

RCSI^{smj} Ethics Challenge winner 2009

“Whatever in connection with my professional practice ... I see or hear, in the life of men ... I will not divulge.”

– Hippocratic Oath
(5th Century BC)



Royal College of Surgeons in Ireland Student Medical Journal 2010; 3: 20-24.

Introduction

The RCSI^{smj} Ethics Challenge 2009 presented the case of a rural GP in Ireland who has diagnosed one of his patients, Richard, as HIV positive. Given a troublesome marriage in which Richard and his wife Sheila have stopped any form of intimacy, the GP is threatened with litigation should Richard's HIV status become known to Sheila. The age-old notion of patient confidentiality is, clearly, at the centre of this ethical dilemma. This article aims to identify the ethical issues raised by the case, to address

these academically and to suggest how the situation might be addressed in a satisfactory manner.¹ Throughout the article weaknesses of the arguments are also identified. The underlying question that is posed is of interest to medical students who will encounter ethical dilemmas throughout their careers: how is it possible for a GP to reconcile his professional duty of confidentiality with protecting the welfare and health of another patient and of society in general?

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Ethical issues

The case raises key ethical issues, which merit academic discussion. The core issues are:

- Richard's autonomy and right to confidentiality;
- Sheila's autonomy and right to health;
- the GP's dilemma in respecting Richard's confidentiality while simultaneously safeguarding the health of Sheila and of society at large;
- the GP's "duty to warn";
- the GP's choice of method of disclosure;
- Richard's and the GP's responsibility to prevent transmission; and,
- the GP's responsibility to notify authorities.

Background – ethics

Before the case is tackled it is important to establish basic principles of ethics and law that can be referred to in our line of argument. There are four basic principles of ethics (the "Belmont principles") that must form the basis of all medical decisions for doctors:

- beneficence: an obligation to provide the most beneficial treatment;
- non-maleficence: the duty to protect persons from harm;
- autonomy: the patient's right to an informed, uncoerced decision with regard to their diagnosis and treatment (informed consent and patient confidentiality are extrapolations of this principle); and,
- justice: the physician's responsibility to provide equal medical care to all.²

The main conflict for the GP in this situation is the balance between Richard's autonomy in terms of confidentiality, and non-maleficence towards Sheila, who is at a potential risk of contracting HIV.

Background – Irish Medical Council guidelines

According to the Irish Medical Council (IMC), there are four circumstances in which exceptions to confidentiality may be justified without the patient's consent:³

1. When ordered by a judge in a court of law, or by a tribunal established by an act of the Oireachtas.
2. When necessary to protect the interests of the patient.
3. When necessary to protect the welfare of society.
4. When necessary to safeguard the welfare of another individual or patient.

The IMC further stipulates that in cases where one of the above is satisfied, notifications to third parties should, if possible, be made with the informed consent of the patient.³

In accordance with point 4 of the IMC framework, the GP is obliged to safeguard Sheila's welfare by informing her of Richard's diagnosis. Although the couple is currently not intimate with each other, a legitimate potential risk of transmission exists

due to the nature of their relationship (i.e., marriage).⁴

Also, the IMC guideline to protect the welfare of society is pertinent to this case and will be explored in more detail shortly. Does the GP need to be concerned about the welfare of society? Are there any guidelines that require him to alert the authorities to prevent local transmission?

Legal issues and physician litigation

Despite such guidelines, physician liability and potential legal cases must still be addressed. To illustrate physician immunity, a case in India (where the Medical Council employs almost identical ethical guidelines)⁵ is used here.

The 'Mr X vs. Hospital Z' case involved a man's claim for damages against a hospital whose staff informed his future wife's family of his HIV status. The court held that the future wife's right to health, and the provision of the Indian Penal Code, which makes it an offence to knowingly risk spread of an infectious disease, legally negated the patient's right to confidentiality. Furthermore, the Indian Code of Medical Ethics permits the disclosure of otherwise confidential information when there is a health risk to another person.⁶ Thus, the GP in this case should receive a favourable verdict if a legal case is filed against him. Naturally, this conclusion must be drawn cautiously since it is based on the assumption that no other factors confound the case.

The Tarasoff case and the "duty to warn"

The Tarasoff case was a landmark trial in the USA in which Prosenjit Poddar had informed counsellors of a fantasy to harm an unnamed love interest, who was readily identifiable as Tatiana Tarasoff. Poddar's healthcare providers raised concern but efforts to commit him as an inpatient were dropped as authorities found him to be "rational". Two months later, Poddar stabbed Tarasoff to death. The courts ruled that counsellors had had the "duty to warn" Tarasoff. The conclusion of the trial has altered the practice of healthcare. It is now widely accepted that a patient's "protective privilege ends where the public peril begins".⁷ Applying both current Irish legal requirements and the Tarasoff case to our dilemma, there seems to be an obligation on the GP to inform Sheila. The weakness of this argument, however, is that the breach of confidentiality and consequent repercussions are based on assumptions of how Richard will act, not on his actions themselves. We assume that he will have intercourse with his wife. But how can the GP justify pre-emptively disrupting Richard's life despite knowing that Richard and Sheila are not sexually intimate?

From an academic perspective, the literature shows that anywhere between 40 and 65% of HIV-positive individuals (both heterosexual and homosexual) fail to disclose their condition to all of their sexual partners.^{8,9,10} For argument's sake, if we assume that Richard will fall into this category, then we must further examine disclosure, reasons for non-disclosure and the benefits of disclosure of HIV status in order to obtain the best outcome for all those involved.

Disclosure

HIV status disclosure has long been recognised as a complex interaction of individual beliefs, social support, and relationship types and their sexual nature.¹¹ In the current biopsychosocial model of healthcare, it is paramount to recognise these factors in the prevention of further HIV transmission.^{12,13,14,15}

Thus, the following question arises: to whom does the patient need to disclose their HIV status? Is it only to sexual partners? Or is it also to friends, family, employers, healthcare providers or even strangers? Commonly cited reasons for non-disclosure include stigma, need for privacy, fear of rejection by sexual partners, denial, low viral load, type of sex, location of sexual encounter, legal reprisal (fear of arrest), and condom use (no need to disclose).^{9,16,17} Interestingly, research shows that individuals who self-identify as homosexuals, ethnic minorities, sex workers, or those who report depression, are less likely to disclose.^{17,18}

Open disclosure has been found to lower infection rates, as persons are motivated to adopt safer sex practices.¹² It is also recognised that non-disclosure plays a central role in global HIV transmission and is associated with greater sexual risk taking.^{13,14} Social analysis has shown that HIV disclosure to one's family, friends, and lovers – although potentially socially detrimental – was also found to be positively related to social support and the use of more adaptive coping strategies.¹⁹ The implications of this literature on our case are that these are the issues that Richard needs to have addressed before he can disclose his status to his wife. His main concern is further marital discord, perhaps even separation from his wife. Undeniably, Sheila is at risk of infection. However, being the immediate patient, the GP's role would be to address Richard's underlying concerns. The communication involved in this type of counselling would ensure that the GP has done everything in his power to gain informed consent from Richard before informing Sheila. This step is not strictly necessary – it is merely humane.

HIV in stable relationships

With an increasing number of HIV infections occurring in stable relationships, the burden of coping with HIV notification and its economic, emotional and physical impacts is well established. In contrast, little has been written on the impact of HIV disclosure on partnership durability or dissolution. The literature, using cohorts from Northern Thailand, Uganda and Malawi, identifies the following six factors that determine marital stability in couples in which only one partner is HIV positive:^{20,21,22}

- gender (males are more likely to divorce an HIV-positive wife than vice versa);
- duration of partnership before disclosure;
- economic constraints;
- the role of the extended family for social support;
- fear of stigmatisation by community;
- and,
- the existence of children, which is strongly correlated with a decision to stay in the marriage.

The weakness of this approach is that the presence of risk factors predisposes to, but does not predetermine, individual behaviour. Consequently, although Sheila is a female and the couple has two children, it would be impossible to judge Sheila's reaction. Furthermore, a particular weakness of this argument is that conclusions based on this literature need to be drawn with caution because of differences in cultural, economic and religious circumstances.

Partner notification

The next issue that we explore is the role of the GP and how he can best address this situation.

The literature suggests three methods of partner notification. Partners may be notified: by index case – “patient/self-referral”; by a healthcare worker – “provider referral”;²³ or, by “contract referral”, in which healthcare workers encourage index patients to notify their partners.²⁴ Although all three approaches have been shown to be successful methods of disclosure,²⁵ researchers in North America have shown that provider referral generally ensures that more partners are notified and medically evaluated than self-referral does.^{26,27,28}

In the last decade, literature has been published regarding recommendations and guidelines for breaking bad news.²⁹ However, it is important to note that there is little evidence about the best approach, so most guidelines are based on opinion.³⁰ Buckman developed a six-step protocol that the GP may employ in this circumstance. The model is based on private meetings with no time constraints, in which both partners can have all their ideas, expectations, concerns and questions addressed.²⁹

This academic point addresses one of the core issues in our case, and suggests that the GP should inform Sheila personally in order to ensure her safety. A compromise solution between the methods of disclosure could be a combination of the three approaches. For example, the GP could encourage Richard to notify Sheila during a joint consultation in his practice. This method would change the dynamics of confidentiality between the GP and his patients and ensure that accurate information is conveyed to Sheila. The session may also be used to answer any medical questions that Sheila may have.

Transmission prevention

Viral load, the chief predictor of HIV transmission, is dramatically reduced by successful antiretroviral treatment.^{31,32} Promoting both condom use and antiretrovirals will further reduce the chances of transmission.³³ It is important to keep in mind that the risk of transmission increases both with increasing number of encounters and the nature of encounters. Encouraging abstinence is a possible measure; however, it is generally less utilised in the setting of serodiscordant couples.^{34,35} Recently, international research has made it clear that male circumcision can be efficacious in reducing the risk of HIV transmission from men to women.³⁶

In keeping with non-maleficence, it is essential for the GP to address prevention of HIV transmission between Richard and Sheila. Whatever the result of the marriage, it is crucial that the GP educates both Richard and Sheila on HIV prevention for the benefit of Sheila and all their future potential sexual partners.

Disease notification

In a broader sense, the GP's responsibility for reporting Richard's HIV status to public authorities is disputable. In Ireland³⁷ and the United Kingdom,³⁸ in contrast to the USA,³⁹ HIV is not a notifiable disease. This is despite evidence that many Irish healthcare professionals believe that HIV should be notifiable.⁴⁰ Reports recognise that the current status of notification in Ireland has significant implications for epidemiological studies and causes considerable underestimation of the prevalence of HIV.⁴⁰ The GP's approach in this case should be to keep Richard's HIV status confidential in terms of the broader community. Unless he has occupational exposure that may put others at risk, there is no utilitarian benefit of disclosing his status to the community. The weakness of this approach is that HIV surveillance and epidemiology is impeded, but its strength is that it upholds the patient's confidentiality and dignity.

Conclusion

Breach of confidentiality is a contentious issue that requires ethical sensibilities and a thorough understanding of current legal

guidelines. Both of these must then be synthesised into a plan of action for the GP involved in the case. Given the information presented, we therefore suggest that the GP take the following approach:

- applying the Belmont principle of non-maleficence, the IMC guideline of disclosure to safeguard the well-being of a third party, and the "duty to warn", the GP should set out to inform Sheila of Richard's HIV status;
- the GP should address Richard's reasons for non-disclosure and counsel him on the benefits of disclosure. This is in line with the Belmont principle of beneficence;
- the GP must progress to inform Sheila; he may do this himself, or by encouraging Richard to do so. This needs to happen in private, with sufficient time for both Richard and Sheila to ask questions and voice concerns;
- Richard and Sheila should both be counselled in the prevention of HIV transmission and safe sex practices; and,
- as HIV is not notifiable in Ireland, authorities need not be informed in this instance.

In conclusion, it is evident that the management of a couple in which one partner has been diagnosed as HIV positive is a complex issue. The Hippocratic Oath, in which doctors swear to confidentiality, should be implemented with consideration for the ethical and legal context.

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