Family Secrets: A Challenge for Family Physicians

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In the privacy of the doctor's office patients sometimes reveal information that they wish to conceal from their families. Such secrets can present ethical challenges for us as family physicians.[1] Some physicians believe that our primary responsibility is to accept, without challenge, any secrets that are revealed within the physician-patient relationship.[2] I disagree. By accepting some secrets unchallenged, we may inadvertently support dysfunctional behavior patterns and miss opportunities to encourage healthier communication between patients and their families. Furthermore, colluding in a secret with one family member may jeopardize our relationships with other family members, limit our freedom to provide appropriate health care, and force us to compromise our own integrity. In order to navigate around these dangers, I believe we must (1) respect confidential information while we advocate greater openness in families, and (2) set limits that ensure we can maintain our own integrity and remain trustworthy in our relationships with all our patients.

Consider two hypothetical examples, the first of which is based on an article that appeared in this journal last year[1]:

Harvey is in the office and has just told me a secret. He had an affair while out of town on business. Since his return he has had sexual relations with his wife, Anne, who is also my patient. Now Harvey has a penile discharge and he wants me to treat both Anne and himself. He refuses to tell his wife about his affair—he says it will end his marriage. He proposes that he tell his wife that he has a urinary tract infection and that I recommend she receive prophylactic antibiotics.

Harvey's request raises many issues. I have an obligation to maintain confidentiality and to offer both Anne and Harvey appropriate medical care. It is questionable whether keeping this secret is in the best interest of either patient. Regardless of the possible impact of the secret on them or their relationship, however, I have a personal and professional commitment to telling the truth. To agree to participate in deceiving Anne would compromise my own integrity; it would also communicate to Harvey that I am willing to be dishonest with patients in certain situations. He would have reason to distrust me, as would Anne if she discovered I had lied to her.

Now a 16-year-old patient, Patricia, is in the office. She lives with her parents and younger brother, who are also my patients. She has just told me a secret. She is sexually active with her boyfriend. She has not told her parents, and she insists that they must not find out. She wants birth control pills, but she is sure that she cannot keep the prescription hidden from her mother. She proposes that I prescribe them for her "menstrual cramps," although she actually does not have this symptom.

Patricia's request for secrecy and deception presents similar challenges. I feel a responsibility to maintain confidentiality and to provide her with good medical care, including offering her birth control pills (unless there are medical contraindications). But I also feel an obligation to encourage her to make the best decision she can about how open to be with her parents. While it is important to respect an adolescent's need for privacy, I cannot automatically assume that keeping her sexual activity a secret from her parents is in her or her family's best interest. Patricia's sexual activity may be developmentally appropriate for her. It may also be that her parents would support her in an appropriate and respectful manner. In any event I am not willing to lie about Patricia having menstrual cramps in order to protect her secret.

Secrets in families come in many forms. Different authors have categorized them in different ways.[3–7] Family therapist Imber-Black[3] categorizes them as "positive," "toxic," or "dangerous." Positive secrets involve appropriate and healthy kinds of concealment. A teenager may

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conceal from his parents his infatuation for the girl next door. A couple may wait a few weeks before telling their families of a just-discovered pregnancy. Spouses keep secrets about what gifts they will give each other on holidays. Most people in our culture would accept these secrets as appropriate and healthy.

In contrast, toxic secrets often involve the erosion of trust in relationships within the family or between family members and others. When a diagnosis is withheld from a dying patient, it can create distrust in the physician-patient and physician-family relationships. When parents conceal from their child that she or he was adopted, trust within the family is weakened. Harvey's secret threatens the level of trust between him and his wife, while his proposed solution could foster distrust for me, his physician. Patricia's secret might foster distrust in her family, and my active participation in the lie would indicate to her that I am not always honest.

Imber-Black defines dangerous secrets as those that require immediate action by the professional as an advocate for the patient's safety. I see these as a subset of toxic secrets. They include secrets about child abuse or a plan to commit suicide or homicide.

Positive secrets require no special action by physicians. Knowledge of dangerous secrets generally necessitates that physicians break the rule of confidentiality and inform the relevant parties or agencies. Toxic secrets such as Harvey's and Patricia's, however, can be especially difficult for physicians since there is no legal mandate to act. In these situations, our obligations to maintain confidentiality, to treat illness and dysfunction, and to be honest may conflict. They can be even more challenging for physicians when the keeper of the secret feels powerless or fears violence if the secret is revealed.

Several physicians, philosophers, and mental health professionals have written about managing secrets in various settings.[3–8] Based on these sources, I have established the following guidelines, which I have found helpful. While not intended as a "cookbook," they can help us to deal with the challenges of assessment and treatment that can be associated with secrets.

1. Respond carefully to any request to discuss a secret. When a patient begins an encounter with "I need to tell you something, but you have to promise not to tell anyone," assure the patient that you will be supportive in any way you can, but that there are limits to your freedom to keep secrets, such as when someone is suicidal or homicidal.

2. After hearing a secret that you judge to be toxic, explore with the patient the implications of keeping the secret and the choices she or he has for sharing the information. Ask what it is like to carry the secret, and who would be helped most by keeping the secret. Who would be hurt most by its disclosure? Discuss hypothetical future events, such as a family member inadvertently discovering the secret or developing an illness because of the secret. The perceived need to keep a secret can blind the secret-holder to the wider and long-term impact of doing so, as well as to the range of possible ways to share the information, and the benefits that might result from disclosure.

3. While helping the patient to broaden his or her perspective, clarify in your own mind what problems underlie the secret and what impact the secret may have on the patient and family members. Be an advocate for open communication at an appropriate time if you believe that such openness is in the patient's and family's best interest. Offer to facilitate a family meeting in which the secret-holder can reveal the information in a less threatening environment, or, alternatively, refer the patient to a mental health colleague. If you are unclear about how to act, consult with an ethics committee, another physician, or a mental health colleague.

4. Consider the possibility that this one secret may be a sign of more generalized difficulty with communication in the family. In addition, be aware that sometimes patients ask physicians to collude in secrets when they are actually looking for help in revealing them.

5. While being an advocate for openness, *do not*, except in the case of dangerous secrets, break confidentiality yourself. Rather, facilitate the process of open communication among family members. Sharing the content of the secret is the responsibility of the secret-holder.

6. When a patient remains committed to withholding information from family members, respect the decision. Patients usually know best what they need to do, just as physicians usually know best how to avoid compromising their own values. If a patient's plan threatens your relationship with other family members (for example, treating Harvey's wife for a fictitious urinary tract infection), be straightforward and honest with the patient about what you will and will not do. Make it clear that you will not lie to support their secret.

7. Use your ongoing relationship with the patient as a resource. Although there may be a tendency to "forget" a secret once the crisis has passed, you as a health care provider have the option of raising the issue again at a future time.

How might these guidelines work in practice?

With Harvey, in addition to treating him with appropriate antibiotics and laboratory tests, I would want to explore the possible implications of his secret with several questions including: How should we deal with

the possibility that other sexually transmitted diseases might be involved, such as HIV and syphilis? Could Harvey's wife, and not the woman of his out-of-town liaison, be the one who gave him the disease? Why is he so sure that revealing this information would lead to the end of his marriage? What would it be like if his wife discovered his secret 5 years from now? How would it be for him to carry the secret in the meantime?

As Harvey and I discussed the implications of his secret, I would urge him to be open with his wife. I would point out the medical risks of his secrecy, as well as the possible dangers for his relationship. I would explain that I would not lie to his wife, but that I would support him in finding alternative approaches to his dilemma. If his wife came in to be treated for his "urinary tract infection," I would refer her to Harvey and let him explain the reason why she needs antibiotics. Anticipating that this response on my part might be very upsetting to his wife, and ultimately to their relationship, I would suggest that Harvey consider other less volatile approaches. I would suggest that he and his wife make a joint appointment with me so that he could share his secret in a safer environment. He could also discuss the situation with a family therapist with whom I work closely. The choice of approach would be his, but I would specifically refuse to be dishonest.

One obvious risk of this approach is that Anne might not get appropriate early screening or treatment. Without a legal requirement that I contact her or the local health department, there is no guarantee that Anne will be informed about her risk of sexually transmitted disease, unless she develops symptoms. In the absence of mandated physician reporting, I would let the responsibility to inform Anne rest with her husband. I would make this clear to Harvey at the time he came to me with symptoms, and to Jane, if the secret were revealed after she became symptomatic.

With Patricia, I would have several questions as well: How does she think her parents would respond if she told them about her sexual activity? And what would happen if they found her birth control pills? What would it be like for her to keep her secret from her parents? And on what experiences does she base her answers?

Unlike Harvey's secret, Patricia's has no direct medical consequences for her family members. Thus, I have to decide how much to advocate for openness based on Patricia's answers and my prior knowledge of the family. If Patricia and her parents have drastically different values, she may need to keep her sexual activity a secret. On the other hand, they may already suspect that Patricia is sexually active and be concerned about whether she is taking steps to prevent pregnancy. By discussing her secret with them, she might actually allay some of their fears. Ultimately it would be Patricia's decision of when and what to tell her parents, but I would encourage her to think it through carefully.

Regardless of Patricia's decision, I would offer her a prescription for birth control pills but refuse to lie about the reason for them. She would need to know how I would respond if her parents asked me about the pills, her level of sexual activity, or the reason for that day's appointment. I would tell her that I could encourage them to speak directly with her about their questions, or suggest they make an appointment with their daughter and me to discuss their concerns. I would not break confidentiality, but I would also respect her parent's inquiries.

Secrets within families are at times appropriate and even joyful, and at other times a sign of serious individual and family dysfunction. As physicians we need to negotiate with patients about the support we can and cannot offer them in keeping secrets. We need to approach each situation as unique, asking ourselves whether keeping that secret allows us to maintain our personal and professional integrity, and whether it helps the patient to make choices she or he will feel good about over the long term. This process, while not guaranteeing perfect outcomes, will protect our relationships with all members of a family, and support our own well-being as well as that of our patients.

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