

Virtual Mentor

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ETHICS CASES

Repeating an Attending Physician's Unseemly Remarks

Commentary by Peter A. Ubel, MD, and Robert M. Veatch, PhD

Alex, a third-year medical student, is in the middle of his surgery rotation. He frequently finds himself rather shocked by some of the unseemly remarks that his attending, Dr. Tate, makes during surgery and between seeing patients on rounds. A highly respected surgeon, Dr. Tate is personable with patients and well liked by them, but his comments to his residents and medical students outside of patient earshot are often distasteful and inappropriate (e.g., “Sure I can fix his heart now but he’ll croak before Christmas” or “It’s hardly worth it to consent her—she’s way too dimwitted to understand a thing” or “This patient was here in January and is so fat that she literally broke the bed”). The other med students also seem put off by this behavior, but no one has said anything to Dr. Tate.

Almost every day at lunch, Alex relates several of Dr. Tate’s comments to his friends. Meg, another third-year on a different rotation, feels uncomfortable when Alex discloses these details. She pulls Alex aside after lunch one day and shares her concerns. “Alex, what happens on rounds or in the operating room is supposed to be kept confidential. I agree that Dr. Tate’s comments are distasteful, but I don’t think you should be gossiping to other students about him.”

Alex scoffs, “There’s nothing wrong with sharing an attending’s comments as long as the *patient’s* confidentiality is maintained.”

Commentary 1

by Peter A. Ubel, MD

In the mid-90s I met Ari Silver-Isenstadt, a medical student who had been asked by his school to take a year off from his medical training to pursue a master’s degree and, more importantly, to take a step back from what the school perceived to be his inappropriately confrontational behavior. While rotating through an affiliated hospital, you see, Ari had complained that the nametags provided to him by the hospital didn’t properly identify him as a medical student, as if the hospital were trying to hide his amateur status from their patients. The hospital didn’t take too kindly to his criticism. On a subsequent rotation through the ob/gyn clinic, Ari refused to “practice” a pelvic exam on an anesthetized woman because he wasn’t sure anyone had asked her permission. That put an abrupt end to his rotation.

Ari’s situation raises an important ethical question: When medical students witness, or are even asked to participate in, unseemly behavior, do they have a moral duty to

do something? Or instead, as Alex's case study forces us to ask: do they have a duty to remain silent, to protect patient and physician confidentiality?

Leaders at Ari's medical school felt that he should have remained quiet in the face of such modest ethical breaches and waited to address these problems when he was in a leadership role himself. Indeed, when I was a medical student, I sat in on a case conference once in which an oncologist stood up and explained to the audience that, although the patient's metastatic cancer was "incurable, the patient requested chemo anyway, so we offered him a cycle of salvage chemo. Unfortunately, the patient passed away the following week." I was stunned by what I considered to be an example of cruel overtreatment. So I stood up, my short white coat announcing to the rest of the audience my lowly status as a medical student, and asked how this oncologist could justify "torturing this patient in the last week of his life." After the conference ended, the chief medical resident pulled me aside and told me that, although he understood my point, I was only hurting my own career by confronting a senior physician in such a public manner.

No medical student should be expected to confront her superiors every time she encounters questionable behavior. Therefore, when Ari did choose to confront his faculty mentors, he was not responding to the call of moral duty. Instead, he was going beyond his duty—he was demonstrating moral courage. Where would our world be if no one took the risk of confronting powerful people when they believe those people are abusing their power?

What about Alex, then—the student in this case? Alex is not exhibiting morally courageous behavior by discussing Dr. Tate's behavior with his classmates. Instead, I expect that Alex's lunchtime conversations are an attempt to sort out his own moral and professional feelings. It is important for medical students to have these kinds of conversations. Medical students confront all kinds of morally questionable behavior during their training. They are exposed, as in Alex's case, to shocking and inappropriate humor. If they simply ignore these ethical breaches, they may become immune to them, thereby following suit when they become attending physicians. It is really important for medical students to talk, at a minimum with each other, about the moral questions they face in their work lives, so they can better think through how to behave in their own futures.

Do Alex's conversations violate some kind of intraprofessional confidentiality? No—Alex doesn't owe Dr. Tate any kind of confidentiality. Tate, on the other hand, owes it to Alex to act as a better role model.

The real ethical question here then is not whether Alex should be able to discuss his moral concerns with his classmates. It's whether Alex has a duty to go further, to act with moral courage and confront his superior. Confronting Tate head-on isn't the right course, however, if Alex doesn't think Dr. Tate would take such confrontation well. It probably won't change Tate's behavior, and will only end up hurting Alex.

It would be better instead for Alex to speak in confidence with the faculty member who organizes the surgery rotation for medical students. The confidentiality that matters in these discussions, by the way, is not any patient's confidentiality. Alex doesn't need to mention any patients by name in describing Tate's behavior, and he certainly doesn't have to protect Dr. Tate's confidentiality—in fact he needs to let people in power know that Dr. Tate is behaving this way. The confidentiality that matters here then is Alex's. He should be able to report Tate's behavior to the powers that be without suffering undue consequences.

The preceptor should promptly determine whether Alex's story holds up by interviewing students and others who work or have worked with Tate. If the story is substantiated, the preceptor should tell Tate that colleagues and supervisees “have witnessed inappropriate behavior” on his part and that if he doesn't improve his behavior, he will no longer be allowed to supervise medical students.

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Commentary 2 **by Robert M. Veatch, PhD**

The norms of confidentiality have a long and confusing history. Although most assume that in the health care arena confidentiality has always prevailed, the reality is much more complex. Since the days of the Hippocratic Oath, the physician was asked to promise only to keep confidential “that which should not be spoken abroad” [1]. The obvious question is what should be spoken abroad. The traditional answer in Hippocratic ethics was surprising. The physician had a right (or even a duty) to disclose information that he believed would benefit the patient, even though the patient might object to the disclosure. By contrast, physicians were not supposed to speak abroad patient information for the benefit of third parties (threats to harm others or expose them to risk of a communicable disease).

The “Tarasoff” case (known by the name of the third-party victim) changed all of this. Health professionals were found to have a legal duty to warn potential victims of their patients' credible threats of harm [2]. More or less at the same time, moral agreement began to emerge that paternalistic disclosures for the patient's benefit but against his or her will were found no longer acceptable. The AMA, for example, changed its policy on confidentiality in 1980 [3].

In the present case, Alex's comments about the insensitive remarks of Dr. Tate give us the chance to add even more nuance to the confidentiality norms. I will argue that Alex is not subject to any professional norm that would limit transmission of his observations of his surgery instructor. To do so, I need to take up four issues: the distinction between patient confidentiality and confidentiality among professional colleagues, the moral grounds of the confidentiality duty, limits to the promise of confidentiality, and the source of the norms related to confidentiality.

Patient Confidentiality and Confidentiality between Health Professionals

The traditional norms of confidentiality govern patient information. They say nothing about information pertaining to colleagues or fellow members of the health professions. Thus, even if we can figure out what duty Alex and Dr. Tate have regarding patient information, this tells us little about Alex's disclosures of Dr. Tate's remarks. The norms of patient confidentiality exist for specific reasons—the physician's learning extensive information about the patient to facilitate the treatment and the inequality in the clinical relationship—and cannot be generalized to other relationships. These are quite different in the relation between student and instructor. Just as the norms of patient confidentiality do not tell us whether the patient has a duty to keep observations about his or her physician confidential, so they do not tell us whether there should be limits to a student's disclosing observations about an instructor.

That being said, it is striking that Dr. Tate's offhand comments, in fact, disclose quite a bit of patient information. The first comment discloses a bit about diagnosis and prognosis. The second comment discloses an assessment of patient intelligence. (It also reveals Dr. Tate's poor understanding of the concept of consent. Consent is not something a doctor does to a patient. It is an act of the patient. No health professional should ever talk of "consenting" someone.)

Moreover, when Alex repeats these comments he is disclosing patient information to his fellow student. The norms of patient confidentiality probably permit communication of patient information to colleagues and students when necessary to carry out professional duties, but should not be seen as permitting an unlimited exception to the duty of confidentiality when talking to professional colleagues. Meg did not need to know the patient's prognosis or intelligence; perhaps Alex did not need to know this either. In this case, Alex may not be able to keep the patients' identities from Meg, but even if he could the disclosure would still breach confidentiality. Even if Meg cannot identify the patient, Alex is still disclosing confidential information. Anonymizing information does not necessarily negate the confidentiality duty.

The Moral Grounds of the Confidentiality Duty

Let us assume that Dr. Tate's insensitive remarks did not actually disclose information about specific patients, but nevertheless did reveal an inappropriate attitude for a physician. What is Alex's duty regarding passing on such remarks? He would not be guided by patient confidentiality norms. Is there a similar duty of

confidentiality regarding information one has observed or remarks one has heard by a colleague? To answer this, we must ask upon what the various confidentiality obligations are grounded.

Sometimes people assume that confidentiality is grounded in the right to privacy. Privacy comes in two forms: informational privacy and observational privacy. Privacy is the state of not having personal information disclosed to others (the hacking of a computer to see someone's tax returns) or the state of not being observed by others (the peeping Tom). Whether one has a right to either form of privacy is a complicated issue. I probably have a moral right not to have my computer hacked, but not to have information I post on the public portion of my Facebook account kept private. I have a right not to have people look in the window of my home, but not to avoid having people observe me as I walk down the street.

An expectation of confidentiality arises when a promise—explicit or implicit—is made or a privacy norm is established by public policy. We don't promise people that their Facebook accounts will not be examined or that they won't be watched walking down the street. We do not have a general right of confidentiality, only a right established by promise or policy. The traditional Hippocratic Oath apparently did not promise patients a right not to have their information disclosed if their physicians decided the disclosure would further their best interest. It did, however, promise that patient information would not be disclosed to third parties even when those third parties were at risk of serious injury from the patient. In the final decades of the twentieth century we renegotiated those promises so that paternalistic disclosures were no longer acceptable, but certain disclosures to protect third parties were acceptable, that is, physicians no longer promised to keep patient information confidential if disclosure would protect third parties from serious injury. At least physicians should no longer make such promises. They would violate the law if they kept such promises. Hence, posting the World Medical Association's Declaration of Geneva on the waiting room wall (which promises confidentiality without the third-party exception) would, in effect, be promising to break American law if the Tarasoff situation arose.

The Limits to the Promise of Confidentiality

Now the question for Alex is whether he promised not to reveal what Dr. Tate said. Presumably, he has at least implied a promise not to reveal patient information so the patient-relevant pieces of Dr. Tate's remarks should not be disclosed. There is no reason to believe, however, that Alex has ever promised to refrain from disclosing the information and observations about his instructor. In fact, such a promise would run afoul of the medical profession's norms of self-regulation, in which colleagues who observe inappropriate or dangerous behaviors in their fellow workers—a surgeon who operated while intoxicated, for example—are sometimes considered morally required to disclose that information.

It seems clear that Alex has not made a blanket promise of confidentiality regarding information and observations about fellow students or professionals. If he has made

such a promise, it was a moral mistake. We must reserve the right to speak up in cases in which a colleague's behavior is inappropriate. In fact, we should also place some limits on the promise we make to patients, reserving the right to speak—perhaps the duty to speak—if a patient's behavior poses a serious risk of harm to others. I once felt forced morally to support a breach of confidentiality regarding a research subject when the data contained convincing evidence that the subject had committed a homicide.

Alex's case is more complex. He surely has the right to report his instructor to appropriate authorities if he believes Dr. Tate's attitudes and behavior vis-a-vis patients are clearly wrong. More generally, if Alex has not made any promise to keep his knowledge of Dr. Tate's attitudes confidential, he is not bound by a duty. He might, for example, be perplexed about what he should do regarding Dr. Tate and want an informal consultation with a fellow student about an appropriate strategy, and revealing it would be acceptable.

That being said, there are norms of discretion about what we say about any friend or associate's observed behavior. As a medical student Alex should be learning to exercise such discretion, not becoming a busybody who repeats observations about friends or colleagues just for the fun of it or as a sort of social capital. Nevertheless, he has no duty to refrain from transmitting Dr. Tate's comments except for the patient-revealing elements. If he is conscientiously pursuing an action to begin the review of Dr. Tate's disposition and whether he is an appropriate clinician-instructor, Alex may, in fact, have a duty to transmit.

The Source of the Confidentiality Norm or Promise

If, in fact, Alex's obligation is governed by social norms and promises made, we should pay attention to the source of these norms and promises. If they are presently ambiguous, as they appear to be, we should ask who should make them clearer. Traditionally, we believed that the profession had the responsibility to generate or articulate norms for professional conduct. Thus, the AMA was widely considered authoritative and could have spoken more explicitly on what physicians and medical students ought to be able to transmit when they observe a colleague's suspect attitudes or behavior.

Since the 1970s, however, we have questioned the legitimacy of the professional organization's authority to establish norms for professional conduct, at least as that conduct impacts nonprofessionals such as patients. We now generally hold that the broader social policy has this responsibility [4, 5]. Secular society or religious institutions are more appropriate bodies to articulate the moral norms of human conduct, including conduct between professionals and lay people. The wise former executive vice president of the AMA, James Todd, understood this when, in the report of the committee he chaired in 1979, he said, "The profession does not exist for itself, it exists for a purpose, and increasingly that purpose will be defined by society" [6].

Thus, my conclusion is that there is no clearly established duty of confidentiality among professional colleagues or medical students beyond the usual norms of discretion among acquaintances and, in fact, there is sometimes a duty to disclose the inappropriate behaviors of colleagues. If more explicit confidentiality promises among medical professionals are to be developed, the lay community should participate fully. That is what is called for if future patients are to be protected from professionals insensitive to patient rights, including the right to be respected.

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