care provider should typically remain confidential, it is not reasonable to assert that *all* such information should remain confidential. When information is not kept confidential, we should be cautious in determining the extent of what should be disclosed, to whom it should be disclosed, and under what circumstances it should be disclosed.

Patients consult with physicians as experts in the treatment of intimate and personal conditions. Due to the expertise of the physician and the need to consider highly personal concerns, the physician–patient relationship is **fiduciary** in nature. A fiduciary relationship is a type of special relationship under the law. Certain relationships are considered to be deserving of special protection, for example, parent–child, spouse–spouse, physician–patient, and lawyer–client. One who is a fiduciary owes an elevated measure of trust, loyalty, and good faith in his or her dealings with the other. Fiduciary relationships are often one-sided; for example, a physician has fiduciary duties to the patient, but not vice versa. As a fiduciary the physician must act in the best interests of the patient, and the patient must be able to put his or her well-being in the hands of the physician.

Given the unique and intimate nature of the physician–patient relationship, the relationship cannot be construed as based entirely upon an ordinary contract. In a relationship that is united through a contract, typically the parties can negotiate “at arm's length.” A contract ideally should be negotiated in a very objective way, without, for example, personal or emotional commitment. When negotiating a contract, people mutually pursue their own interests, and so, ideally, a contract is in the equal interests of both parties, but this is often not true. Thus, objectivity, careful inquiry, and self-protection are helpful in negotiating a contract. In a medical relationship, a patient typically rightfully places trust in a health-care provider, and a health-care

provider attempts to promote the well-being of a patient. Neither party acts with the detachment of an arm's-length relationship. Because the patient is at a disadvantage, due both to illness and to a lack of thorough medical knowledge, the relationship between a health-care provider and a patient requires special considerations designed to protect the patient.

In many contractual relationships we have little reason to expect confidentiality. A painting contractor may feel free to discuss the fact that you or I hired him or her to paint a room. But we do not expect a health-care provider to discuss our medical problems with others, at least not without very good reason. In fact, confidentiality of medical records is often legally and morally required. We now discuss why medical information is so special in this regard.

A patient rarely employs a physician directly. A majority of Americans are provided health insurance by their employer, and that insurance directly or indirectly compensates physicians. Often the employee/patient has only a limited choice of primary physicians. Sometimes employees are given a cost incentive to go to certain physicians. This also tends to curtail the choice of a health-care consumer and may hamper the development of a trusting relationship.

Current health-care insurance realities provide further reasons to protect patients. Medical care is highly personal, but often a patient sees a series of health-care professionals, sometimes for only a few minutes and then never again. Protecting privacy and confidentiality under these conditions becomes even more crucial than before, when many people developed a fuller trust relationship with their physicians and other health-care providers.

Patients typically highly value the following qualities of a physician: compassion, sympathy, and integrity—all terms that involve virtues. A sympathetic person, for example, is a virtuous person and so is thought to be more likely to help another or to do the right thing for another, for example to relieve another person's suffering. Compassion involves a sharing of interests and feelings such that one tends to understand the basis of another's needs and desires. Integrity involves a willingness to do the morally right thing, often associated with one's role, in spite of temptations not to do the right thing. These traits are all highly desirable in a health-care professional.

These virtues go beyond the competent and honest provision of services that one would expect in a contractual relationship. In short, it is difficult to construe "human" characteristics such as being sympathetic and compassionate in terms of contractual obligations. Medical care depends on trust. Acceptance of and confidence in medical treatment, in times of illness and dependency, is ideally based in trust. Trust involves more than confidence in medical ability. It also involves confidentiality; trust that personal information will not be disclosed.

The Physician's Obligation of Confidentiality

Confidentiality dates back to the Ancient Greek Hippocratic Oath: "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about."

Despite reasons for keeping patient disclosures confidential, physicians are under an ethical and legal duty to report certain facts. Traditionally, physicians have been under a legal duty to report to authorities evidence of gunshot wounds, child abuse or neglect, and certain communicable diseases such as syphilis and tuberculosis. In some cases, a physician or psychiatrist is also under a duty to warn a third party of threats made by the patient. Thus, issues of social good may override the rights of the patient. The American Medical Association's Code of Medical Ethics contains a provision prohibiting a physician from revealing confidences or health problems, unless the physician is required to do so by law or to protect someone's welfare. The Code concludes: "The [medical] record is a confidential document involving the patient-physician relationship and should not be communicated to a third party without the patient's prior written consent, unless required by law or to protect the welfare of the individual or the community."¹

Most states in the United States recognize a physician-patient "privilege" whereby typically any information is confidential when communicated to a physician or a psychotherapist during the course of the physician-patient relationship. The patient is the "holder" of the privilege, and typically the physician must assert a privilege on behalf of the patient to maintain the confidentiality of such communications. In the 1973 Alabama case of *Horne v. Patton*, a physician was held liable for disclosing to the patient's employer information regarding the patient's condition acquired during the course of the physician-patient relationship. The Court held that the disclosure of possibly sensitive and embarrassing information without the patient's consent violated the patient's right to privacy.²

The other side of confidentiality is patients' rights to access their records. At least half the states have statutes permitting patients access to their own medical records, and the American Medical Association asserts a right of patient access: "Patients have an ethically and legally recognized right to prompt access to the information contained in their individual medical records."³ However, some courts continue to deny access. For example, in *Cynthia B. v. New Rochelle Hospital Medical Center*,

1 AMA Code of Medical Ethics, Section 7.02.

2 *Horne v. Patton*, 287 So. 2d 824 (1973). See also *Stewart v. United States*, 2012 U.S. Dist. LEXIS 118079 (N.D. Ala 2012).

3 AMA Code of Medical Ethics, 8.06.

Box 8.3: Reporting Colleagues for Violations of Confidentiality

Are health-care providers morally required to report fellow workers who violate patient confidentiality?

Health-care providers often do talk about patients to other patients and also fail to protect patient information. Often other health-care providers know about these transgressions. Many ethicists believe that health-care providers who know about transgressions should take actions to ensure they do not occur again.

There are many ways to report transgressions. For example, a nurse may make a report to his or her head nurse. A staff bioethicist might be informed. Another course of action might be to remind a colleague about the requirements and value of confidentiality. Whether this is appropriate will depend on hospital policy and possible legal requirements. If this course is adopted, there should be reason to believe it will be effective.

Still, reporting a colleague is difficult to do, so some ethicists might claim that it is not a moral requirement. However, given the need for confidentiality, it would certainly appear to be morally required, regardless of whether it is legally or institutionally required.

The American Nurses Association Code of Ethics maintains that patients' welfare and rights are paramount. A nurse has a responsibility to protect the rights of patients. This suggests that following the code of ethics may require informing authorities that another nurse or health-care professional violated confidentiality.

a New York court denied access to the medical records of a mental patient even though the patient waived confidentiality rights. The Court stated that it was acting to protect the patient.¹

HIPAA Regulations

In the United States, the federal government passed a law that helps to define and enforce confidentiality in health-care settings. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions to help ensure the confidentiality of medical records.² A main feature of the adopted rules is the notion that disclosure of medical information should be kept to the minimum necessary. HIPAA includes monetary damages for improper handling of information.

1 *Cynthia B. v. New Rochelle Hospital Medical Center*, 458 N.E. 2d 363 (1983). See also *Serrano v. Lutheran Social Servs of Metro, N.Y., Inc.*, 996 N.Y.S. 2d 91 (2014).

2 Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. No. 104-191, 110 Stat. 1938 (1996), 45 Code of Federal Regulations (CFR) sections 160, 162, and 164.

According to the federal government's overview of the HIPAA confidentiality regulations, the following guidelines should be followed:

The Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, protected health information to the minimum necessary to accomplish the intended purpose. The minimum necessary standard does not apply to the following:

Disclosures to or requests by a health care provider for treatment purposes.

Disclosures to the individual who is the subject of the information.

Uses or disclosures made pursuant to an individual's authorization.

Uses or disclosures required for compliance with the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Rules.

Disclosures to the Department of Health and Human Services (HHS) when disclosure of information is required under the Privacy Rule for enforcement purposes.

Uses or disclosures that are required by other law.

...

The Privacy Rule defers to State or other applicable laws that address the ability of a parent, guardian, or other person acting in loco parentis (collectively, "parent") to obtain health information about a minor child. In most cases under the Rule, the parent is the personal representative of the minor child and can exercise the minor's rights with respect to protected health information, because the parent usually has the authority to make health care decisions about his or her minor child.

Maintaining Confidentiality

Maintaining privacy and confidentiality in the age of computerized information is problematic. The problem may be exacerbated by the fact that eventually all medical records will be digitized. The moral principle is clear: efforts must be made to

ensure confidentiality, even in terms of computerized data. Records on a computer are available to many health-care professionals who should not have access to them. Confidentiality about patients in a clinical trial is also difficult to maintain, because in a large trial the records of many patients are kept on computer files. Many institutions conducting clinical trials, such as teaching hospitals, undertake special efforts to protect trial information that travels on laptop computers. For example, specially protected flash drives may be used. Special legal requirements may be involved with such information, for example requiring notification of the patients involved if confidentiality is breached.

Of course, health-care professionals routinely talk with each other about patients and about difficult-to-treat health problems. They often talk about troublesome patients, for example those who are overly demanding, obnoxious, or hard to deal with. Some of these discussions might be appropriate in order to gain information about the proper way to handle difficult patients. But often they are not. It is tempting to discuss situations just to “let off steam” about difficulties faced. Some patients may not be rational and are thereby rude or otherwise offensive to health-care professionals in general. Some capable patients act in similar ways. While talking about disagreeable patients might be a good way for health-care workers to console one another, even if only emotionally, it is not permitted—legally or morally. This is the general rule: When discussing the health of a patient with another health-care professional, only the minimum amount of information necessary for legitimate health-care purposes may be disclosed about the patient. This is true both in law and in ethics. Discussing such information with relatives or friends is not permitted.

However, not all information gained in a health-care setting is covered by confidentiality. Some courts have held that facts regarding the patient that the physician observes are not privileged. For example, courts often hold that a physician could disclose observations she made which would be apparent to anyone. Such information would not be obtained as the result of privileged communication. An observed fact, in this context, is something that anyone could easily see, such as a burn on someone’s face. Disclosing that Smith has a burn on her face is not a breach of confidence. The burn is obvious to everyone. But other facts, such as the fact that Smith has trouble sleeping, or that Smith drinks half a bottle of scotch every night, are not in plain sight. When Smith comes in feeling ill, the fact that Smith has a blood infection is known from a test performed because of communication. It is not in plain sight. Some courts have held, however, that any such information may not be disclosed if it is likely to be “embarrassing” to the patient. For example, evidence of marks on a patient’s arm indicating drug abuse may not be disclosed, as this would presumably be embarrassing to the patient.

While it is understandable that information in plain sight is not held to be confidential, other court conclusions negating confidentiality are not as easy to justify. In the 1978 Louisiana case *Acosta v. Cary*,¹ the Court held that an employee's communications to a physician in the employ of his company are not privileged insofar as the communications relate to a medical injury the patient alleged to have suffered during the course of his or her employment. Morally speaking, it makes sense to think that employees are protected in health-care encounters. However, the physician is paid by the employer. The conclusion is that while employees may believe that the information they give to a company physician is privileged and protected, that is not always true. In these cases, the physician has divided loyalty, to both the patient and the company, and so the patient should be aware of the fact that he or she has a reduced expectation of confidentiality.

Other Legal Exceptions to Confidentiality

Although confidentiality is supported by the law, the law also recognizes exceptions to confidentiality. For example, patients may waive confidentiality. That is, they may voluntarily disclose information to third parties regarding their medical condition, as when a patient permits disclosure of information to family members. Similarly, many consent forms include the provision that the patient consents to the health-care provider's discussion of the patient's case with other providers, if necessary, for the purpose of improving the treatment of the patient. Moreover, health insurance contracts impose the requirement that the condition of the patient be disclosed to the insurance carrier for the purpose of determining coverage issues.

Patients also waive their right to confidentiality when they place their medical condition "in issue" by initiating a Workers Compensation claim or other litigation relating to their medical condition, such as a malpractice action. For instance, in the 1985 New York case of *Fedell v. Wierzbieniec*, the Court held that the patient waived the physician-patient privilege by initiating a lawsuit relating to her medical condition. Disclosure of information by the physician was held to be permissible.²

An exception to the requirement of confidentiality has been recognized in regard to court-appointed psychologists and psychiatrists. In the 1983 Illinois case of *Bond v. Pecaut*, an appointed psychologist submitted a letter to the Court describing a mother's emotional problems.³ The Court allowed the psychologist to breach the mother's confidentiality on the basis that it constituted a "reasonable intrusion" on her

1 *Acosta v. Cary*, 365 So. 2d 4 (1978).

2 *Fedell v. Wierzbieniec*, 127 Misc. 2d 124 (1985). See also *Holze v. Healthcare Services, Inc.*, 801 N.Y.S. 2d 804 (2005).

3 *Bond v. Pecaut*, 561 F. Supp. 1037 (1983).

Box 8.4: Case Study: Dr. Dorchester's Curiosity

Dr. Sally Dorchester is a resident in a small hospital in western Montana. On her rotation in the internal care unit, Dr. Dorchester notices that a neighbor, Mr. Eaton, is waiting in the emergency room. She sees Mr. Eaton at a monthly block dinner on her street, and wonders what his problem might be. She briefly thinks that he might ask her about his illness, as sometimes happens to a physician at a party, and she would be embarrassed if she didn't know how to respond. So she thinks that some early information might help in case he asks. Dr. Dorchester checks Mr. Eaton's record on the hospital's computer system and discovers that he has been diagnosed with syphilis. She is shocked, partly because she is close friends with Mrs. Eaton, and wonders if Mrs. Eaton knows about it. Dr. Dorchester thinks that Mrs. Eaton should know because she might be infected herself and not be receiving treatment for it. That evening, Dr. Dorchester tells her husband, a lawyer, what she has found out about Mr. Eaton. She thinks she might talk with Mrs. Eaton to find out if she can somehow raise the issue in a subtle way, but her husband says that she would be treading in dangerous waters and strongly advises that she should keep the information to herself. Dr. Dorchester thinks that this is probably good advice, but wonders whether she will be able to follow through with it when she next speaks with Mrs. Eaton.

First of all, Dr. Dorchester has no moral right to check the patient's record. Her reason for doing so is flimsy, and it is difficult to believe that any bioethicist would support her decision to check the record. There is no medically valid reason to check the record.

Once Dr. Dorchester has the information, let's suppose that, against the advice of her husband, she decides to warn her friend. Would this be morally appropriate? A consequentialist might argue that once the information is known, a warning is appropriate. But this answer does not take into account the full consequences of such an action. Dr. Dorchester does not know whether Mr. Eaton has confided in his wife and does not know what Mr. Eaton's physician is doing. Dr. Dorchester has special obligations as a physician, and to violate those obligations is likely to have negative consequences. A breach of confidentiality makes many patients less likely to seek medical care or to confide in a physician.

While a consequentialist might decide that providing the information would be morally acceptable, a deontologist is likely to disagree. For Dr. Dorchester not to abide by her obligation of confidentiality is wrong, and it seems like this case is not an exception to the rule. Thus, for a deontologist, Dr. Dorchester's conduct is not permissible.

privacy. The Court noted that the information was directly relevant to determining which parent was best suited to assume custody of the child and that the information would not be disseminated to the public at large.

Further, considerations of the public good are taken to justify the imposition on health-care providers of the duty to report certain medical conditions to public agencies such as departments of public health. The reportable conditions are usually infectious diseases that pose a risk to the public at large. Providers are also required to report to law-enforcement agencies evidence of violent attacks such as gunshots and knife wounds, and to report evidence of certain types of abuse, such as child abuse, elder abuse, and domestic violence to law-enforcement agencies.

An additional exception to the right of confidentiality is the duty to warn. The duty to warn differs from the duty to report in that the former is intended to facilitate the protection of a specific individual rather than the public at large. A duty has been created for health-care providers to warn third parties of imminent threats of violence against them by patients. In the 1990 California case *Tarasoff v. Regents of the University of California*, the Court ruled that psychiatrists were under a duty to warn a third party of threats against her life by one of their patients.¹ The psychiatrists were on the staff at the University of California. A student patient indicated that he intended to kill a specific student. Because of the requirement of confidentiality, the psychiatrists did not attempt to warn the intended victim. The patient killed her. The *Tarasoff* Court ruled that the safety of persons outweighs the patient's right to confidentiality when the patient expresses a believable, specific intent to harm a particular person.

The decision is, however, problematic. Knowing that a psychiatrist or psychologist has such a duty to disclose information about a credible threat against a specific individual may lead patients to avoid making threats or talking about enemies in general. As a result, individuals may avoid seeking the help they need. Indeed, dissenting judges in the *Tarasoff* case made the point that confidentiality is essential to successful treatment. They argued that the duty to warn will deter patients from disclosing any propensity toward violence they may have, and that the result will be an increase in violence. Also, confidentiality is a patient's right. Disclosing information is inconsistent with that right, something that is at the least unfortunate.

1 *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976). In *Ewing v. Northridge Medical Center*, 120 Cal App 4th 289 (2004), the court extended the *Tarasoff* duty to situations in which the psychotherapist learns of the threat made against a third party from an individual other than the psychotherapist's patient. See also *Singleton v. United States Dep't of Veterans Affairs*, 2013 U.S. Dist. LEXIS 115148 (E.D. Mich. 2013).

Box 8.5: Extracts from *Tarasoff v. Regents of the University of California*

From the Majority Opinion

On October 27, 1969, Prosenjit Poddar killed Tatiana Tarasoff. Plaintiffs, Tatiana's parents, allege that two months earlier Poddar confided his intention to kill Tatiana to Dr. Lawrence Moore, a psychologist employed by the Cowell Memorial Hospital at the University of California at Berkeley. They allege that on Moore's request, the campus police briefly detained Poddar, but released him when he appeared rational. They further claim that Dr. Harvey Powelson, Moore's superior, then directed that no further action be taken to detain Poddar. No one warned plaintiffs of Tatiana's peril....

We recognize the difficulty that a therapist encounters in attempting to forecast whether a patient presents a serious danger of violence. Obviously, we do not require that the therapist, in making that determination, render a perfect performance; the therapist need only exercise "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances." (*Bardessono v. Michels* (1970 ...)).

The risk that unnecessary warnings may be given is a reasonable price to pay for the lives of possible victims that may be saved. We would hesitate to hold that the therapist who is aware that his patient expects to attempt to assassinate the President of the United States would not be obligated to warn the authorities because the therapist cannot predict with accuracy that his patient will commit the crime.

Defendants further argue that free and open communication is essential to psychotherapy; that "Unless a patient ... is assured that ... information [revealed by him] can and will be held in utmost confidence, he will be reluctant to make the full disclosure upon which diagnosis and treatment ... depends." (Sen. Com. on Judiciary, comment on Evid. Code, § 1014.) The giving of a warning, defendants contend, constitutes a breach of trust which entails the revelation of confidential communications.

We recognize the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy, and the consequent public importance of safeguarding the confidential character of psychotherapeutic communication. Against this interest, however, we must weigh the public interest in safety from violent assault....

We realize that the open and confidential character of psychotherapeutic dialogue encourages patients to express threats of violence, few of which are ever executed. Certainly a therapist should not be encouraged routinely to reveal such threats; such disclosures could seriously disrupt the patient's relationship with his therapist and with the persons threatened. To the contrary, the therapist's obligations to his patient require that he not disclose a confidence unless such disclosure

is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger...

If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify concealment. The containment of such risks lies in the public interest...

From the Minority Opinion

First, without substantial assurance of confidentiality, those requiring treatment will be deterred from seeking assistance. It remains an unfortunate fact in our society that people seeking psychiatric guidance tend to become stigmatized. Apprehension of such stigma—apparently increased by the propensity of people considering treatment to see themselves in the worst possible light—creates a well recognized reluctance to seek aid. This reluctance is alleviated by the psychiatrist's assurance of confidentiality...

Second, the guarantee of confidentiality is essential in eliciting the full disclosure necessary for effective treatment. The psychiatric patient approaches treatment with conscious and unconscious inhibitions against revealing his innermost thoughts...

Third, even if the patient fully discloses his thoughts, assurance that the confidential relationship will not be breached is necessary to maintain his trust in his psychiatrist—the very means by which treatment is affected.

All authorities appear to agree that if the trust relationship cannot be developed because of collusive communication between the psychiatrist and others, treatment will be frustrated.

Given the importance of confidentiality to the practice of psychiatry, it becomes clear the duty to warn imposed by the majority will cripple the use and effectiveness of psychiatry. Many people, potentially violent—yet susceptible to treatment—will be deterred from seeking it; those seeking it will be inhibited from making revelations necessary to effective treatment; and, forcing the psychiatrist to violate the patient's trust will destroy the interpersonal relationship by which treatment is affected.

Source: *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976).

EVALUATING THE *TARASOFF* CASE

Although the precedent set in the *Tarasoff* case is now law, at least in California, the case can also be evaluated from a moral point of view. Note that both the majority and the minority opinions recognize the importance of confidentiality, especially in mental-health care, but the majority views that right as more limited than the minority. Both argue as consequentialists, and both come to different conclusions.

The majority believes that the public is better off when, in certain cases, protection of third parties is allowed to override confidentiality. The minority claims that creating a duty to warn “will cripple the use and effectiveness of psychiatry.” This suggests that the public interest is better served when the duty to warn is restricted. In effect, the minority believes that more lives might be saved by enforcing confidentiality.

The problem with the consequentialist debate is that it is difficult to know which side is best able to predict the consequences. This is made more difficult by the fact that the circumstances are not commonly encountered. Given the rarity of circumstances, it is hard to believe that the imposition of a duty to warn will in fact cripple such mental-health care. On the other hand, it is difficult to believe that many lives, if any, would be saved by a duty to warn. A deontologist need not appeal to the facts of the matter in the way that a consequentialist must. Instead, a Kantian deontologist is likely to believe that respect requires confidentiality, even when it leads to dire consequences.

In certain jurisdictions, what is now known as the *Tarasoff* duty has been extended to include communications not only to psychotherapists but also to any health-care provider. Nonetheless, since warning third parties compromises confidentiality, the duty to warn based upon the *Tarasoff* case is not universally followed. Approximately 27 states impose a mandatory duty to warn. Nine states and the District of Columbia confer upon psychotherapists a privilege, but not a duty, to warn. This means that psychotherapists may choose to warn a third party but are not required to do so. Fourteen states and federal law have no relevant statutory or case law regarding the duty to warn. One state, Virginia, has rejected the duty to warn.

It may seem that confidentiality is like a strong right until the many exceptions are considered. People may argue that there are too many exceptions, but medical information is important to many others besides those who need care. Often a third party, such as an insurance company, pays for medical care, and the price an individual pays for this is some loss of confidentiality, regrettable as that is. When medical information can prevent serious harm to society, most people probably support the need for disclosure of such information, under carefully specified circumstances. However, the fact that different states have different exceptions means that we have good reason to question the moral status of those exceptions.

HIV and the Law

In the United States, HIV and AIDS are given special consideration in many state statutes. A number of factors make HIV and AIDS a special case: the great fear that followed public recognition of the disease, the fact that AIDS is not as contagious, by casual contact, as feared by many, and that disclosure of AIDS may lead

to discrimination related to perceptions that it is caused by irresponsible behavior or sexual preference. Unfortunately, the variety of different approaches around the nation means that careful attention should be paid to differences in state law.

Physicians are required by law to report to public-health authorities evidence of communicable diseases such as syphilis and tuberculosis. This might apply to AIDS as well. Some states require reporting, often anonymously, of asymptomatic HIV infection. Many states have enacted a strict rule prohibiting disclosure of information specifically related to AIDS. Nevertheless, a variety of exceptions are typically included in such statutes. A Florida law, Fla. Stat. Ann. 381.004(3), as is the case in many states, takes a strict view on the confidentiality of AIDS-related information. It provides that “No person in this state shall order a test designed to identify the human immunodeficiency virus, or its antigen or antibody, without first obtaining the informed consent of the person upon whom the test is being performed...” Exceptions include those who are incapable of making an informed judgment. Test results are confidential; however, a list of exceptions applies, including reporting to “[t]he department, in accordance with rules for reporting and controlling the spread of disease, as otherwise provided by state law.”¹

Many health-care providers believe that a patient who is HIV-positive and has unprotected sex poses a direct threat to the health, even life, of the third party. In such a case, they believe, the *Tarasoff* duty should be extended to justify notifying the third person of the threat posed by continued unprotected sex with the patient. In fact, some states legally permit disclosing HIV information to people at risk, including those in sexual contact or who share needles. For example, Georgia’s code explicitly permits informing sexual partners: “When the patient of a physician has been determined to be infected with HIV and that patient’s physician reasonably believes that the spouse or sexual partner or any child of the patient, spouse, or sexual partner is a person at risk of being infected with HIV by that patient, the physician may disclose to that spouse, sexual partner, or child that the patient has been determined to be infected with HIV, after first attempting to notify the patient that such disclosure is going to be made.”²

As in Georgia, a health-care provider in California has a privilege, though not a duty, to inform a partner of a patient who is HIV-positive of the risk of unprotected sex with the patient. The different issue of a provider’s duty to a third party to inform the *patient* of her HIV status was decided in *Reisner v. Regents of the University of California*. The Court held that the defendant physicians were liable

1 Fla. Stat. Ann. 381.004(3).

2 O.C.G.A. § 24-9-47 (2002).

to a third party for failing to disclose to the minor patient and her parents that the patient, Jennifer Lawson, was HIV-positive.¹ The 12-year-old patient was infected with HIV-tainted blood during surgery, a fact that was discovered the day after the surgery. Nonetheless, the physicians failed to disclose to the patient or to her parents that she was infected. Only two months prior to her death from AIDS did the physicians disclose the fact that the infection occurred five years previously. When the child was 14, she became intimate with a boy of her approximate age. The boy became infected with HIV. He brought suit against the girl's physicians on the basis of the *Tarasoff* duty. The Court held that physicians were liable to the boy because it was foreseeable that the patient would have a boyfriend and become intimate.

Reisner is similar to *Tarasoff*. In deciding the former, the judges made reference to the latter. But there are also ways in which *Reisner* is different. In *Reisner*, the physicians failed to disclose the fact to the patient and the family of the patient, while in *Tarasoff* the failure to inform involved a specified third party. In this case, the failure to inform the girl eventually harmed a boy, a third party. The court did not claim that the boy should have been informed; rather, it determined that the liability involved failure to warn the girl and her parents. Nevertheless, the duty to inform was considered to follow from *Tarasoff*, due to the involved risks.

Duty to Warn of Genetic Risk

In general, we assume that a patient's particular medical conditions are applicable to that individual alone. However, the assumption that medical information is unique to an individual has been shown to be false in the case of genetic conditions. Genetic conditions, defined as "changes in a gene or genes," are often caused by the inheritance of an affected gene. Accordingly, genetic data reveal genetic risk information about not only the individual but his or her relatives as well. This personal yet simultaneously familial information raises issues with regard to health-care professionals' legal and moral obligations to disclose genetic information to at-risk relatives. Therefore, a potential conflict may arise within the health-care-professional-patient relationship if the patient refuses to warn at-risk relatives. In particular, does a physician have a duty to warn a child that a disease of a parent may require that the child take special measures to ensure good health? If so, confidential information may need to be disclosed.

1 *Reisner v. Regents of the University of California*, 31 Cal. App. 4th 1195 (1995). See also O. Nnamuchi and R. Nwabueze, "Duty to Warn of Risk of HIV/AIDS in Africa: An Appropriate Legal Response?," *Annals of Health Law* 22 (2013): 386-406.

Box 8.6: Excerpt from *Reisner v. Regents of University of California*

In *Tarasoff*, a therapist who knew his patient intended to kill a young woman failed to warn the woman or her parents and the patient later killed the woman. When the woman's parents sued the therapist and others for her wrongful death, the therapist claimed the only duty he owed was to his patient. Our Supreme Court disagreed, holding that "[w]hen a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances." (*Tarasoff v. Regents of University of California*.) ...

... [O]n the pleadings before us, where warning Jennifer would have been a reasonable step to take in the exercise of the standard of care applicable to physicians, Defendants' liability is not conditional upon Daniel's identity being known or ascertainable, and we cannot factually presume Jennifer or her parents would have ignored Defendants' warning. According to Daniel's complaint, as soon as Jennifer and her parents discovered Jennifer had AIDS, Daniel was immediately notified. As a result, it appears a timely warning to Jennifer probably would have prevented Daniel's injury.

Source: *Reisner v. Regents of University of California*, 31 Cal. App. 4th 1195 (1995).

Two court cases came to different conclusions. In the 1995 case *Pate v. Threlkel*, a Florida Court denied such an obligation.¹ The *Pate* court took a similar position to the *Reisner* court in holding that the physician only has a duty to disclose the subject information to his or her patient. But in *Safer v. Pack*, a New Jersey Court argued that imposing on physicians the obligation to inform third parties is reasonable.² In finding that Dr. Pack had a duty to inform his patient's daughter that she was at risk for developing cancer, the *Safer* court held:

We see no impediment, legal or otherwise, to recognizing a physician's duty to warn those known to be at risk of avoidable harm from a genetically transmissible condition. In terms of foreseeability especially, there is no essential difference between the type of genetic threat at issue here and the menace of infection,

1 *Pate v. Threlkel*, 661 So.2d 278 (1995).

2 *Safer v. Pack*, 677 A.2d 1188 (1996). See also A. Prince, "Comprehensive Protection of Genetic Information: One Size Privacy or Property Models May Not Fit All," *Brooklyn Law Review* 79 (2013): 175–227.

contagion or a threat of physical harm.... The individual or group at risk is easily identified, and substantial future harm may be averted or minimized by a timely and effective warning.

Therefore, the *Safer* court expressly disagreed with the *Pate* court:

We decline to hold as the Florida Supreme Court did in *Pate v. Threlkel*, *supra*, 661 So.2d at 282, that, in all circumstances, the duty to warn will be satisfied by informing the patient. It may be necessary, at some stage, to resolve a conflict between the physician's broader duty to warn and his fidelity to an expressed preference of the patient that nothing be said to family members about the details of the disease.

It has been argued, however, that there are significant dissimilarities between the nature of the threats to third persons by disease or violence on the one hand, and by dangerous genetic conditions on the other.¹ The duty to warn third persons of threats of disease or violence has been construed as applying only to threats of "serious injury." It is not clear what genetic conditions would constitute a threat of "serious injury" sufficient to constitute a duty to warn a family member who may be affected by the defective gene or genes. Further, in court cases that follow *Tarasoff*, the third party or parties the patient threatens have in fact constituted individual persons who are easily identified and located. In many cases, the number, identity, and location of persons who share a specific genetic characteristic will not be readily ascertainable.

In addition, when an individual makes a threat of great bodily injury against a third person, the threat is reasonably likely to occur. Probabilities regarding the manifestation of genetic abnormalities are not nearly as simple to calculate. The uncertainty of the seriousness of the threat of harm, coupled with the probability of its manifestation, compound the vagueness of a legal duty to warn. Further, the duration of the threat may be different in each case.

1 Cf. G.J. DeMarco, G. Jones, and P. Ford, "Do You Have a Duty to Inform Third Parties of Cancer Risk?," *Clinical Oncology News* 11.8 (Nov. 2008); M.R. King, "Physician Duty to Warn a Patient's Offspring of Hereditary Genetic Defects: Balancing the Patient's Right to Confidentiality Against the Family Member's Right to Know—Can or Should *Tarasoff* Apply?," *Quinnipiac Health Law Journal* 4 (2000): 1–38; R. Suarez, "Breaching Doctor-Patient Confidentiality: Confusion Among Physicians about Involuntary Disclosure of Genetic Information," *Southern California Interdisciplinary Law Journal* 21 (2012): 491–521.

CONCLUSION

Health care involves highly sensitive information; improper use of that information can be embarrassing and harmful, and can even disrupt the needed trust between patients and health-care providers. Therefore, the discussion in this chapter of the concepts of privacy and confidentiality is hugely important. We covered both concepts because they are logically related. Interestingly, the legal right to confidentiality is based upon the constitutional right to privacy. Indeed, other rights in the medical context, such as the right to refuse life-saving medical treatment and the right to make choices regarding procreation, are based upon the right to privacy.

Health-care providers face many situations in which there may be temptation or even obligation to breach general rules of privacy and confidentiality. Such exceptions should be kept to the minimum required by legal and moral obligations.

EXERCISES AND DISCUSSION QUESTIONS

1. Evaluate the following case. Be sure to answer the included questions.

Joe Lindfield, 59 years of age, was hospitalized with a blood infection. Although somewhat incoherent when first hospitalized, he responded almost immediately to intravenous doses of several antibiotics and quickly gained full mental capacity while in hospital. Very early on the second morning of his stay in the hospital, he overheard a patient in the hall saying the same words over and over again. It sounded like a male voice, apparently complaining that a nurse had hurt him. He said: "Why are you doing that. It hurts." He must have said that 100 times. Finally, to Joe's relief, the complaint stopped. It seemed to him to have lasted approximately 20 minutes.

Joe mentioned the incidence to a Nurse Lattimore, asking what the patient was complaining about. Lattimore told Joe that the patient is actually a 69-year-old woman named Marie. She is a bit of a problem for the staff, partly because of episodes like the incident that morning. She had to be taken for dialysis, and suffered from heart failure and kidney problems. The nurse said that Marie is facing a dismal future and will probably die soon. She is not competent, the nurse explained, and is not being harmed in any way by the medical staff. She often says the same thing over and over again. Since Joe had once taken a class in bioethics, he began to feel uncomfortable that he had asked about the patient. As the nurse continued,

he realized that his question had not been appropriate. But he was happy to hear that the patient was not suffering at the hands of the health care team.

Was Joe wrong to ask about the patient? Was Nurse Lattimore wrong to disclose information about the patient?

2. Evaluate the following case. Be sure to answer the included questions.

Katrina Ashton is 15 years old and is pregnant for the first time. She lives with her mother and father and has been sexually active for over a year. She has a steady boyfriend, Bob Taylor, who is the second person she has had relations with. They usually use a condom, and when they do not, he withdraws in order to avoid pregnancy. On presenting to her family physician, Dr. Kingston, for a physical exam needed for a school activity, a blood test indicated pregnancy, which Dr. Kingston suspected. Katrina was shocked and couldn't understand how it could have happened, given their precautions. Dr. Kingston tried to explain the risk of pregnancy despite efforts to avoid it, including risks of disease. Abstinence was the only sure way, but failure to use a condom was taking a real chance. Katrina didn't seem to understand and reasserted that this couldn't have happened and wanted to know if the doctor was sure. He was. Dr. Kingston went on to say that she now, more than ever, needed the support of her family. Katrina insisted that they not be told, and asked about an abortion. Their state permits a physician to keep such information from parents, but Dr. Kingston thinks that such laws are ridiculous and harmful. He untruthfully told Katrina that without her parents' approval she could not have an abortion, and so she might as well tell them because they will soon know anyway. After all they will get the insurance statements which will sooner or later indicate the pregnancy. Katrina adamantly rejected Dr. Kingston's advice and harshly told him she would get another physician.

That evening, Dr. Kingston called Katrina's mother and told her that Katrina was pregnant. Her mother, although shocked, was thankful for the information and said she would support her daughter and would discuss with her the available options. Dr. Kingston was relieved that he made the phone call.

That evening her mother engaged Katrina in a conversation. It went badly, even though Katrina's mother tried to approach it with kindness and understanding. Things gradually got out of hand. After a serious verbal fight, some pushing occurred and Katrina was slapped, causing some scratches. Katrina threatened to call the authorities to report the event as abuse, but instead left the house. A week later she hadn't returned and her mother had no idea where she was.

Dr. Kingston deceived Katrina about parental approval. Is the deception morally acceptable? How would a principlist decide whether the deception was acceptable? Would the deception be an exception in Gert's rule theory?

3. Explain the difference between privacy and confidentiality.
4. Does privacy extend a person's control over his or her life?
5. Should there be as many legal exceptions to confidentiality as there now are?
6. Should the right to privacy be based on respect for autonomy?
7. Does a consequentialist theory adequately support privacy?
8. What is the best moral support for the right to privacy?
9. Does privacy have a negative impact upon women?
10. Do you side with the majority or the minority view in *Tarasoff*? Why?
11. Is it morally appropriate for a nurse or physician to discuss a patient's medical details with the patient's spouse? What if the patient is not competent?
12. Do you believe that the duty to warn will have a significant negative impact on the flow of information in mental-health care?
13. Is it morally defensible to demand that health-care professionals refrain from discussing cases with their own close friends and family members?
14. Is covert surveillance morally appropriate in cases of suspected Munchausen syndrome by proxy?
15. Should HIV and AIDS be treated as exceptions to confidentiality regulations?
16. Is it morally acceptable to share genetic information with a patient's family members without the patient's consent?

17. Should the duty to warn be extended to genetic information? In your answer, compare, contrast, and evaluate the court cases *Safer v. Pack* and *Pate v. Threlkel*.

18. Suppose there is a nationwide system containing the computerized records of patients. That system could help provide better care, for example in emergency situations where a patient is far from home and is unable to answer questions. Do the benefits of such a system outweigh the potential risks to confidentiality?