

Should Institutions Disclose the Names of Employees with Covid-19?

Prestigious University is a large, private educational institution with a medical school, a university hospital, a law school, and graduate and undergraduate colleges all contiguous to each other on a single campus. In the face of the Covid-19 pandemic, while students were on spring break, they were told by the president to return to campus only briefly, at appointed times, to retrieve their belongings if they lived in the dormitories. Students would then not be permitted back on campus for the rest of the semester. Classes went online. Some staff members remained on campus during this transition period

to facilitate the move-outs and to clean and disinfect campus buildings.

On March 23, 2020, the faculty, students, and staff were sent the following email by the university's director of infection control and public health, who is a medical doctor with a master's in public health:

Dear Members of the Prestigious University Community:

We have become aware that a Prestigious University staff member has tested positive for the virus that causes Covid-19. The individual, who was last on campus on March 16, is now in isolation at their permanent residence and is doing well clinically. The university has already

identified those members of our community who may have been in close contact with this individual, and we are working to notify them. Further, this individual's local health department has a protocol for identifying people who have been in direct contact with anyone testing positive for Covid-19 (such as this Prestigious University staff member) so that they can self-quarantine and watch for COVID-19 symptoms for a period of 14 days from their last contact with the infected individual. Out of an abundance of caution, we are reaching out to you to make you aware of these developments.

A professor in the Philosophy Department has asked the ethicists at the medical school whether such contact tracing suffices as a response to this discovery. "Don't the members of the community deserve to know who this is? Isn't there a mandate to identify this person in order to maximize public health benefits and slow the spread of this deadly virus?"

commentary

by Daniel P. Sulmasy

It is widely acknowledged that the duty to protect patient confidentiality is not absolute and can be loosened under circumscribed conditions, such as when protecting confidentiality endangers public health. Confidentiality, however, is a critical value, vitally important to the patient-physician relationship. Decisions to breach confidentiality must be tempered by a principle of restraint in public health ethics—that one should always employ the least invasive, least coercive means necessary to achieve a vital public health goal. Diminishing

the spread of the SARS-CoV-2 virus, which is very contagious and carries a mortality rate of around 1 percent, is a vital health goal. The question posed by this case is how best to balance public health against the duty to minimize deviations from the norm of respecting patient confidentiality.

Public health measures in place at the time of this writing—social (or physical) distancing and self-quarantining of mildly infected persons and their close contacts—are an attempt to stop the virus from spreading exponentially. Contact tracing through the self-reporting of recent close interactions by persons known to be infected with Covid-19 is a part of that strategy. One could be more draconian: new

surveillance technologies that employ facial recognition, security cameras, and phone GPS monitoring could attempt to identify everyone who spent at least fifteen minutes within six feet of every infected individual, and we could forcibly quarantine each contact. A strategy like this might be effective, but it seems to violate the principle of restraint in public health ethics that prevails in liberal democratic societies.

Voluntary contact tracing is not perfect. Patients might not remember all their contacts. But the perfect should not be the enemy of the good.

The philosophy professor suggests an alternative strategy—the public naming of infected individuals. This strategy, however, would breach confidentiality

without contributing much to the goal of diminishing viral spread, potentially even detracting from that goal.

Casual contact for very short periods is not likely to spread the virus. Many faculty members might not even recognize the names of staff members, let alone remember if they had close contact with them. Further, public health intrusions on privacy should generate actionable responses. But knowing that one had casual contact with an infected individual would lead only to calls for self-monitoring, which everyone is supposed to do anyway. Moreover, infected surfaces transmit the virus much less efficiently than close contact with infected persons. Merely having had brief contact (less than fifteen minutes) with the infected individual, without having been physically close, ought not to trigger self-quarantine. Public naming might also deter infected individuals who test positive at their physicians'

offices from reporting results to their employers. They might fear the public embarrassment of being named if they self-report, leading to lost opportunities for contact tracing.

I would therefore argue that there is no case for Covid-19 exceptionalism regarding breaches of confidentiality. The public health standard for communicable diseases is discrete contact tracing without the additional breach of confidentiality that comes with public naming. Contact tracing is of proven benefit for diseases such as tuberculosis and meningitis. Standard contact tracing might even be amplified by, where possible, public notification of locations and times at which an infected person might have exposed others. But making a special case for Covid-19 by resorting to public naming might stoke already high anxiety among citizens. In the absence of a known public health benefit for naming beyond what is achievable

by contact tracing, no one's claim to a "right to know" for personal reasons outweighs the duty to protect patient privacy.

One could ask an infected individual to consider voluntary public disclosure, but one should avoid undue pressure that might diminish the voluntariness of this gesture. Voluntary public disclosure could and should be done by the individual through private communication channels, not by public health authorities or the infected individual's employer.

Patient confidentiality remains a very significant value. It is under threat from social and technological developments Hippocrates could never have imagined. There are times that it must be breached for the sake of public health, but only with an effort to limit the scope of that breach.

commentary

by Robert M. Veatch

Even the best contact tracing can inform only those that the Covid-19-positive person can identify and remember to name. Many university staff members have contact with dozens, perhaps hundreds, of people daily, some of whom the infected person doesn't remember or even know. If the infected individual was last on campus seven days before the letter was sent, then they were contagious for perhaps several days when still on campus. The people with whom they interacted could have been infected but not yet be symptomatic. These individuals have a real medical interest, potentially a life-or-death interest, in knowing that that person might have been infectious when they interacted. The philosophy professor has a strong case to make for revealing this person's identity. This is potentially a case where the traditional confidentiality duty ought to be overridden.

Traditional medical ethics has always rightly included a presumption

of confidentiality. Yet medical ethics has also always included exceptions to protecting confidentiality. The original Hippocratic oath stated that one should not disclose "that which ought not be spread abroad," implying that some disclosures might be appropriate or even required. The oath has been interpreted as identifying what should be disclosed by the core Hippocratic principle of benefiting the patient according to the physician's "ability and judgment." Hence, until the 1970s, both the American and British medical associations acknowledged a paternalistic, patient-benefiting exception to the duty of confidentiality. It was morally mandatory to breach confidentiality when the physician believed it would benefit the patient.

Of course, in the staff member's case, the disclosure benefit redounds to third parties. Beginning in the 1970s, both state law and professional ethics began rejecting the paternalistic exception, replacing it with a more defensible exception where disclosure promised protection of third parties from credible threats of grave bodily harm. In the United States, this began with the legal requirement of health profession-

als to warn. The case involved a college student whose girlfriend had broken up with him and who then conveyed to a psychologist that he planned to kill her. After he followed through on that plan, the health professional was found guilty of failure to warn. In general, if the threat to others is severe enough and credible enough, both the American Medical Association and the law now recognize a duty to breach confidentiality.

Since then, other cases have led to the same conclusion. In Denver, a student entered a movie theater and shot randomly after conveying his distress to his therapist. Most concluded that the therapist had a duty to warn if she found his threat credible. Similarly, in the era when HIV was of great concern in the United States, an HIV-positive man confessed to physicians that he was trying to have sex with women to express his general anger with anyone who was female (blaming women in general for his becoming infected).

The staff member's case raises similar issues. Some members of the university community are at real risk but can't know they are without knowing

the person's identity. Only a fraction can be identified through contact tracing. That staff member should be asked to consent to having their identity disclosed, and that person has a duty to the community to agree. If the individual refuses, then a difficult assessment must be made. Depending on whether the person's position puts them in contact with many people, the timing of the exposures, and an estimate of what the exposed individuals can do to protect themselves, the name should be disclosed.

If the one deciding whether to make such a disclosure at an institution is not a physician but an administrator, then the obligation at stake would be whether there is a duty to protect employee identity. Once again, although that duty is less thoroughly analyzed than the physician's duty to a patient, it seems reasonable that there are limits to confidentiality when there exists a credible threat of grave bodily harm to another.

The staff member at Prestigious University should be identified for some scores of contacts to monitor themselves

and for thousands of others to be assured. There is no other reason for the university's infection control director to send the notice. Our duty to the community must be balanced against the right of confidentiality.

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