Closely related to privacy is the principle of confidentiality. In its simplest form, this principle states that a health care professional may not reveal to others the information given to her by one of her patients without that patient’s consent. Confidentiality has been a basic tenet of traditional Western medicine for centuries and forms an important part of the physician–patient relationship. The principle is stated in the Hippocratic Oath, which many medical students take upon graduation. It is reaffirmed in the American Medical Association’s Code of Medical Ethics. (See Section 3, Ethical Statements.)

One explanation for the importance of the principle confidentiality in medicine is based on its consequences: the advantages of adhering to the principle and the long-term disadvantages of ignoring it. If health care practitioners promise to keep all revelations confidential, patients are more inclined to be completely honest and will reveal sensitive information needed to evaluate their problems. Without the promise of confidentiality the trust so necessary to a successful physician–patient relationship would be exceedingly difficult to establish. Another reason for the importance of confidentiality is based on the value of privacy itself. By keeping silent about those private matters a patient reveals to her, a physician shows the respect owed to that patient as a person.

The ethical obligations to protect privacy and confidentiality are given legal recognition in a variety of ways. Violations of ethical standards can be grounds for physician discipline, including license revocation. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards, the basis on which health care facilities become eligible for reimbursement from major third-party payers, provide for the confidentiality of patient records. Among patient rights, JCAHO lists the right “to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy” and the right “to expect that any discussion or consultation involving his care will be conducted discreetly and that individuals not directly involved in his care will not be present without his permission.”

 Patients may bring tort suits for invasion of privacy or breach of confidentiality. Physical intrusion into protected seclusion is a classic example of the tort of invasion of privacy; patients have recovered damages, for example, for the embarrassment caused when unauthorized people are present during a medical examination. Unauthorized photography or recording is another classic example of the tort of invasion of privacy. Patients can also recover damages for breaches of confidentiality if providers fail to meet professional standards for the protection of confidential information. There have been quite significant damage awards, for example, in cases in which a patient’s employment was jeopardized by the release of information that he was HIV-positive.

Standard formulations of the obligations of privacy and confidentiality, however, set them within customary or legal limitations; hence privacy and confidentiality are often compromised. Health care providers are typically required to report gunshot and knife wounds, as well as cases of suspected child abuse and a variety of infectious diseases. Some states have statutes that require physicians to respond to police requests to test blood alcohol levels and report the results. Many states have “implied consent” statutes under which possessing a driver’s license is treated as implied consent to a blood test in suspected DUI (driving under the influence [of alcohol]) cases. These statutes permit patients to refuse the blood alcohol test if they are willing to relinquish their drivers’ licenses. All these statutes typically make the provider immune from suit for complying with legal mandates.

There are three reasons usually given for overriding a patient’s rights of privacy and confidentiality: (a) a more important right of the patient is at stake; (b) a more important right of someone else is at stake; or (c) a very important social good is at stake. Thus while health care providers are obligated to honor privacy and confidentiality, they should recognize that a stronger obligation—such as the duty to prevent serious harm to others—may sometimes be overriding.

NOTES
1. The Court appealed to the right of privacy in ruling that the state may not interfere with a married couple’s decision to use contraceptive devices (Griswold v Connecticut, 381 U.S. 479, 1965). Later the Court used the right of privacy to construct a barrier to state interference in women’s decisions to seek abortions (Roe v Wade, 410 U.S. 113, 1973).

Legal Requirements for Notification

Holly M. Smith

Case 8-1

A 30-year-old man comes to the emergency department (ED) claiming that he has been shot. He states that he is willing to undergo emergency tests and treatment only if the physician agrees not to call the police. He also states that he will leave the ED if the physician does not promise this. The patient walked into the department, and he seems capable of walking out under his own power. Gunshot wounds are potentially, but not always, fatal. The victim refuses to say where the wound is, and based on this limited data, the physician must make her decision.

Commentary

The emergency physician in this case has the following alternatives:

a. Convince the gunshot victim that he should allow the physician both to treat his wound and to inform the police.

b. Forcefully restrain the victim, treat his wound, and inform the police.
c. Insincerely assure the victim that she will not report the wound, treat the injury, and then report it to the police.

d. Agree to treat the wound but not inform the police.

e. Not treat the victim and not report the incident to the police.

f. Not treat the victim but report the incident anyway.

Clearly, option A is the best alternative, but it may not be possible to carry it out if the victim resists persuasive efforts. If option A is unavailable, which of the remaining choices would be the best course of action, and why?

Moral and Factual Considerations

Several moral considerations have immediate bearing on the physician’s choice. First, the physician is in a position to provide the victim with a good in the form of restored health (insofar as it can be restored). Second, while there is a moral and legal presumption in favor of confidentiality between physician and patient, this has been legally abrogated (in most or all states) by a “reporting” law requiring physicians to inform police about injuries, such as gunshot wounds, that are likely to have arisen as a consequence of criminal acts. The purpose of such laws is, broadly speaking, either to procure the arrest and conviction of the criminals responsible for these acts or to protect innocent parties who might be injured in the future. Such laws serve legitimate state purposes. On the other hand, they may discourage some wounded persons from seeking medical aid. Because of this “chilling effect” and the essential nature of medical services, it would be unfortunate if medical institutions were to become, in any substantial way, an extension of the police power of the state. Third, the physician has a moral obligation to obey any law that serves a valid state purpose. Fourth, if the physician violates the reporting law in this case, she risks being subjected to legal sanctions herself. Punishments for such violations tend to be minor, compared to those for other offenses (for example, in Arizona the maximum prison sentence is thirty days). But such a punishment would represent a substantial financial loss to the physician and might result in dismissal from her position or in revocation of her hospital privileges. Thus, if the physician treats but fails to report this wound, she may do so at some personal cost.

Few relevant facts are known. It seems probable that the victim’s wound is more than superficial, since his aversion to having it reported to the police would have encouraged him to treat it with home remedies if it had appeared trivial. On the other hand, the victim’s ambulatory state and attitude toward treatment indicate that he believes, possibly with good reason, that the wound is unlikely to be immediately fatal. We can make only limited guesses why the victim does not want the incident to be reported. Perhaps he wants to protect a relative or friend who fired the gun or he may wish to avoid contact with the police because of unrelated shady dealings in his life. He himself may be innocent of any wrongdoing, but he may wish to avoid retaliation by his attacker(s) if the case is reported. The reason for his reluctance could make a difference in the physician’s decision about according to his request. Finally, since so little is known about the victim or his circumstances, it is difficult to predict whether the physician’s disposition of this case might produce a flurry of similar requests on the part of future gunshot victims.

Before we scrutinize the options themselves, we must distinguish between two types of reporting laws. An “attention” law requires the physician to report any gunshot wound that comes to her attention in the course of her practice; a “treatment” law only requires the physician to report any gunshot wounds that she treats. (Arizona law is neatly ambiguous between these two groups, stating that “a physician. . . called upon to treat any person for gunshot wounds . . . which may have resulted from a[n] . . . unlawful act, shall immediately notify the chief of police . . . .”) The victim obviously assumes that the relevant law is a treatment law, so that the physician is only required to report his wound if she actually treats it. For brevity in the following discussion, I will join him in this assumption. However, applicability of the attention law would make a difference in assessing some of the physician’s options. Let us consider the physician’s alternatives.

Option B: Restrain the Victim, Treat Him, Inform Police

Option B is clearly morally impermissible. It is true that the physician could achieve the good of health for the victim by forcibly restraining and treating him, and then calling the police. But it should be remembered that it is only legally—and morally—permissible for the physician to treat him if he consents to treatment. If the victim had chosen to remain at home and treat his wound with home remedies, the physician could not intervene and force medical treatment or hospitalization on him, even if his life were at stake. Similarly, it is not permissible for the physician to force treatment on the unconsenting victim inside the ED, even if his life is at stake. Nor can the physician claim that forcing treatment on the victim is the only way to satisfy her moral obligation to obey the reporting law, since if she does not treat the victim, she is not legally required to report his wound (under a treatment law) and so does not violate her duty to obey the law if she does not report it. Option B must be dismissed.

Option C: Lie to the Victim, Treat Him, Inform Police

Option C involves insincerely assuring the victim that the police will not be called; treating him and then calling the police. This option also achieves the goal of restored health for the victim, but it violates two stringent moral demands. First, it requires the physician to make an insincere promise (or to lie). Second, like option B, it requires that the physician treat the victim without his consent. This requirement may be less obvious than if the physician physically forced treatment on the victim. But the victim will consent to treatment only on the condition that the police not be informed. Since this condition is not met, consent has not genuinely been obtained. There is no great moral difference between options B and C. Physically forcing a person to undergo treatment he has refused is not much worse, if at all, from deceiving him into being treated.
This assessment of option C might be argued against on two grounds. First, it might be argued that the moral position of the victim is weak: at the very least he is demanding that the physician violate the law. Second, he himself may have violated the law (if, for example, he received the wound during some criminal activity). Hence it could be argued that he does not deserve full moral respect, so that it is morally permissible to violate his rights (for example, the right not to be lied to and the right to be treated only with his consent) to secure the moral good of preserving his health. I would reject this line of thought. The physician cannot be certain that the victim was himself committing any criminal act at the time the wound was inflicted—he may be entirely innocent. Additionally, while it is true that the victim is attempting to induce the physician to violate the law, this in itself does not seem sufficient grounds to abrogate respect for his right not to be duped or forced into unwanted treatment.

It might be argued that it would not really be wrong for the physician to break a promise to the victim not to call the police, for when a person promises to do something morally (or legally) wrong, she creates no moral obligation to perform the promised act. For example, if the physician promised a mobster to murder one of her patients (an important witness), that promise would create no obligation on her part to follow through, since the promised act is wrong from the beginning. Similarly, it might be claimed the physician would be morally “safe” to falsely promise the victim not to call the police. Because the promised act would be morally and legally wrong from the beginning, her promise would create no obligation to keep the promise.

This argument, so far as it goes, is correct. The physician’s insincere promise to the victim would not create an obligation to not inform the police. However, she would have been wrong to make such a fraudulent promise in the first place. This is the moral wrong, not her violating the promise once made. My former conclusion stands. Option C should be rejected.

Option D: Treat the Victim, Do Not Inform Police

Option D involves the physician’s acceding to the victim’s conditions by treating him without reporting the wound to the police. This option secures the good of restoring the victim’s health at the moral cost of violating the obligation to obey the law. Although it avoids any violation of the victim’s rights, it does render the physician vulnerable to possible legal sanctions if the incident comes to the attention of police or hospital authorities. Assessing this option requires us to weigh the good to be achieved against the immorality of violating the law and the possible personal cost to the physician. In weighing these factors it is important to remember that physicians are not under a general moral duty to provide the good of health whenever and wherever they can. Such a duty would place too great a burden on them. Except in limited circumstances (for example, when a physician has already accepted someone as her patient), providing medical care is, at most, a morally gratuitous act which that physician may or may not choose to perform. That the physician who follows option D would be providing medical care at the cost of violating the law and exposing herself to some personal sacrifice means that this act cannot be her duty. At most, it is a morally gratuitous act that she is free to perform or to refuse. Whether it is even a morally good act depends upon circumstances she cannot know: whether the wound is serious, whether it is treatable, whether it was inflicted by a dangerous criminal who must be apprehended before he commits worse atrocities, whether penalties will be imposed on her for not reporting the wound, and so forth. We can only conclude that option D may be a morally permissible act. If there is no important criminal to apprehend and if treating the victim would save his life, option D is a good, but not obligatory, act. On the other hand, if apprehending the criminal is important, option D may instead be wrong.

Option E: Refuse to Treat the Victim, Do Not Inform Police

Option E involves the physician’s refusing the victim’s conditions: she neither treats him nor reports his wound to the police. This option clearly fails to promote the good of restoring the victim’s health, but the physician has no strict moral obligation to do that; since the victim does not consent to it, and he himself is willing to accept this result.

Pursuing option E does not require the physician to violate any positive duty, such as that of treating a consenting patient, obeying the law, or not making fraudulent promises. It is true, however, that while the physician does not violate the letter of the law, she does fail to promote the purpose of the law: in not reporting the wound, she does not facilitate the apprehension of criminals nor help prevent further criminal activity. But she has no strict obligation to do this, at most it is a gratuitously useful act which she (like any citizen) is free to do or not to do. And given the disadvantages of having medicine become an extension of the police power of the state, one hesitates to say that it would be morally desirable for the physician to report the wound when not formally required to do so. Thus option E appears to be a morally acceptable choice for the physician.

Option F: Refuse to Treat the Victim, Inform Police

The disadvantages of having the physician report the wound when not formally required to do so help us rule out option F as inferior to option E. Option F involves the physician’s not treating the wound but reporting it to the police nonetheless. Such a report would not only entangle the physician unnecessarily in police activities but is also unlikely to accomplish a great deal in the way of criminal apprehension or crime prevention, since the untreated victim will hardly have provided the physician with crucial identifying information. Nothing is gained by this option, and a good deal may be lost. (Of course, this assessment may change if new information becomes known later on; for example, a significant crime is reported in which it seems probable that the victim was involved.)

A Different Scenario

It is worthwhile to call attention to one possible variant on this case which the physician might have to face. Suppose the physician refuses to treat the victim according
to his stipulations, and the victim walks out of the hospital and then collapses. He is brought back, unconscious, by personnel unacquainted with the case. What should the physician do at this point? It might be tempting to conclude that the physician should treat the victim and also inform the police, on the grounds that the victim’s state requires medical assistance, that the victim himself (being unconscious) does not withhold consent for treatment, and that the law requires the wound to be reported. But this line of thought is inadequate. The physician already knows, because of her previous interview with the victim, that he does not consent to treatment in conjunction with informing the police. That refusal to consent covers the present circumstances as well as the earlier ones. For the same reason, a physician cannot argue that a Jehovah’s Witness, who has previously refused all blood transfusions, may be transfused now that he is unconscious and cannot withhold consent. The prior refusal of the Jehovah’s Witness to consent governs all circumstances, and so does the prior refusal of the gunshot victim. On the other hand, we can hardly recommend that the physician eject the victim onto the street in his unconscious state. Here it appears that the only acceptable course of action is for the physician to treat the patient without informing the police, at least until the patient has regained consciousness and is able to decide whether to leave the hospital or to accept a police report.

NOTES
1. Arizona Revised Statutes, Section 13-3806.

Answering Questions from “ Relatives”

Ruth R. Faden

Cases

The ED in the hospital nearest a college campus has admitted four 22-year-old male college seniors in the past half-hour.

Case 8-2

The first senior is being seen for pharyngeal gonorrhea, a venereal disease often associated with homosexual activity.

Case 8-3

The second senior is being tested for an apparently intentional antihistamine overdose. He is doing well, and after several hours of observation, he will be referred for psychiatric care.

Case 8-4

The third senior was brought in by ambulance, after having been injured in an automobile accident. He has a neck strain, but his x-rays are negative. He will be released shortly.

Case 8-5

The fourth senior was also involved in an automobile accident. He is unconscious and is in critical condition with multisystem injuries.

The mother of each of these students calls long-distance to inquire about the medical condition of her son. What information, if any, should the physician give in each case? Does upholding patient confidentiality depend upon the nature or the severity of the illness?

What information, if any, should the physician give to a caller other than the parent? What if the patient does not have any family, and a friend inquires about his condition? What if the inquirer is a reporter from the local newspaper?

Commentary

Few moral rules in the health professions are as widely accepted as those of confidentiality and privacy. Without such rules, it is feared that people will hesitate to seek medical help for potentially embarrassing or stigmatizing problems and that patients will withhold personal but medically relevant information from health care providers.

In addition to these utilitarian justifications for rules of confidentiality and privacy, the injunction to respect the autonomy of patients demands respect of their confidences and thus provides an additional, if not primary, moral warrant for such rules. It also assumes that privacy is a basic human need and thus that respecting a patient’s privacy is a fundamental moral obligation.

The standard “operational definition” of the rule of confidentiality is that health professionals may not disclose information about a patient to other parties without the patient’s consent. Exceptions to the rule may be morally permissible (depending on the circumstances), but the burden of moral proof falls on those who would violate it. It is arguably the case that confidentiality and privacy rules are somewhat less binding in emergency medicine, where the physician–patient relationship is less well established.

Application of Principle of Confidentiality to Cases 8-2 and 8-4

When applied to cases 8-2 and 8-4, the rule of confidentiality yields a clear answer: no specific information about the son’s medical condition may be disclosed to the mother without the son’s permission. It is a simple matter for the physician to put off the mother’s initial inquiry and return her call after having checked with the son to ascertain his preferences. Even in case 8-4, where there is no obvious reason to think a son would wish to keep his medical situation from his mother, it would be inappropriate