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# From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine—Part II: Challenges in the Emergency Department

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Part I of this article reviewed the concepts of privacy and confidentiality and described the moral and legal foundations and limits of these values in health care. Part II highlights specific privacy and confidentiality issues encountered in the emergency department (ED). Discussed first are physical privacy issues in the ED, including problems of ED design and crowding, issues of patient and staff safety, the presence of visitors, law enforcement officers, students, and other observers, and filming activities. The article then examines confidentiality issues in the ED, including protecting medical records, the duty to warn, reportable conditions, telephone inquiries, media requests, communication among health care professionals, habitual patient files, the use of patient images, electronic communication, and information about minor patients. [Ann Emerg Med. 2005;45:60-67.]

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### INTRODUCTION

Part I of this article focused on the conceptual, moral, and legal foundations and limits of privacy and confidentiality. It addressed 3 important questions: (1) How are privacy and confidentiality defined? (2) What are the major moral and legal reasons for respecting patient privacy and confidentiality? and (3) What are the major moral and legal limits on the professional duty to respect patient privacy and confidentiality? This second part of the article will use the conceptual, moral, and legal framework of Part I to address privacy and confidentiality issues commonly encountered in the emergency department (ED). Following the convention adopted in Part I of the article, this part of the article will use the term “privacy” to refer to protection from the physical presence of or exposure of one’s body to unauthorized persons and “confidentiality” to refer to protection of patient information from disclosure to unauthorized persons. The article will begin by examining privacy issues and then consider confidentiality issues in the ED.

### PRIVACY ISSUES IN THE ED

#### ED Design and Patient Volume

Unlike other hospital units, where private and semiprivate rooms assist in the protection of privacy and confidentiality, EDs often contain large treatment bays in which multiple patients may be housed for long periods, separated from one another only by curtains, if at all. In one study, investigators reported frequent breaches of privacy and confidentiality in a university hospital ED.<sup>1</sup> ED patients in another university hospital reported that they were more likely to be seen and overheard by unauthorized persons in curtained treatment areas than in rooms with solid walls.<sup>2</sup> Although 92.6% of the 104 patients in the latter study reported that their expectations for privacy in the ED were met, 4 patients (all in curtained treatment areas) reported withholding part of their medical history, refusing part of their examination, or both because of privacy concerns. These limited studies, and the authors’ personal experience, suggest that patient privacy in the ED is routinely compromised by physical ED design, crowding, or lack of caregiver vigilance.

When the ED becomes crowded, there may be no practical alternative to placing patients on gurneys in close proximity to one another in treatment areas and hallways for extended periods, greatly exacerbating endemic problems of protecting privacy. ED crowding has become such a common and widespread occurrence that one recent commentator satirically describes “the emerging subspecialty of Hallway Medicine.”<sup>3</sup> Thus, the physical limitations of the ED and the high volume of patients may make the preservation of privacy (and confidentiality) extremely difficult.

Problems of ED design and crowding are, of course, institutional and social issues largely beyond the control of individual emergency physicians. In response to these difficult conditions, however, emergency physicians can take important steps to protect their patients from unnecessary and undesired physical exposure. Emergency physicians should strive to minimize patient waiting time in ED treatment areas, thereby reducing overall patient volume. Emergency physicians should also use all available treatment areas and partitions to separate patients from one another as effectively as possible. They should insist on the use of movable privacy screens when procedures and tests (such as ECGs) must be performed on patients in open areas. When the opportunity arises, emergency physicians should advise designers of new and renovated EDs about ways to make patient privacy and confidentiality a high priority in a patient-centered ED environment.

### **Patient and Staff Safety**

In some cases, it may be appropriate to limit the physical privacy of a particular patient to protect the patient or ED staff from harm. If, for example, a patient poses a grave risk of self-destructive behavior and staffing levels do not allow near-constant observation of the patient, placing the patient in an easily observable area near the nursing station may be preferable to restraining the patient physically or chemically. Similarly, when staffing levels are limited, it may be necessary to place severely ill or injured patients in an area where a single nurse can continuously monitor several patients simultaneously. Patients who exhibit or seriously threaten violence against ED staff or others in the ED may need to be interviewed, observed, and treated in secure areas and in the presence of hospital security personnel or law enforcement officers to protect staff or others at risk.

### **Visitors**

Visitors often provide important comfort and support to the ED patient, but at times certain visitors may add stress or otherwise be unwelcome to the patient. Emergency physicians should protect patient privacy by allowing visitors into patient care areas only when approved by the patient. If the patient is unable to consent, a surrogate should give permission before allowing visitors to enter the clinical area. Visitors should be identified and registered with security before ED entry. On arrival at the bedside, visitors should be instructed to remain with the patient they are visiting and restricted from entering

unauthorized areas of the ED, where they may inappropriately observe other patients or overhear confidential information.

### **Law Enforcement Officers**

Law enforcement officers play several legitimate professional roles in the ED. They may be present in the ED at the request of caregivers to provide physical protection to ED staff, patients, and visitors from a potentially violent patient or visitor. Law enforcement officers may transport injured or ill patients to the ED from the scene of an accident or a violent crime. They may also come into the ED to collect physical evidence, interview crime victims or suspects, or otherwise pursue investigation of an actual or potential crime.

Each of these activities may justify giving law enforcement officers access to ED patients, thereby intruding on their privacy. Ordinarily, ED patients should be asked for and give their permission to be visited by law enforcement officers and to have patient information released to law enforcement officers.<sup>4</sup> Persons transported to the ED in the custody of law enforcement officers, as, for example, crime suspects or prison inmates, may have limited rights to physical privacy and confidentiality. Although *ex parte* warrants can grant police access to patient information, law enforcement activities should not otherwise interfere with patient care. Similar to other visitors, law enforcement officers should also not be allowed to wander and view patient care activities not related to their reason for being in the ED.

### **Students and Other Observers**

Observation of and participation in clinical care are essential aspects of medical education, and medical and other health professions students are frequently present in the ED. Because the presence of students in the ED serves socially valuable educational and therapeutic roles, whether patients should have control over their presence is a controversial issue. Some maintain that patients may not refuse the presence of students in a teaching institution, whereas others believe that consent to the presence of students may be presumed if the patient does not actively object, and still others maintain that explicit consent should be obtained from patients for the presence of students.<sup>5</sup> Most patients accept the participation of students in their own medical care despite its circumscription of their privacy.<sup>6-10</sup> Patients should be informed of the identity and role of all of their caregivers, including students. Careful consideration should be given to patient requests that students not participate in their care. Honoring such requests may depend on the reasons for the request. For example, if a request is based on the student's race, it should not be honored. If, in contrast, a request is made because of a personal relationship between the patient and the student, it should be honored.

Others may also request permission to observe care in the ED, as, for example, a high school student considering a health professions career. Because these observers do not play a role in caring for the patient, the patient's explicit consent should be

obtained for their presence. If patients are unable to consent or refuse, a reasonable person test may be used to determine whether it is morally permissible for an observer to be present by asking the question, "Would a (hypothetical) reasonable person object to the presence of the observer?" Observers without a legitimate clinical service or educational role should not be allowed in the clinical area.<sup>11</sup>

### Filming Activities

Recorded images of patients, including photographs, films, and videotapes, are produced in EDs, as in many other health care settings, for a variety of reasons, including documentation of the patient's condition and treatment, quality assessment and improvement, education of health care professionals, and biomedical research. Videotaping as a valuable tool in emergency medicine education, for example, was reported as early as 1969.<sup>12</sup> The use and disclosure of images made for the above purposes raise important questions of patient confidentiality that will be discussed below. Because physicians, nurses, or others already participating in the care of the patient are typically the ones who take photographs or make videotapes for the above purposes, these activities do not generally raise additional issues of invasion of the patient's physical privacy.

In the past decade, a new impetus for the filming of patients in hospitals and EDs has emerged, namely, the popularity and proliferation of reality-based television programming depicting emergency medical treatment. Emergency physicians have been active in participating in these programs and have even surveyed the attitudes of ED patients and caregivers toward filming for this purpose.<sup>13</sup> The appropriateness of filming in the ED for commercial television programming has been the subject of spirited debate in the emergency medicine literature.<sup>14-25</sup> Proponents of filming in the ED for reality TV programs argue that this practice offers a variety of potential social benefits, including more accurate public education about emergency treatment and injury prevention and increased public scrutiny of emergency practices.<sup>15,16,18</sup> Although they acknowledge that patient privacy and confidentiality are compromised by filming and that patients' abilities to consent may be limited, proponents claim that invasions of privacy are already commonplace in the ED and that most patients do not resent the loss of privacy and are in fact eager for their "15 minutes of fame" on national television.

Opponents of filming in the ED for commercial television argue that this activity unjustifiably invades patient privacy.<sup>14,17,19-25</sup> They point out that some filmmakers use the approach of filming without permission and asking for permission to air the film later. Under this approach, by the time permission to air a film is requested, the patient's physical privacy has already been violated by the very presence of a film crew within an area where the patient has a "reasonable expectation of privacy," the standard that must be satisfied both legally and ethically. If filmmakers do seek consent from patients before filming, another problem confronts them. To capture the sense of drama and life-threatening danger to which

these shows aspire, patients who are approached for consent are often vulnerable and in a state of compromised decisionmaking capacity. Included in this category are patients with acute medical conditions (eg, myocardial infarction), chronic medical conditions (eg, stroke), psychiatric disturbances, mental retardation, limited education, language barriers, or incarceration. Such patients often cannot give valid consent to be filmed. ED staff or students are also vulnerable to coercion and may feel obliged to consent to being filmed.<sup>25,26</sup> Because they are dependent on their supervisors or instructors for their continuing employment or advancement, staff and students, like many patients, may believe that they will not be treated as well if they do not accede to requests to be filmed.

In recent years, several professional organizations have formulated policies about the filming of patients. These policies emphasize the role of consent before filming. In its *2004 Comprehensive Accreditation Manual for Hospitals*, for example, the Joint Commission on Accreditation of Healthcare Organizations has added the following new standard: "Consent is obtained for recordings or filming made for purposes other than the identification, diagnosis, or treatment of the patients."<sup>27</sup> The Joint Commission on Accreditation of Healthcare Organizations recognizes a limited exception to this standard if the patient is unable to give consent before filming and consent is obtained for any subsequent use of the film. An American Medical Association Code of Ethics opinion issued in 2001 also requires previous consent of the patient for filming, except when the patient is "permanently or indefinitely incompetent."<sup>28</sup> An American College of Emergency Physicians policy adopted in 2002 "discourages the filming of television programs in emergency departments except when patients and staff members can give fully informed consent prior to their participation."<sup>29</sup> One final policy, adopted by the Society for Academic Emergency Medicine in 2001, rejects all commercial filming of patients in the following words: "Image recording by commercial entities does not provide benefit to the patient and should not occur in either the out-of-hospital or emergency department setting."<sup>30</sup> Physicians and administrators should also be aware that civil lawsuits for the tort of invasion of privacy have recently been filed against some hospitals and producers involved with these activities, and some hospitals have already entered into out-of-court settlements.

## CONFIDENTIALITY ISSUES IN THE ED

### Protecting Medical Records

Because it documents the patient's care and facilitates communication among health professionals, the medical record is an essential source of personal health information. In addition to ED records, access to medical records from previous hospitalizations informs and thereby improves treatment in the ED. Emergency physicians must, however, protect patient confidentiality by preventing unauthorized persons from viewing patient records. Standard measures for protecting medical records include establishing a secure location for records, returning records to that location after use rather than

leaving them on a counter or table, and removing or covering information on the front of the patient's chart.<sup>31,32</sup>

Many EDs are now using computer applications for patient tracking, physician order entry, prescription and aftercare instructions, and keeping the medical record. In such cases, lists of patients along with their chief complaints are typically displayed on status boards that can be accessed by various computers around the department (similar to the white grease boards that used to be a staple in many EDs). In such cases, computers must be situated so that the public cannot view them, and privacy screens may be required in certain locations. All such computers should require password access, and access should be granted only to those with a legitimate need for it. These computers must also be set to automatically "time out" (revert to the screen saver) within a short period when not in use, if they are not closed by the user. Computer systems that are used to view imaging studies should have similar safeguards.

### **Duty to Warn**

As noted in Part I, US courts have recognized a physician duty to warn third parties when a patient poses a significant danger to their health or safety. This duty will, for several reasons, usually be more difficult to identify and carry out in the ED than in other practice settings. There are, to be sure, ED patients who may endanger others through their violent or reckless actions or their infectious diseases. Because emergency physicians typically lack an ongoing or long-term relationship with their patients, they will often be unable to assess the degree or seriousness of the risk a psychiatric or substance-abusing patient may pose to third parties. Even if they do diagnose a severe and highly contagious disease, emergency physicians will usually require the cooperation of the patient to identify third parties who may be at risk. A possible alternative, if such a patient refuses to cooperate, may be to impose isolation or quarantine on the patient, in concert with public health officials.<sup>33</sup>

### **Reportable Conditions**

In response to recent national emergencies, particularly the terrorist attack of September 11, 2001, public health authorities have expanded the existing list of reportable conditions. The subsequent discovery of anthrax-infected mail has focused attention on reporting of suspected bioterrorist agents such as anthrax, tularemia, plague, botulinum, and smallpox.<sup>34</sup> In response to the worldwide spread of several new and potentially lethal infectious diseases, exacerbated by increased international airline travel, reporting has also been mandated for severe acute respiratory syndrome, West Nile virus, monkey pox, and Ebola virus. The recent emphasis on these conditions and the legal duty to report them impose clear limits on confidentiality.<sup>33</sup> Because patients with these catastrophic infectious diseases are likely to seek care at an ED, emergency physicians must be prepared to identify the conditions and to communicate with public health authorities in ways that protect the populace and guard patient confidentiality whenever possible.

As noted in Part I, state statutes establish clear legal duties to report suspected abuse or neglect of children and dependent elderly persons. The moral basis for this duty, protection of vulnerable individuals from harm, is also clear. Unlike pediatricians or family physicians who may observe and care for children over a period of years, however, emergency physicians must typically make a decision about reporting on the basis of a single patient encounter. The potential danger to children and elders of unrecognized abuse and neglect underlines the importance of careful examination and history taking in the ED to identify suspected cases of abuse or neglect.

### **Telephone Inquiries From Family and Friends**

Telephone inquiries for patient information raise several problems of confidentiality. ED professionals may have difficulty, especially if they are not already acquainted with the caller, in ascertaining his or her identity and relationship to the patient. Even if the caller's identity can be confidently established, the patient may not be able to give consent for release of information. Institutions should develop policies for responding to telephone inquiries, including mechanisms for obtaining patient consent for release of information and for ascertaining the identity of the caller (by, for example, returning a telephone call).<sup>35,36</sup> Unless the caller's identity and relationship to the patient is confidently established and the patient or a surrogate gives consent for release of information, telephone inquiries for patient information should generally not be honored. Other overriding concerns may occasionally justify the limited release of information over the telephone. For example, an emergency physician may judge that it is permissible to reassure a frantic relative that a loved one who has been involved in a major traffic accident is actually alive and well or may encourage a family member to come to the hospital, if the opposite is the case. In such situations, the family member should be expected to identify the patient by their exact full name, without prompting.

### **Media Requests for Patient Information**

In general, it is best for requests by the media for information about patients to be referred to the hospital's public relations department or to someone else administratively charged with handling such requests. Some hospitals confirm that a particular patient has been transported to the hospital and provide information about the patient's general condition (eg, fair, critical, stable, treated and released). Hospitals should obtain the patient's permission for release of this information when possible. Other hospitals use a "no comment" policy in all cases. Inquiries related to possible crimes should be referred to the police conducting the investigation. If the patient is a celebrity or public figure, emergency physicians may be inundated with media requests for information; often, such requests can be referred to a personal spokesperson or publicist.

### **Communication Among Health Care Providers**

Emergency physicians must often share protected health information with other physicians and health care professionals to provide appropriate care for the patient. Communication of

patient information to other health care professionals for this purpose does not constitute a violation of confidentiality. Such information should, however, be shared with others involved in the patient's care only as needed and in appropriate settings.<sup>37-39</sup> In the ED, for example, physicians should avoid discussing patient information or dictating patient notes in treatment bays or open workstations where they can easily be overheard by anyone nearby. Health care professionals may be tempted to divulge patient information to colleagues (or others) in situations when it is not necessary for any medical purpose.<sup>40,41</sup> This temptation may arise when the patient is a public figure, is well known in the institution, or has an unusual condition, but health care professionals must recognize that disclosing private information in such circumstances is morally and legally unjustifiable.

The above review of privacy issues examined the relationship between patient privacy and the presence in the ED of health professions students. Student access to patient information raises similar questions about confidentiality. If students are viewed as professionals-in-training who contribute to patient care and who understand and respect patient confidentiality, their access to patient information may be justified on therapeutic grounds. As noted in Part I, the Health Insurance Portability and Accountability Act (HIPAA) privacy rule places the training of health professions students under the category of "health care operations," thereby allowing the disclosure of information to students without patient authorization.<sup>42</sup>

### Habitual Patient Files

EDs commonly keep files of patients who are suspected of seeking drugs—most often opiates or benzodiazepines—for nontherapeutic purposes, including recreation, abuse, or resale. Such files have been termed "habitual patient files" and, less appropriately, "repeater files," "frequent flyer files," and "special needs files."<sup>43</sup> Although the efficacy of these files in reducing total visits to EDs or altering patient treatment plans has never been established, their common use mandates an examination of the confidentiality issues arising from their existence.

In establishing and using habitual patient files, emergency physicians should be familiar with state and federal laws that regulate these activities. Ideally, a hospital or other health care attorney with expertise in confidentiality issues should be consulted to ensure that a particular process conforms to these laws.

In general, habitual patient files are permissible if their goals include protecting patients from harm as the result of drug abuse, preventing the inappropriate use of valuable ED resources, or protecting society from harms caused by the resale of ill-gotten drugs or the actions of intoxicated persons. Habitual patient files may also contain specific treatment plans—worked out in advance with managing physicians—for patients with chronic pain conditions.

It is permissible (under HIPAA and other regulations) for physicians to share protected health information with other physicians for the purposes of treatment. Other members of the

health care team may also be permitted access to patient information on a need-to-know basis. In general, such sharing should occur within a single institution, and calls between institutions for information should not be honored. The habitual patient file should be kept in a secure location and should be viewed in private. Access should be limited to authorized personnel, and browsing of the file should not be permitted. One suggestion is to create an electronic habitual patient file with password protection and the ability to access the files from many sites within a department. Inappropriate release of information contained in habitual patient files could result in fines or other penalties.

### Use of Patient Images

This article has reviewed the potential threat to patient privacy from filmmakers recording patient images, especially for commercial purposes. Once images have been made, their possible use or dissemination also poses a threat to patient confidentiality. As noted above, images can serve a wide variety of purposes, including documentation, treatment, quality assessment, education of health professionals and the public, research, and commercial entertainment. The rationale for and scope of disclosure of patient information differs significantly among these various purposes.

Images made for documentation and treatment typically contribute directly to patient welfare and remain a part of the patient's medical record. Standard measures to protect the medical record from inappropriate access should therefore be sufficient to protect the confidentiality of these images.

Patient images are also recorded for quality assessment (eg, the practice in some EDs of videotaping some or all trauma resuscitations).<sup>44</sup> Although the potential value of this use of patient images for improving emergency treatment is significant, the patients taped do not benefit directly from their own taping and are unable to consent to the taping. Only health professionals directly involved in the practices under analysis and in the quality assessment process have access to these images, however. Although the HIPAA privacy rule does not require patient authorization for using patient information for this purpose, some notification of this practice, such as signs posted in the ED, may be advisable on moral grounds.

The use of traditional photographs for teaching purposes has been a longstanding practice in medical education, and the use of digital photography and videotaping is rapidly expanding.<sup>45,46</sup> Multimedia educational presentations also offer clear educational benefits.<sup>47-51</sup> Because this information is usually disseminated only to health professional educators and their students, its use has been largely accepted by the professional community and the general public. Nevertheless, an American Medical Association policy entitled "Filming Patients for Educational Purposes" asserts that "informed consent should be obtained before filming whenever possible. If it is not possible to obtain consent from the patient before filming, then consent must be obtained before the film is used for educational purposes."<sup>52</sup> This policy allows surrogate consent for the use of

a film only in the case of minor children or permanently incompetent adults. In a similar statement, the International Committee of Medical Journal Editors asserts that “identifying information should not be published in written descriptions, photographs, or pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication.”<sup>53</sup>

If explicit informed consent is required for use of images in professional education, it should follow that it is also required for use of images in research, public education, and entertainment, where the potential scope of dissemination of the images is much greater. Informed consent should ordinarily be obtained for publication of a patient image even if the image does not identify the patient.<sup>54</sup>

### Electronic Communications

Technology has greatly facilitated the transfer of patient information, and health care providers are using electronic records with increasing frequency.<sup>55-57</sup> The benefits of electronic storage, retrieval, and transmittal are numerous; they include the timely availability of information to clinicians such as medical history, medications, and previous ECGs. These benefits may be especially important in the ED because patients often arrive without documentation of their condition or of treatment provided at other institutions. A disadvantage, however, is that widespread availability of electronic records and the use of electronic data transmission opens the door to unauthorized access, a clear violation of confidentiality. Stories abound of “hackers” who have found access to supposedly “secure” information, such as financial and even national security information. The HIPAA privacy rule requires that access to electronic records be given only to authorized individuals.<sup>42</sup> A HIPAA-authorized security rule, to take effect in April 2005, will require that electronically transmitted health information be encrypted according to strict standards.<sup>58</sup>

Medical records are also sometimes transmitted by fax. In such cases, safeguards must be in place, including ensuring that the receiving fax number is correct and that machines that receive faxes are in secure locations accessible only to authorized personnel. When ED reports are automatically transmitted to primary care providers after an ED visit, it is important that the database of fax numbers be updated periodically. (Similarly, the database of e-mail addresses must also be periodically updated if reports are automatically transmitted by e-mail.) It is also good practice for the fax cover sheet to indicate the confidential nature of the items being faxed. When documents that are received either electronically or by fax will not be made part of the permanent medical record, care must be taken to dispose of them confidentially. Shredders or dedicated locked trash bins are often used for this purpose.

### Minors and Confidentiality

Confidentiality for minor patients presents special concerns in emergency medicine. Numerous factors must be considered when a minor patient requests confidential health care,

1. Keep doors and partitions closed to prevent observation of patients by unauthorized persons.
2. Ask patients before allowing third parties (friends, law enforcement officers, ED observers) to visit them.
3. Obtain the patient’s informed consent before filming, especially for commercial purposes.
4. Keep paper and electronic medical records, including laboratory results and radiographs, out of the reach or sight of unauthorized persons.
5. Do not discuss patients or dictate patient notes within the earshot of unauthorized persons.
6. Do not disclose patient information to colleagues or others unnecessarily.
7. Do not disclose patient information by telephone without patient permission.
8. Obtain the patient’s informed consent for the dissemination, publication, or broadcast of recorded patient images.
9. When a document containing patient information is not needed, dispose of it properly by, for example, shredding or placing in a locked receptacle.
10. Guard and do not share your password to computerized patient information.
11. Educate staff about privacy and confidentiality practices in the ED.

**Figure.** Practical ways to protect privacy and confidentiality in the ED.

including the best interest of the patient, future patient attitudes toward health care, concerns of the parents, federal and state laws, and public health issues.<sup>59-61</sup> Physician attitudes about issues of adolescent confidentiality show considerable variation in different health care settings.<sup>62,63</sup>

For minors who do not meet criteria for emancipation or “mature minor” status and whose conditions do not receive statutory confidentiality protection, issues of confidentiality can be difficult. For example, parents may request health information about their child, but the minor patient may, for a variety of reasons, request that the information not be disclosed to them. Ideally, education of minor patients about the importance of parental involvement in their health care may bridge the gap between the parties. In most such cases, minor patients should be encouraged to be open about health care decisions with their parents. If consent cannot be obtained from the minor patient, the issue of disclosure to parents becomes more controversial. Some argue that parents have a right to receive health information about their dependent children. Others believe that minor patients have the same rights of privacy and confidentiality about health care as adults, particularly because adolescent minors are more likely to seek health care when confidentiality is ensured.<sup>64,65</sup> In general, decisions about disclosure without consent of a minor patient should be made in the best interests of the patient and his or her parents, with careful consideration of state and federal law.

Emergency physicians should generally respect the confidentiality of students seeking treatment for substance misuse, sexually transmitted diseases, contraception, and pregnancy, but

seriously ill teenagers and those threatening to harm themselves or others will generally require hospitalization and disclosure to their parents or guardians. In such cases, consent from the adolescent patient should be obtained whenever possible.

In conclusion, respect for privacy and confidentiality in health care is a professional responsibility with strong moral and legal foundations. Given this mandate, it is paradoxical that emergency physicians often treat patients for whom privacy and confidentiality are of vital importance in settings where privacy and confidentiality are extremely difficult to protect. This article addresses the paradox by examining the scope and limits of the emergency physician's responsibility to protect privacy and confidentiality. The Figure offers a summary listing of practical ways to protect privacy and confidentiality in the ED.

The recent HIPAA privacy rule attempts to reinforce the protection of personal health information and to make the use and disclosure of such information by providers more understandable to patients.<sup>42</sup> Whether such transparency engenders more trust or more suspicion in the minds of ED patients remains to be seen. Because legal mandates are neither necessary nor sufficient to satisfy the moral obligations of physicians, it is essential that physicians understand and accept their responsibility to protect privacy and confidentiality on moral and legal grounds.

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