Case-Based Ethical Argument: Confidentiality

Jenkins offers a case of a patient who presents to the emergency room with an arm fracture after what the patient discloses as a fall (1,2). However, once the patient is in a private room with Nurse Jenkins, she tells her that this was an injury sustained from intimate partner violence. The patient confides in Jenkins and asks her to (a) not document the real reason for her injury and (b) not disclose the violent incident to the attending physician. Additionally, the patient refuses further physical examination/treatment. The nurse then finds herself in an ethical dilemma where she has to choose between maintaining patient confidentiality and aligning with beneficence as a means to protect the patient and her children (1,2). Transposing into the role of the PA, our patient discloses she is a victim of domestic violence and asks us to not act on the information. Thus, the ethics question becomes "should we honor the patient's request for nondisclosure (including discussion with the attending physician and documentation)?" Our decision is to disclose the information to the physician and document it on the basis of the principles of autonomy and beneficence.

One of the statement values of the PA profession involves the responsibility of "health, safety, welfare, and dignity of all human beings," by upholding the tenets of autonomy, beneficence, and nonmaleficence (3). Beneficence means that PAs should act in the best interest of the patient, which means providing appropriate care (3). As a PA, we want to provide appropriate and adequate care for a blow resulting from domestic violence as opposed to treating a "fall" as disclosed by the patient. If we do not disclose the information of the incident then, essentially, we are only treating the patient for a broken bone and neglecting other injuries, which would go against the guidelines of our profession. However, if she openly disclosed the violent incident at firsthand, a completely different course of plan would have ensued. If she allowed a complete history and physical to be conducted along with comprehensive documentation then there would have been a need to further examine injuries sustained from the violent incident such as pain upon inspiration. Thus, not disclosing the real cause of the injury would dismiss the need for an accurate and appropriate care. If we are not treating the underlying cause, we are not maximizing the benefit of care and may cause potential harm in the future as a result of neglected care. Our decision to disclose the information and to document is an example of maximizing benefit and minimizing preventable harm, which aligns with the core principle of beneficence (4).

Similarly, our decision to disclose information is built on the principles of autonomy. Because she is a victim of domestic violence, we believe she is not thinking rationally (autonomy as effective deliberation) and may be unaware of the repercussions that will result from not disclosing the information (autonomy as moral reflection) (5). When evaluating autonomy as authenticity, we have to take into consideration that pain might cause her to act out of character (5). In this case, pain from domestic violence may cause her to be more inclined to not disclose information regarding the violence. Thus, she may be making the decision of non-disclosure and refusal of physical examination out of fear, which may not align with her values and who she truly is. She came in to seek care but if the appropriate care is not provided, did she really get the quality care she came in for? Moral reflection requires awareness of individual values and principles after thoughtful examination (5). Thought process can also be compromised as a result of false assumption or lack of information. The patient might not be aware of the possible treatment she is neglecting because of nondisclosure. This episode of irrational thinking is not an example of the patient's true and authentic self, and due to this, we feel the patient is unable to appropriately dictate her true moral reflection, or rather, her true

essence and thought process of self. Thus, we will not respect autonomy because of these principles.

While we are expected to protect our patients, the binary between right and wrong becomes murky as other confounding variables, such as confidentiality and truthfulness, cause responsibilities to be redefined. In Kirk's "Confidentiality" paper, the author acknowledges the necessity for patient confidentiality and offers respect for personhood, optimizing outcomes, and preventing harm to maintain patient confidentiality (1, 6). While Kirk outlines best practices, Jenkins' example of a real patient demands us to push the aperture between right and wrong. Kirk declares that "in sum, respecting confidentiality is intentionally engaging a set of behaviours that fosters the trust of patients and families in clinical relationships in a manner that maximizes beneficial clinical outcomes, avoids preventable harm, and respects the personhood of all parties involved" (6). There is truth to this; however, it is important to note that, in this instance, the violation of confidentiality is not rooted in malice or a form of medicine that is not patient-centered. Instead, this incidence is deeply rooted in patient-centeredness, respect, and protection for the patient. We as the provider are leaning on our knowledge, our degree and license, our responsibilities to law and society, and can justify our decision as we believe this is the decision that aligns with the common good of the patient and is, in actuality, aligned with her best interest, her moral integrity, and her authenticity. This would be her decision if she was able to align emotions and thoughts in order to make proper decisions.This is a prime example of when confidentiality and patient autonomy should be breached as the benefits outweigh the risks or harms.

Some may argue that autonomy as free action as well as obligation to beneficence may be violated as a result of disclosing information which can cause more harms/risks. Reporting this information may cause fracas between the spouses, resulting in more physical and emotional harm and a loss of trust in the healthcare system. However, the same can be held true even if actions were not taken. The patient will continue to be in the continuous cycle of intimate partner violence, sustaining more injuries as well as psychological harm, and perhaps harm to the children involved. The patient is not aware of the extent of the situation. Therefore, when a patient offers information that she is in danger, and perhaps will be danger again along with her children, confidentiality is no longer a priority. Disclosure becomes the clear choice, and appropriate care and treatment becomes the first priority. This is grounds for not respecting autonomy and breaching confidentiality to promote beneficence.

To summarize, our decision is to disclose the truth regarding our patient being a victim of domestic violence, and we have demonstrated that this argument is an ethically justified action through the principles of beneficence and autonomy. We believe that this decision is made in the best interest of the patient, that the benefits outweigh the risks, and that because the patient presents with impaired judgment and irrational thought process, it is our moral obligation to disclosure the truth and violate patient confidentiality. Our decision honors confidentiality as this is an example of when confidentiality can be broken in order to protect the patient and honor her safety.

References:

1. Kirk T. Summary of HPPA 514 Confidentiality Discussion Exercise 11/6/2019
2. Jenkins A, Millward J. (2006). A moral dilemma in the emergency room: Confidentiality and domestic violence . Accident and Emergency Nursing, 14(1), 38-42.
3. AAPA. (2013). Guidelines for Ethical Conduct for the Physician Assistant Profession. https://www.aapa.org/wp-content/uploads/2017/02/16-EthicalConduct.pdf
4. Yeo, Michael et al. (2010). Beneficence . In M Yeo et al. (eds.). *Concepts and Cases in Nursing Ethics.* [3rd edition] Ontario: Broadview Press, pp. 103-116.
5. Yeo, M et al. (2010). Autonomy [selections]. In M Yeo et al. (eds.). Concepts and Cases in Nursing Ethics. [3rd edition] Ontario: Broadview Press, pp. 91-97, 103-109
6. Kirk, TW. (2015). Confidentiality. In N Cherny, M Fallon, S Kaasa, R Portenoy, & D Currow (eds.). Oxford Textbook of Palliative Medicine. (5th ed.) New York/London: Oxford University Press, pp. 279-284