

## Confidentiality, trust, and sexually transmitted infections

*The author thanks PA Steve Hale, who sent in this case and a series of questions about it. Mr. Hale's case is presented first, followed by his questions in the ethical quandary section and the response in the discussion section.*

### ›CASE

You test a patient for sexually transmitted infections (STIs) at her request. She tests positive for *Chlamydia trachomatis* infection. You call and ask her to come to the office to discuss her test results. You give her medication for the infection, and you counsel her to refrain from having sex with anyone—especially with anyone with whom she has had sex in the past 60 days, until those persons are treated. You ask her to encourage her recent sex partners to be tested and, if necessary, treated. You also provide patient education about chlamydia. You suggest strongly that the patient return for a routine retest and examination in 6 months, explaining carefully that any of her partners who are not effectively treated for chlamydia may reinfect her.

### ›THE ETHICAL QUANDARIES

- Have you done enough by treating this patient for this infection, even though she might become reinfected if her partner does not seek care?
- Should you counsel every woman to be tested for syphilis, HIV infection, hepatitis B and C, chlamydia, gonorrhea, and trichomoniasis? Or should you offer those tests routinely only to women who fall into certain high-risk categories?

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- Should you give the patient medication for up to two sexual partners and educational materials for any other partner? Should you insist on treating the partner also? Or should you refer them both to the local health department in the interest of community health?
- Since STIs are a community health hazard, should you ask the patient for information about her partners and send it to the health department? Should you inform the health department about the patient and tell her that the department will call? From a practical standpoint, how do you maintain a good relationship with your patient while insuring proper treatment of infected community members who are not patients in your practice?
- Is it ethical and adequate to treat just one person for an STI when STIs are a community problem that must be addressed by someone with the interests of the community at heart? How do you strike the right balance between patient care and care for the community? How do you address the need for the patient to contact and seek treatment for her partners in the event of a positive diagnosis?
- Should you test women at risk for common STIs (by current CDC guidelines) as part of a routine check-up, without obtaining their express written consent? If you do, are you assuming wrongly that patients having routine checkups want information about and testing for the most common threats to their health?

Mr. Hale says that he errs in favor of testing even low-risk women because testing is easier during a routine check-up and a woman's partners may not be as low-risk or monogamous as she is. This is his bias as a retired army PA who ran an STI clinic for 6 years.

### ›DISCUSSION

Mr. Hale's questions fall into three categories: medical or public health practice, ethical concerns about confidentiality, and ethical concerns for patient autonomy. The questions about medical or public health practice are beyond the purview of this column. **CONFIDENTIALITY AND PUBLIC HEALTH** issues are challenging. The foundation of patient confidentiality is the fiduciary responsibility to our patients that is based on trust. Medical confidentiality has a long history rooted in the Hippocratic Oath. The World Medical Association Declaration of Geneva seems to go further: "I will respect the secrets which are confided in me, even after the patient has died."<sup>1</sup> When trust is established in the PA-patient relationship, the patient's narrative will include intimate details that if not included would hamper our ability to provide comprehensive assessment and proper treatment.

Professional ethics requires thoughtful deliberation about the obligations of the profession. The Guidelines for Ethical Conduct for the Physician Assistant Profession reflects such thoughtful deliberations.<sup>2</sup> This document states: "Physician assistants hold in confidence the information shared in the course of practicing medicine."<sup>2</sup> This obligation is further described in the document: "Physician assistants should maintain confidentiality. By maintaining confidentiality, PAs respect patient privacy and help to prevent discrimination based on medical conditions. If patients are confident that their privacy is protected, they are more likely to seek medical care and more likely to discuss their problems candidly."<sup>2</sup>

Here, though, is the conundrum: Infectious disease—in this case, an STI—is a danger to the public health. Our guidelines identify our obligations:

“Patients should be treated as self-governing persons who are allowed to act in accordance with their freely-chosen, informed choices.”

“Physician assistants should work for the health, well being, and the best interest of both the patient and the community. Sometimes there is a dynamic moral tension between the well being of the community in general and the individual patient. Conflict between an individual patient’s best interest and the common good is not always easily resolved. In general, PAs should be committed to upholding and enhancing community values, be aware of the needs of the community, and use the knowledge and experience acquired as professionals to contribute to an improved community.”<sup>2</sup>

As individual PAs, our patients are our highest priority. We have a bound obligation to sustain their best interest. To break that bond, there must be a considerable justification. A theoretical justification in which the public good outweighs the patient’s right to privacy and confidentiality might include violence and violent crimes—hence mandatory reporting of knife and gunshot wounds. Abuse and neglect of vulnerable populations (elders and children) must be reported. Finally, specific contagious diseases such as tuberculosis and hepatitis are reportable. Certain STIs—including syphilis, gonorrhea, and chlamydia—must be reported,<sup>3</sup> and there must be contact tracing and treatment whenever possible. The rationale of public good outweighs the patient’s right to privacy and confidentiality. Nationally reportable diseases from anthrax to yellow fever can be found on the CDC’s Web site.<sup>3</sup> Each state and county may require reporting of additional diseases.

In 1969, Prosenjit Poddar, a student at the University of California, was seen by a psychologist at the university clinic. He told the psychologist he was going to kill an unnamed woman

who was easily identifiable as Tatiana Tarasoff. The psychologist was so concerned that he contacted the university police, who apprehended Mr. Poddar. They released him after a short stay when they considered him rational and no longer a threat. No one notified Ms. Tarasoff or her family of the threat. The psychologist decided that no further action was needed to deter Mr. Poddar. Two months later, Mr. Poddar stabbed Ms. Tarasoff to death. Her survivors brought suit against the psychologist and the university for negligence, and the court found in favor of the Tarasoffs. The California Supreme Court specifically addressed the issue of patient confidentiality, stating that “the protective privilege ends where the public peril begins.”<sup>4</sup> Other courts have since broadened this decision to protect and warn. Even without knowing the intent to cause harm, the clinician has an obligation if the patient’s action or inaction will cause harm. Such is the case with STIs.

**INFORMED CONSENT** has its foundation in the principal of autonomy, which entails concepts of privacy, freedom of choice, and self-determination. The application for PAs is that patients should be viewed and treated as self-governing persons who are allowed to act in accordance with their freely-chosen, informed choices. Informed consent is a form of truth telling.<sup>5</sup>

Informed consent is an integral component of the practice of medicine. Our profession describes it in our ethical guidelines, explaining that “... a PA provides adequate information that is comprehensible to a competent patient or patient surrogate. At a minimum, this should include the nature of the medical condition, the objectives of the proposed treatment, treatment options, possible outcomes, and the risks in-

involved. PAs should be committed to the concept of shared decision making, which involves assisting patients in making decisions that account for medical, situational, and personal factors.”<sup>2</sup> In my view, “the medical conditions” include the tests or screening tests for the medical conditions.

Busy schedules and limited time with our patients make the application of informed consent a challenge. The literature shows that involving the patient in the process of informed decision-making is frequently overlooked. One of the early (1982) Presidential Commissions for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research on Making Health Decisions reported that informed consent was obtained 96% of the time for surgical procedures but that for routine blood and radiographic tests, it was obtained less than 50% of the time.

We provide our patients with information and data in many formats. The most common are the words we use in our conversation. The ethical response to the current case is to obtain consent before obtaining any specimen for testing. The core underlying principle is the trust upon which the PA-patient relationship is based—trust that all the information will be provided by the PA and trust that all the information provided by the patient will be kept in confidence. Only extraordinary circumstances should interfere with that trust. **JAAPA**

## REFERENCES

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