Navigating Ethics of Physician-Patient Confidentiality: A Communication Privacy Management Analysis

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Abstract

The ethics of physician-patient confidentiality is often fraught with contradictions. Privacy boundaries are not always clear, and patients can leave an interaction with their physicians feeling uncomfortable about the security of their private medical information. The best way to meet confidentiality and privacy management expectations that patients have may not be readily apparent. Without realizing it, a physician may communicate a patient's information in ways that are inconsistent with that person's perceptions of how his/her medical information should be treated. A proposed model is presented as a tool for physicians to better serve the privacy and confidentiality needs of their patients. This model depends on the communication privacy management (CPM) perspective that emerged from a 35-year research program investigating how people regulate and control information they consider private and confidential. A physician's use of this model enables the ability to establish a confidentiality pledge that can address issues in understanding the best way to communicate about privacy management with patients and more likely overcome potential negative outcomes.

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I am a patient in a special unit where the staff have meetings every week. They discuss the test results and whatever they want to discuss. You sort of find out along the way. They don't tell you what goes on, but you get second-hand information. The nurse will come back and say: "At the meeting the doctor said this … ." I don't like them discussing me behind my back.[1]

Confidentiality in medicine involves a careful balance of respecting patient autonomy, the duty to warn, protecting confidential patient information, and soliciting appropriate disclosures.[2–4] For each issue, there are fundamental ways that communication is instrumental in traversing the management of confidential private information. Sharing patient information is important to leverage the power of collaboration between the physician and relevant medical team members. Patients often do not understand the full implications of why sharing their private medical information is vital to their care. Although managing confidentiality is guided by ethical and legal principles, many ambiguous situations still arise in the course of patient care, leading to predicaments in privacy management.[4–7]

Research shows that managing privacy boundaries is a delicate balancing act.[6,7] If the regulation of privacy and confidentiality in medical encounters is conducted without consciousness, awareness, and curative intention, the outcome can be counterproductive for patients and physicians, with the potential to compromise ethical and care standards.[8]

Communication Privacy Management and Patient-Physician Relationship

Communication privacy management (CPM), is a theoretically driven perspective derived from a 35-year social-behavioral research program investigating how people manage private information.[7],[9] In this report, the CPM perspective is applied to better understand the basis for ethical predicaments in confidentiality between patients and physicians. Briefly, CPM argues that managing privacy and confidentiality means navigating between the need for autonomy and the need for connectedness with others. Navigating is necessary because people want to take others into their confidence (granting access), yet desire to keep a measure of autonomy and privacy (resulting in concealing or protecting information). CPM uses a privacy boundary metaphor representing where private information is located and identifies how the privacy management system operates.

In considering the physician-patient relationship within the CPM perspective, physicians have potentially two privacy boundaries they regulate with patients. They have their own personal privacy boundaries and judgments about situations where personal disclosures are made to patients. Physicians also serve as guardians or co-owners of their patients' private medical information and are included within the patient's privacy boundary surrounding that information. As co-owners, physicians have a complicated role in that they have to make decisions about issues such as the best treatment plan or a prognosis on the basis of information they gather from tests, and they must deliver that information to the patient. In doing this, physicians often have to judge when to share information with the patient about his/her case, how much to share at any given stage of treatment, what to share, and who else to tell about the patients' confidential medical information. Because the medical information belongs to the patients, they feel that the physicians' choices about these issues necessarily need to include conversations with them.[5] The reason these issues arise is illustrated in the evidenced-based principles of CPM theory. There are three main CPM principles: 1) privacy ownership, 2) privacy control, and 3) privacy turbulence.[7],[9],[10]

Privacy ownership refers to the fact that people believe their private information belongs to them and they *own* the right to control access to that information. When "original" owners grant access, they create authorized co-owners or confidants who are expected to act responsibly by fulfilling the original owner's expectations for third-party access. Physicians are granted authorized co-ownership or guardian status by patients so that they can administer medical care.

Privacy control defines the system that regulates access and protection of privacy boundaries surrounding information considered personal and within an individual's jurisdiction to regulate. Privacy control is enacted through using privacy rules that regulate access and protection; for example, a patient might say, "I talk only to my doctor about my HIV status and no one else."

Privacy rules are developed on the basis of motivations, assessments of risks and benefits, orientations toward privacy, and situational demands. Thus, needing to trust a physician to gain health care can motivate a patient to reveal information. For the patient, granting access likely includes judging risks and benefits of allowing complete or partial access. Nevertheless, when the patient discloses information, the physician becomes an authorized co-owner or guardian and, with that, comes an implied expectation that the physician will "care" for the information in the way the patient expects. If these expectations about responsible treatment of the information are violated, *privacy turbulence* results in the physician-patient relationship.

Personal-Professional Boundaries in Confidential Physician-Patient Relationships

Whereas the physician's confidant role is professionally, ethically, and legally guided, it is also determined by the interface of the physician's own privacy rules—about maintaining personal and professional boundaries—with individual patient privacy rules. Stemming from professional training, physicians develop their own set of privacy rules and management strategies to regulate their emotions and personal information.[11],[12] Physicians learn ways to keep their feelings within their own privacy boundary and under their own control. By using an effective privacy regulation process, physicians are able to protect their own privacy while maintaining a professional physician-patient boundary in the name of objectivity. Having a clear sense of demarcation between the personal and professional is necessary and can afford a physician the ability to better serve in the role of confidant for patients.

The road to effective navigation of both patient and physician privacy boundaries may be predicated on the physician's ability to learn how to be more reflective about communication in patient care.[12] From the literature, we find that physicians trained to have a greater awareness of

where boundary lines can become blurry—particularly with emotional objectivity and empathy—are more able to communicate effectively.[12],[13] Physicians' sharing personal emotions, concerns, and experiences can have both positive and negative effects on the physician-patient relationship. Consequently, the judgments made need to rely on clear guidelines with sensitivity to the impact that sharing (ie, crossing a privacy boundary) and not sharing have for the process of patient care.[12]

Blurring Privacy Boundaries in Physician-Patient Relationships

Both patients and physicians encounter privacy management predicaments. When physicians make inappropriate or unrelated personal disclosures to patients, the patient may feel baffled about the confidant's role a physician is playing. A study found that more often than would be expected, primary care physicians tend to disclose unsolicited and contextually irrelevant personal information to their patients.[14] McDaniel et al[14] found that 85% of primary care physicians made such disclosures that had little to do with the patients' cases. Interestingly, this research also shows that after physicians disclosed, patients did not necessarily turn the conversation back to the reason they were seeking medical care; nor did the physicians. Furthermore, patients did not find that the physician's disclosure was helpful in any way.

> **A *confidentiality pledge* advocates that patients and physicians openly discuss the ways patients want their information treated.**

Receiving disclosures of a personal nature from physicians may put the patient in an awkward position. There is an embedded expectation of responsibility for the patient as the physician's confidant. Consequently, unless the disclosure is contextually relevant to the patient's case or can potentially be used therapeutically, a physician's personal disclosure can compromise the ability to establish a professional trusting relationship with the patient.[6] For example, if physicians reveal their personal marital problems when listening to a patient's description of medical issues affecting his/her marriage, the patient might feel compelled to comfort the physician.[15] In these situations, an implicit confidentiality promise that patients often assume between themselves and

physicians becomes reversed and the patient is the confidant with implied responsibilities to the physician.

However, disclosures reinforcing concepts that focus on taking the perspective of the patient can have a powerful impact on how privacy boundaries are regulated. Reinforcing concepts such as *normalcy* (eg, "Your concerns are not uncommon; many of my pregnant patients have the same fears"), *empathy* (eg, "I share your frustration that we have not been able to adequately manage your pain, but we are committed to finding a solution"), and encouraging *hope* (eg, "I know quitting smoking is difficult because I've done it, and I believe when you are ready, you will too") can facilitate effective disclosure for the physician, maintain a useful relationship, and positively influence health outcomes.

Considering these issues speaks to the importance of locating expectations about managing confidentiality and reflecting on how role shifting can disrupt the patient's assumptions about physician behavior when in a confidential medical relationship.[12],[14] Explicitly inquiring about the patient's expectations concerning how private and confidential information will be managed sets the path to increasing trustworthiness and the ability to actively attend to the patient's desires for privacy management. Doing so also helps to guard against the possibility of mistaking where the borders are between the professional and the personal boundaries.

As this report transitions into presenting a confidentiality negotiation system, it is important to make note of the position on privacy taken in this article as compared to the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA).[16] Whereas HIPAA is geared toward providing legal parameters, this essay goes beyond the borders of biomedical intent stipulated by the act. Instead, the argument here focuses on learning how people talk and interpret messages in building relationships concerning regulating their confidential private information.

Confidentiality Negotiation System: Differences Navigated

Physicians and patients operate on a different set of assumptions about how the health care system works. For physicians, navigating in the health care system is part of their daily routine. Physicians rely on the admission process and paperwork to outline requests for private

information that, for them, is normative. Patients understand they must provide access to their private medical information, but they have less experience with this system than do the physicians. Furthermore, patients uniformly do not believe all their private information somehow belongs to and should be shared with the physician.[15] The incommensurate experiences that the patient and physician may have illustrate underlying issues that can result in miscommunication and violated expectations for privacy management. The outcome can lead to what CPM refers to as "privacy turbulence." Because of these miscommunications, trust may be damaged and difficult to restore.

Physicians must be equipped with effective ways to overcome barriers and to negotiate useful privacy decisions. Through training, physicians can improve their understanding of the patient's privacy orientation and learn new ways of negotiating an agreed-on set of privacy rules to better serve the patient's needs. The five-point model and case study application discussed in the next section illustrate key aspects of confidentiality negotiations, with the goal of establishing a CPM *confidentiality pledge.* This model is geared to quickly identify the main points of discussion for physician-patient interaction about confidentiality. Obviously, the length of time invested depends on an individual physician's needs and desires regarding the extent of implementing the model.

Communication Privacy Management Confidentiality Pledge Model

A *confidentiality pledge* advocates that patients and physicians openly discuss the ways patients want their information treated. Constructing this pledge seems best used in an initial face-to-face interaction with the patient as the physician is becoming familiar with the case. In this way, going forward from this initial encounter, the physician is illustrating a level of care and concern for the patient's wishes regarding information considered private. Doing so creates a heightened sense of trust for the patient. Likewise, the pledge also raises awareness of where there are privacy boundary lines for both physician and patient, thus thwarting breaches of confidentiality that can lead to negative outcomes in patient care. A patient's reluctance to engage in conversations about protection of his/her confidentiality may clue the physician into the level of

trust or lack thereof that a patient is feeling. In addition, not wanting to share private information may signal other potential problems that could be related to the patient's condition. Considering these possibilities likely helps the physician recognize more attention is needed to unearth the reasons a patient feels reluctant. The basic model can serve as a template to pursue a more in-depth discussion if necessary.

The proposed model gives a clear and concise vision of how to address these problems before they become obstacles, thereby increasing the potential for beneficial patient care.[17] As Table 1 illustrates, using the CPM Confidentiality Negotiation System to develop a confidentiality pledge can be achieved with a five-point model that asks *who, what, where, when,* and *how.*[7] This model shows how to discern ways in which patients define the disclosed medical information as confidential. In addition, it identifies where the borders are located in patients' privacy boundaries surrounding confidential information and aids in judging the level of needed control that patients want over their information. Furthermore, the model sets parameters for areas most likely to concern confidential information, namely, seeking permission to tell information, and creating informational co-owners or shareholders (eg, clinicians, team members and other personnel, family members, and friends). The model also identifies circumstances in which the patient and physician negotiate protection of and access to information, including how, when, and why information might be protected or granted access. Doing so communicates an understanding of rights of ownership (in personal, not necessarily legal terms), granting the ability to exercise control over the information when someone else (eg, the physician) is given license to make the decision on the patient's behalf.

Table 2 provides a teaching hospital's case study analysis to illustrate how a physician might negotiate a confidentiality pledge with patients. This case illustrates the way a physician could open the door for patients to express concerns or expectations they have, by describing practices and policies of sharing patient information among medical staff. In turn, patients are invited, through conversations with the physician, to articulate boundaries for information they do or do not want shared with others, such as certain family members. Likewise, physicians are able to get a better understanding by inviting patients to voice expectations and confirm an understanding of how their information should be managed. These conversations help frame an agreement about the expectations for confidentiality that align physician-patient understandings of how personal

and confidential information is handled. By opening the discussion to patients' questions, concerns, amendments, and issues surrounding how best to treat confidential information, the physician prevents the possibility of ethical questions in the future. Physicians can proactively address these matters, decreasing the potential for patients' surprises and anger about how their information is shared.

A confidentiality pledge with patients can produce a clear and efficient mutual understanding between the physician and patient for how private and confidential information is handled and delivered.[7] Thus, documentation of a negotiated written agreement identifying how the patients believe their information should be managed and the information they define as confidential generates a confidentiality pledge. The general scope of that pledge can easily be integrated into the physician's medical history discussion during an initial visit with the patient. In today's world of electronic medical records, such a pledge may more likely be used if it were found early in the record, perhaps in the problem list, associated with the demographic information or with other documents such as a do-not-resuscitate order.

Conclusion

An examination of the way that a physician's role as confidant is defined captures the relational complexity of decision making where a patient's privacy management is concerned. Accordingly, when physicians and patients jointly articulate privacy management expectations and negotiate a mutually agreed-on set of privacy rules for patient information, it sets clear parameters. In addition, doing so may also make physicians mindful about their own privacy boundary management with patients. Use of the model to establish a confidentiality pledge can help solve some implicit problems in understanding how to communicate about privacy management with patients and can overcome potential negative outcomes.

Disclosure Statement

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Table 1

Communication privacy management confidentiality negotiation system

Question	Physician perspective	Patient perspective
Who? Identification of physician and medical treatment team	Name and describe the main team members for the patient (eg, physician partners, nurses, physician assistants, residents, medical students). *Discuss general policies of information sharing.*	Ask the patient who s/he sees as individuals who should know about his/her medical information. Who is the patient willing to accept as part of his/her treatment team and why?
Why? Discussion of confidentiality	Indicate the importance for the physician-patient relationship to know how the patient is thinking about protection of and access to his/her medical information.	Determine who the patient considers part of his/her health care team and why (eg, a family member). *Ask about rules for disclosure of private information for each of the people the patient names (eg, mother).*
What? Roles and functions in information sharing	Explain what the role and function of each member of the medical team is and why that person's role is important to the patient's treatment. *Discuss parameters for information sharing for each member.*	Establish what role or function of sharing information the patient is willing to allow for each team member playing a part in his/her care. *Ask about the patient's information access and protection rules and determine why they exclude certain people.*
Where and when? Sharing of patient's private medical and personal information	Identify where, when, and how a patient's confidential information will be necessarily shared and with whom (eg, team meetings). *Discuss circumstances when information will likely be shared and why, the typical times information will be shared, how the information will be communicated (eg, electronic medical records), and individuals likely to be told.*	This step is part of discerning the patient's privacy rules for disclosure and protection. S/he will tell you how s/he wants his/her information shared, when, and with whom, or how s/he wants the information protected. This step includes family members, friends, ex-spouses, and others the patient may or may not want to know his/her information. *Ask the patient's preferences and have ready explanations for situations that s/he might identify that hamper the ability to provide good patient care.*
Negotiation Finding out and telling expectations for sharing and protecting patient information	Recognize that this is the opportunity for a discussion with the patient about information s/he owns and wants control over. Doing so shows respect and increases a sense of trust for the patient.	The physician's concern about a patient's sensitive information will increase patient confidence in the physician and lead to a better physician-patient relationship.

Table 2

Negotiated confidentiality: teaching hospital case example

Question	Sample comments by physician
Who? Identification of medical staff	Hi, Ms Jones. I'm Dr Smith, one of the partners in XYZ Clinic.
Why? Discussion of confidentiality	Before we talk about what brought you in, I want to discuss how we deal with the information you give me, things like your test results, and generally how we treat your information.
	We know what you tell us is private, but I would like to have a conversation about your feelings when it comes to involving others in knowing your information. We care about confidentiality and need your input.
What? Roles and functions in information sharing	Just so you know, we are a clinic with five physician partners and a nursing staff. Because we are affiliated with XYZ Medical School, we also have resident physicians and medical students.
	All of us would likely see your medical information because we are a team that is here to help you. Sharing your medical information gives us the ability to provide you the best kind of care.
	Any learners who are involved in your care follow the same legal and ethical standards we do to protect your confidential information.
	Any time your personal information is shared without you being present, it is kept strictly confidential.
Where and when? Sharing of information	So, we tell each other your progress by using chart notes, or on our confidential electronic medical record system, in meetings with each other, and discussions about test results, observations any of your medical team makes when they see you, as well as in talks with your primary care physician.
	Clearly, I want you to know that you can ask about who knows your information at any time.
What? Learning patient privacy rules	Now that I gave you a sense of how we keep your information confidential and with whom it might be necessary to share your medical information for your best care, I would like to know if this fits with what you expected to happen.
	You were asked to sign a HIPAA privacy form granting others permission to know your medical information. But I would like to have guidance about things such as the timing of telling a designated family member about medical tests.
	This is just an example of possibilities where I may not be clear about your information-sharing preferences.
	You may not really know all your preferences until you are presented with information about your condition. All this just means that I want you to know you can alert me to any ways you need me to keep your information confidential, even from family members.
	There may be times that I would not be able to comply with your privacy request, but I will try at every turn to remain respectful of your wishes in protecting your confidentiality in the way you want me to.
	At any time, feel free to outline your own concerns for how information is shared.
Reinforce	What questions or thoughts do you have about how we will handle your personal information, and are there issues we did not discuss that are important to you about your information?

HIPAA = Health Insurance Portability and Accountability Act