Rethinking the Ethics of Confidentiality and Health Care Teams

by Ruth B. Purtilo

The concept of confidentiality and existing guidelines for its application must be revisited now that health care teams have replaced the single health professional-patient relationship — and now that the teams themselves are evolving into those directed to whole patient care and those focused on one procedure. Information is necessary to help health care professionals make judgments and apply their skills to patients' problems, but since patient care teams vary in their composition, skills, and their goals for the patient, the central questions become who should receive information, and why. The article uses the distinction between moral and instrumental teams and team functions to suggest new guidelines and refute the notion that confidentiality is a decrepit concept.

An oft-cited article on confidentiality bears the fetching title, "Confidentiality in Medicine — A Decrepit Concept" (Seigler 1982). However beleaguered the authors declared the concept to be more than a decade ago, confidentiality seems as compelling as ever in the corridors of everyday health care. For instance, a major U.S. teaching hospital on the east coast announced a "campaign promoting patient confidentiality" as the feature story in its May Newsletter (Brady 1998).

The campaign includes educational sessions and materials regarding conversations, the use and handling of health care records, email communications, posters, and articles in hospital publications. Patient expectations of confidentiality are reinforced through reminders posted in elevators and elsewhere and in brochures distributed throughout the inpatient and ambulatory care areas. Personnel are reminded that confidentiality is an ethical and legal responsibility.

It is, then against a backdrop of doubt about the viability of confidentiality, on one hand, and its ethical importance and utility on the other, that special challenges to confidentiality arise in the team setting. This paper describes those challenges and provides recommendations for health care teams.

Health Care Teams — A New Concept

Although confidentiality is recognized as one of the oldest and most persistent ethical themes in health care oaths, codes, and practices, these oaths, codes, and practices arose in the context of a single doctor as the means of health care delivery. The delivery of health care through teams is a relative newcomer. Sociologists, health-policy analysts, and others who comment on changes in health care systems and structures usually put the beginning of health care team approaches during World War II (Brown 1982). This tendency is not surprising: health professionals necessarily worked shoulder to shoulder in the war effort, medical specialization emerged, and health care services were centralized in large institutions during this period.

Among its more useful ends, the team-oriented approach was expected to enhance the coordination, comprehensiveness, and continuity of care; acknowledge the growing sophistication of professional contributions by nurses, therapists, technologists, and others formerly viewed solely as physician helpers; and improve efficiency. Understandably, the team approach was quickly

accepted by patients, health professionals, and administrators, and it was not limited to direct patient care. For instance, health education, community outreach, institutional planning and administration, and quality assurance functions were also restructured into team management activities.

To this day the team ideal persists as the actual practices of health care teams continue to evolve. Direct patient care teams, the focus of this paper, are the norm in almost all health care settings. By contrast, the single health professional-patient relationship is nearly a thing of the past. Still, little has been written about the special challenges to confidentiality that can arise in the team setting.

Confidentiality and the Evolution of Health Care Teams

Confidentiality is related to privacy in its polarity with "public" information and is a valued means of protecting a person's dignity, rights, and essential preferences. Every health professional learns that within the special context of the health professional and patient relationship, the patient accepts the necessary risk of a one-way disclosure of private information that may be harmful, shameful, or embarrassing. The patient tells the health professional a myriad of private things in good faith; the professional in turn sifts through the facts, hoping to glean relevant information but realizing that both relevant and irrelevant information must be identified and sorted. The professional necessity of building and maintaining trust within the health professional and patient relationship by honoring the confidentiality of the information is well known. However, the most fundamental and important questions are these: who should receive information that a health professional has, and why.

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In addressing these questions, the general guideline has been that any professional who needs certain types of information about the patient to perform his or her professional tasks and foster the patient's well-being should receive information. Information is necessary to help these professionals make judgments and apply their skills and techniques to the patient's problem. In the past, since members of the patient care team were involved in all aspects of a patient's care, the practice developed that all team members would share the same information. Elsewhere I have argued that patient care teams vary in their composition, skills, and — of special relevance to confidentiality — in the goals they deem relevant to a single patient (Purtilo, 1995a). I propose that in some cases this assertion raises new questions about the appropriateness of existing confidentiality guidelines in the health care team setting.

Patient care teams can be divided into two major categories according to function. One, which we call the *moral* function, focuses its daily activity and goals on the whole patient rather than on the patient's illness. The other, which can be called the *instrumental* function, does not focus its daily activity on the whole patient, but only on the patient's need for technical medical assistance. Of course, some members who have predominantly moral functions do exercise strictly instrumental functions, and vice versa. While some team members engage in both functions, the two functions are distinct and often a whole team will be limited to one or the other type. My proposal is that moral teams or members serving moral functions on a largely instrumental team, should be included in all information that any team member considers confidential. In contrast, instrumental teams or moral team members with instrumental functions may not be legitimate recipients of all confidential information.

Moral Functions and Patient Confidences

The team or team members that have moral functions are familiar in traditional medicine and health care ethics. Therefore, the less than ideal term *moral team* reflects the notion that medicine is directed to the good of the whole patient as is the activity of this type of team (Purtilo 1995b). In the days when team care began, almost all teams were moral function teams. Prior to the "technological miracles" of antibiotics, ICUs and transplantation (to name a few), health professionals directed their attention to the greater human needs of the sick, injured, or dying person who more often than not could not be helped by medicines or other technologies (Cassell 1993). Judgment about the successful outcome of the intervention was based on how well the patient was doing overall, not on the response of any symptom or physiological or psychological system. Activities of all members of such teams included comfort measures, reassurance of patients and their families, and the development of treatment protocols based on the professionals' assessment of how the regimen would affect the social, emotional, and spiritual needs of the person.

An expression that captures the core value of this team's basic function is *beneficence*, manifested as coordinated and comprehensive care designed to be helpful to the patient in his or her life predicament. Such teams are still integral and important components of the health care delivery system. Some examples are rehabilitation teams, geriatric care teams, hospice, and discharge teams. Though their members apply highly technical interventions, these teams measure success by how well the patient fares within the context of his or her life plan. In addition, members of teams that do not focus on the whole patient assume these moral functions. Examples are social workers, chaplains, psychiatrists, and some therapists.

Often one of the biggest challenges for such teams or team members is to justify their labor-intensive activities in, say, managed care organizations by identifying treatment outcomes according to current criteria of success (Purtilo 1994; Hadorn 1992). In fact, the difficulty of measuring the good outcomes of such teams and team members, has resulted in many of their patients being classified as "outliers" in reimbursement systems. They are, that is, listed as patients whose continued care is not adequately captured by the usual outcomes criteria.

Sensitive information relevant to a patient's treatment regimen can be disclosed to all moral team members. Together they are the "body" providing care for this person. Furthermore, all team members sharing a moral function on instrumental teams should share this information, since the goal for each is the beneficent care of the whole person.

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Instrumental Functions and Patient Confidences

By the 1950s it was evident that the comprehensive and coordinated care envisioned in the team model requires the services of many different professionals in addition to those who provide care directed to the whole person.

In the wake of expensive and complex machines that were, in effect, new extenders of care, technology experts were added to traditional (i.e., moral function) teams. The function of these

experts was *instrumental*: their activity alone would not guarantee a patient's well-being. Their goal was to perform technical procedures as one "instrument" to that end. The extent to which moral function team members relied on this expertise was expressed by one of the nurses involved in caring for Barney Clark, the recipient of the first artificial heart transplant in 1982. She said during a panel discussion reviewing the procedure, "The most important member of our team was the biomechanical engineer. The rest was quite routine. But when the monitors starting going off we wanted him there, and right away!" In this era of technological medicine it was only a matter of time before whole teams were organized explicitly for the sake of performing highly technical procedures requiring expertise more akin to that of an engineer or bench scientist than a traditional giver of care (Reiser and Anbar 1984). With such a focus, the disconnect between the traditional team goal of treating the whole patient and that of addressing a sign, symptom, system, or dysfunction is complete.

One example of the many instrumental teams operative today is the cardiac catheterization team. Members of such teams

> may hope or even assume, that at one point discussion has taken place regarding the role of the cardiac catheter in promoting this patient's overall well-being; but their team work can be completed successfully without any knowledge of such a goal. Their activity will be governed predominantly by the need to insert the catheter competently and efficiently (Purtilo 1994).

In this situation, a serious question arises about the wisdom of sharing sensitive information with team members whose functions are instrumental. Such knowledge may be relevant to a person's well-being but have no bearing on the safety or effectiveness of the professionals' technical activities or their ability for compassionate interactions during the treatment procedure.

A genetics evaluation team may need to know some things about the patient but not, say, the patient's homosexual orientation, while a hospice team treating patients with AIDS may find this information essential for many reasons related to the patient's overall care and support. The surgical team may not need to know the patient's employment history to perform even the most intricate procedures, though the discharge team may find it key information. In short, for team members or teams engaged in instrumental functions, a much more circumspect and targeted sharing of potentially harmful, shameful, or embarrassing information can be defended as being in the patient's best interests in most cases.

Decisions about information must never be an arbitrary withholding or disseminating of patient confidences. Instead, the judgment must always be made whether one or the other is in the patient's best interests.

The principle of beneficence applies equally well to the appropriate functioning of both types of teams and team members. The motivation not to harm through unnecessary disclosure of sensitive information requires that the patient's good be the measuring rod for action. So, too, do disclosures designed to prevent or remove harm and make a positive difference in the patient's situation. Moreover, the motivation to prevent harm and make a positive difference requires a smoothly functioning team characterized by trust and trustworthiness among the members themselves (Purtilo 1995b). Therefore, decisions about information must never be an arbitrary withholding or disseminating of patient confidences. Instead, the judgment must always be made whether one or the other is in the patient's best interests.

Confidentiality, Teams, and Good Care

What, then, should be the overarching practice guidelines related to confidentiality in the team setting? Several guidelines take into account the evolution of team functions while honoring the necessity of sharing confidential information.

1. Disclose sensitive information to other teams or team members on the basis of its relevance to the patient's beneficent treatment. This guideline is in contrast to traditional patterns, which suggest a mandatory (or at least, permissible) sharing of all information among all team members involved in a patient's care.

2. Set the content, timing, and the means of sharing sensitive information with other teams and team members so that the disclosure fosters team effectiveness, rather than satisfies traditional expectations of who will be informed of what.

3. Exercise vigilance regarding one's own motivations and insights regarding disclosures. This posture counsels reflection before making decisions about disclosure that depart from long-held policies or practices.

4. Exercise creative professional responsibility regarding the age-old mandate to respect patient confidences, and think expansively about all the ways in which confidences can be appropriately honored in the team setting.

   If formal practices (e.g., reporting in the patient's medical record, team conferences, staff rounds) compromise a selective sharing of information, the principles guiding appropriate disclosure can still be practiced in the equally important context of conversation and other informal exchanges.

5. If more formal policies or practice guidelines are needed to reflect the team's evolving structures, team members should work to effect these changes.

In conclusion, health care and by extension health care teams, already have many ethical guidelines that continue to be responsive to changing situations, and guidelines related to confidentiality are among them. Confidentiality need not become a decrepit concept in spite of challenges imposed by the evolution of team functions.

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