A Married Man Seropositive for Human Immunodeficiency Virus

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JOHN G. PRICHARD, MD (*Assistant Professor, Departments of Family Medicine and Internal Medicine*): Today's case involves issues likely to be increasingly encountered by family physicians; thus it is propitious for this conference. As there are difficult legal, clinical, and ethical components, I have asked several colleagues to discuss each area in some detail. I begin by presenting the patient's history and clinical findings.

CASE PRESENTATION

A 47-year-old married father of two was seen in consultation because of a positive serological test for human immunodeficiency virus (HIV). He had obtained the test, on his own initiative, at an alternate test site. He complained only of difficulty in falling asleep during the previous three months. He denied weight loss, fever, cough, dyspnea, symptoms referrable to the gastrointestinal tract, or new skin lesions. He denied sensory changes, memory deficits, or difficulties with calculations. His past medical history was remarkable for an appendectomy at age 7 years and multiple fractures resulting from a skiing injury at age 28 years. He otherwise has enjoyed good health and has continued to be a vigorous skier, sailor, and tennis player. He does not smoke, consumes 1 to 3 oz of alcohol daily, and takes no medications. He is employed as a senior geologist for an oil exploration company, and he travels extensively in the Middle East, Europe, and Latin America. In the past ten years, during lengthy travels abroad, he engaged in a number of homosexual affairs. He nonetheless considers his marriage to be very stable and is committed to its continuance. His family and friends are unaware of his bisexual behavior, and he is adament regarding confidentiality of his medical record. Two sons attend high school.

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A physical examination revealed a muscular, anxious man who appeared somewhat younger than his age. Height was 72 inches and weight, 172 pounds. Findings on examination of the ears, eyes, nose, and throat were unremarkable. Multiple, greater than 1-cm nodes were palpable in the supraclavicular fossa bilaterally, in both axillae, and in both femoral regions. These nodes were soft, nontender, and nonfixed. Bilateral epitrochlear nodes were palpable. An examination of his skin disclosed no abnormalities. The chest was clear to percussion and auscultation. Cardiovascular and genitourinary tract examinations were normal. There was no hepatomegaly, no masses or tenderness on palpation of the abdomen; however, the spleen tip was palpable 2 cm below the left costal margin. Findings on detailed neurological examination were normal.

Laboratory studies disclosed a white cell count of 4 $\times 10^6$/L (4000/mm^3) with a normal differential. The hemoglobin was 101 g/L (10.1 g/dL), and the platelets were 72 $\times 10^9$/L (72 $\times 10^3$/mm^{-3}). The serum ferritin level was elevated, the serum iron and iron-binding capacities were diminished. The sedimentation rate was 42 mm/h. The reticulocyte count was 0.013 (1.3 percent). The red cell indices and peripheral blood smear were normal. Results of a 20-item chemistry panel, which included measurements of renal and hepatic function, were within normal limits. Findings on chest x-ray film were unremarkable. A VDRL was nonreactive, and a serological study for HIV was positive by Western blot.

On a return visit to discuss the results of laboratory tests, he denied any new symptoms. He refused to discuss the HIV seropositivity with his spouse. He wished to continue being seen at this institution but forbade any discussion of his illness with anyone other than himself. The patient stated that he felt he could maintain a relationship with his spouse without continuing to expose her to the virus. Further diagnostic studies were recommended but declined for the present.

I have asked Dr. Morris to begin the discussion by identifying some legal issues raised by the case—particularly regarding confidentiality and the duty the physician might have toward the patient's spouse.

LEGAL ISSUES

DR. MORRIS (*Assistant Professor, Department of Family Medicine*): A major issue of legal importance in this case is whether a physician may be held liable for unauthorized disclosure of confidential information. More specifically, we are concerned with whether the physician may disclose the patient's seropositivity to his wife or any third party.

Confidentiality is central to each physician-patient encounter. Its importance in our daily activities has been emphasized since the Hippocractic oath, is still emphasized in ethics manuals, and is currently addressed in statutory law. On the federal level, the Federal Drug Abuse and Treatment Act has provisions for maintaining confidentiality. State licensing statutes usually contain provisions against unprofessional or dishonorable conduct as well as provisions regarding confidentiality.

There are at least four legal theories under which a physician may incur liability for unauthorized disclosure of confidential information. The first is violation of a statute. In one case involving a statutory licensing provision, it was held that unauthorized disclosure of confidential information by a physician would give rise to a civil action for the damages naturally arising from such a wrong.[1] In another case involving a licensing statute, it was held that the standards set out in the statute were merely administrative provisions and did not give the patient a right to recover for an alleged wrongful disclosure of medical information.[2] Hence, a court's interpretation of relevant statutory provisions may vary from state to state.

The second theory of liability is invasion of privacy. In one case involving unauthorized disclosure of confidential information by a physician to an insurance company, the court stated:

> The preservation of the patient's privacy is no mere ethical duty on the part of the doctor, but is a legal duty as well, so that the unauthorized revelation of medical secrets, or any confidential communication given in the course of treatment is tortious conduct which may be the basis for an action in damages.[3]

An important factor to be considered, however, is the person to whom disclosure was made. In a case in which the physician discussed his patient's condition with the patient's wife, it was held that there was no invasion of privacy, as it was a reasonable disclosure to persons who had a legitimate interest.[4] In the present case, although unauthorized disclosure of confidential material could expose the physician to liability, there may be some protection if the disclosure were only to the patient's spouse.

The third theory under which a physician may be held liable for unauthorized disclosure is breach of the physician-patient confidential relationship. Though not recognized in some jurisdictions, disclosure without consent may be seen as a breach of a fiduciary relationship, giving rise to a cause of action.[5]

The fourth theory under which a physician may incur liability is that of professional negligence or malpractice. Malpractice is defined as "any professional misconduct, unreasonable lack of skill or fidelity in professional or fiduciary duties, evil practice, or illegal or immoral conduct."[6] There are basically four elements, each of which must be proven to establish malpractice. Only two are pertinent in this case. First, there must exist a fiduciary relationship that creates a responsibility, or duty, on the part of the physician to conduct himself professionally. This duty is inherent once the physician-patient relationship is established. Second, there must be some breach of this duty or deviation from an accepted standard of care. There is precedent to support a physician's disclosure of information about a patient to others, even if such disclosure is unauthorized. In *Tarasoff v Regents of the University of California,*[7] which involved a therapist who did not disclose information to a third party, the court stated:

> . . . once a therapist does in fact determine or . . . should have determined, that the patient poses a serious danger . . . to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.

Clearly our patient poses a potential danger to his wife. This precedent offers some guidance as well as support for the argument that one would be protected from liability for unauthorized disclosure of confidential information.

Legal defenses to suits for unauthorized disclosure of confidential information include the following: disclosure in the public interest, disclosure only to those with legitimate interests, duty to disclose imposed by law, and absence of malice. In one case involving disclosure of a mistaken diagnosis of syphilis, the court stated:

> Where a physician makes a disclosure of information imparted by a patient to secure treatment, believing that such disclosure is necessary to prevent the spread of disease, and the physician acts in good faith, with reasonable grounds for his diagnosis and without malice, he cannot be held liable in damages by his patient, even though he is mistaken in his diagnosis.[1]

The defense that disclosure is required by law may become relevant, in some jurisdictions, in light of proposed communicable disease reporting statutes that might require that HIV seropositivity be a reportable condition.

In summary, unauthorized disclosure of confidential information arising during a physician-patient encounter may expose a physician to liability. There exists, however, some protection against liability if the disclosure is shown to be in the public interest, is disclosed only to the patient's spouse, or is required by law.

ETHICAL ISSUES

EARL E. SHELP, PhD (*Assistant Professor of Medical Ethics, Department of Community Medicine; Fellow, Theology and Medical Ethics, Institute of Religion*): When

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faced with a difficult decision that is not strictly medical in nature, clinicians tend to seek the guidance of either statutory or case law. As the legal overview just provided indicates, however, the law doesn't always provide clear answers. Ethics and moral instruction have a long history of providing guidance for human conduct and, at least in theory, serve as a foundation for laws governing human interaction.

The contribution that ethics provides to the practice of the healing arts is reflected in the hippocratic writings, including the Hippocratic oath, that are often referenced as the moral charter documents for scientific medicine. Over the centuries a series of principles and rules of conduct have evolved to guide medical practitioners in their pursuit of knowledge and in their efforts to benefit patients.[8] These principles and rules, at times, may appear to conflict, thus placing a physician in a situation of not being certain about the right course to follow. The most obvious conflict that the physician faces in this case stems from a desire to respect a patient's request for confidentiality and a sense of duty to protect the patient's wife from possible harm, more specifically, HIV infection. It should be noted that the duty of physicians toward individuals who are not their patients is a relatively new concept in the history of medicine. The Tarasoff opinions are landmarks articulating this individual-specific duty. Prior to Tarasoff, however, a physician's duty to protect people who are not the physician's patients was directed more toward the public's welfare.

The conflict implicit in the present case is not novel from a moral point of view. It is analogous to conflicts regarding confidentiality involving other sexually transmitted diseases. Physicians and medical ethicists, prior to the appearance of HIV, debated whether a breach of confidentiality regarding a sexually transmitted disease was justified. We are now faced with the question of whether the rules of confidentiality change when the secret is HIV infection. Given the particularly sensitive nature of this information, it should also be asked whether there are practical strategies a physician may adopt to avoid the sort of conflicts apparent in the present case.

The patient's presumption is that whatever a physician learns during a clinical encounter will be kept secret unless a patient consents to specific disclosures. There are two types of moral justifications for the rule of medical confidentiality. A deontological justification is, simply, that it is right to keep promises. The promise of secrecy may be implicit or explicit to the patient-physician relationship and should be kept unless there are overriding reasons not to do so. A consequentialist justification is that a patient's forthright and honest communication promotes the ability of physicians to benefit patients individually or as a class. Thus, it can be morally argued that confidentiality ought not to be breached unless a patient consents or is required by law.[9] Neither exception applies in the present circumstance.

In this case, the physician reasonably could ask what action is morally permissible. The moral principle of beneficence states that moral agents should do good, or when it is not possible to achieve a good, do that which will prevent or lessen harm. As a general guide to conduct, the principle of beneficence provides a valuable instructive service.[10]

There are several goods that might deserve protecting in the present case: keeping promises, maintaining a patient-physician relationship, maintaining a patient's trust, and protecting the patient's wife from potential HIV infection. Among the possible evils or harms to be avoided or lessened are infection of the wife by the husband with HIV, loss of the individual patient's trust, undermining of the public trust in the medical profession, loss of the patient-physician relationship, and a breach of an implicit or explicit promise. The good selected to be pursued or harm to be avoided will reflect the values of the person choosing. Thus, whether the physician in the present case decides to respect confidentiality or decides to disregard the patient's request, the choice will carry a price of risking certain harms or sacrificing certain goods.

Based upon this analysis, two recommendations are offered: (1) Physicians should not make implicit or explicit promises that cannot or will not be kept; (2) with respect to information derived from HIV antibody testing, clinicians should recognize the sensitive nature of the test result and should order the test only with appropriate counseling and consent, making certain that the patient understands how the physician intends to handle the test result.

DR. PRICHARD: Thus far we have developed some of the legal and ethical issues that the present case illuminates. I have asked Dr. Goolishian to discuss an approach toward this and similar conflicts from his perspective as a family therapist.

A FAMILY THERAPIST'S PERSPECTIVE

DR. HAROLD GOOLISHIAN (*Clinical Professor, Department of Family Medicine; Director, Galveston Family Institute*): We can spend a good deal of time on the issues of confidentiality, right and duty to inform, and legal malpractice issues. Certainly these are cogent and important issues that deserve attention.

On the other hand one could also think of this case from the perspective of a patient who is having difficulty disclosing. From this perspective the problem is the patient's, and the question we then ask is in what way can the physician intervene in such a way that the issue of disclosure ceases to represent a problem.

Insofar as possible, we should operate on the premise that the best people to solve problems are those who have them. We must try to understand and position ourselves within such a framework so that we can be consultants to the patients' work rather than doing it for them.[11]

In the practice of medicine and other healing arts, it is often necessary to make a distinction between social control and treatment. Social control is the mandating and enforcing of conduct and behavior. Treatment is an expert consultative process that permits individuals to change themselves. Control limits behavior, while treatment optimizes the opportunity for changing behavior. As healers, treatment and consultation are always preferable to control, provided of course that the option is open to us. Sometimes the choice is determined by the questions we ask, such as in this case. Whose problem with disclosure is it?

There are a myriad of details regarding the social, psychological, family, community, church, business, and other contexts in this patient's life that must be assessed to understand clearly how we might intervene so that disclosure is no longer a problem for the patient discussed today, and he may do what, I think, he knows he must do. It is imperative that we understand his reasons, his anxieties, and our role in being able to assist him with his difficult task. In problems of this sort, as in many others, our attitudes, fears, concerns, and values can complicate our task. To enter into a therapeutic conversation regarding this man's dilemma, we must have the capacity to respect and understand his concerns and his style.[12] We can then promote the opportunity for him to solve his problem rather than for us to do it for him. In matters of urgency we sometimes move too fast. With a problem such as the one presented today, it is urgent that we proceed as slowly as time permits.

The patient, in this instance, is obviously a man of high intelligence and accomplishment. He enjoys a high status in his career, community, church, and family. He is accustomed to controlling his life and making his own decisions. These are all strengths that one could use to make the problem truly his. In the final analysis he is the person with the problem of disclosure, not the physician. This is, it seems, still a matter of treatment, not a matter of control.

DR. PRICHARD: We have had an opportunity to meet with this gentleman on two subsequent occasions. Our approach was similar to that outlined by Dr. Goolishian. We were able to discuss his personal fears and concerns for his family and allow enough time for him to formulate his own plan of management. He has since disclosed the nature of his illness to his wife, explaining its origin as a consequence of a distant, no longer extant, heterosexual affair. We are currently providing medical and supportive therapy for both him and his wife. We have obtained an HIV assay as part of her evaluation. Results are not currently available, though it is important to note that seropositivity is not necessarily to be expected.[13] Though the patient's risk of developing acquired immunodeficiency syndrome will increase with time,[14] at least for the present,

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some of the psychologic and social morbidity attendant to HIV infection may have been obviated.

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