

Work stories

Vanya Kovach PhD

In 2006, the New Zealand Police launched its now long-running recruitment campaign based on the slogan 'Better Work Stories', and many might have wondered what duties of confidentiality should constrain officers when talking about what happens to them at work.* But we must acknowledge that talking to our partners and friends about significant events has undeniable value, because storytelling is a central part of human life, connecting us to others and revealing us to ourselves. However, when these events occur in professional life, this very natural aspect of life is curtailed by obligations of confidentiality. The aim in what follows is to raise some questions about work stories and to explore one argument for allowing them, under certain circumstances, and with certain limitations.

The telling of work stories in the professions is not much studied or the ethics of it often addressed.† However, one 1982 study in the USA reported that while 17% of patients had the expecta-

tion that their case would be discussed with the medical staff members' spouse or partner, 70% of medical staff admitted that this was a common practice. Only 9% of patients thought it likely that medical staff would use their case as an interesting story to tell to non-medical friends at a party, and yet 45% of medical staff reported that they did this. Interestingly, only 2% of patients expected that they might be identified by name to non-medical personnel, and only 8% of medical staff acknowledged that they had done this.¹ No studies have been done in New Zealand, so as yet we have no information about the expectations of patients here.

What telling of stories is allowable by law? The Health Information Privacy Code (2008) Rule 10, 1(e) allows that patient information may be used 'in a form in which the individual concerned is not identified', and this is clarified as use 'within the agency' or by students writing case histories of patients who have consented to be seen by that student.

Note, though, that these restrictions on the use of anonymised information are in the non-binding commentary section of the Code. It seems the law does not clearly determine, at least in this Code, whether anonymised information can be used for other purposes, though the implication is that any use should be connected with health care. Just what this might encompass is a matter for ethical debate.

The professional obligation to keep information about patients confidential is grounded on a number of different values or principles: respect for patients' autonomous control over themselves; promises made by professionals to their clients; benefits that can only be gained when a client is assured that the information they provide is kept secret, and the relationship of trust between clients and professionals.‡ The general requirements of the obligation of confidentiality in health care, as set out in numerous codes of ethics, are that information given by patients to

* At the time, the police had no formal code of ethics, but the vulnerability of the people they come in contact with should suffice to ground an obligation of confidentiality. Many of the work stories recorded on the police website are general and innocuous, but one worrying one is posted, entitled 'Pregnant'.

† A number of empirical studies have been published about patient expectations of confidentiality, but the ethical issue of work stories in particular has not been much examined. One exception is: James S. Gossip, stories and friendship: confidentiality in midwifery practice. *Nursing Ethics*. 1995;2(4):295–302. The issue is mentioned, but not discussed, in the canonical text Beauchamp TL and Childress JF. *Principles of biomedical ethics*. 6th edition. New York: Oxford University Press; 2008, p 305.

‡ An excellent (and classic) paper on the justification and limits of confidentiality is: Bok S. *The limits of confidentiality*. *Hastings Center Report*. 1983;13(1):24–31.

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The **ETHICS** column explores issues around practising ethically in primary health care and aims to encourage thoughtfulness about ethical dilemmas that we may face.

THIS ISSUE: Vanya Kovach, ethicist with the Philosophy Department at The University of Auckland, explores the morality and legality of health professionals' shared anonymous stories about their patients.

health professionals is to be used only for the purposes for which it was given, and that this information, and any facts about the patient's condition, be shared only with those who have an institutionally-recognised role in the care of the patient, unless the patient gives permission for others to have access. Legitimate exceptions to these requirements are made when serious and imminent harm to the patient or third parties threatens or when the court orders, and when the use of statistics based on patient information is allowed for audit and service provision planning. All of this is familiar, and accepted. Concerns have been raised about the debasement of confidentiality, given the number of staff who might have electronic access to a patient's information,² and no-one believes that bedside curtains in wards are soundproof, but the expectation of patients persists that only a few will know the intimate details of their medical conditions, and their familial and social circumstances.

However, we know that work stories abound, and that there are a variety of motives for telling them. Stories are told to provide entertainment, for social self-promotion, to establish commonality, to unwind and unload at the end of the day, to warn of health dangers or to stimulate reflection and gain counsel and comfort. Other factors may have significance in evaluating the recounting of a story which involves information about patients, and these include who is speaking, who is listening, the level of detail which is disclosed, the context in which the information was gathered and recounted, and the expectations of the people whose information is being disclosed. Some of these factors will be explored in the following three scenarios.

1 *A doctor is regaling her friends with stories at a dinner party, and describes an unnamed patient in a way that makes them seem ridiculous.*

There are a number of reasons why this might be unacceptable. Even if it is argued that this is not a breach of confidentiality, because the information is anonymised, this behaviour is in conflict with other professional obligations: to treat one's patients with dignity, and to respect them. Although the doctor may not be able to show disrespect to a particular person if their name is not mentioned, she can herself fail to respect them—and also encourage disrespect to others who share characteristics with the person in the story. There is no direct harm to the patient, but there may be harm to the doctor's character and to the reputation of her profession in the minds of the hearers. Perhaps it could be said that no trust between patient and doctor is lost, as the patient is unaware that they have been used in this way. But the obligation is to be *trustworthy*, not *trusted*. Trustworthiness is a disposition which can be understood as consisting of a collection of conditionals: ...If I was asked to lie...If someone offered me money... (and, most relevantly here) if my patients *did* hear me talking about them... But what of telling an unnamed patient's story without disrespect?

2 *A nurse is concerned about the unhealthy habits and risky behaviour of her young relatives. Motivated by her love for them, and, she thinks, a proper professional desire to educate and inform, she tells them some stories about unnamed past patients who have suffered seriously from the effects of those behaviours.*

In this case there is no disrespect to patients and no attack on their dignity. This is not a case of using patient infor-

mation for the purposes for which it was given, and yet the motive for telling the stories is consistent with the wider aims of health care. We accept the use of anonymised patient information for medical education, so is its use for education of the wider public any different? First, patients usually do have an expectation that their cases will be used for teaching;⁵ second, such teaching takes place in a formal context where only medical professionals attend, and third, the hearers take themselves to be under obligations of confidentiality and respect. (Note that if medical students discuss cases in bars, the latter two conditions are not met.) One further difference is that the use of detailed cases is necessary for medical education, but not for passing on health advice, though there seems little doubt that stories do lodge in the minds of hearers more firmly than do generalisations and statistics. If we do think that the necessity for telling the story is important in its justification, then this might show that even respectful recounting of cases, as interesting stories, is unacceptable.

3 *A pharmacist has encountered a troubling situation, which raises a number of ethical and clinical issues and he is unsure about how to respond. He has discussed it with a colleague, but reached no conclusion. He spends the evening talking about the case with his partner,¹¹ (mentioning no names or identifying characteristics), framing and reframing the facts, constructing and evaluating different solutions, struggling to find a good way to proceed. He is tense and unhappy, and feels responsible for things outside of his control. His partner listens, asks questions, suggests alternative points of view, and tries to get him to see that he is doing all that he can. Is this apparently common occurrence acceptable in the light of obligations of confidentiality?*

§ If patient expectations are relevant to the justification of what we do, then research into what they are is essential, as is public acknowledgement of what medical professionals actually do with stories.

|| What follows might apply to close friends, or relatives, as well as partners.

In this case, again, no lack of respect or attack on dignity is involved. But, again, the information has been disclosed to someone who has no formal role in the care of the patient, and who is therefore not under any formal obligations to keep the information confidential. Is it safe to disclose, in these circumstances? This might depend on a number of factors. Although no names are mentioned, will the partner know who the patient is? In small communities, it might be hard to avoid this. Is the partner someone who takes seriously the trust reposed in him or her, when these stories are shared? Or are they likely to pass the stories on, for entertainment, self-promotion or even spite? Two positions are possible here; first, that all such discussions are to be prohibited, because safety from identification or from misuse cannot be fully assured or enforced, or second, that such discussions are acceptable to the extent that it can be reasonably predicted that the information is safe, given the degree of detail disclosed, the social context of the people involved and the character of the partner.

In the situation described, there are two purposes for telling the story. One is to seek assistance in making a decision about how to act. Should this take place outside the health care team? Reasons for maintaining that it shouldn't include not just confidentiality but efficacy, as non-medical partners are likely to lack

the relevant knowledge and experience needed for assisting decision-making, though they may be able to contribute astute questions and useful perspectives. Decision-making might be aided by discussion with a partner, but it cannot be claimed that they have a necessary role in the process. The other purpose for telling the story is more personal. The pharmacist may need to vent emotions, explore psychological issues, or seek comfort. He may need to talk over his responses to challenges, sad outcomes and mistakes in order integrate them into his life and the way he thinks about himself, both personally and professionally. This second purpose is consistent with the goals of health care, in that it provides significant support for

true of a partner, though in most cases we can assume that the partner has at least that capacity for close attention and sympathetic concern that a therapist offers. One important limit to what is told is suggested by identifying this purpose of telling work stories—what is talked about must be 'about me', and that the detail disclosed should be only enough to provide the necessary context for understanding the personal difficulties and distress experienced.

Perhaps what this shows is that all health care workers should have regular professional counselling, and this may be so. However, there is a deeper purpose to sharing work stories with

Whereas social workers and counsellors have formal supervisory relationships within which they can reflect on how they have been affected personally by incidents in their practice, most health professionals do not

a professional to perform his or her role. But is this sufficient to satisfy the intent of the Health Information Privacy Code, and the ethical basis of promises of confidentiality?

How necessary is it for the pharmacist to seek this support from his partner? Whereas social workers and counsellors have formal supervisory relationships within which they can reflect on how they have been affected personally by incidents in their practice, most health professionals do not. Colleagues may perform this supervisory and counselling role, though they might have limited time, and lack the skills or the intimacy of relationship required for such 'counselling' to be effective and safe. Of course, this could be equally

partners, and that is to meet the need to be known intimately, and to share our lives fully with our life companions. Professional life requires that we abjure many quite natural things—including always applying our own morality to the work that we do. It is not too much to ask that in joining a profession we give up the freedom to use our work stories to gossip, preen and entertain, but is it too much to ask that we give up sharing our whole selves with our partners?

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References

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