Limits of confidentiality: Disclosure of HIV seropositivity

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You are providing long-term follow-up to an HIV-positive patient on whom you operated several months ago. The patient is actively engaged in a sexual relationship with one of your colleagues. The patient admits that he has not disclosed his HIV status to his partner, and adamantly refuses to do so. Which of the following is your appropriate response?

A. Request an ethics consultation from your ethics committee or consultant.
B. Disclose out of personal loyalty to your colleague.
C. Respect professional confidentiality regardless of the circumstances.
D. Forget the matter. It has nothing to do with surgical therapy.
E. Ensure that your colleague is informed about potential exposure to HIV infection.

Principles are the foundations of intellectual constructs like medical ethics.¹ Respect for individual autonomy has been one of the core principles of medical ethics for decades. Confidentiality in the professional relationship is a duty derived from respect for the patient’s autonomy.² Confidentiality is also a function of beneficence, another of medicine’s basic ethical principles. The principle of beneficence obligates the physician to behave in a manner that can be reliably expected to result in net clinical benefit for people suffering from disease.¹ Physician-patient confidentiality is also utilitarian, in the sense that it encourages patients to be forthcoming in providing their physicians with an accurate history, particularly regarding personal issues that might normally be considered embarrassing or otherwise sensitive.² The strength of its foundation in two of medicine’s bedrock ethical principles, as well as its practical role in the diagnostically and therapeutically essential element of the medical history, tends to make the concept of physician-patient confidentiality nearly unassailable.

Nevertheless, none of the major physician organizations that have published comprehensive statements of medical ethics has claimed that patient confidentiality is absolute and should be applied without exception. The American College of Surgeons’ Statement on Principles requires that “the surgeon should maintain the confidentiality of information from and about the patient, except as such information must be communicated for the patient’s proper care or as is required by law.”³ Suspension of physician-patient confidentiality in compliance with law is easily understood, but what principles define the limits of confidentiality when potential harm to a third party is abetted by the physician’s silence? What is required to establish an ethically justified exception to one of medicine’s abiding principles?

The onset of the worldwide AIDS epidemic has been perhaps the single most transformative event in medical ethics during the last century. Conflict between the rights of the individual and those of the culture at large and its public health interest has been intensified as never before by the disease’s complex associations with sexuality, homosexuality, drug abuse, social stigma, high contagion, high lethality, extraordinary treatment costs, worldwide epidemiology, and containment strategies. Ethical analysis typically attempts to identify and recommend right action without imposing burdens that either side of a debate will find unjustly intrusive. The unique paradoxes of the HIV-AIDS epidemic persistently challenge the practical application of this principle.

HIV-associated diseases have only recently been transformed from uniformly lethal to chronic conditions somewhat susceptible to long-term medical management, though treatment is notoriously expensive, rife with complications, and not universally available. Whereas two decades ago nondisclosure of one’s HIV-positive status to sexual partners or others exposed to transmission routes put them at unknowing risk of death, nondisclosure now represents imposed risk of serious, chronic, life-shortening infection and all its attendant societal, financial, and personal encumbrances. Which of the two is more desirable must be left to the judgment of the sufferer. As Pinching has suggested, “The infection is so intensely private in its
transmission, the disease so isolating and so personally devastation in its impact, it readily distinguishes the reality of what people are and do, from the rhetoric of what others feel they should be and do.4

Refusal to disclose HIV+ status is not uncommon. A 1998 study showed that 40% of HIV+ patients did not inform sexual partners of their status, and 57% of those engaged in unprotected sex.5 Surreptitious transmission of the virus remains a major public health hazard. Though many states have recently passed laws subjecting such transmitters to felony indictment, prosecution is considerably rarer than the offense. The bioethical endorsement of a duty to warn is not thought to require that health professionals actively investigate whether their HIV+ patients are putting others at risk. The duty applies only when health professionals are made aware that specific individuals are so imperiled.6

These considerations suggest that exceptions to physician-patient confidentiality are justifiable on the basis of precisely the two ethical principles that support it. The principle beneficence obligates the physician to desire and seek a beneficial outcome for those who suffer from disease. Particularly in the context of an epidemic, this desire and the actions required in its pursuit cannot ethically be confined to the patient now seated in the exam room to the detriment of all others. The physician is indeed obligated to provide treatment to the patient who has entrusted himself to the physician’s care, and to do nothing to worsen that patient’s medical condition, even if to do so might be of some conceivable benefit to the public health. Notifying the patient’s sexual partner of the sero-positivity will, however, do nothing to negatively affect your patient’s medical condition, and it will promote the principle of beneficence by potentially preventing disease transmission to your colleague. Particularly because of the high lethality and major functional impairment still associated with HIV-related diseases, you may furthermore be obligated by provisions of the Tarasoff rule to notify your colleague of the risk presented by this patient. This landmark California civil ruling found a mental health practitioner and his institutional employers liable when the therapist failed to notify an individual whom a psychotic patient threatened to murder during a therapy session. The Court ruled that the imminent danger to a specific person outweighed confidentiality considerations, writing that “the protective privilege ends where the public peril begins.”7

Respect for autonomy, the other pillar supporting physician-patient confidentiality, honors the right of each individual to decide his or her own best interest. The principle of informed consent is derived from this entitlement, and obligates physicians to advise patients of the risks as well as the benefits of a proposed therapeutic intervention so a patient can decide which path to take. Full disclosure of critical information is essential to implementation of this principle. Your patient is effecting depriving his partner, your colleague, of the right to personal autonomy by withholding critical information the partner needs to make a decision about whether and in what manner to continue their relationship. The patient’s deception, which in fact be felonious, creates no obligation for you to abet it. The same respect for autonomy you showed him during the informed consent process that preceded his surgery should properly be afforded your colleague in the face of a potentially life-altering medical condition.

The physician’s obligation in this case is therefore clear: the patient’s sexual partner must be promptly informed. Option C is therefore ruled out, because the ethical justifications for an exception to the confidentiality rule have been established. Option D is a dereliction of moral responsibility in this case, and should be rejected. Ethical consultation with a committee or ethicist should be sought when the physician is confronted with competing ethical interests not readily susceptible to conclusive analysis. Because a conclusion is available in the manner described here, Option A is not necessary. Option B should be dismissed because, though it points in the right direction, it does so for the wrong reason; the ethical justifications for protecting others in this case are beneficence and respect for autonomy as a matter of professional responsibility, not personal loyalty to a colleague.

The party with the greatest ethical responsibility in this case is the patient. He should be informed that he has an obligation to inform those he has put at risk, and that he must do so promptly. The physician can offer to assist in this process. If the patient agrees to accept his responsibility, the physician should advise him that the physician will be following up with the sexual partner in a short but reasonable time, perhaps 48 hours. If the patient refuses, the physician must act independently. Absent corrective measure by the patient, Option E is the most ethical course of action.

One final consideration is that physicians have been successfully sued for releasing information about patients’ HIV status.8 The possibility must be balanced against the equivalent risk of liability for failing to ensure that endangered third parties have been warned. The physician should be led by the ethical analysis, specifically to the conclusion that there is an inescapable ethical obligation to see to it that the HIV patient’s sexual partners are informed that they are at risk.

REFERENCES
7. Tarasoff vs Regents of the University of California 581 P2d 534 (1976) California Supreme Court.