

Chapter Eight

CONFIDENTIALITY, PRIVACY, TRUTH TELLING, AND MEDICAL ERROR

Trust provides the basis of all intimate relationships, and it is essential in the formation of all professional relationships. For example, truthful and detailed information is required if a physician is going to properly diagnosis an illness, but in order for patients to feel comfortable with the provision of detailed information, they must first trust that the data provided will be kept confidential. People who are ill, particularly those facing the end of life, are especially vulnerable.

The responsibility for creating safety with the vulnerable patient lies with the professional: the clinical social worker, physician, nurse, psychologist, medical ethicist, and others. The best way to establish safety is to assure that personal and private information remains private. Most professions have a strict set of guidelines within their codes of ethics that dictate how and when information can be relayed and to whom such information can be given. Hospital policies and regulations, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) guidelines, and federal regulations also dictate how private patient information can be shared. All of these standards and guidelines are beneficial at the time of the establishment of trust, and they are essential to the development and sustenance of a professional relationship. At the same time, they may be confusing. On occasion, these guidelines and regulations inhibit the provision of information at times when families are desperate to know things that the healthcare provider is forbidden to tell.

The goal of this chapter is to first clarify why we keep information private and under what circumstances we are permitted to provide information to others. Second, this chapter will explore the nature of

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truth telling in the hospital environment. Third, within each section the regulations that guide the keeping of secrets in the professional environment will be discussed, as well as when and why laws or circumstances may require that the professional break a confidence. Finally, this chapter will touch upon medical error and the responsibility of the hospital and the institution to report and discuss such errors openly. Information on the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, which regulates the kinds of information that can be revealed within healthcare institutions and to whom this information can be revealed, is also presented.

THE SECRETS WE KEEP

As humans enter into relationships, the degree to which one member shares personal information with another defines the intimacy of that relationship. Intimate relationships are rooted in loyalty and the keeping of a confidence is the test. There are often boundaries on what type and under what circumstances information is shared. When boundaries are not in place, providing intimate data may feel inappropriate or embarrassing. Recall the last time someone sat next to you on an airplane or a bus and told you his/her life story, complete with way too much personal information. Such a breach of intimacy rules can make the listener uncomfortable. This discomfort stems from the fact that there was no shared understanding between the speaker and the listener as to the boundaries of the relationship prior to the sharing of this intimate data. Normally, as relationships get emotionally closer the degree of intimacy increases on both sides. This works for relationships between friends and lovers as well as with relationships between professionals and their patients or clients. What is required of a close friend or lover differs from the degree of confidentiality that must exist between a doctor and a patient. For example, if I become aware that my best friend's husband may be abusing prescription medication I might try to speak with him about his dependence and see if I can help. However, if a patient tells her doctor of her concern that her husband may be abusing prescription medication, the physician cannot call the patient's husband to discuss this issue, even if the husband is his patient. The husband would have to come to the physician,

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requesting help. The friend, however, based upon the intimacy of the relationship, can risk the breach of confidence that the professional cannot, legally and ethically. This professional relationship could not survive without such a contingency in place (Bok, 1983).

**BLENDING OF PRIVACY, CONFIDENTIALITY,
AND AUTONOMY**

Numerous reasons exist for why professionals keep secrets, not the least of which is to generate an atmosphere of trust. Professional relationships are formulated and maintained upon trust. In the medical field, confidentiality of medical information has been part of medical practice since its inception as a profession. The Hippocratic Oath states, in part: "Whatever, in connection with my profession, or not in connection with it, I may see or hear in the lives of men, which ought not to be spoken abroad I will not divulge as reckoning that all should be kept secret" (quoted in Britton, 1975, p. 34). This trust allows patients to share the personal information that doctors require to diagnose and treat illness. Clinical social workers cannot obtain the data required for a clinical psychosocial assessment nor could psychological intervention continue without a trusting relationship between the patient and the clinician. For example, if I went to my doctor to discuss my concerns with sleeplessness and divulged the details of a case that had been keeping me up all night, he would be bound to keep the case details confidential as well as the fact that I suffer from insomnia.

Privacy is connected closely with the concept of autonomy and self-determination. As stated in chapter 3, preservation of autonomy is one of the primary principles of the informed consent statute. Legally, a variety of constitutional rights involve aspects of autonomy and privacy, such as abortion rights, rights to contraception and procreation, issues related to shock treatments, rights against psychosurgery, and issues related to behavioral therapy and surrounding the provision and withdrawal of life-sustaining therapies (Shapiro & Spece, 1981). The sense of privacy discussed within the law refers to a "zone of privacy." This zone of privacy is about the process surrounding the keeping of secrets. According to U.S. Supreme Court Justice Blackman, the zone of

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privacy consists of “personal rights that can be deemed fundamental, that is implicit in the concept of ordered liberty” (Shapiro & Spence, 1981, p. 56). The right to confidentiality between doctor and patient stems from an unspoken contract, whereas the right of privacy is said to be constitutionally based.

The preservation and expression of autonomy is dependent upon confidentiality. The capacity to participate in the informed consent process relies on the patient’s ability to assimilate and provide information. The provision of information depends on the trust and loyalty generated within the medical profession, which is formulated upon the ability of the profession to keep such data confidential. Within medical decision making, two factors are required to support autonomous choice: “One is the ability to keep private information private and the other is the independence to make certain kind of important decisions” (Shapiro & Spece, 1981, p. 56).

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According to Bok (1983), confidentiality refers to “the boundaries surrounding shared secrets and the process of guarding these boundaries” (p. 25). Confidential information can be quite intimate in nature or may not be intimate at all. The information may seem trivial in substance and might even seem false, nonetheless, it must be kept private—except under certain defined circumstances. These circumstances include the threat of danger to self or others, the provision of medical information to designated surrogates in a situation where a patient is believed to be incapable of participating in the informed consent process (see chapter 3), insurance companies, and the reporting of child abuse, elder abuse, gunshot wounds, and car accidents, as dictated by state and federal law. The sharing of medical information to family members, surrogates, or friends is guided by federal HIPAA standards (discussed later in this chapter).

Even if the patient does not directly request that shared information be kept secret, the moral, ethical, and legal responsibility of most professionals is to keep such data private. The obligation to keep patient information confidential is part of an unspoken contract

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between patient and doctor (Bok, 1983). However, maintaining a level of confidentiality is not a simple process.

HOW SECURE IS THE PATIENT RECORD?

Medical records contain personal data, which, in some cases, if revealed, could prove personally devastating. Embarrassment and humiliation can lead to damage to self-esteem; loss of employment; loss of social, educational, and financial opportunities; and even lead to discrimination and infringement upon legal rights (Clever, 1985). Despite the harm that would come from a breach of confidence of the medical record, legal concern about protection of such information is fairly new. "The privacy interest recognized in medical records is in its infancy" (Schuchman, 1982). Years ago, a breach in confidence was at the discretion of the family or town doctor. Currently, however, with the advent of third-party payment, the increased presence of government participation in medical care, and the advent of automated record keeping, there is an increase in the amount, type, and accessibility of medical data available on any one individual (Clever, 1985).

The technology of record keeping has changed greatly over the years. More patient data is automated and it is now possible for thousands of people to have access to one patient record. Most medical offices and some hospitals keep totally automated medical records. In addition, medical records are not only sought by those in health care or associated with health care. Private medical information may be sought by law enforcement, public health officials, occupational and health researchers, third-party payers, and employers (Clever, 1985). It is the ease of access combined with the increased number of people who want access that has created a new level of fear in the general public. There is a sense that such data is at risk of being accessed by any individual with the skills to break or hack into a computer system that contains confidential patient information.

Of additional concern is the requirement that healthcare employees obtain medical care and treatment within the hospital system through which they are employed. Another worry is companies who hire a company physician to care for employees who are ill or injured in the workplace; it is not always clear to the employee where the loyalties of the "company doc" lie. For example, if I am hospitalized in the

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hospital where I am employed, who can access my medical record? How much information on my condition does human resources have a right to access? Can my boss review my automated record to find out when I will be discharged and when I will be able to return to work? What prevents a breach of confidence from occurring?

Most hospitals and physician offices have safety mechanisms in place to prevent outsiders from accessing data contained within the automated patient record and have hired companies to create a fire wall to prevent unauthorized access. Hospitals have started to create strict policies that prohibit unauthorized access to patient records, especially employee records. These hospitals have code-tracking devices that alert the information systems departments if unauthorized access occurs. Breach of the confidentiality policy can result in a formal penalty up to dismissal from one's job.

Privacy Protection of the Medical Record

The constitutional and common law reference to a right to privacy usually refers to the right to be free to be left alone and free to control one's personal information (*Katz v. United States*, 1967; *Roe v. Wade*, 1973; *Griswold v. Connecticut*, 1965; *In Re: Karen Ann Quinlan*, 1996). This request for creation of a tort right of privacy was first recognized in a *Harvard Law Review* article by Warren and Brandeis published in 1890. This article discussed how the advance of civilization had eroded the privacy of the individual, thereby making privacy much more essential. It was speculated that the invasion of privacy led to mental pain and distress and called for protection from this inflicted injury.

Over time, various health law cases referred to a constitutional right to be left alone (*Olmstead v. United States*, 1928) and a general constitutional right to privacy (*Griswold v. Connecticut*, 1965). In 1970 the U.S. Supreme Court first examined privacy issues related to the medical record.

In *Whalen v. Roe* (1968), the U.S. Supreme Court reviewed the constitutionality of a New York statute that required that all prescriptions for dangerous drugs be filed with the State Health Department. The file contained the name, address, and age of all patients prescribed these drugs, along with the name of the physician who wrote the prescription, the dose and name of the drug, and the pharmacy filling the prescription (Clever, 1985). The appellate court contended

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that this statute violated the patient's right to avoid disclosure of personal matters and that it impeded individual decision making. The Supreme Court disagreed.

Similarly, in the case of *Planned Parenthood of Missouri v. Danforth* (1966), the court decided that the recording laws did not violate a woman's right to have an abortion. Both cases, *Whalen* and *Planned Parenthood*, acknowledged a privacy interest in medical records (Cleaver, 1985).

The common law efforts at protection have succeeded but are considered by Cleaver (1985) and others to be inadequate. "Common law protections for sensitive medical information include actions for invasion of privacy, defamation, breach of confidence, breach of statutory duty, breach of fiduciary duty, breach of contract, and tortious interference with a contractual relationship" (p. 176). The focus of these actions seems to be upon the disclosure of the information and not upon the safety of the medical record itself.

Federal Freedom of Information Act (FOIA) and Privacy Act of 1974

The purpose of the FOIA was to allow public access to federal records. The act is based upon the premise that a truly informed public is essential to a democratic form of government. However, the FOIA was not prepared for how this act would affect medical records held by the government. To counteract the disclosure encouraged by the FOIA, the government enacted the Privacy Act of 1974, which states, "The right to privacy was personal and fundamental" (Cleaver, 1985). The Privacy Act is aimed at promoting governmental respect for the privacy of its citizens. The Privacy Act had several requirements within it, all aimed at protecting disclosed information and giving individuals limited control over their medical records that are held by the government (Cleaver, 1985).

State-Held Open Records and Privacy Statutes

Several states have enacted open records and privacy statutes with privacy protections. These protections relate to records held by a state agency or a state-funded entity and pertain to the "collection, maintenance, use and disclosure of personal information" (Cleaver, 1985, pp. 176-177). The state laws are not applicable to federal agen-

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cies and differ greatly in the type and extent of the protection noted in federal statutes.

Health Insurance Portability and Accountability Act (HIPAA) and Patient Privacy

A major piece of federal legislation, the Health Insurance Portability and Accountability Act (HIPAA), and Patient Privacy (1996) focused upon three direct areas related to patient care: insurance portability, administrative simplification, and privacy and security. Healthcare employees undergo training programs in order to learn how to abide by HIPAA standards. Lack of compliance can result in governmental fines up to \$250,000, imprisonment, and disciplinary action, up to and including termination of employment. Deadlines for compliance with the privacy requirements were in April, 2003.

Under the privacy and security section of this legislation, healthcare providers must use certain methods in an effort to assure that a patient's "protected health information" remains private and secure. Institutions and all healthcare employees are required to provide patient medical information on a need-to-know basis only to individuals, institutions, or organizations that use this information to provide treatment, obtain payment, or perform related healthcare operations. This restriction applies to all information—verbal, written, or electronically stored—and consists of the patient's general information: name, medical record number, Social Security number, address, and date of birth. The restriction also applies to health information such as diagnosis, medical history, treatments, and medications.

Strict rules are in place to govern the release of protected health information (PHI) when this information is not being used for treatment, payment, or healthcare operations. The established rules vary depending upon the degree of sensitivity of the requested information. If PHI is to be released it is only, in most circumstances, after a patient has signed an authorization giving consent. A valid authorization to release PHI must contain the following:

Patient's full name at the time the treatment was rendered
Identification information (date of birth, Social Security number, medical record number)
How the released information is to be used

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- Name of facility where PHI was created
- Name of the person, company, or agency to whom the information is to be released
- Dates of treatment
- The exact type of information to be released, specified on the document, for example, behavioral health, HIV
- Date and signature of the patient or legal representative

In addition, institutions are required to post in the public areas and to hand out public notices that outline how patients' health information may be used or disclosed. Patients are to be notified of their rights under HIPAA and whom to contact if they feel their privacy rights have been violated. Patients have a right to receive an accounting of the date of the disclosure of their medical information, the name of the entity or person who received the PHI data, a brief description of the PHI disclosed, and the reason for the disclosure.

The HIPAA standards also contain guidelines for purchasing, the use of protected health information in marketing, the use of protected health information in fundraising, and the use and disclosure of protected health information for research purposes pursuant to HIPAA privacy rules.

Physician-Patient Privilege

The relationship of trust developed between a doctor and patient is referred to as physician-patient privilege. Legal reference to this relationship only pertains to the protection of the patient medical record from disclosure during the discovery phase; it does not pertain to any other areas. The privilege is in place to protect the patient but does not protect the physician or the medical institution where the care was provided (Cleaver, 1985). The patient can choose to waive the privilege, otherwise waiver is implied in situations where the patient is bringing a personal injury action. However, this type of waiver only applies to the part of the record pertaining to the injury alone. The privilege is "further limited by statutory and common law exceptions which have been created where important public interests are at stake and where the intrusion of patient privacy interests would be minor" (Cleaver, 1985, pp. 177-178).

WHO CAN ACCESS THE PATIENT RECORD

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Determining who can gain access to a patient's medical record is resolved through a series of questions (Cleaver, 1985):

What is the purpose for which the medical records are being requested?

What are the laws governing the request and the parties?

Who is the subject of this record?

What is the status of the party seeking access to this medical record?

What degree of confidentiality would remain if the request for access were granted?

Purposes for Released Medical Records

Public health. The privacy interests of the individual patient can be diminished for the sake of public health, public epidemiological interests, and for occupational health research. The open records statutes of various states call for a balancing of individual private interests with the interests of the public's need to know (Cleaver, 1985).

Reporting laws. Many states require the reporting of "venereal diseases, child abuse, elder abuse, injuries caused by deadly weapons, fetal deaths, and abortions, as well as prescriptions given for dangerous drugs" (Cleaver, 1985, p. 178). Social workers must be particularly careful in reporting suspected child abuse and elder abuse, for it is a requirement of most states and has direct impact on the maintenance of a state license to practice social work.

Duty to warn: The Tarasoff case. The duty to warn comes from the case of *Tarasoff v. Regents of the University of California* (1976). In this case, Prosenjit Poddar was a graduate student at the University of California who had dated a woman named Tatiana Tarasoff. She broke off this relationship and Poddar sought psychotherapy at the university clinic. He confided to his psychologist that he intended to kill an unnamed woman when she returned from a trip.

The psychologist could identify this woman as Tarasoff and he notified the campus police that Mr. Poddar was dangerous and that he

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should be committed for observation and treatment in a psychiatric hospital. Poddar was detained but released by the local police, who saw him as rational. Poddar broke off his relationship with his therapist and two months later he killed Tatiana Tarasoff. The Tarasoff family brought suit against the psychologist, his supervisor, the campus police, and the University of California for failing to warn them of the peril their daughter was in, and also for failing to detain Poddar for treatment. The suit was at first dismissed but then the California Supreme Court reversed this dismissal, stating that:

regardless of the therapist's unsuccessful attempt to confine Poddar, since they knew he was at large and dangerous, their failure to warn Tatiana or others likely to apprise her of the danger constituted a breach of the therapist's duty to exercise reasonable care to protect Tatiana (Roth & Meisel, 1977, p. 509).

Physicians, psychiatrists, therapists, social workers, and all concerned have a duty to conduct a detailed assessment of the dangerousness of a particular patient, and they have a duty to warn. The assessment of dangerousness should include: the patient's behavior, affect, somatic functioning, interpersonal relationships, and cognition, or the acronym *BASIC*. (Oppenheimer & Swanson, 1990).

When assessing a patient's behavior, the therapist should complete a detailed violence history, including how recently these actions occurred, as well as the severity and frequency of violent actions. The therapist should discover if the patient has been arrested or convicted of violent behavior. Was the patient ever hospitalized for "dangerous" behavior? Has the patient reported being in an altercation at work, school, or in bars? Was the patient a victim of child abuse? Did the patient witness spousal abuse as a child? Has the patient participated in abusive behavior toward a spouse and child? Does the patient have a history of poor impulse control? If the answer to a majority of these questions is yes, Oppenheimer and Swanson (1990) speculate that past behavior is the best predictor of a patient's future behavior. They recommend that the therapist gain insight into the patient's current circumstances, being particularly aware of answers to the following questions: Is the patient's present situation similar in any way to a past

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situation when the patient became violent? Has the patient made a specific threat against an identifiable victim? Although a verbal threat alone is not sufficient cause to warn an intended victim, these authors suggest that the therapist should ascertain how the patient intends to implement the plan. This should include an assessment of the lethality, and the detail, coherency, and organization of the plan, suggesting that a highly lethal, well-organized plan to harm another person increases the likelihood of danger.

In the assessment of affect, Oppenheimer and Swanson (1990) recommend that the therapist assess if the patient is angry, sad, or labile. They suggest that, "if the patient seems angry, the therapist should assess if the anger is over-controlled or under-controlled; over-controlled anger can be more dangerous than anger that is easily expressed" (p. 182). The therapist should assess if the anger is generalized or directed toward an individual, or both. Anger directed toward an individual by a generally angry person increases the likelihood that violence will occur.

In the assessment of somatic expression, Oppenheimer and Swanson (1990) state that this refers to the general physical functioning and health of the patient. Somatic symptoms are said to provide an index of the patient's stress level, which can have detrimental effects on health. The deterioration of health is not the sole predictor of violence but when combined with the disinhibiting effect of alcohol or drugs, an increased propensity toward violence is possible.

In the assessment of the patient's interpersonal relationships, the therapist should review how connected the patient is with others. Is the patient emotionally connected with family, friends, or coworkers? Is the patient in frequent contact with others? It is believed that low levels of social support and the presence of social isolation often increase the likelihood that violence is possible, especially if the person to whom the patient has directed anger has been a main support person. Feelings of isolation and loneliness can predicate acting out, as can a history of using violence in the past to resolve conflict.

In the assessment of the cognitive expression of the patient, Oppenheimer and Swanson (1990) recommend that the therapist gain a detailed history of the patient's homicidal ideation and fantasies. The therapist should investigate if the patient anticipates any adverse con-

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sequences for actions. If so, does this anticipation reduce the intensity of affect? Further, is the patient able to separate the fantasy of desiring to harm another person from the actual behavior? In the assessment of the patient, does the patient report having hallucinations, delusions, or paranoid ideations? Oppenheimer and Swanson speculate that the “presence of a psychotic thought process increases the likelihood of violence” and therefore the assessment of such is crucial (p. 182).

If the patient is assessed as being at risk for performing violence toward another, then the therapist must come up with a plan to involuntarily commit the patient if the patient will not agree to voluntarily seek psychiatric treatment. The therapist may choose to notify the police, utilize social or environmental manipulation “to reduce lethality,” or use conjoint therapy with the patient and the intended victim.

No matter what plan the therapist decides is optimal, warning the victim must be part of any plan, even when such a warning will violate the trust between the patient and the doctor or therapist. Roth and Meisel (1977) suggest that the therapist inform the patient of the limits of confidentiality by stating what the therapist is obligated to do and thereby gain permission to contact the intended victim. It is essential that social workers, physicians, psychologists, and counselors make every effort to inform the intended victim while maintaining the trusting relationship between themselves and the patient. However, if there is a choice between maintaining the relationship and warning the intended victim, the therapist must issue the warning. The ruling in the Tarasoff case is frequently cited in social work literature and texts as evidence that confidentiality is not the only rule for social workers to heed.

Consumer health organizations. Under the FOIA, consumer health organizations may research government-funded medical providers and are permitted to publish their findings in order to advance consumer knowledge of available medical care (Clever, 1985).

Law enforcement purposes. In situations where the disclosure of information is necessary for public purposes, medical records can be subpoenaed for use in administrative or grand jury investigations.

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These cases may apply to situations of Medicaid and Medicare fraud, employee health and safety, medical misconduct, and/or nonpayment of taxes (Clever, 1985).

Medical records can also be sought in civil actions. These records are necessary in actions related to personal injury, insurance policy disputes, and issues related to malpractice, divorce, and when wills are contested. However, in cases such as these, discovery can be opposed by statutes that make such information privileged (Clever, 1985).

The use of medical records in criminal cases can be varied. The defendant or the prosecution can offer the record in evidence. Records may be used in presenting considerations or they can be used to impeach the credibility of a witness. Conflict exists as to whether or not a witness can be impeached by his/her own medical record. According to Clever (1985), "victims' medical records are admissible if relevant to an element of the crime. The defendant's own records may be admitted if it is important to consider the state of his/her health or mind at the time of the alleged crime" (p. 168).

Third-party payers. Insurance companies, the government, and employers have a legitimate need to see health information under certain circumstances. Most people do not object to information being provided to insurance companies, unless they refuse to pay the claim or the way they obtained or shared medical information is questioned. Insurance companies only have the right to part of the medical record and it is the responsibility of the physician to go through the medical office record and to surrender only pertinent information (Clever, 1985; Holloman, Edwards, & Matson, 1994). Anytime private medical information is provided to a third party, there are potential consequences. For example, if this information were to get into the hands of the employer or a life-insurance salesman, the patient could be denied life insurance or could lose his/her job or be denied a promotion (Garrett, Baillie, & Garrett, 1993).

Patient Viewpoint on When Confidentiality Can Be Breached

Sankar, Moran, Merz, and Jones (2003) reviewed 122 articles that reported research with patients regarding confidentiality and they

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found the following: First, patients were “confused about basic ethical, legal, and practical limits on medical confidentiality. Second, patients’ confidentiality concerns were often more local and specific than the concerns that policies and new federal regulations address. Third, patients prefer that medical information be used exclusively for treatment and, finally, patients will delay or forego treatment, or alter stories about symptoms and onset of illness, to be sure those details never emerge publicly” (pp. 665–666).

Patients’ opinions vary by population as to when confidentiality can be broken, which information can be provided, and who is an allowed recipient (Sankar et al., 2003). For example, adolescents permitted breaches of confidentiality based upon the severity of the problem, such as with sexual abuse or suicide attempts, and required information was delivered to the appropriate parties in these situations. Female victims of domestic abuse stated that confidentiality could be breached only in situations where the woman “wanted relief from the burden of disclosure” (Rodriguez, Craig, Mooney, & Bauer, 1998, pp. 339–340).

Patients are not generally aware of the specific laws protecting medical information. However, they expect that their medical information will be kept confidential. In several studies, patients accepted that information would be shared among doctors, but they rejected the release of information to employers, family members, and third-party payers (Ginsburg, Menapace, & Slap, 1997; McGuire, Toal, & Blau, 1985; Schmid, Appelbaum, Roth, & Lidz, 1983; Kinzie, Holmes, & Arent, 1985; Lorge, 1989; Merz, Spina, & Sankar, 1999; VandeCreek, Miars, & Herzog, 1987; Trippitelli, Jamison, Folstein, Bartko, & DePaulo, 1998).

Interestingly, patients expressed concern that nurses and medical students had full access to their medical records. Some indicated that they did not want office staff to have access at all (Sankar et al., 2003). Patients wanted only limited access of records by certain members of the healthcare teams, and even more limited access to certain family members. Many patients did not anticipate that their cases would be presented at large conferences, or shared with the spouses of their physician or discussed at parties (Weiss, 1982). The concern of this patient population was that their private medical information would

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find its way into their intimate social circle and cause some patients to forgo treatment or change medical information to avoid this type of disclosure. Statutes and laws were aimed at preventing this very concern; patients would avoid treatment if confidentiality could not be assured. The current protective practices do not seem to go far enough to assure that the trusting relationship sought at the beginning of the medical profession can be attained. Trust remains one of the primary factors necessary in the building and maintaining of the relationship between doctor and patient, and indeed, among all helping professionals.

TRUTH TELLING

Who has a right to it and when should truth be told? Healthcare ethics is fraught with dilemmas like the conflict that occurs when you are faced with two competing principles. For example, one may believe that every effort should be made not to lie to a patient while following the principle of maleficence, which states that a physician should do no harm. However, sometimes physicians have to lie to avoid harming their patient. Lying can be defined as a “falsehood in those circumstances in which the other has a reasonable expectation of the truth” (Bok, 1983, p. 14). There is no absolute right to the truth because circumstances change with each case. This makes the choice to provide or withhold the truth confusing at best. For example, Mrs. Pallocette is an 89-year-old woman who has been diagnosed with metastatic breast cancer, with metastases to her spine, liver, lungs, and femurs. She has a history of depression and anxiety, especially since the death of her eldest son Joe, who died of lung cancer. She was born outside of Palermo, Italy, and her family is not in the habit of openly discussing illness. Mrs. Pallocette’s daughter Rita requested that her mother not be told of her diagnosis. She fears that her mother will “have a breakdown” if she is told of her diagnosis because “they would have never discussed her illness in the old country.” In this case, the provision of the truth could prove harmful to this patient.

Ethically, each case requires that the physician or health care professional ask the following questions (Garret, Baillie, & Garret, 1993, p. 106):

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- Who is requesting the information?
- Where is the conversation taking place?
- What is the role or position of the communicators?
- What is the nature of the truth involved in the exchange of information?

In the case of Mrs. Pallocette, the daughter is requesting that the whole truth not be told to her mother. She is having this conversation in a private conference room close to her mother's room. Rita is the power of attorney for her mother. The nature of the truth is the withholding of her full diagnosis to keep the patient from further emotional trauma and to follow how her culture and family would have dealt with such a diagnosis. It would be ethically appropriate to follow this request, at least for the time being. The doctor may accept this initial request, with the contingency that if Mrs. Pallocette asks direct questions related to her diagnosis he will answer them, or he may suggest that they both meet with Rita's mother to assess which questions to answer in relation to her illness. As can be seen by this case, each situation presents its own unique features requiring careful consideration.

MEDICAL ERROR

In medicine, mistakes are unfortunately common. Because physicians are human, mistakes are expected and at times even understandable (Wu, Cavanaugh, McPhee, Lo, & Micco, 1997). However, despite the fact that errors occur and are expected, patients and their families are rarely informed of these errors. One study completed by Wu, Folkman, McPhee, and Lo in 1991 demonstrated that medical residents reported informing their attending physicians about serious mistakes only half of the time, and told families of these mistakes less than a quarter of the time.

The AMA code of ethics requires that a physician report an "accident, injury, or bad result stemming from his/her treatment." Frequently, it is assumed that this means that the physician should tell the department director or supervisor. The American College of Physicians Ethics Manual (1992) states that physicians should disclose to patients

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information related to a procedural error or errors in judgment made in the course of providing treatment. In consideration of this requirement, the logical question is; Why are errors discussed with patients and families so infrequently? Some state that the single most significant obstacle to reporting medical error is fear of malpractice litigation (Baylis, 1997; Liang, 1999; Martin, Wilson, Fiebelman, Gurley, & Miller, 1991; Wu et al., 1997; Leape, 1994). Ironically, "however, several studies have indicated that open communication, honesty, and disclosure of mistakes to patients will actually decrease the likelihood of a lawsuit" (May & Aulisio, 2001). Communication issues were cited as the primary reason for lawsuits in 80% of the cases, according to one study (Avery, 1985). However, fears do not change overnight, nor do physicians suddenly learn how to communicate more effectively because they wish to disclose an error to a patient or their family.

A mistake is defined as a "commission or an omission with potentially negative consequences for the patient that would have been judged wrong by skilled and knowledgeable peers at the time it occurred, independent of whether there are any negative consequences" (Wu et al., 1997, p. 770). Errors can be system based because they occur on a systems level. In this form of error, the mistake occurs from flaws in the system where medicine is practiced. In situations where such errors occur, the system is so inherently flawed that it sets the individual up to make mistakes. When a system error occurs, the responsibility for its occurrence is shared by a series of individuals, not just one.

Conversely, individual errors occur as a direct result of deficiencies "in the physician's own knowledge, skill, or attentiveness" (Wu et al., 1997). In cases of individual error, the physician is solely responsible.

Ethically, individuals have a right to know when a medical mistake occurs because it is logical and appropriate and is a matter of respect (Finkelstein, Wu, Holtzman, & Smith, 1997). A recent report published by the Institute of Medicine, *To Err Is Human*, stated that "most errors and safety issues go undetected and unreported, both externally and within health care organizations" (Kohn, Corrigan, & Donaldson, 1999). How patients and families are informed of medical error is outlined within hospital policy or institutional policy. The JCAHO has

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strict guidelines in each institution regarding the reporting of medical errors, as do most state departments of health. It is imperative that the clinical social worker become aware of these policies, guidelines, and standards.

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Standard 1.07(a) of the NASW Code of Ethics (1996) states that “Social workers should respect clients’ right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation research. Once private information is shared, standards of confidentiality apply.” (Reamer, 1998, p. 56).

Social workers can disclose confidential information with the consent of the client or other person legally authorized to do so [Standard 1.07(b), NASW Code of Ethics, 1996]. As previously stated, there are exceptions to this standard. Local, state, and/or federal regulations may require disclosure of confidential information that pertains to a number of sources such as: protection of third parties from harm [Standard 1.07(c)]; mandatory reporting of suspected child or elder abuse and neglect; assessment, treatment, or referral of clients for substance abuse issues; coordination of services with other agencies involved with the client; service delivery within the agency that serves clients (with other staff members); deceased clients; news media; peer supervision and consultation; minors’ parents or guardians; or law enforcement. Social workers must clarify when consent is and is not necessary for such disclosures (Reamer, 1998).

Additionally, social workers should inform clients whenever possible that they are going to disclose information and should reveal the possible consequences of the disclosure. When social workers enter into the helping relationship, a discussion of what confidentiality means and what the limitations are to the clients’ rights to confidentiality is necessary. The social worker must inform clients of circumstances that may cause disclosure to become necessary, as in the disclosure of abuse or intent to harm another person [Standard 1.07(e), NASW Code of Ethics, 1996]. Even in these cases, unless the social

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worker believes there will be further harm, the client should be informed that the disclosure is to take place and why.

In the medical setting, ensuring privacy and confidentiality of client's information is often difficult, for the reasons enumerated earlier in this chapter. Social workers have a particular responsibility, however, to make every effort to protect information that patients share as well as information that is to be shared with patients and families. For example, Jack Smith, 80 years old, is transported to the emergency department of a large urban trauma center for treatment after he fell from a ladder while cleaning the gutters on his house. Mr. Smith's wife rides with paramedics during the transport. They arrive at the emergency department and Mr. Smith is immediately taken into the trauma room for treatment. Mrs. Smith is greeted by the social worker, who escorts Mrs. Smith, who is tearful and visibly shaken, to a private family room. They discuss the circumstances of the injury and Mr. Smith's medical history and the social worker quickly assesses the couple's psychosocial-spiritual history while they await the outcome of the initial medical assessment.

Particularly since the diagnosis is unknown, privacy for this family is essential. Mr. Smith's daughter and son-in-law arrive shortly after the physician and nurse have told the wife that he has suffered a severe spinal cord injury at C2 level and has been placed on a ventilator to assist him to breathe. The physician also stated that because of the severity of the injury, the likelihood that Mr. Smith will regain consciousness and be able to breathe on his own without ventilatory support is very small. The family is left to discuss with the social worker what Mr. Smith's wishes for treatment would be in this situation. Such an intimate and difficult discussion calls for the utmost privacy and confidentiality. As other family members begin to arrive, Mrs. Smith is asked who she would like to be with her in the "family room" for discussion and disclosure of confidential information about the end-of-life decisions to be made.

While this level of privacy may be possible in some circumstances and is certainly ideal, most of the time it is difficult to ensure. Considering that most hospital rooms are semi-private, often the patient's roommates may be present during discussion of diagnosis, prognosis, and treatment options. The social worker may be able to arrange fam-

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ily meetings with the physician and other healthcare professionals when the roommate is out of the room for physical therapy, for example. If the patient can physically leave the room, the social worker's office or other private office or conference room may be used. At the very least, the patient and family should be asked whether they are comfortable discussing personal information with the roommate present.

The home setting is much more intimate and privacy may afford the patient and family better control. In this setting, the professionals are the outsiders and patients and families feel most comfortable—on their own turf. However, as many health professionals enter the home, privacy may diminish there as well. Consider the daughter caring for her mother, who is dying from pancreatic cancer. A hospice nurse visits twice a week and a nurse's aide visits every other day to bathe the patient. This patient and family are giving up precious privacy to allow professionals to assist with care. The social worker can examine the arrangements for care and discuss how to schedule visits to maximize privacy. Perhaps afternoon visits for bathing will be best, as the daughter feels she is able to spend more quality time with her mother in the mornings.

Social Workers and HIPAA

The HIPAA medical privacy regulations apply to all healthcare professionals, including social workers working in healthcare facilities. Social workers should make themselves aware of these regulations and of the way their facility records compliance with the law. The NASW Code of Ethics (1996) places a higher standard on social workers than HIPAA regulations to maintain confidentiality of client records. According to the HIPAA Privacy Rule, social workers may disclose patient information without patient consent for a number of purposes. For example, this disclosure may occur if there is a court order. However, if a court orders disclosure of patient information and the social worker believes this will cause harm to the patient, then a request should be made that the court withdraw the order or limit the information that is to be disclosed [Standard 1.07(j), NASW Code of Ethics]. If a subpoena is issued, special procedures under the HIPAA Privacy Rule apply; it is noted that this is inconsistent with the NASW

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Code of Ethics, unless the patient has consent to the disclosure or is court ordered, or meets other mandatory disclosure requirements (i.e., state laws). In addition, if the state law is more protective of patient privacy than the HIPAA Privacy Rule, then the stricter standard is to be followed. If a social worker should receive a subpoena or have other questions about what is legally required, he or she should seek legal counsel to be sure of the correct action. Hospitals and most healthcare facilities have legal counsel on staff that can be consulted in these matters.

Chapter Conclusion

A trusting relationship with healthcare professionals is essential to good medical care. In these relationships we trust that personal information will be kept confidential. Patients expect to be told the truth regarding their illness and treatment options. These signs of respect can go far in transforming impersonal healthcare facilities or agencies into caring institutions. The vulnerability of people who are ill, and particularly those facing death, must be protected. End-of-life decision making requires that patients and families be extended, as much as possible, privacy, confidentiality, and truth telling, even in the face of medical error.

The concept of privacy and confidentiality is familiar to social workers and to most other professionals through their codes of ethics. The NASW Code of Ethics (1996) holds social workers to strict professional standards of ethical conduct regarding confidentiality; in some cases they are expected to uphold higher standards than state or federal laws (HIPAA) may require. Social workers are skilled in the essential components of helping relationships and should assist other professionals to recognize when these relationships are not working effectively. Social workers can instruct and model ways to provide adequate assurance of privacy and confidentiality to meet the needs of patients and families when they are most vulnerable.