New Concepts of Confidentiality in Family Practice

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Medical confidentiality protects the physician-patient relationship and ensures privacy so that intimate information can be exchanged to improve, preserve, and protect the health of the patient. The ethical and legal basis of confidentiality forms a conditional rather than absolute privilege, however, and numerous exceptions currently exist whereby third parties with a legitimate interest have access to patient information. Family medicine may now be another exception because its conceptual framework abandons the old model of treating just the individual and employs a more advanced model of treating both the individual and the family.

Using the argument that the treatment of a diseased individual really means treatment of the diseased family, traditional limitations on the scope of confidentiality need expansion. Critical information may necessarily have to be sought outside these limits for diagnostic purposes as well as successful treatment of family disease. At the initial visit, therefore, patients need to be informed that limited portions of confidential information may need to be shared with other members of the family, but that only information necessary and relevant to the treatment of the problem will be shared.

Maintaining confidentiality in the traditional sense presents a new problem, as the model for a family physician interacting with a patient has changed from physician-patient to physician-patient-family. In contrast with previous work in the family practice literature,[1,2] this paper will provide a historical description of the theories of confidentiality in the area of family medicine to support the concept of a patient's limited informed waiver. The radical implications of changing such a philosophy are illustrated by using the example of a deadly disease that potentially affects the family and carries a socially unacceptable stigma. The problem is developed by first looking at the purpose and importance of confidentiality using medical and legal models. The limits of confidentiality become more clear when specific exceptions are elucidated, but the new model for confidentiality based on the family practice philosophy tends to complicate already tenuous boundaries. An example of a medical condition illustrates arguments for and against keeping information confidential, and recommendations are made in an effort to help family physicians wrestle with this sometimes difficult area.

PURPOSE, IMPORTANCE, AND DEVELOPMENT OF CONFIDENTIALITY

The purpose of medical confidentiality is the protection of the physician-patient relationship; privacy of medical information has always been recognized as essential to the practice of medicine, yet the physician's role has been uncertain.[3] In testimony before a congressional committee, the American Medical Association (AMA)[4] put forth the basic case of medical confidentiality:

> Patients have every right to expect that the intimate, personal information communicated to physicians will remain private . . . confidentiality encourages patients to be candid with their physicians, and candor is essential to effective diagnosis and medical management of the patient's ailments.

Although patients have a right to expect privacy, the

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TABLE 1. MEDICAL DATA USERS*

1. Public health agencies
2. Medical and social researchers
3. Rehabilitation and social welfare programs
4. Employers
5. Insurance companies
6. Government agencies
7. Education institutions
8. Judicial process
9. Law enforcement and investigation
10. Credit investigation agencies
11. Accrediting, licensing, and certifying agencies
12. Media

*From Gellman[3]

definition does not imply absolute privacy.

The personal and private nature of confidentiality is also reflected in its legal definition:

> Privileged and personal information entrusted to another that shall not be divulged to a third party without the consent of the subject of the information. Personal information is considered to be any data that indicate things done by or to an individual or make it possible to infer a person's personal characteristics or behavior.[5]

The legal definition allows for at least two exceptions: information can be divulged either if consent is obtained or if the information does not implicate some private aspects. Privilege is actually conditional, making room for numerous other exceptions.

Confidentiality is important because it protects privacy, which is bound up with self-respect and personal integrity, and it makes possible, within the professional relationship, an exchange of information of an intimate kind aiding communication and providing a basis of trust between physicians and their patients' care.[6] Privacy is one form of supposed guarantee to a patient that he may disclose "even that which is embarrassing, disgraceful or incriminating"[7] to improve, preserve, and protect the health of the patient.

Obligations to respect the privilege of confidentiality have an ethical and legal basis. Ethical and legal obligations are based on the Hippocratic oath, which requires a physician to maintain confidential all information entrusted to him.[8] Violation of this principle may result in peer action from the medical society. Much of case law, albeit relatively scarce, has its basis on this ethical principle.

There is no doctrine of common law obliging a physician to hold confidential information entrusted to him by a patient, as exists in the relation between lawyer and client, priest and parishioner, and husband and wife. Further, there is no privilege of confidentiality under federal law. In response to this lack of protection and partly to support the ethical responsibility of the physician, individual states developed privileged-communication statutes applicable to court and quasi-court proceedings prohibiting physicians from disclosing information acquired in caring for their patients.

Outside the court, common law torts of defamation of character and invasion of privacy apply, and more recent developments using contract law provide even further regulation.[9,10] A cause for action, however, is frequently dispelled if the information is "true." The privilege to provide information that can potentially result in defamation (either libel or slander) is granted in numerous areas by medical data users (Table 1).

Invasion of privacy, another personal tort applying to confidentiality,[11] can be defined as freedom from unreasonable interference in one's personal affairs. In 1974 Congress enacted the Federal Privacy Act, declaring that informational privacy is a personal and fundamental right protected by the US Constitution. However, some believe the Freedom of Information Act does more than any other enactment in the last 50 or 60 years to end privacy by increasing exceptions to confidentiality.[12] As is true of the tort of defamation, the gradual erosion in the right of privacy is due to many new legitimate third-party interests.

A key aspect of the development of confidentiality is based on the following model: the physician cares for an individual with a medical problem that affects only that individual. Although this model has worked well for many years, progress in the conceptual framework of family practice has resulted in a more advanced model defined by the 1984 Congress of Delegates of the American Academy of Family Physicians[13]:

> Family Practice is comprehensive medical care with particular emphasis on the family unit, in which the physician's continuing responsibility for health care is not limited by a patient's age or sex, nor by a particular organ system or disease entity.

As a somewhat ambiguous statement, this definition hazily defines the family as the unit of care. While some writers express strong opinions in favor of a family systems model of care,[14] others object on the basis that making the family the unit of care in every case is an overstatement, and that the family is only one of a number of systems of which individuals are members.[15]

Regardless of these arguments, the family physician who views the patient with a disease within the context of the whole family understands that the disease also may affect the other members to a greater or lesser degree. One may then argue that since the disease affects the whole family, the limits of confidentiality are not bounded by the individual and are extended to the family.

CONDITIONS FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

The new trend from traditional values of strict confidentiality to more relaxed values (consistent with a stronger social consciousness) was accompanied by a new concept of limiting the general obligation of the physician to protect a patient's privacy. Under certain circumstances and without the consent of the patient, holders of confidential material may disclose information to interested third parties with legitimate interest without resulting in cause of action.[16,17] Indeed, there are times when providers of care must actively disclose information. The following partial list of circumstances demonstrates the variety of conditions.

Confidential information may be disclosed under the following circumstances:

1. To legitimate third parties with patient's consent under any circumstance
2. To third parties with legitimate interest, as with reimbursement from third parties such as an insurance company or governmental reimbursement programs such as Medicare
3. When information about a patient is clearly obtained in a relationship other than a physician-patient relationship (eg, psychiatrist interviewing applicant for a job related to stress, etc)
4. To researchers for research and data collection
5. To other physicians or reviewing agencies for medical peer review
6. To the public when the public itself constitutes a legitimate third party with legitimate interest (eg, public figures)
7. To patient's spouse about medical condition of patient (under certain circumstances)
8. To legitimate third parties involved in genetics concerns

Confidential information must be disclosed under the following circumstances:

1. When the court so orders for various reasons
2. When it relates to reportable diseases such as communicable disease, occupational disease, epilepsy, congenital defects
3. When it involves wounds suggesting the patient is a victim or perpetrator of a violent criminal act (eg, gunshot wound)
4. When it involves child abuse
5. When the patient is an immediate threat to himself or to society

FAMILY MEDICINE—ANOTHER EXCEPTION?

Implied in the definition of family practice is the wide scope of its involvement in the family. The new model for medical practice no longer isolates an individual with a medical problem, but rather embraces the entire family. Along these lines, and in accord with the current legal trend of society rising to a higher order than the individual with respect to confidentiality, one strategy becomes clear. When a family disease is the issue, the physician may need to engage the entire family, risking breach of confidentiality to treat the disease optimally. An important issue beyond the scope of this paper is the confusion over the definition of a family disease. Nevertheless, it is now recognized by family practice specialists that virtually all diseases affecting an individual will have some effect on other family members.

A straightforward example of a family disease formerly treated within the context of physician-patient relationship is alcoholism. There is general agreement that the crux of the disease is denial by the patient and sometimes the family and that continuous confrontation is necessary even to begin successful treatment. Present ethical and legal standards place the physician in conflict.

On the one hand, the physician's duty of confidentiality to the individual is an acceptable social standard (Alexander v Knight),[18] and personal torts of privacy (Barber v Time)[11] and defamation (Vigil v Rice)[19] lend legal support. Furthermore, statutes on physician conduct (Schaffer v Spicer)[20] and on an implied contract between physician and patient (Geisberger v Willuhn)[21] regulate the exchange of information. Over recent years, some legislatures have even established protection for patients involved in drug and alcohol rehabilitation programs.[22]

On the other hand, some argue that the Hippocratic oath is not an absolute statement,[1] and therefore some leeway exists. Ethically, the physician may have a duty to disclose limited information to family members when it is done with the intention of helping the patient into the recovery phase of his disease. Indeed, in accordance with the Hippocratic oath, the physician's ultimate goal is to relieve pain and suffering of his patient, which may necessitate involvement of other members of the family; and in the example of a family disease, the patient is the combination of both patient and patient's family.

In terms of personal torts, a cause of action may not necessarily be found on the basis of defamation, as true existence of the disease is adequate defense; and because the limits of privacy are bounded by the family in a family disease, invasion of privacy involves dispersion of information outside the family. However, information must be directly relevant to the disease, and conveyed only to legitimate third parties; any exchange of information outside these limitations may constitute breach of these torts. Third parties within this context refers to those individual parties with authority recognized by law.

Society and compelling state interest are beginning

to achieve parity with the order of individuals through public health statutes. As an example, physical abuse to the rest of the family, which can be a symptom of alcoholism, is as important as child abuse, a reportable condition. Based on the reasoning of statutes relating to child abuse, therefore, one can rationalize the creation of statutes reporting alcoholism when information remains confined to the family and is used solely for treatment purposes.

Case law has legitimized reporting of information to legitimate third parties when the individual represents a threat to himself or society.[23] Furthermore, additional support to expand the traditional concept of confidentiality now includes the right of the patient's spouse to be apprised of the patient's medical condition,[24] informed consent and confidentiality in genetics screening,[25] and greater diversity of public health statutes.

Most recently, cause of action for failure to respect confidentiality has been based on breech of an implied contract.[21] Conditions of an agreement must clearly affirm to the identified patient the expanded nature of confidentiality when dealing with a family disease, because if the patient accepts, he has waived confidentiality for this purpose. It is the opinion of this author that although this process may initially inhibit a free-flowing dialogue, the significantly increased benefit of treating the entire family far outweighs the importance of strict confidentiality. Even with this extension, the continued importance of confidentiality in protecting the privacy of the patient exists in any matters not directly relevant to the welfare of the family.

As the traditional concept of a patient-physician relationship has developed into a broader role to include the family in the family practice specialty, so too must the limitations on confidentiality be expanded to include members of the family to promote optimum health care. Based on the above arguments, the following are recommendations to be presented to the patient at the initial visit:

1. Family problems must involve treatment of the family, not just the individual.
2. When dealing with a family disease, limited portions of confidential information may need to be shared with other members of the family.
3. Only that information necessary and relevant to the treatment of the problem will be shared.
4. The patient will be made aware in advance of all communications.
5. The patient will need to sign a consent form explicitly stating his understanding and agreement to the expanded nature of confidentiality.

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