

Commentary

Ethics roundtable debate: Is a physician–patient confidentiality relationship subservient to a greater good?

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Abstract

Is a health care provider's most proximal obligation to individuals or society as a whole? Our International panel of critical care providers grapple over the issue of whether patient–physician confidentiality exists as an open ended ideal it should be subservient to a greater good.

Introduction

Traditionally, the physician–patient bond is considered as sacrosanct as that between parishioner and priest. The patient has an expectation of absolute trust and confidentiality. Were it not so, failures to disclose sensitive history could result in misdiagnosis and great harm to the patient. However, this bond is muddied somewhat when potential for harm to other innocents rests on it. In this case, a patient has disclosed an irresponsible act. As a result, others may be at risk for harm if the physician remains silent. Our panel grapples with the balance of individual rights versus a greater good.

The case

A 25-year-old young man is dropped off by a friend at the emergency department (ED) and states that he was in a motor vehicle accident 30 min before arriving. He says that his car was extensively damaged but that he was able to get out of the car and walk around at the scene. There was no loss of consciousness. He states that the police were at the

scene investigating. He does not volunteer whether the police questioned him personally or why the police let him leave. Except for bumps and bruises, he is not significantly injured enough to justify a radiograph or computed tomography scan of his head. However, I detect the odor of ethanol on his breath, and so I order a blood ethanol to evaluate his capacity further. It is my opinion that if he is legally impaired, then he cannot leave the ED unless someone picks him up and assumes responsibility for him. He does not refuse the test and his blood ethanol level is 0.17 mg/dl, indicating that he is legally impaired.

Emergency physicians know that people who think they might be legally impaired have a strong incentive to leave the scene of accidents to avoid detection by investigating police. This patient's story about being involved in a multicar crash severe enough to cause significant property damage, and then the investigating police allowing him to leave the scene without checking him for potential ethanol intoxication does not ring true. I have an ethical dilemma. Do I have a responsibility to call the police and inform them that an impaired person in the ED may have left the scene of an accident where injuries to others might have occurred? Alternatively, am I mandated to keep silent regarding anything the patient may have told me because of the confidentiality of the doctor–patient relationship?

What decision should I take to serve the greater good?

A perspective from India

Farhad Kapadia

In my hospital in Mumbai (formally Bombay), India, the main issues in such a scenario would be what my legal obligations are and what my ethical considerations should be. The doctor–patient contract is guided by the Indian Contract Act. In accordance with our hospital's legal council, we must maintain patient confidentiality by law. However, this may be overridden in specified circumstances, an example of which is when it is in the public interest to do so. Thus, I am legally protected if I choose to override patient–doctor confidentiality. On an unrelated issue, the Indian Contract Act specifies that a person cannot enter into a contract if they are intoxicated and not in a proper state of mind. The law requires that police be informed of all patients with trauma who require admission. Because this patient does not require hospital admission, this does not apply. Legally speaking, it is my decision as to whether the police must be informed. Our hospital's in-house medical lawyer always advises that when in doubt one should inform the police. However, this is overly bureaucratic and often leads to much red tape and harassment of the patient and family. In many clinicians' opinions, unnecessary involvement of the police is best avoided, so that the patient and family may be spared the subsequent bureaucratic problems. My initial instinct would be to try to avoid involving the police.

From an ethical perspective, there is a conflict in that I must respect my patient's confidentiality but I must also protect the public from any harm arising from my allowing the patient to leave with his current blood level of alcohol, which is in the legally impaired range. Essentially, I would inform him that he needs to call a responsible relative to the ED, and that that person may take him home, ensuring that he is not the one driving. If the patient does not agree to wait, then I would inform him that I will contact the police, because in my view he may pose a danger to the general public in his present condition. Another, albeit less desirable option would be to ensure that he leaves the ED by some form of public transport (e.g. a taxi).

I would not inform the police that such a patient had presented to our ED in order to assist in their official investigation into an accident, even though it may have caused serious injury to others. This probably reflects a general culture of avoiding official police involvement with all its subsequent bureaucracy. If needed, the police would easily be able to trace the patient from the vehicle registration. They could then approach the hospital for the case notes from the hospital ED visit, if they felt that it would help in their investigation.

South African confidentiality: protection of the individual patient

Arthur Morgan

The medical profession is virtually unique in civilized society in that it has been required to develop its own standards of behaviour in obtaining the personal details of patients by questioning and examining in ways that are not generally acceptable within society. The doctor needs this privilege to make a diagnosis and treat the patient with compassion and competence, while allowing for patient autonomy. A major part of this relationship is the trust that no information about the patient will be given to other people.

In South Africa doctors are, like any other member of society, bound by laws that demand correct behaviour, as defined by the Government that represents the whole country. There are also, however, specific laws, rules and guidelines that govern doctors.

The National Health Act, Section 14 [1], states:

- 14 (1) all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential.

- (2) subject to section 15, no person may disclose any information contemplated in subsection (1) unless:
 - a. the user consents to that disclosure in writing;
 - b. a court order or any other law requires that disclosure; or
 - c. non-disclosure of the information represents a serious threat to public health

Part of the ethical rule number 12 [2], states that:

A practitioner shall only divulge verbally or in writing any information regarding a patient which he or she ought to divulge in terms of a statutory provision or at the instruction of a court of law or where justified in the public interest ...

The South African Medical Association (Meyer E, personal communication) advises breaking confidentiality only when nondisclosure of the information represents a serious threat to public health.

The World Medical Association states in its Medical Ethics Manual [3] that:

Conditions for breaching confidentiality when not required by law are that the expected harm is believed to be imminent, serious (and irreversible), unavoidable except by unauthorised disclosure, and greater than the harm likely to result from disclosure.

There is thus concurrence that whilst confidentiality is central to the doctor/patient relationship, it is not absolute, and information may be divulged to prevent serious danger to society.

Whether a patient has already been involved in, or even caused, a motor vehicle crash is of no interest to a doctor, beyond the need to diagnose and treat the injuries sustained. The doctor is certainly not expected to, nor obliged to, report this to any authority, and may indeed be asked to justify to a court of law and to the Health Professions Council of South Africa any voluntary reporting of such an event to a third party. However, when a drunk person is about to drive out of the hospital property this is a legitimate concern to society as a whole and this could be reported to the authorities, as represented by the local police, in the hope that the drunk would be stopped and a potential crash averted.

An Australian ambulance paramedic's perspective

Chris Cotton

In Shakespeare's *Julius Caesar*, the quote, 'The fault, dear Brutus, is not in our stars, but in ourselves, that we are underlings' has often been interpreted to mean that fate is not what drives men to their decisions and actions, but rather it is the human condition that does so. Perhaps Shakespeare's insight into the human condition can be used to parallel why a clearly intoxicated driver cannot be sheltered from being held accountable for his fallibility.

As an ambulance paramedic, attending to people who leave or abscond from the scene of a vehicle accident for reasons such as alcohol or other illicit drug intoxication is not an infrequent occurrence. The issues from this paramedic's (prehospital) perspective in relation to reporting them appear to revolve around three fundamental tenets.

Privileged information

Wearing a paramedic uniform and responding to an individual such as described in this case has the potential to give the paramedic a unique window to develop a rapport with the patient. The unique, voluntary passage of critical information between patient and paramedic is usually considered by paramedics and their patients to be privileged. This is often with good reason; a person who confides in a paramedic usually does so because paramedics are believed to be trustworthy, professional, and likely to influence their treatment [4]. The Australian College of Ambulance Professionals Code of Ethics [5], and the South Australian Ambulance Service's internal code of conduct both in fact behold members to confidentiality in the provision of health care.

Is this information of a confidential nature?

When should 'privileged' information become 'public' information? Although being intoxicated is not necessarily a

reportable event, the vehicle accident certainly is, and it is reasonable to alert the appropriate agencies when a clear breach of law has potentially occurred. In this instance, because the individual is clearly intoxicated it could reasonably be argued that the information is not of a confidential nature and therefore requires mandatory reporting to law enforcement authorities for follow up through the judicial process.

Community versus individual benefit

The laws designed and enforced by society are there to protect people from events that may endanger them. Being in control of a motor vehicle while intoxicated constitutes such a danger, and mandates that these events attract stiff penalties to deter the behaviour. If a paramedic ignores their responsibility to report reasonable suspicions, then they may inadvertently potentiate future tragedy to innocent members of society. Therefore, the overriding benefit for society must be weighed against those for the intoxicated individual seeking care.

Summary

As Shakespeare wrote of fate, the human condition and our actions, it is perhaps prudent to reflect on the meaning of this salient quote from Cassius in *Julius Caesar*. We are responsible for our actions, and we should look to ourselves for our remedies. If we are to provide the best care to the public we serve, then we should remember that we did not cause this situation – the intoxicated driver did. There are consequences for his actions that extend beyond our immediate, professional and compassionate care of him as our patient.

I have a responsibility to protect innocents as well as the guilty

David Crippen

I have a strong suspicion that this patient is lying and that he might have left the scene of an accident to avoid arrest for driving under the influence of ethanol. The way he relates it, his story is unlikely to be true. The police would never allow him to leave the scene of an accident if there was any suspicion that he was impaired. If I detected ethanol on his breath then the police would have too – it is their job to notice. He would be given a roadside sobriety test, which he would have failed as he did in the ED and would have been arrested. He knew he was circumventing that by leaving the scene of the accident. His admission that his car was extensively damaged implies that the other vehicle involved might have been equally extensively damaged, and that the other occupants in it might be still there, injured at the scene. It is entirely possible they are stranded in a poorly occupied area and no one but my patient knows of their whereabouts.

Clearly, my patient has a right to privacy and privileged communication with me as his physician. However, his right to privacy is not an open-ended ideal. I think that that right is subject to constraint if it has the potential to hurt

innocents. However, I think my duty to protect his privacy is trumped by my duty to investigate the safety of potentially injured other innocents that may have been put at risk by my patient's illegal and self-serving behavior. What is the potential detriment from breaking the doctor–patient confidentiality bond for the sake of a greater good [6] – that this patient will not trust me anymore? I can live with that. The benefit is the potential to save the lives of injured innocents awaiting a rescue that may come too late unless the authorities are notified of its necessity. I am not a priest and I am not a psychiatrist – the usual stereotypes of open-ended confidentiality. I have a duty to use good clinical judgment to treat my patient's injury and an equal duty to protect others as my patients [7]. He does not enjoy an unbreakable bonding with me as it pertains to his irresponsibility and/or illegal activities. I would call the authorities and tell them that I suspect there are injured people in a car accident nearby and that they need to question my patient about it.

This call serves the greater good.

Too much information muddies the water

Holt N Murray

The case at hand represents an atypical presentation of the duty to warn principle. This concept is usually discussed within the framework of psychiatric patients who express homicidal ideations toward specific individuals. The Tarasoff case [8] has served as the basis for both Canadian and US law obligating physicians to protect third parties. In psychiatric cases most physicians now readily accept their ethical and legal responsibilities to warn third parties who are at risk for bodily harm. The duty to warn principle is a very important exception to the confidentiality imposed by the doctor–patient relationship.

Breaching the expectation of confidentiality provided by the doctor–patient relationship should only occur in select circumstances. The severity of inaction and the temporal pressure of the situation should be considered in the decision to break confidentiality. It cannot be considered ethical to preserve confidentiality above the life and health of an innocent third party. In this case, both conditions are met. There is a real risk of bodily harm to a third party, and any delay in locating the third party could result in greater injury.

For these reasons the police should be informed of the location of the accident so that they can investigate. If the patient is willing to disclose the location of the accident, then the police can be informed without disclosing the name of the patient. This

would, of course, be the best option, preserving the doctor–patient relationship while protecting third parties at risk. If the patient is unwilling to disclose this information in an anonymous manner, then the duty to warn third parties requires that the police become involved so that they can conduct a proper investigation. In either case, the temporal pressure of the situation requires immediate identification of potential victims.

The patient's blood alcohol level is irrelevant in this decision. If the patient were impaired and confused because of hypoglycemia, then the case would not appear to be an ethical problem. Certainly, ordering the alcohol level after the patient has been determined to be clinically impaired does little more than compound the ethical problems. Was the ethanol level obtained to provide information for the police? Does it alter the course of medical treatment? Was the patient also screened for other common agents of intoxication?

In this case there is an immediate need for action, but with the explosion of new genetic tests there is a renewed debate over the duty to warn principle [9]. Genetic testing now enables us to predict, with limited certainty, an event that may occur in the distant future. Although these genetic issues represent the other end of the spectrum, they illustrate that our obligation may extend beyond the patient in our immediate care to those we will see in the distant future.

Wrap-up: some final thoughts

Gil Ross

It is all about duty – the duty owed to a patient by a health care professional. ED physicians have a duty to diagnose and treat this patient in accordance with the accepted standards of medical practice and opinion. These health care providers also have a duty to protect their patient's confidentiality – to hold sacred the physician–patient privilege.

From time to time society imposes a duty that may supersede that of the physician–patient privilege. By statute, when presented with instances of suspected child abuse, health care providers are deemed 'mandatory reporters'. Under this law, the health care professional has no discretion and is legally obligated to notify the authorities. Society has recognized that health care professionals are the first line of defense in child abuse cases. However, in this hypothetical case the issue of potential child abuse is not relevant.

In the scenario the ED physician notes that he has 'an ethical dilemma'. In truth, he may be having a crisis of faith, a nagging conscience, or a feeling that he is being placed in a moral conundrum. However, there is no ethical dilemma. Ethically, this patient's right to confidentiality trumps our collective disgust with those impaired drivers who are wreaking havoc on our roads.

A government may enact legislation making physicians mandatory reporters of suspected drunk drivers. This would create a duty on the part of the health care professional to report those actually or suspected of driving while

intoxicated. If one assumes that addiction, whether to ethanol or other drugs, is an illness, then such legislation may make it impossible or impractical for the addicted individual to speak candidly to his or her doctor. Such legislation would only act to impede any opportunity for treatment. Of course, such legislation sets us all on a very slippery slope. One can only imagine what 'socially undesirable' behaviors will be the next to require mandatory reporting.

In short, the doctors should be the doctors and the police should be the police. Treat this injured patient in accordance with the standard of care and protect this patient's right to confidentiality. Allow the police the opportunity to practice their profession. If the authorities are doing their job, then they will 'come a calling' and, on their own, find this patient.

Of course, this hypothetical situation ignores the realities of life. In most EDs and trauma centers the police, along with paramedics, are frequent guests. The 'ethical dilemma' is often resolved with a raised eyebrow and a nod of the head or gesture directing a police officer's attention to a certain examining area. No words are spoken and, at least on a superficial level, no confidentiality is breached. The health care professionals can then delude themselves into believing that they have acted appropriately, and can go to sleep that night feeling good about 'doing the right thing'. In reality, the 'wink and a nod' solution is no solution at all. It is intellectually dishonest and constitutes a breach of the duty to protect this patient's right to confidentiality.

Competing interests

The author(s) declare that they have no competing interests.

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