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**Is it Acceptable for a Physician to Break Confidentiality in the Case of Sexually
Transmitted Diseases? A Mapping of Young Kuwaiti's Views**

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Is it Acceptable for a Physician to Break Confidentiality in the Case of Sexually Transmitted Diseases? A Mapping of Young Kuwaiti's Views

Est-il Acceptable qu'un Médecin Rompe le Secret Médical dans le Cas des Maladies Sexuellement Transmissibles ? Une Cartographie des Positions des Jeunes Koweïtien.

Abstract

Introduction: Confidentiality is essential for the establishment of trust between physicians and their patients.

Objectives: The circumstances under which it is acceptable to young Kuwaiti for a physician to break confidentiality to protect the spouse of a patient with a sexually transmitted disease (STD) were examined.

Method: A sample of 263 young Kuwaiti indicated the acceptability of breaking confidentiality in 48 scenarios that were all possible combinations of five factors: disease severity, **time taken by the physician to discuss with the patient**, the patient's intent to inform the spouse about the disease, the patient's intent to adopt protective behaviors, **and the decision to seek the advice of an expert in infectious diseases** before breaking confidentiality.

Results: Through cluster analysis, four qualitatively different positions were found: *Quite never acceptable* (6% of the sample, mostly males), *Depends on husband's willingness to inform* (3%), *Depends on husband's protective behavior* (29%, mostly females), and *Quite always acceptable* (32%). The remaining participants did not express any clear view.

Conclusion: **In Kuwait, students' trust in the medical profession** is, therefore, not likely to be seriously undermined if, from time to time, and in well-specified cases, individual physicians decide to break confidentiality when facing dilemmas of the kind examined in the current study.

Key words: confidentiality; patient-physician relationship; sexually transmitted disease; Kuwait

Résumé

Introduction: Le secret médical est essentiel au maintien de la confiance entre patients et médecins.

Objectifs: Les circonstances à propos desquelles les jeunes Koweïtiens considèrent qu'il est acceptable pour un médecin de rompre le secret médical ont été examinées.

Méthode: Un échantillon de 263 jeunes Koweïtiens a jugé du secret d'acceptabilité de la rupture du secret dans 48 cas de figures représentant toutes les combinaisons possibles de cinq facteurs: la gravité de l'infection, le temps pris par le médecin à en discuter, l'intention du patient d'informer son épouse, l'intention du patient de protéger son épouse et le fait de solliciter l'avis d'un expert en infectiologies avant de rompre le secret.

Résultats: Une analyse en cluster a permis de mettre en évidence quatre positions qualitativement différentes: *Jamais très acceptable* (6% de l'échantillon, surtout des hommes), *Dépend de l'intention d'informer* (3%), *Dépend de l'intention de protéger* (29%, surtout des femmes), et *Presque toujours acceptable* (32%). **Quelques participants n'ont pas exprimé de position que l'on puisse caractériser.**

Conclusion: Au Koweït, **la confiance placée par les étudiants dans les médecins** ne risque pas d'être sérieusement diminuée si, de temps en temps, et dans des circonstances particulières, certains médecins décident de rompre le secret médical pour protéger la vie d'une personne.

Mots-clés: secret médical; relation patient-médecins, infection transmise sexuellement;

Koweït

Is it Acceptable for a Physician to Break Confidentiality in the Case of Sexually Transmitted Diseases? A Mapping of Young Kuwaiti's Views

Confidentiality is essential for the establishment of trust between physicians and their patients. Lack of trust would impede complete disclosure of information, in particular disclosure of sensitive information. In a context of incomplete or false information, medical diagnosis is uneasy or unfeasible, tests that would have been useful may not be performed, and treatment that would have been urgent may be delayed. The earliest codes of medical conduct already recognized the importance of confidentiality (Edelstein, 1943).

Confidentiality has its limits: The value that physicians and patients attach to confidentiality can conflict with the value they attach to justice and to life itself (Gibson, 2006). It is the case when a physician, after having provided his/her patient with detailed information about his serological status, realizes that the patient will probably do nothing to protect family members and other persons from contagion. **In other words, confidentiality may reach its limits each time a patient, because of lack of concern or downright hostility towards others would put them at risk of dying or at risk of being severely ill (Bennett, Draper, & Frith, 2000).** Not trying to protect the people who might be victims of this patient may be viewed, by some people, as accepting to be his accomplice. Then, the physician faces a dilemma (Barker, 2006). Should s/he break confidentiality in view of protecting somebody else? Should s/he maintain confidentiality because confidentiality is an ethical cornerstone of good therapy, and local codes of ethics request it in all circumstances (Kipnis, 2006)?

Health Professionals' Views about the Rupture of Confidentiality in Cases of Severe Infection

The issue of confidentiality is particularly sensitive when it involves the infection of a spouse or a sexual partner with a lethal or very severe sexually transmitted disease (STD)

(Abraham et al., 2002; Subramani, 2019). Several studies have explored the opinions of health professionals on the breach of confidentiality in the case of HIV transmission. In the United States, health professionals generally agree that the value of confidentiality is less than the value of life (DiMarco & Zoline, 2004; Keffala & Stone, 1999; McGuire et al., 1995; Stewart & Repucci, 1994), and their views tend to align with the Tarasoff decisions (Totten, Lam & Reeder, 1990).

US physicians, therefore, essentially conceive confidentiality as a means to save lives. As a result, confidentiality loses its meaning in cases where lives may be endangered because of non-communication of information. In France, however, it has been shown that general practitioners are systematically hostile to the idea of breaking confidentiality (Moatti et al., 1995). In this country, medical confidentiality is, like the secrecy of confession, unqualified. In the course of their work, physicians (like Roman Catholic priests) must, for the good of all, place themselves outside certain common rules of society (Kipnis, 2006).

Public's Views about the Rupture of Confidentiality in Cases of Severe Infection

The general public's views about confidentiality have also been studied. Jones (2003) presented English patients with scenarios depicting a dilemma of the confidentiality *versus* life type and asked to decide whether confidentiality should be breached. Support for breaking confidentiality in order to protect third parties was quite high. For example, in the case of a patient with an STD who would not tell his spouse, 50% suggested that it was the physician's responsibility to call her.

Guedj et al. (2006) presented French lay people with a series of scenarios depicting a husband found to have an STD and whose behavior varied from complete retention of information to complete disclosure to the partner. Through cluster analysis, they found four qualitatively different positions. Eight percent considered that breaking confidentiality was never acceptable, 60% considered that it was acceptable each time the patient had no intention

to inform the spouse, and no intention to adopt protective behaviors, 20% considered that it was acceptable each time an expert in STD was consulted, and 9% percent considered that it was always acceptable. A small sample of physicians was also included in this study. Their positions totally differed from lay people's views: 86% considered that the breaking confidentiality was unacceptable, irrespective of circumstances, a result that was consistent with the findings by Moatti et al. (1995).

A study using the same set of scenarios was also conducted in Chile and the same set of positions was found (Olivari et al., 2011). Chilean lay people did not differ much in their views from French lay people but most Chilean physicians (90%), by contrast with French physicians (14%), agreed with the view that confidentiality must be broken when a spouse's life is in danger. This difference between physicians in different countries can be explained by the fact that the American, British and Chilean codes of ethics state that breach of confidentiality is considered legitimate when disclosure is necessary to avoid serious harm to the patient or others (American Medical Association, 1994; British Medical Association, 1999; Colegio Médico de Chile, 2008). In France, as mentioned above, the code of ethics emphasises the preservation of patient confidentiality in all cases (Conseil National de l'Ordre des Médecins, 1996, 2002).

The Present Study

The present study examined Kuwaiti young people's views regarding confidentiality. It was motivated by the fact that knowledge about the views of patients and people in general regarding this sensitive issue is scarce. In Kuwait, confidentiality is protected by the Islamic Code of Medical Ethics (2009): "The Doctor shall put the seal of confidentiality on all information acquired by him through sight, hearing or deduction. Islamic spirit also requires that the items of the Law should stress the right of the patient to protect his secrets that he confides to his Doctor. A breach thereof would be detrimental to the practice of medicine,

besides precluding several categories of patients from seeking medical help.” The position expressed by this Code seems, therefore, to be similar to the one adopted by the French Code of Medical Ethics.

Our main hypothesis was that most participants would conform, in their judgments, to the Islamic Code of Medical Ethics. **In other words, they should consider breaking of confidentiality is never permissible, and therefore, never acceptable.** This hypothesis was based on previous findings on Kuwaiti students’ positions regarding another health ethics issue for which the Code’s recommendations are very unambiguous: medically assisted suicide (Sachedina, 2005). In this previous study, and as expected, 44% of Kuwaiti students systematically rejected the possibility for the patient to resort to assisted suicide, in accordance with the Code. Twenty-three percent were hesitant: They somewhat take into account the circumstances (e.g., the patients request, their age, the type of suffering) but their responses were always located close to the unacceptability pole. Only a minority (16%) expressed the view that the acceptability of resorting to an end of life procedure mainly depended on the patients’ age, irrespective of their wishes, and another minority (11%) expressed the view that it depended on the many circumstances characterizing the case, and particularly on the patient’s request.

Our secondary hypothesis was that a minority of students would express positions that would be reminiscent of the ones found in Chile or in France, namely an Always acceptable position and a position that takes into account the circumstances, namely the patients’ willingness to inform and/or to protect their spouses.

Method

Participants

A total of 238 university students (64% females) participated in the study. Age ranged from 19 to 40 years ($M = 24.04$; $SD = 6.14$). None was currently in bad health. All were from the Muslim community.

Material

The material was borrowed from the study by Guedj et al. (2006). It consisted of 48 vignettes showing a story of a few lines, a question, and a response scale. The stories were composed according to a five within-subject factor design: (a) the transmissible disease's level of severity (severe or lethal), (b) the time taken by the physician to inform the patient regarding severity of the disease (**little time or a lot of time**), (c) the patient's intent to inform or not his spouse (no intent, or "one of these days", or inform immediately), (d) the patient's intent to adopt protective behaviors (no intent or intent), and (e) the physician's decision to consult an expert in STDs before calling the spouse (call or no call). **This last factor expresses the degree of caution before acting shown by the physician.**

The story context was held constant. All the patients described were men, and in each case the doctor decided to personally call the patient's wife to inform her that her husband had an STD. No specific STDs were mentioned in the stories. The question was: "To what extent do you believe that the decision made by the physician is acceptable?" A 15-point response scale (0-14) with anchors of not acceptable at all and completely acceptable was provided.

An example of a scenario is the following: "Mr. Al Ramani comes to see Dr. El Hage. The results of analyses show that Mr. Al Ramani is currently infected with a sexually transmitted disease. Given the current state of our knowledge, the consequence of this infection will, after a medium amount of time, be fatal. Dr. El Hage spends much time in discussing with Mr. Al Ramani the consequences of this infection, the risks of spreading it, and the precautions that can be taken against spreading it. Mr. Al Ramani manifests, during the visit, his intention not to mention his state of health to his spouse, for fear of social and

family consequences. It also appears to Dr. El Hage that Mr. Al Ramani will do nothing to protect his spouse during sexual relations. Worried about the health of Mr. Al Ramani's spouse, Dr. El Hage decides to call her and keep her informed about her husband's infection and, above all, about the risks incurred. Before taking this step, Dr. Cartier has taken the precaution of requesting the advice of Professor Al Arabi, a specialist in STD's. To what extent do you believe that the decision made by Dr. El Hage is acceptable"?

In designing the Arabic version of the material, guidelines proposed in the literature on cross-cultural methodology (Brislin, 1970) were followed as closely as possible. One of the authors was, in addition, fluent in Arabic and in English.

Procedure

The site was a vacant classroom at the university. Each person was tested individually or in groups of 2-4 persons. The procedure followed Anderson's (1997, 2008) recommendations for this kind of study. The participants took 20-40 minutes to complete the ratings. The participants knew in advance how long the experiment would last. No one complained either about the number of vignettes or about the credibility of the proposed situations. The protocol was approved by the Committee on Ethics of the College of Social Sciences of Kuwait University. Informed consent was obtained from all participants in the study, and strict anonymity was respected.

Results

A cluster analysis was conducted on the raw data (Hofmans & Mullet, 2013). A five-cluster solution was retained. Ten participants were not classified because their ratings seemed to be completely erratic. In order to test the differences between clusters, an overall analysis of variance (ANOVA) was conducted on the raw data with a Cluster x Severity x Time x Intent to inform x Intent to protect x Expert, 5 x 2 x 2 x 3 x 2 x 2 design. Cluster was a between-subjects variable, and the other factors were within-subject variables. Owing to the

great number of comparisons, the significance threshold was set at .001. All main effects and most interactions involving the cluster factor were significant. As a result, five separate ANOVAs were performed at the cluster level.

For 15 participants (6%) ratings were, as can be observed in Figure 1 (left-hand panel), always close to the unacceptability pole of the response scale ($M = 3.67$, $SD = 1.46$). **This cluster was the expected *Quite never acceptable* cluster.** As can be observed in Table 1, males expressed this position more often than females.

For seven participants (3%), ratings were, as can be observed in Figure 1 (second panel) considerably higher when the patient was willing to immediately inform her spouse ($M = 10.76$, $SD = 0.84$) than when he was unwilling to do so ($M = 2.89$, $SD = 0.50$), $F(2, 12) = 58.13$, $p < .001$, $\eta^2_p = .91$. **It was called *Depends on husband's willingness to inform his spouse*.** As can be observed in Table 1, males expressed this position more often than females.

For 70 participants (29%), ratings were, as can be observed in Figure 1 (third panel), higher when the patient was unwilling to protect his spouse's health by using protective devices ($M = 10.36$, $SD = 0.83$) than when he was willing to do so ($M = 5.10$, $SD = 0.67$), $F(1, 69) = 291.92$, $p < .001$, $\eta^2_p = .82$. In addition, ratings were slightly higher when the husband did not intend to inform his spouse ($M = 8.72$, $SD = 0.90$) than in the other cases ($M = 6.99$ and 7.47 , $SD = 0.76$ and 0.65), $F(2, 138) = 30.56$, $p < .001$, $\eta^2_p = .31$. This cluster was called *Depends on husband's protective behavior*. As can be observed in Table 1, males expressed this position less often than females.

For 75 participants (32%) ratings were, as can be observed in Figure 1 (right-hand panel), always close to the acceptability pole of the response scale ($M = 10.78$, $SD = 1.41$). This cluster was the expected *Quite always acceptable* cluster.

Finally, for 61 participants (27%), ratings did not deviate much from the middle of the response scale (not shown). This cluster was, therefore, called *Undetermined*.

Discussion

Contrary to our main hypothesis, a majority of participants expressed positions that were favorable to the breaking of confidentiality, at least in some circumstances. About one third of them considered that, in the specific case of STD, notifying the patient's spouse of the risk of transmission was always an acceptable decision. Such a principled position has already been observed by Guedj et al. (2006) among French participants (9% of the sample) and by Olivari et al. (2011) among Chilean participants (12% of the sample). Interestingly, male participants expressed this position as frequently as female participants. On the other hand, only six percent of the participants, mostly males, fully adhered to the recommendations of the national Code of Ethics; that is, they expressed a *Never acceptable* position. In the studies conducted in France and Chile, the percentages of participants expressing this position were also very low (10% and 2% of the sample, respectively).

About one third of participants, mostly females, considered that when the patient did not intend to inform his spouse and to protect her health, notifying her was an acceptable decision. However, if the patient agreed to take measures in view of protecting his spouse's health, notifying her was not considered as acceptable, even if the patient did not inform her of his illness. About 70% of French or Chilean participants expressed a similar position.

A small percentage of participants expressed the view that it was acceptable for the physician to notify the spouse of her husband's illness each time that the patient has agreed to inform her. At first glance, this position seems contradictory. It can be interpreted, however, as reflecting the idea that, once the spouse has been informed by her husband, giving her additional information about the consequence of the illness and the ways to protect one's health cannot do harm. This position was, however, never found in previous studies.

Finally, about a quarter of the participants were completely undecided. The existence of such a lack of position, although at first sight disconcerting, is congruent with the results of

previous studies on complex societal issues allowing people to express a non-position (e.g. Neto et al., 2013). Johnston Conover, Searing and Crewe (2002) listed reasons why survey respondents may be unable to express an opinion on important societal issues: level of knowledge deemed insufficient, perceived incompetence in the field, fear of voicing preferences publicly, holding unwelcome opinions, genuine doubt, and protection against what is perceived as an infringement on privacy. In this case, we can surmise that the third and fourth reasons are at work. This point is methodologically important. If the participants in this sample had been requested to provide only one answer - to a generic item or a single script - their responses would have been construed as moderate support for the breach of confidentiality. By asking participants to respond to a number of textured scripts, it was possible to differentiate between absence of opinion and moderate support.

Limitations

The current study has several limitations. First, the participants were limited to students. Generalizations to older adults must, therefore, be done with care. Second, the case in which the patient decided not to inform his spouse about his STD but planned to adopt protective behaviors may have seemed somewhat difficult to implement to some participants, although no one pointed this out. Third, the acceptability ratings were made about hypothetical cases. Fourth, the importance attributed to the information may depend on the way it is delivered. For example, STD severity would have had more impact if it had been labelled HIV-AIDS. Fifth, multiple other factors may influence physicians' and patients' decisions; even though, previous work suggested that the factors that have been considered in the study have wide generalizability.

Implications

Despite these limitations, the current results should make physicians and policy makers aware that in Kuwait, as well as in other countries, at least some people (students in

this case) may be sensitive to the influence of situational factors on the difficult moral decision of whether or not physicians should break confidentiality when they suspect that a patient may cause harm to someone else (see also Guedj et al., 2009; Muñoz Sastre et al., 2014; Olivari et al., 2015). Therefore, trust in the medical profession (at least among students) is not likely to be seriously undermined if, from time to time, and in well-specified cases, individual doctors, faced with such dilemmas, decide to break confidentiality by calling patients' relatives in the event of a probable life-threatening situation (Gibson, 2006).

Kuwaitis, and probably not only students, may well understand that by doing so, health professionals demonstrate that they value life and justice above all other considerations (Zinn, 2003). Rather than agreeing with that part of the official code of ethics that concerns confidentiality, they would in fact tend to agree, as did the French participants (Guedj et al., 2006), with the American Medical Association's Code of Ethics which, as early as 1912, and after ten years of experimenting with a code of ethics that advocated confidentiality without exception, determined that there “are occasions, however, when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected because the physician has knowledge, obtained through confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case, the physician should act as he would want another to act towards one of his own family in like circumstances” (American Medical Association, 1912).

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Table 1. Demographic Characteristics of the Sample. Composition of the Clusters.

Characteristic	Cluster						Total
	Quite Never Acceptable	Informs Spouse	Protects Spouse	Quite Always Acceptable	Undeter- mined	Unclas- sifiable	
	Gender						
Male	9 (11) ^a	7 (8) ^a	13 (15) ^a	29 (34)	25 (30)	2 (2)	85
Female	6 (4) ^a	0 (0) ^a	57 (37) ^a	46 (30)	36 (24)	8 (5)	153
Age							
18-21 Years	3 (3)	5 (4)	34 (31)	36 (32)	27 (24)	7 (6)	112
22+ Years	12 (9)	2 (2)	36 (29)	39 (31)	34 (27)	3 (2)	126
Total	15	7	70	75	61	10	238

Note: Figures in parentheses are percentage computed in row. Figures with the same superscript are significantly different, $p < .05$.

Figure 1. Mean acceptability (on the y-axis) of breaching confidentiality for four of the five clusters, as a function of the patient's intent to inform his wife (on the x-axis), and the combination of the patient's intent to use protection (the two curves).

