

ment, the private bounty-hunter does an important and worthwhile job. Viewed in this light, the punitive damages system exists not to provide plaintiffs with windfalls, but to induce the bounty-hunter to do her job. And this provides an important practical argument against slashing punitive damages: if we cut back on the bounty-hunter's reward too much by limiting punitive damages or contingency fees, we will lose out on needed law enforcement.

For as we have seen, government is incapable of controlling white-collar wrongdoing, though it may work to control the villainous poor. That leaves the punitive

damages system, which—warts and all—stands out as our best hope for protection from the villainous rich.

—David Luban

This article was condensed and adapted from "Let the Punishment Fit the Tort," a talk given at the Institute's Workshop on Philosophy and Public Policy, held at the Catholic University of America on June 21-23, 1989. Sources used in writing this article are: *Kelco v. BFI*, 845 F. 2d 404 (2nd Cir. 1988); Jean Hampton, "The Retributive Idea," in Jeffrie G. Murphy and Jean Hampton, *Forgiveness and Mercy* (Cambridge University Press, 1988); Marc Galanter, "Punishment Civil Style," (unpublished); and *Grimshaw v. Ford*, 119 Cal. App. 3d 757 (1981).

Who Is the Patient?

New genetic discoveries and technologies in medicine have raised a host of profound ethical questions. One of the most prominent concerns our understanding of the traditional obligations of the physician, in particular, his obligation regarding confidentiality. As we learn more and more about the genetic basis of many diseases, questions such as "To whom does the physician owe a duty of confidentiality?" are becoming increasingly difficult to answer. Part of this difficulty can be traced to a transformation in our understanding of who is the patient, and a corresponding change in our understanding of the physician-patient relationship.

Let me illustrate this transformation with an example, based on a true case recently told to me. A young boy has been diagnosed as having hemophilia A. Since this is an x-linked, recessive disease, there is good reason to believe that the boy inherited the defective gene from his mother who in turn inherited it from her mother. (Because it is a recessive disease, these women are under no risk of contracting any symptoms or suffering the disease themselves even though they carry the harmful gene.) The physician learns that the boy's mother has two sisters. Given the available information, each of these sisters has a 50-percent probability of also being a carrier of the harmful gene. The physician wishes to inform these sisters of their condition, since it might affect their reproductive plans, but the boy's mother, who has had a terrible falling out with her sisters, forbids it. Bent on withholding information as a way of getting revenge on her sisters, she insists that the boy's right to confidentiality be respected.

Admittedly, articulating the ethical question raised by this sort of case as "Who is the patient?" is not the usual approach. A more common one would be to frame the ethical question in terms of the scope and

limits of the physician's duty of confidentiality to the patient. Thus, if the medical condition may (or must) be disclosed to others, this is because the duty of confidentiality here is outweighed by other obligations. By presenting the issue instead in terms of who the patient is, I am trying to underscore a shift in how such cases should and will be seen. If the physician must disclose the information to others, this does not reflect a duty or consideration that competes with the integrity of the physician-patient relationship. Rather, it grows out of that very relationship. Disclosures in these cases are not "news leaks." If and when they are justified, they arise from the physician's loyalties and obligations as a physician to the patient. The physician's disclosure, if it is to have this kind of justification, must be to his patient. The crucial question, however, is who is the patient.

We can get a better understanding of how this question will become increasingly significant by analyzing the hemophilia example. Let me begin by examining three different models of health care that might be invoked to frame the ethical dilemma raised.

The Private Health Model

The most familiar model is what we could call the *private health model*. Its clearest applications are to cases of physical injury or non-communicable diseases. In such cases, the question "Who is the patient?" has an obvious answer: the patient is the particular individual suffering the disease or accident. According to this model, the physician's mission is to care for his patient and treat the medical condition. This mission, however, is constrained by a respect for the autonomy of the patient. This respect is generally taken to mean that the physician must have the patient's informed consent before performing any major medical intervention. Fur-

thermore, the physician owes a duty of confidentiality to the patient.

On this model there are two arguments for the physician's duty of confidentiality. One argument looks at the consequences of assigning such a duty. By binding the physician in this way, we encourage the patient to provide the physician with any information that might help in providing medical care, regardless of how embarrassing or awkward the information might be thought to be. Without this duty, people might withhold information or even fail to seek medical care because they fear that their broader interests might be jeopardized. The other argument looks at the rights of the patient, in particular the right to privacy. Insofar as the patient has a right to privacy, the physician has a corresponding obligation to respect that right, which is expressed in a duty of confidentiality.

Of course, the duty of confidentiality on the private health model is not absolute. The most notable exception is when disclosure would prevent the occurrence of serious harm. That exception, however, does not arise in this case. Disclosing the genetic information would at most succeed in preventing the birth of possible harmed individuals, but that is quite different from preventing any actual harm. (If this isn't clear, imagine the case where the aunts are informed, but they decide nevertheless to have children. Given that the children, including any who are born with hemophilia A, might not otherwise have been born, can we say that any of them have been harmed?) Thus, we should conclude that, whatever the physician's own feelings in this case, he is ethically obligated to keep the information confidential. Since the two sisters are not the physician's patients and no harm is threatened to any actual, identifiable party, he has no special duty toward them.

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Drawing by Gonick from *The Cartoon Guide to Genetics*
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It might be thought that this problem could be avoided by the physician's simply announcing in advance that his duties of confidentiality have several exceptions. Among those exceptions are cases where the physician believes that disclosing medical information to a patient's relatives could result in a direct benefit to them. The patient is thus told that access to health care services is contingent on his consenting to these exceptions.

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This approach, however, faces several problems. First of all, what is the moral justification for this modification in the duty of confidentiality? Can it be reconciled with the arguments for confidentiality identified in the private health model? Or does this modification represent a new exception to that duty, requiring its own justification? Second, suppose the patient does agree with this restriction. Is the physician then obligated to inform relatives in cases such as the one above? If he is obligated, is it because he is a *physician* or would anyone who learned the relevant information have the same obligation to inform the relatives? Finally, what happens if the patient refuses to consent to these restrictions? If the physician refers the patient to some other physician who doesn't place such restrictions, then the potential problem is simply passed to someone else. From the standpoint of the medical community, the problem remains. If the physician does not refer the patient to anyone else, does this mean that the patient is to be abandoned? This hardly seems to be a satisfactory result since the point of placing these restrictions was, in effect, to ensure that the physician is not forced to ignore important health concerns.

The Public Health Model

A different approach to the problem of disclosure is the *public health model*. Its clearest application is to cases of highly contagious diseases. In such cases, the patient is the public, and the physician's mission is to promote the public's health. Concepts such as autonomy or informed consent are to be understood in terms of the political will and decision-making process of the public. There is, however, no duty of confidentiality in this model since it plainly makes no sense to talk about such things with respect to the general public.

Because the public's will doesn't always reflect a consensus, the mission of the public health model may, at times, conflict with a respect for the autonomy of some individuals. As the case of quarantine or mandatory vaccinations illustrates, public health measures

may require restricting some people's liberty or ignoring some people's choices. While these conflicts point to regrettable costs in this model, they do not give rise to any constraints on the physician's mandate, given the sheer magnitude of the serious harm that would be avoided. The public's health cannot be sacrificed for the sake of the rights of some individuals. Because of this decisive normative feature in the public health model, identifying anything as a public health problem is a significant matter. Some of the darker moments in our history arose from incorrectly characterizing some problems as public health problems. In many cases, for example, state sterilization laws enacted in the early part of the century were based on the view that "feeble-mindedness" was a public health problem. Unchecked, it would undermine the quality of the race. In a famous Supreme Court decision, Justice Oliver Wendell Holmes said, "The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. . . . Three generations of imbeciles are enough."

Let us suppose that hemophilia A is taken to be a public health problem. Then, according to this model, the physician has no duty of confidentiality in this matter; instead he has a duty to inform not only the sisters of their possible medical condition, but also anyone else who is responsible for controlling the spread of this disease.

While both the private health and the public health models have some legitimacy, neither perfectly fits the facts of this example. The private health model is not entirely appropriate, because we are dealing with a *transmissible* disease. We should not see the disease as confined to isolated individuals, for how we treat the disease in one individual will affect the likelihood of its appearing in another individual. But neither is the public health model entirely appropriate because we are dealing with a *non-contagious* disease. The general

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public is not at any special risk because some individuals have this disease. Indeed, as we noted, no actual people are at risk, only the possible offspring of women carrying the relevant gene could be affected. If we regard incurable genetic diseases, such as hemophilia A, as public health problems, then we are in effect regarding the birth of certain kinds of individuals as public health problems, a view that is as ominous as it sounds.

The Family Health Model

Finally, let us consider what we could call the *family health model*. As the name suggests, the physician's patient is the entire family, where "family" is understood to refer to a genetic network rather than a social institution. The physician's duties are to the family as a whole. While his respect for the family's privacy obligates him to refrain from disclosing any information to unrelated third parties, this obligation does not extend to the family itself. The family's privacy is plainly not violated by disclosing information to other family members.

The family health model seems to acknowledge that genetic diseases are often family diseases, and so it seems to be tailored to fit some of the ethical problems arising in this area. It also seems to fit the current practice of some physicians since members of a family typically see the same physician. Nevertheless, this

The family health model seems to acknowledge that genetic diseases are often family diseases, and so it seems to be tailored to fit some of the ethical problems arising in this area. Nevertheless, this model has problems as well.

model has problems as well. First, if the family is the patient, the physician would seem to be ethically obligated to ensure that all its adult members are informed of the medical situation. But many families are scattered, with some members completely out of touch with others. Without a radical change in the profession, the physician does not have the resources to track down distant family members. Moreover, many families are divided. Who, then, speaks for the family? Who decides that some piece of information should be kept confidential? Rather than clarifying the ethical issues, the family health model may simply shift them.

I don't wish to suggest that the options I have surveyed are the only options or that the problems I have raised with them are insoluble. We have only begun to reflect on these matters. But as we learn more and more about the genetic basis for various common diseases, such as cancer, Alzheimer's disease, manic-depressive psychosis, diabetes, and others, this kind of case will become progressively familiar. As our scientific understanding of diseases improves, our moral responsibilities will become more complex. A diagnosis will not only identify a disease; it may also thereby indicate the medical condition of other individuals. Thus, physicians from a wide range of specialties will increasingly find themselves confronting situations where it is not clear who the patient is, and consequently, what their responsibilities and obligations are.

—Robert Wachbroit

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