COMMENTARIES

Confidentiality vs harm to another

SUNIL K PANDYA

Dr. Bawaskar's sensitivity in this matter deserves applause (1).

The principle of confidentiality dictates that what is discussed by doctor and patient remains between them and should not be divulged to anyone else without the patient's express consent.

A major exception to this diktat is harm to another if confidentiality is maintained. In the US case that is now referred to world-wide when this issue is being discussed, *Vitaly Tarasoff et al, Plaintiffs and Appellants, vs Regents of the University of California et al, Defendants and Respondents* (2), the judge's decision on July 1,1976 was clear.

Prosenjit Poddar, a student from Bengal, had confided to Dr. Moore, his psychologist, his intent to kill Tatiana Tarasoff for having jilted him. The head of the department of Psychology overruled Dr. Moore's suggestion that Poddar be committed to a psychiatry clinic. Poddar killed Tatiana. In the ensuing trial, the California Supreme Court found that a medical professional has a duty not only to a patient, but also to individuals who are in danger consequent to the acts of that patient.

In the case of Dr. Bawaskar's patient, there was a manifest, malignant brain tumour, known to carry a very high risk of mortality.

It is the duty of the treating neurosurgeon to convey this sad news to the patient and his family. Since the patient was of marriageable age, it is obvious that with such a tumour, the union would lead to incalculable harm to the prospective bride. The woman and her parents should have been provided details of the illness and prognosis by the patient and his family. An instruction to this effect from the doctor to his patient would have been correct and salutary.

As matters stand, the doctor failed in his duty as physician, friend, philosopher and guide to his patient, his family and to the hapless, now pregnant, wife.

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References

1. Bawaskar HS. Can doctors advise beyond the purely professional? *Indian J Med Ethics*. Published online on July 1, 2019. DOI:10.20529/IJME.2019.035.
2. Supreme Court of California. *Vitaly Tarasoff et al, Plaintiffs and Appellants, v Regents of the University of California et al, Defendants and Respondents*. 551 P.2d 334 (Cal. 1976). 1976 Jul 1 [cited 2019 Jun 20]. Available from: https://www.courtlistener.com/c/Cal.%203d/17/425/

The uninformed spouse: Balancing confidentiality and other professional obligations

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Abstract

I use the case study presented by Bawaskar (1), which I refer to as the "The Case of the Uninformed Spouse", to illustrate an ethical conflict between medical confidentiality and the duty to protect and inform an involved third party, who in this case is the patient's spouse. The central question raised by Bawaskar based on this case is, "Is it the physician's professional obligation to counsel the patient against marriage?" In this commentary, I will attempt to answer this question while also engaging with the ethical conflict in this case and what issues may arise if the physician had indeed considered revealing information to the patient's partner against the wishes of the patient. I engage on the concept of "harm" to discuss the moral scope of the duty to warn an involved third party and when it is justified to breach confidentiality of the

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patient. Based on the ethical analysis, I conclude that, in this case and in analogous cases, healthcare professionals should not breach the confidentiality of patients and should uphold it as the basis for trust within the doctor-patient relationship. Further, I state that it is part of their professional obligation to advise and provide psychosocial care through counselling to ensure comprehensive care.

Keywords: Confidentiality, duty to warn, harm, trust, patient's and family member's interests

On confidentiality and protection of a third party

One of the central values of medical practice is confidentiality, which serves to preserve trust within the doctor-patient relationship. The major reason to preserve confidentiality is that medical information is private and disclosure to unauthorised persons can harm the interests of the patient, often leading to stigma, loss of job and housing. The patient-physician relationship is built on trust, breach of confidentiality undermines it and damages the relationship and interferes with the treatment (2). The duty to patient confidentiality has been well acknowledged and is upheld by the international community, medical councils, and guidelines. The view that confidentiality should never be broken, that it is absolute or unqualified confidentiality, has been argued as being central to protecting the vulnerable (3, 4). However, many scholars have agreed that confidentiality may be breached when maintaining it could result in serious harm to a third party (5–8).

The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. (hereinafter Code of Ethics) (amended upto October 8, 2016) (9), formulated by the Medical Council of India (MCI), upholds confidentiality. However, this duty is not considered absolute and it advises doctors to consider weighing the benefits of breaching patient confidentiality against their duty to society. Clause 2.2 of the Code of Ethics, explicitly states that "a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidence as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would wish another to act toward one of his own family in like circumstances." Further, the Supreme Court of India in *Mr X v Hospital Z*, 1999, discussed the scope of a blood donor's right to privacy of his medical records (10). The doctors, in this case, had disclosed, without obtaining permission from the donor, his HIV- positive status to the donor's fiancé. The court highlighted that the doctor-patient relationship allowed certain exceptions where "public interest would override the duty of confidentiality, particularly where there is an immediate or future health risk to others". Extending this rationale, the Supreme Court further reasoned that a patient with HIV "cannot marry". Later, acting on a petition in 2002, the court issued a clarification in the Hospital Z case, where it held that the right to privacy of the patient with HIV were not violated by the doctor; however, the clarification restored the right to marry to persons with HIV (10). Thus, it is clear that there are indeed exceptions to confidentiality and that it is not an absolute ethical principle or value in present day clinical practice. Some scholars have emphasised the moral duty of clinicians to inform sexual partners of HIV patients of their health status, and suggested that comprehensive community health programmes should consider both the policies for patient confidentiality and partner notification (11).

The ruling in the landmark Tarasoff case (12) , cited by Pandya in his commentary on Bawaskar (13), has influenced much of the ethical and legal debate around confidentiality and protection of a third party. In this case, a student had disclosed to his psychiatrist his intention to kill his former girlfriend, Tatiana Tarasoff. The psychiatrist informed the campus police, but did not inform the girlfriend, in order to maintain patient confidentiality. Later, the student killed Tarasoff. The Tarasoff family subsequently sued the university, stating that the doctor did not protect their daughter. The ruling holds that the obligation of confidentiality should give way when a doctor is aware that a patient may seriously injure some identified other person (3). Thus, the duty of patient confidentiality could be overridden by the "duty to warn" third parties. While the scope of the Tarasoff ruling has been questioned, most accept the moral duty to warn parties at risk (14). The Tarasoff case has been instrumental in setting standards for disclosure in infectious diseases and genetic testing. However, it has been subjected to critical debate.

The case of the uninformed spouse involves a patient who was diagnosed with grade IV glioblastoma multiformy before his marriage. The patient and his family hid this information from his soon-to-be partner and continued to do so well after the marriage. A few years into the marriage and when she was pregnant, the spouse became aware of the patient's condition and she confronted the doctor: as to "why he had not counselled the patient against marriage"(1). Though there is no explicit discussion in the case study regarding the ethical dilemma or tension between maintaining confidentiality on the one hand, and informing the partner about the diagnosis on the other, this case presents us with an ethical challenge along with the opportunity to build practical suggestions for patient-family-physician disclosure practices by negotiating the ethical tensions. Given the lack of certain facts provided in the case study, in my analysis I presume that counselling of the patient and family members on treatment and overall psychosocial care needed for a cancer patient and his family members was not provided. Further, I assume that the surgeon was aware of the patient's marital status during the treatment after the patient's marriage, as he was continuing his treatment with the same surgeon.

Does the "harm" justify the breach of confidentiality?

Though there is a consensus on justifying the breach of confidentiality in order to warn third parties who could suffer direct harm, the ethics and the justification of breach of confidentiality and the duty to warn should be treated differently in different cases. This is well established, particularly in the instance of infectious diseases such as HIV and TB,

and genetic testing and risk disclosure. In the eventuality that an HIV- positive patient does not want their partner to be informed, it has been recommended that the physician should override the patient's right to confidentiality and inform the partner to protect them from possible harm. This is justified because, the harm that results from breaking the confidentiality does not outweigh the expected harm to the partner (15: pp 305-12). Similarly, it is applied to cases of child abuse, contagious diseases, and treatable genetic findings (16, 17).

The case of the 'uninformed spouse' does not neatly fall into any of the previously categorised cases wherein breach of confidentiality has been justified. Here we need to engage with the ethical question whether the duty to warn, or rather, the duty to inform the partner sufficiently justifies the breach of the patient's confidentially? If the doctor does not inform, as has occurred in this case, is the physician ethically accountable for disregarding the duty to protect the partner from possible "harm"? The harm principle or vulnerability principle is an established ethical principle which states that "interference with an individual's freedom can be justified when there is a likelihood of harm to others" (2: p 7). It seems reasonable to state that the patient's decision not to inform the partner about the diagnosis, before or after marriage, is morally incorrect regardless of his reasons and value system. This decision could have an extremely negative impact on his partner's overall psychosocial well-being, and could lead to constraining the partner's decision-making abilities with regard to marriage choices and reproductive choices. Finally, the deception could lead to the partner losing status within the patriarchal society without her having had a say in it. Furthermore, the diagnosis of manifest malignant brain tumor, reduced quality of life during treatment, and the high risk of mortality, directly affect the partner too.

The dilemma in this case is that it is not clear if the duty to prevent "harm" to the partner sufficiently outweighs the duty to protect patient confidentiality. In other words, the harm principle requires that there be a significant threat to life or serious health risks to a third party that can justify the breach of confidentiality (2, 15). An in-depth analysis defining "harm" and what counts as serious "harm", its ethical analysis, the disclosure practices, and "duty to warn" would be an interesting study in and of itself. However, I would like to note here that the harm principle is based on certain assumptions of "harm"(18), wherein, what counts as "harm" to one person or group or culture, may not be considered similarly by others, as the assumption is built on subjective understandings within socio-economic, cultural, and political contexts. For instance, social and economic harm can be considered as equally important as psychological or physical harm, as it is based on one's application of the varieties of welfare or harm (18, 19).

Doctors need to balance maintaining confidentiality in order to respect the autonomy and privacy of patients against the competing ethical claims of involved third parties, often family members in order to protect them from possible harm (20). In order to protect the family member from harm, information may have to be released which could violate the patient's confidentiality and privacy. In order to provide guidance to protect third parties from harm, we can begin with the current framework and guidelines of disclosure of information in instances of infectious diseases and genetic testing. Within these guidelines it is argued that physician can and should inform third parties or the partner who may be affected, as it can reduce overall harm. Thus, the obligation to maintain patient confidentially diminishes when withholding information can affect the health or cause serious harm to a third party. It is also argued that in the case of genetic testing, physicians can inform third parties who may be at risk, as it can ameliorate the possible harm by providing choices on their lifestyle, reproductive plans etc. However, there are debates around who should disclose information to the involved third party with regard to genetic testing, whether it should be the patient or the physician (20, 21). With regard to infectious disease like HIV/AIDS in India, it is the treating physician's obligation to inform the partner of the patient, though they need to inform the patient before disclosure. If the patient refuses to waive confidentiality with respect to their partner, the physician should inform the identified sexual partner (22: Chap IV, cl 9). In the case of the uninformed spouse, we cannot rely on the established ethical guidelines built around infectious diseases or genetic tests, as in this case, the patient's brain tumor is not infectious and it is not a hereditary disease. Therefore, there is nothing that can directly harm a third party or family members' or put their health at risk.

Hence, rather than focussing on ethical guidelines on breaching confidentiality in instances of genetic testing or infectious diseases, it will be helpful if we understand the duties of disclosure involving threats of harm. As discussed earlier, the Tarasoff case argues for disclosure to third parties in situations where a patient refuses to warn the concerned third party who may be at immediate risk or harm. Tarasoff and the case of the uninformed spouse are not perfectly analogous, as the present case does not involve imminent "harm" or "threat" or "risk" to the partner as discussed in the Tarasoff case. Further, in order to understand the moral scope of this "duty to warn (or inform)" an ethical analysis that justifies this duty is required. Sulmasy (14) presents seven factors which could help guide physicians to consider when duties to third parties should prevail over the duty to maintain patient's confidentiality. He mentions that the more powerful each factor is, the stronger becomes the need to warn or inform the third parties. They are "as follows: (1) the gravity of the harm; (2) the probability of the harm; (3) the identifiability of the victims of the harm; (4) the imminence of the harm; (5) the probability that an intervention can mitigate the harm; (6) the degree to which means other (sic) of breaching confidentiality have been exhausted; and (7) whether the patient himself or herself is the agent of the harm."(14)

In the case of Tarasoff, involving a psychotic murderer, and in the case of a non-compliant HIV- infected patient, the potential harm flows from the patient. If the physician has exhausted

all the ways of convincing the patient to warn or inform the directly involved third parties or partners, there are sufficient grounds to breach confidentiality. Informing involved third parties is also accepted as a moral duty in the case of genetic testing (20). This leaves us with the question, in the case of the uninformed spouse, whether the potential harm in this case justifies the duty to warn or inform the partner. Given that the gravity of harm to the partner may not be considered "grave" as per the set of established guidelines and framework, as the harm is not imminent, and the life or health of the partner is not put at risk, the duty to warn or inform without the consent of the patient is not justified. However, the overall psychosocial well-being and quality of life of the partner is at stake. There also exist other means of intervening, such as advising the patient to inform the partner about the diagnosis, its implications and the care it would demand for the overall care of the patient during treatment. The physician, in this case, had not considered this option as part of his professional responsibility to provide a certain standard of care. It is recognised that a patient's cancer experiences should be understood within a social and family context, and it is advised to consider psychosocial care of patients and families to provide comprehensive cancer care (23, 24).

Advancing psychosocial care: Involving both patient and family members

Given that there is no clear guidance on professional standard of conduct, as illustrated in the case wherein it is mentioned that different physicians follow different standards of consultation and counselling, one significant response may be that in cancer care, which requires family support for the treatment and care of the patient, it is an important professional responsibility to advise or inform patients about the need to discuss or disclose information to family members. Ideally, active caregivers may be included as part of the treatment care consultation process, which can be before or after the diagnosis or during the treatment by discussing with the patient. Thus, as Bawaskar (1) mentioned, counselling can be part of the consultation process. However, I would disagree that the doctor should be involved in personal decisions and life choices of the patient, such as counselling against marriage. Marriage is a natural right that every individual possesses, and the doctors should not be interfering or advising on the personal choices of the individual out of social concern, especially within an asymmetric power relationship between doctor and patient. The surgeon has no "duty to counsel" on marriage and other personal life choices unless the patient asks for their medical advice on such matters. The surgeon may also refer the patient to seek further psychological care. Even if the surgeon knew that the patient was planning to marry, the surgeon cannot counsel against marriage, however if the patient demands counselling the surgeon has the duty to provide the necessary care as it is part of the professional obligation to provide comprehensive care. The focus of counselling and consultation should be on the implications of the diagnosis, what it means to the patient and family members or fiancé, and discussion regarding the inclusion of family members in the overall care of the patient and family members' well-being and interests. This is particularly important as the patient may be in need of emotional and psychological support from family members, and in particular, the partner or spouse. There are many studies which suggest that during cancer treatment, anxiety, depression, distress, and sexual disorders will affect the patient-partner relationship, which in turn affects the patient's care and treatment (25–27). Thus, the inclusion of family members in the consultation process enables overall holistic care for the patient's psychosocial well-being.

Rather than delve into the theoretical discussion on applying unqualified confidentiality or qualified confidentiality here, I emphasise that practical methods such as consultation and psychosocial counselling would provide comprehensive cancer care. Thus, the ethical principles involved here have a practical value, given that every principle has certain exceptions or needs negotiation. Given that recent debates over the treatment of cancer patients acknowledge the value of psychosocial care of patients and their family members, it is relevant for physicians to include and care for family members by involving them in the consultation and counselling process. This will help reduce their distress, depression, anxiety, post-traumatic stress, and demoralisation. Various studies have established that the experiences that cancer patients have to deal with during the illness and the psychological aspects of suffering from cancer have a strong emotional effect, and that patients would need family support to cope with them (28). Thus, as part of the standard care, the assessment of the emotional concerns of the patients and close family members who may be caregivers, should be part of every clinical encounter by healthcare professionals (23). Further, the responsibility extends to addressing the concerns of the immediate family members. For instance, it is important to provide consultation and counselling on how to deal with depression and anxiety, and increased emotional distress with the patient and caregivers during different stages of cancer care. In the case of possibility of death, family members need to be informed to help them prepare for and manage their trauma and grief.

Conclusion

In the case of the uninformed spouse, the physician should have acted as a facilitator and should have provided consultation and counselling while considering both the patient's and the family members' interests at large. I conclude that in this case, the surgeon was right to avoid breaching of confidentiality. However, as part of the counselling process, the surgeon should have discussed the implications of not disclosing information to the partner. In such cases, physicians can enhance the care and interests of the patient by considering the partner as an active caregiver and by encouraging the patient to involve the partner in the consultation. This would alleviate the psychosocial stress of the partner and such forms of harm. Thus, the physician could have carried out the consultation and counselling, involving the

partner as well, as part of their professional duty rather than considering it, as in the present case, as lying beyond their duty.

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References

1. Bawaskar H. Can doctors advise beyond the purely professional? *Indian J Med Ethics*. 2019 Jul-Sep;4(3) NS:209-10. DOI: https://doi.org/10.20529/IJME.2019.035
2. Macklin R. HIV-Infected psychiatric patients: Beyond confidentiality. *Ethics Behav*. 1991;1:3–20. doi:10.1207/s15327019eb0101_2.
3. Kipnis K. A defense of unqualified medical confidentiality. *Am J Bioeth*. 2006 Mar-Apr;6(2):7–18. doi:10.1080/15265160500506308.
4. Kipnis K. A defense defended. *Am J Bioeth*. 2006 Mar-Apr; 6(2): W32-W34. doi:10.1080/15265160500506407
5. Robertson C. The consequences of qualified confidentiality. *Am J Bioeth*. 2006 Mar-Apr;6 (2):31–2. discussion W32-4
6. Duncan RE, Newson AJ. Clinical genetics and the problem with unqualified confidentiality. *Am J Bioeth*. 2006 Mar-Apr;6 (2):41–3. discussion W32-4.
7. Hodge JG. The legal and ethical fiction of "pure" confidentiality. *Am J Bioeth*. 2006 Mar-Apr;6(2):21–2. discussion W32-4
8. Bennett R, Draper H, Frith L. Ignorance is bliss? HIV and moral duties and legal duties to forewarn. *J Med Ethics*. 2000 Feb;26(1):9 LP – 15. doi:10.1136/jme.26.1.9.
9. Medical Council of India. The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Code of Ethics Regulations, 2002. New Delhi: MCI; 2002, amended up to Oct 8, 2016. Available from:https://old.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulations2002.aspx.
10. Krishnan J. The Rights of the New Untouchables: A Constitutional Analysis of HIV Jurisprudence in India. *Hum Rights Q*. 2003 Aug;25(3):791–819. doi:10.1353/hrq.2003.0034
11. Abraham S, Prasad J, Joseph A, Jacob KS. Confidentiality, partner notification and HIV infection. *Issues Med Ethics*. Reprint. 2002 Jan-Mar;10(1).157-60. Available from: https://ijme.in/articles/confidentiality-partner-notification-and-hiv-infection/?galley=html
12. Supreme Court of California. *Vitaly Tarasoff et al, Plaintiffs and Appellants, v Regents of the University of California et al, Defendants and Respondents.* 551 P.2d 334 (Cal. 1976). Available from: https://scocal.stanford.edu/opinion/tarasoff-v-regents-university-california-30278
13. Pandya SK. Confidentiality vs harm to another. *Indian J Med Ethics*. 2019 Jul-Sep;4(3) NS:211. DOI: https://doi.org/10.20529/IJME.2019.036
14. Sulmasy DP. On warning families about genetic risk: The ghost of Tarasoff. *Am J Med*. 2000 Dec 15;109(9):738–9.
15. Beauchamp TL, Childress JF. *Principles of biomedical ethics*. New York: Oxford University Press; 2001.
16. Gibson E. Medical confidentiality and protection of third party interests. *Am J Bioeth*. 2006 Mar-Apr;6(2):23–5. discussion W32-4.
17. Baker R. Confidentiality in professional medical ethics. *Am J Bioeth*. 2006 Mar-Apr;6(2):39–41. discussion W32-4.
18. Holtug N. The harm principle. *Ethical Theory Moral Pract*. 2002 Dec;5(4):357–89. doi:10.1023/A:1021328520077.
19. Hanser M. The Metaphysics of Harm. *Philos Phenomenol Res*. 2008;77:421–50. doi:10.1111/j.1933-1592.2008.00197.x.
20. Doukas DJ, Berg JW. The family covenant and genetic testing. *Am J Bioeth*. 2001Summer;1(3):2–10. doi:10.1162/152651601750417784.
21. Hallowell N, Foster C, Eeles R, Ardern-Jones A, Murday V, Watson M. Balancing autonomy and responsibility: The ethics of generating and disclosing genetic information. *J Med Ethics*. 2003 Apr;29(2):74–9.
22. Ministry of Law and Justice. The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control)Act, 2017. New Delhi:MoLJ;2017. Available from: http://naco.gov.in/hivaids-act-2017.
23. Northouse L, Williams A, Given B, McCorkle R. Psychosocial care for family caregivers of patients with cancer. *J Clin Oncol*. 2012 Apr 10;30(11):1227–34. doi:10.1200/JCO.2011.39.5798.
24. Pascoe SW, Neal RD, Allgar VL, Selby PJ, Wright EP. Psychosocial care for cancer patients in primary care? Recognition of opportunities for cancer care. Fam Pract. 2004 Aug;21(4):437–42. doi:10.1093/fampra/cmh415.
25. Badr H, Taylor CLC. Social constraints and spousal communication in lung cancer. *Psychooncology*. 2006 Aug;15(8):673–83. doi:10.1002/pon.996.
26. Ben-Zur H, Gilbar O, Lev S. Coping with breast cancer: Patient, spouse, and dyad models. *Psychosom Med*. 2001Jan-Feb;63(1). 32-9. Available from: https://journals.lww.com/psychosomaticmedicine/Fulltext/2001/01000/Coping_With_Breast_Cancer__Patient,_Spouse,_and.4.aspx.
27. Morgan MA, Small BJ, Donovan KA, Overcash J, McMillan S. Cancer patients with pain: the spouse/partner relationship and quality of life. *Cancer Nurs*. 2011Jan-Feb;34(1):13–23. doi:10.1097/NCC.0b013e3181efed43.
28. Rubin G, Berendsen A, Crawford SM, Dommett R, Earle C, Emery J, et al. The expanding role of primary care in cancer control. *Lancet Oncol*. 2015 Sep;16(12):1231–72. doi:https://doi.org/10.1016/S1470-2045(15)00205-3.