ABSTRACT: Speech-language pathologists have ethical and legal obligations to respect and maintain patient confidentiality. Other moral and lawful responsibilities must be considered in conjunction with the protection of patient confidentiality. This article reviews the moral and legal evolution of patient confidentiality and relevant research articles. Resource guidelines for managing issues and concerns regarding patient confidentiality are discussed.

KEY WORDS: patient confidentiality, ethics, patient rights, speech-language pathology

Most people value their personal privacy. When speaking with others, we maintain a certain physical distance between ourselves and our communication partners that is culturally determined by how well we know them; sometimes, we feel that people are “intruding on our physical space.” People pull their shades down at night so that they can do what they want without being observed; homeowners frequently put fences around their yards for the same reason. Depending on how well we know someone, we share varying amounts and types of information as well as truths about ourselves. For example, when asked by a stranger “How are you?,” most people say “good,” “fine,” or some other brief response with the same literal meaning, regardless of its truth; when asked by a familiar person, people often respond with a somewhat more lengthy and/or truthful response, and, when asked by a highly familiar person, length and/or truth may know no bounds.

Most people also prefer to conduct their business in private; that is, conversations of importance are usually held “behind closed doors.” Their financial, legal, and health matters are regarded by most people as inappropriate for unintended public observation or knowledge.

Closely related to the concept of privacy is the concept of confidentiality. Personal and/or business information shared confidentially is meant to be kept private. It is by virtue of the sharer’s trust in the “sacredness” of the concept of confidentiality that he or she is able to communicate honestly with another. The sharer of the confidential information trusts that the receiver of the information will not disclose what he or she has been told without the permission of the confider. Many friendships have been severed when someone has revealed another’s confidence; many lawsuits have been based on the divulgence of private information.

In order to evaluate, treat, and advocate effectively for patients and families, speech-language pathologists must be aware of and know how to manage a significant amount of confidential information pertaining to these individuals. For example, knowing a patient’s medical diagnosis, medications, and prognosis helps the speech-language pathologist to select diagnostic tools and develop therapy goals.

Defining the patient’s relationship to various family members and significant others allows the speech-language pathologist to identify who he or she should work with to facilitate the patient’s successful carryover of strategies outside therapy sessions.

In the context of the therapeutic relationship that speech-language pathologists, patients, and families develop, a patient or family member may reveal very private, personal information that will have direct bearing on the therapy focus, the composition of the team working with that patient and family, and/or the discharge disposition.
example, the wife of a patient may share that she and her husband have been having significant marital problems since his right hemisphere stroke. An adolescent may confide feelings of significant hopelessness, helplessness, and desperation being the lone survivor of a car accident in which two of his friends died. How should the speech-language pathologist function in these types of situations? The purposes of this article are to highlight and increase awareness of the following: (a) the importance of patient confidentiality, (b) the roles and responsibilities of the speech-language pathologist in respecting and maintaining it, and (c) the other ethical and lawful obligations that a health care provider has that must be weighed in conjunc-

tion with the protection of patient confidentiality. Confidentiality will be defined, its moral and legal evolution will be discussed, and relevant research will be summarized. Resources and supports that are available to help the clinician ethically and legally uphold patient confidentiality will also be identified.

**DEFINITION AND EVOLUTION**

Patient confidentiality may be defined as “an implicit understanding that information divulged by the patient to a professional will not be revealed to another person” (Pannbacker, Middleton, & Vekovius, 1996, p. 5). The maintenance of confidentiality is both an ethical and a legal obligation of health care providers. That is, all clinical practitioners, including speech-language pathologists, must respect and protect the privacy, as well as the dignity, of all patients. Pellegrino and Thomasma (1981) discussed a principle of vulnerability by which the stronger must respect and protect the weaker or compromised. We, as speech-language pathologists, must always remain sensitive to how vulnerable our patients and their families are and act ethically on their behalf.

The ethical importance of confidentiality was formally recognized in the late 5th century B.C.E. when Hippocrates wrote the Physician’s Oath. As cited in Mosby’s Medical, Nursing, and Allied Health Dictionary, the Hippocratic Oath includes the statement that “all that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal” (Anderson, Anderson, & Glanze, 1998, p. 799). In its Code of Ethics, the American Speech-Language-Hearing Association (ASHA) also formally emphasizes the importance of patient confidentiality. ASHA’s Principle of Ethics I states that “individuals shall honor their responsibility to hold paramount the welfare of persons they serve profession-


ally” (ASHA, 1994, p. 1). One of ASHA’s Rules of Ethics pertaining to that Principle, Rule I, further specifies that “individuals shall not reveal, without authorization, any professional or personal information about the person served professionally, unless required by law to do so, or unless doing so is necessary to protect the welfare of the person or the community” (ASHA, 1994, p. 1).

The legal importance of privacy and confidentiality has received attention at federal and state levels, at least in part because so many amendments of the United States Constitution imply it. For example, in 1974, Congress passed Public Law 93-579, the Privacy Act, to protect an individual’s privacy by regulating federal agencies’ collection, maintenance, use, and dissemination of personal information, including educational, employment, and medical history. In Massachusetts since 1979, General Law 111-70E, Patients’ and Residents’ Rights, has existed to ensure that individuals have the right to privacy and confidentiality related to any medical care that they receive. Every speech-language pathologist should be familiar with his or her own state’s legislation regarding patient privacy and confidentiality.

Health care accrediting agencies have standards and/or guidelines that emphasize the ethical and legal importance of patient confidentiality. For example, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO, 1998) has specific standards that address patient confidentiality that a hospital needs to respect in order to receive accreditation or reaccreditation. Adherence to these standards directly involves hospital staff, patients, and patients’ families. Hospitals also have standards, guidelines, and/or patient bill of rights that serve to protect and advocate for patient confidentiality and to educate both caregivers and consumers of expectations and rights regarding the same. For example, the education and training section of the Office of Human Resources Management at the National Institute of Health’s Clinical Center (NIH, 1999) has staff policies and procedures that emphasize patient confidentiality, and these are reviewed during new employee orientation and then annually during each employee’s tenure. NIH’s Clinical Center also has a “Patient Bill of Rights” (1997) that each patient receives in a handbook upon admission. This document discusses the patient’s rights to, and expectations regarding, privacy and confidential interventions.

Hospitals have other reminders of the need for staff to maintain patients’ privacy. For example, in most hospital elevators, a sign is posted with the message “Please Respect Patient Confidentiality.”

**ETHICAL VULNERABILITIES**

Although health care professionals agree, at least implicitly, to protect patient privacy and maintain patient confidentiality while working to help the patient, intentions and actions are not always the same. In 1995, Ubel, Zell, Fischer, Peters-Stefani, and Arnold conducted an observational study of inappropriate comments made by hospital employees in hospital elevators of five area hospitals. Four categories were created to classify inappropriate comments heard: (a) statements violating patient confidentiality, (b) statements reflecting unfavorably on the speaker’s ability or desire to provide high-quality patient care, (c) statements suggesting poor quality of care by other hospital employees, and (d) statements reflecting negatively on patients or their
families. During 259 elevator trips with opportunity for conversation, 39 inappropriate comments were overheard on 36 rides. Inappropriate comments falling into each of the four categories created were heard; violations of patient confidentiality were the most frequently heard (18/39), followed by statements reflecting unfavorably on the speaker’s ability or desire to provide quality patient care (10/39). The disciplines of the speakers who made the comments were tracked whenever possible and were found to include medicine, nursing, and other clinical and non-clinical professions.

In addition to the types of breaches of patient confidentiality described above, respecting patient confidentiality has evolved from being understood/practiced as an absolute “black and white” concept or action and has become a more vulnerable, relative “grey” one. Indeed, in 1982, Siegler described confidentiality in medicine as a “decrepit concept.” He discussed how comprehensive, quality medical care has evolved over time and how these changes have necessitated a modification in the traditional understanding of patient confidentiality. Much has continued to change since Siegler wrote his article.

This gradual transformation has occurred for several reasons. Four of these, which have direct bearing on the speech-language pathologist practicing in a medical setting, will be considered in the remainder of this article.

- The number of individuals involved in any single patient’s care, directly and/or indirectly, has increased over time, making absolute confidentiality difficult to maintain.
- Patients and health care providers do not always have the same view of the obligations associated with protecting patient confidentiality.
- There seem to be discrepancies between what people feel that they should do in certain ethical situations and what they would do in those same situations.
- The number of times that maintaining patient confidentiality would conflict with the law or would result in harm to the patient or others has increased.

A more in-depth discussion of each of these follows.

**Increase in Number of Individuals**

As mentioned above, one of the reasons that patient confidentiality has become a less absolute concept than it has been traditionally is that the number of individuals involved in any single patient’s care has increased, making it difficult for absolute confidentiality to be maintained. In his 1982 article, Siegler described an uncomplicated case of a university medical hospital patient whose medical record was legitimately accessible to between 25 and 100 health care professionals and administrative personnel. These individuals included physicians (primary, consulting, surgeons, covering), three shifts of nursing staff, respiratory therapists, nutritionists, clinical pharmacists, students, unit secretaries, hospital financial officers, and chart reviewers. If this patient had presented with multiple diagnoses, the number of individuals involved in his case would have multiplied. Or, if this patient had been in a rehabilitation hospital or skilled nursing facility, speech-language pathologists, physical therapists, occupational therapists, and/or numerous others would have increased the number of health care staff interacting with this patient and/or having legitimate access to his medical record.

Reflecting back on the two case examples provided earlier, the right hemisphere stroke patient and his wife and the adolescent survivor of a car accident, a psychiatrist, psychologist, and/or social worker may be additional health care providers enlisted to work with either of them. In collaboration with these other caregivers, the speech-language pathologist can help determine what role cognitive–linguistic impairments are playing in each case and can contribute to the development of an effective care plan. Consistent with the goal of helping the patient and protecting his or her dignity and privacy, all health care professionals, including speech-language pathologists, must remember to handle access to, and shared management of, patient information with sensitivity, respect, and confidentiality.

**Differing View of Obligations**

The second reason provided above to explain why patient confidentiality has become a more vulnerable, relative “grey” concept over time is that patients and health care providers do not consistently share the same view of the obligations associated with protecting it. In 1982, Weiss surveyed 177 patients, 53 medical students, and 109 physicians about the confidentiality of information that patients share with physicians. This survey allowed for a comparison of patients’ perceptions of how they thought physicians managed confidential medical information with the way physicians reported they actually did. Results revealed that the patients had higher standards regarding confidentiality than did the physicians and medical students. For example, the physicians and medical students reported discussing cases in nonmedical settings, which most patients did not expect happened. In medical settings, all three groups of subjects thought that it was common practice for physicians to discuss cases informally for second opinions. However, although all three groups of subjects perceived that cases are commonly discussed openly with other staff and as case presentations at large meetings, the physicians and medical students reported that this practice occurs more often than the patients thought it did. Although it is acceptable for (and actually required that) clinicians working with a particular patient discuss that patient, his problems, and his progress in order to continuously maximize the care being provided, such formal and/or informal discussions should only be held “behind closed doors.” And, when a particular patient is being discussed or rounded with a group that includes professionals who are not directly involved in the case, often for educational and/or research purposes, the patient’s identity must be protected, or the patient must consent to being discussed prior to the presentation or conversation (Annas, Glantz, & Katz, 1981).
Discrepancies Between Should Do and Would Do

A third reason why patient confidentiality has become a more relative concept is the existence of discrepancies between what some people feel that they should do and what they would do in various ethical situations. In 1991, Grady, Jacob, and Romano surveyed a group of physicians and nurses about aspects of patient confidentiality. The survey included eight clinical vignettes in which patient confidentiality might be an issue. Participants were asked to indicate which of four possible behaviors they should do and also indicate which of the four behaviors they would do in each situation. At least some of the 751 respondents answered differently regarding what they should do versus what they would do in each situational vignette. Many people can think of situations they have been in where they feel they should have done was different from what they did do. Using available resources for education, guidance, and support is an excellent strategy for health care professionals to take advantage of when they are involved in difficult and/or complex ethical situations. These resources include supervisors, team leaders, facility-based ethics committees, and professional organizations like ASHA.

Increase in Legal Conflicts

And, finally, a fourth reason why patient confidentiality has become a less absolute concept is that the number of times that maintaining patient confidentiality would conflict with the law or would result in harm to the patient or to others has increased. Beauchamp and Childress (1994) discussed a Magnitude of Harm Model in which the probability of risk or harm (to the patient and/or to others) is weighed against the maintenance of patient confidentiality. When the probability of risk is low, the necessity of maintaining confidentiality is emphasized. When the probability of risk is high, the obligation to breach confidentiality increases.

And, in these high-risk cases, health care professionals have legal and/or moral obligations to disclose confidential information. For example, morally acceptable and legally mandated exceptions to maintaining confidentiality include instances of child abuse/neglect, contagious disease, suicide risk with (which the adolescent example in this article presents), and gunshot wounds. In these cases, the implications of a breach of confidentiality are accepted as being outweighed by the importance of reducing threat to others, to the public interest, and/or to the patient him- or herself. When confronted with this type of high-risk case in a medical setting, the speech-language pathologist is typically a member of the patient’s clinical team that will manage the situation with the assistance/guidance of other facility-based (e.g., legal counsel) and externally based (e.g., Department of Public Health) supports.

In summary, as a member of a team of health care professionals working with patients, the speech-language pathologist must always value the importance of patient privacy and confidentiality. Moral and legal guidelines, as well as professional standards, exist to help ensure that health care professionals maintain patient dignity at all times. Medical facilities have additional resources available to support both patients and their caregivers. It is our personal and professional obligation as speech-language pathologists to respect patient confidentiality, adhere to existing guidelines and standards for protecting it, and use supports that are available to make certain that we “do the right thing” at all times.

REFERENCES


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