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Clinical Case
Dual Loyalties
Commentary by Stanley K. Dorst, MD

Mr and Mrs Samir have both been patients of Dr Lachman for 4 years. They live a 30-minute drive from his office, so they regularly schedule their appointments on the same day. As usual he sees Mrs Samir first.

During the examination, Mrs Samir asks if she should see an obstetrician—she and Mr Samir have stopped using birth control (a barrier method) because they are trying to get pregnant. She's a little worried because she's had some lower abdominal pain and post-coital bleeding.

"Well, have you taken a pregnancy test? Some abdominal pain and light bleeding are not uncommon in pregnant women."

"No, we just started trying a few weeks ago."

"Perhaps we should go ahead and do a pregnancy test now," Dr Lachman suggests.

"Would you like me to get Mr Samir in here for the results."

Mrs Samir fidgets for a moment. "Perhaps we better not," she finally says, "I just don't feel very pregnant and that would get his hopes up."

Dr Lachman continues the physical examination and tries to isolate the cause of Mrs Samir's abdominal pain, but he's unable to identify more than just general tenderness.

"Mrs Samir, I'd like to run a couple of tests to rule out infection. Is that okay with you?" Dr Lachman suspects that Mrs Samir has contracted some kind of STD, perhaps from Mr Samir, but he doesn't want to upset her by saying so. She agrees to undergo a few tests.

Just as Dr Lachman guessed, Mrs Samir tests positive for Chlamydia. He informs Mrs Samir, and tells her that she needs to start a course of antibiotics and that he needs to test Mr Samir.

Mrs Samir demands that Dr Lachman not disclose what he has discovered to Mr Samir—test him if he agrees to it, but do not tell him about her condition.

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This is a classic case of confidentiality, and the conflicts physicians can run into because of its requirements. The wrinkle in this case is that both Mr and Mrs Samir are Dr Lachman's patients. As family physicians, we often see many, if not all, members of the same family, and to some extent may view the family itself as being in some sense "our patient." In discussing the case, though, I think it makes sense to start by discussing the confidentiality issues and conflicts in general, and then to analyze whether the particular role Dr Lachman plays raises any other ethical issues.

The expectation that physicians will respect the confidentiality of information disclosed to them by patients dates back at least to Hippocrates. In the Hippocratic Oath, physicians promise "What I may see or hear in the course of the treatment…which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about" [1]. Similar promises are part of the Code of Geneva, and other modern professional codes [2]. There is also significant legal precedent for holding physicians liable for breach of confidentiality [3].
At the same time, physicians may have a conflicting duty to warn others about potential harms which their patients pose. In the classic *Tarasoff* case, the California Supreme Court found a psychologist liable for not warning a young woman and her parents about his patient's intent to kill her [4]. Medical ethicists have generally embraced this ruling, viewing the obligation to preserve confidentiality as being a relative, not an absolute, requirement.

As is true for most situations where there are conflicting ethical duties, there is no clear decision rule that can be followed to determine which duty trumps another in any particular situation. There are, however, some generally accepted guidelines for making that decision in this context. Lo, for example, states that,

> in general, exceptions to confidentiality are warranted under the following conditions: (1) the potential harm to identifiable third parties is serious; (2) the likelihood of harm is high; (3) there is no less-invasive alternative means for warning or protecting those at risk; (4) breaching confidentiality allows the person at risk to take steps to prevent harm; and (5) harms resulting from the breach of confidentiality are minimized and acceptable [5].

In the situation facing Dr Lachman, conditions 2, 3, and 4 seem to be met: it is fairly likely that Mr Samir would become infected with Chlamydia if he and Mrs Samir continue to have unprotected intercourse; there does not seem to be any other way of warning or protecting him from the risk; and it would certainly be possible for him to take steps to prevent infection if he were told of the risk. Condition 5 may also be met, although it is not clear who decides whether the harms would be "acceptable."

The real debate, though, is about condition 1. The usual context in which this has been discussed has to do with partner notification of HIV infection. Despite the marked improvement in our ability to treat HIV infection, I doubt anyone would argue that HIV infection would not be a serious harm to someone. Exactly how serious venereal chlamydia infections are in men is more debatable. Such infections commonly cause urethritis, which is an uncomfortable, but not very serious condition. It could reasonably be argued that urethritis is not a serious enough harm to justify breaching Mrs Samir's confidentiality. However, men with chlamydia infections can also develop epididymitis, although the frequency with which this happens is not clear. In addition, approximately 1 percent of men with Chlamydia develop reactive arthritis, and approximately one-third of those develop Reiter's syndrome. Chlamydia has also been implicated as a possible cause of chronic prostatitis, although the current evidence for this is not very solid [6]. Clearly, these possible harms to Mr Samir are more serious than a simple urethritis, but none of them is life-threatening, like HIV infection would be, and some of them, at least, are quite unlikely to occur.

At the same time, while the potential consequences to Mr and Mrs Samir's relationship from breaching confidentiality could be significant, the overall consequences of this breach are not as serious as they would be for HIV infection, with its potential social stigmatization and loss of insurability. Overall, though, the balance of harms is not as clearly in favor of breaching confidentiality as it would be for a disease like HIV. Does that mean that breaching confidentiality is not justifiable in this situation? There is no clear answer to that question, and probably different ethicists, and different physicians, would come to different conclusions.

It is probably worth mentioning that legal liability in this situation, either for breaching or for maintaining confidentiality, is extremely unlikely to be an issue. Even for HIV, the statutes I am aware of allow physicians to breach confidentiality, but do not require it, so it is most unlikely that a court would have a stronger requirement for a less serious infection. In addition, because most people would feel that Mrs Samir should not have acted in a way that resulted in her infection, and that she certainly should inform Mr Samir of the risk he is facing at this time, it is almost inconceivable that a court would hold Dr Lachman liable for breaching confidentiality if he chose to do so.

So, it appears that breaching confidentiality may or may not be justified in this situation, at least based on Lo's criteria. However, Mr Samir is also Dr Lachman's patient. This certainly makes the conflict more professionally difficult for Dr Lachman, because in order to maintain confidentiality for one patient he would have to withhold important health information from another patient. The question, though, is whether this fact is only emotionally relevant, making the situation upsetting for Dr Lachman, or whether it is ethically relevant, and actually changes the ethical conclusion we should reach in this case.

The patient-physician relationship certainly does impose some special duties on physicians. Many beneficent actions that are generally considered morally obligatory for physicians in relation to their patients are considered to be excessive for

nonphysicians. Most ethicists believe, for example, that health care professionals have an obligation to provide care for HIV-infected patients, even if there is some risk that they may become infected in that process. Taking that same degree of risk would be considered excessive for individuals who do not have the same set of role-based expectations [7].

This type of obligatory beneficence is a matter of weighing personal risk against the good of one's patient, though, and doesn't tell us anything about how physicians should weigh the good of one patient against the good of another patient. Ethicists have generally argued that decisions about each patient must be made separately, and that therefore violating one's obligation to one patient cannot be justified by the fact that it benefits another patient. On the other hand, some theorists have argued that the family unit itself should be considered to be the focus of care in family medicine. If so, treating Mr and Mrs Samir separately would not be justified. Christie and Hoffmaster discussed this in some detail and concluded that considering the family to be the focus of care results in multiple problems, both practical and ethical, and that it should therefore be rejected [8]; I agree with their conclusion. In addition, I would argue that a physician has a moral obligation to protect identifiable others from foreseeable harm and that this obligation is not greater for his or her patients than it is for nonpatients. Specifically, if asked why I didn't warn someone of a risk to her health, I do not feel that stating "because she is not my patient" would be an acceptable response.

In summary, then, it seems that breaching Mrs Samir's confidentiality may be justifiable, depending on how serious one thinks the potential harms to Mr Samir are, and that the fact that Mr Samir is also Dr Lachman's patient would make not breaching confidentiality more uncomfortable, but that alone is not an ethically relevant concern.

On a practical level, of course, breaching confidentiality is not something that should be undertaken lightly. Even if such a breach is felt to be an acceptable option, every effort should be made to avoid doing so. Mrs Samir should be strongly encouraged to either tell her husband about the situation herself or to allow Dr Lachman to do so, in her presence or absence, as she chooses. She should be offered support in going through this difficult experience, including joint meetings with her and her husband, and referral to couples therapy if desired. She should also be advised that it would be unethical for Dr Lachman to test her husband without obtaining his consent for testing and that gaining his consent would require giving him a reason for the test. In addition, she should be reminded that if he is not tested and treated he is likely to develop symptoms, which would certainly result in questions being asked about how he became infected. If he remains untreated, there is also significant risk to her of becoming re-infected, with resultant risks for pelvic infection and infertility. Frequently, working through the practical aspects of the situation helps patients to realize that informing their partners is the best option, and the physician can usually provide valuable assistance in this process.

References

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