Managed care and the paradox of patient confidentiality: A case study analysis from a communication boundary management perspective

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MANAGED CARE AND THE PARADOX OF PATIENT CONFIDENTIALITY: A CASE STUDY ANALYSIS FROM A COMMUNICATION BOUNDARY MANAGEMENT PERSPECTIVE

MARIFRAN MATTSON AND MARIA BRANN

Managed care organizations have become one of the dominant approaches to health care delivery in the United States. This approach has important implications for the confidentiality of patients' medical records; specifically, close scrutiny suggests an inherent paradox concerning the maintenance of patient confidentiality in the age of complex managed care arrangements. Although these systems are designed to provide less expensive, quality care for patients and streamlined efficiency for health care providers, they concomitantly compromise privacy by making patients' confidential records available to a wide range of internal and external audiences. It is this important paradox and its impact on health communication that we seek to address by presenting a case study framed by an extension of Communication Boundary Management (CBM) theory (Petronio, 1991).

Managed care is a broad, and often confusing, term that refers to a multifaceted and continuously evolving system designed to provide quality health care and simultaneously contain costs (Integrated Health Care Association, 2000). Managed care organizations are responsible for the health of an enrolled group of people and, consequently, seek improvements in both the results and the cost-effectiveness of services provided. These organizations include a wide array of health insurers, medical groups, hospitals, and integrated health care systems. Management and control of spending are maintained by closely monitoring how physicians and other medical professionals care for patients; techniques include not allowing procedures to be performed, refusing physicians' permission to discuss alternative procedures, limiting coverage to care by preferred primary care physicians and hospitals, and requiring preauthorization for specialty care (American Medical Association, 1999; Integrated Health Care Association, 2000; University of California, 1999).

The single deadliest blow to confidentiality by all health professionals... is their collusion with managed care.

—Bollas & Sundelson (1995, p. 130)
Managed care was designed to simplify health care systems and contain health care costs; paradoxically, it has simultaneously created an exponential increase in the number of individuals who have access to patients' files, access that may compromise the confidentiality of patients' health communication and their health care. In the managed care environment, the approach to protecting patients' confidentiality seems to be dictated by business interests rather than traditional codes of ethical conduct which state that health care professionals will do their patients “no harm” by maintaining a “duty of silence” regarding communication of patients' private information (Everstine et al., 1980). In the current managed care environment, instead of just the primary physician and immediate staff having access to a patient's information, as many as 17 people now have authorized access to a patient's record (Munson, 1996; Rock & Congress, 1999). Within this system, individuals, such as administrators, employers, insurance company representatives, legal experts, researchers, and police officers, have easier access to a patient's personal health data ("Association Cites Confidentiality Problems," 1999).

Even with confidentiality policies in place at health care organizations and with employees signing confidentiality agreements upon being hired, more breaches of confidentiality may be occurring simply because the number of individuals with access to confidential information increases in a managed care environment. With so many individuals accessing and communicating patients' confidential data through the widespread use of computerized records (Anderson & Brann, 2000; Pendrak & Ericson, 1998; Shalala, 1998; Weingarten, 1992), multidisciplinary health care teams (Cummins, 1993; Dodek & Dodek, 1997; Lazoritz, 1994), and primary care physician serving as gatekeepers to specialists (Bodenheimer, Lo, & Casalino, 1999; Grumbach et al., 1999; Hickey, 1995), the risks for breaching patients' confidentiality inevitably increase. Taken further, confidentiality breaches not only occur through communication processes, they also affect the quality of patients' health communication and health care. Research has shown that patients withhold information from health care providers if they suspect that this information will be communicated to unauthorized individuals (e.g., staff that do not have an essential need to know) or other entities (e.g., employers and insurance companies) (Annas, 1992; Goldman, 1998; Gostin, 1997; Yeo, 1991). If health care providers do not have adequate and useful information, the quality of the care they provide will likely decline (Annas, 1992; Cline & McKenzie, 2000; Goldman, 1998; Parrott, Duncan, & Duggan, 2000; Yeo, 1991).

This broadening of access to patients' records in the managed care environment has led to numerous documented breaches of patient confidentiality. For example, to ascertain the necessity of and payment for treatment, managed care organizations usually obtain patients' personal health information, including symptoms, medications, and therapy notes (Sutherland & Yarbough, 1996). Specifically, it is common for a managed care representative to examine the medical records of psychiatric patients whose therapy appears to be lasting too long. During one such review, a managed care organization learned of specific patients' disclosures about non-health-related activities, including extramarital affairs, homosexual activities, sexual torments, wife-beating, and violent fantasies (A. Allen, 1998; for another pertinent example, see Pendrak & Ericson, 1998). Because sharing sensitive information is expected and often demanded in a managed health care setting, it is even more essential that questions regarding who might have access to patients' personal information be revisited and clearly defined to aid patients' understanding of confidentiality issues and protect their rights of confidentiality (Hodge...

In an effort to understand the communication of confidentiality in the complex managed care environment, a case study analysis, framed by CBM theory (Petronio, 1991), is presented. This theory, although previously focused primarily on interpersonal, micro-level boundaries (Petronio, 2000; for exceptions see Serovich & Greene, 1993; Serovich, Greene, & Parrott, 1992; Serovich, Kimberly, & Greene, 1998), offers unique insight into the management of privacy boundaries. The purpose of this study, then, is to review, apply, and extend CBM theory by further conceptualizing how macro-level boundaries at the group, organizational, and environmental levels affect the privacy boundary coordination of relevant parties in an actual case. From such an analysis, practical recommendations are offered for the maintenance of patients' confidential health information by patients, health care providers, and managed care organizations.

COMMUNICATION BOUNDARY MANAGEMENT THEORY

Previously, CBM theory has provided a useful framework for understanding tensions that are created when individuals are deciding whether and/or how to disclose or maintain private information during dyadic communication. These tensions emerge because there are tradeoffs involved in either withholding or disclosing private information. As Allman (1998) explained, "Individuals create metaphoric protective boundaries that they can use to manage the flow of private information" (p. 178). The metaphor of a boundary is, thus, used to identify a perimeter around private information that may or may not be permeated by sharing it with others (Petronio, 2000). People negotiate boundaries, seeking a balance between privacy and openness, distance and intimacy, and autonomy and interdependence (Greene, 2000; Petronio, 1991; Rosenfeld, 2000; Yep, 2000). CBM theory describes the evolution and enactment of these micro-level boundary rules. What this theory lacks, however, is a sufficiently complex conceptualization of communication boundary management including the macro-level forces that may affect individuals' privacy boundaries, interaction rules, and interpersonal communication about private matters. In overlooking macro-level boundaries, proponents of the theory have neglected situations, such as third-person disclosure of private or confidential information, which may occur beyond the knowledge or control of the primary interactants. Hence, although the private communication of the dyad was the genesis for CBM theory, we seek to extend the theory to include communication by other parties or interests beyond the dyad.

Boundaries are established to protect potential vulnerabilities associated with the revelation of sensitive information for both the discloser and the individual(s) (or other entities) to whom the information is being disclosed (Yep, 2000). These protective boundaries are used to direct the flow of information or other forms of communication between people (Petronio, 1991). Thus, the parties use limits to protect themselves in an interaction. As Yep (2000) summarized,

Partners coordinate the intersection of their own individual boundaries by following specific relational rules that determine the sending and receiving of disclosure information in terms of timing, amount, and context to establish an equilibrium between personal autonomy and relational intimacy. (p. 87)
Boundary perimeters are determined by developing and communicating rules that manage the tension between privacy and disclosure and minimize the risks of vulnerability (Petronio, 1991; Yep, 2000). These rules are initially predicated on participants’ expectations for the interaction and later on the interaction itself. For example, in a health care setting, preexisting rules or social norms create an expectation that communication of sensitive information (e.g., information about physical and/or psychological functions) is necessary to give and receive adequate care. During the interaction, another rule or expectation is used to balance the tension between the desire for privacy and the need for disclosure, specifically, that the information patient shares with her or his health care provider will be kept confidential. It is through a complex matrix of interaction rules, then, that patients’ confidentiality is maintained (or in some cases breached).

Previous literature on privacy boundary management has emphasized micro-level interpersonal issues to the relative exclusion of many macro-level concerns (research by Serovich and colleagues, 1992, 1993, 1998, notwithstanding). In the traditional health care context, disclosure of patients’ personal health information was considered the responsibility of both the patient and health care provider because both parties assumed joint ownership of the shared information. Rosenfeld (2000) claimed the joint responsibility forced the patient and health care provider into an “elaborate communication dance” (p. 12). However, in the case that we focus on in the present study, the primary physician and the patient had already accomplished this dance within their relationship. A problem did not arise until a third party (another physician in the managed care organization who was being sued for malpractice) cut in on the dance by exposing the patient’s confidential medical record in court. As this case will illustrate, in the age of managed care, what and how information is disclosed becomes the responsibility of not only the patient and the primary physician, but also a nexus of health care providers, organizations, and external entities (e.g., the legal community and information services). Although these parties jointly possess the information, implying mutual responsibility, some parties treat this information as if it is individually owned, especially when decisions are made to share the information with others.

**Boundary Structures**

According to CBM theory, the way individuals manage private information depends on the intersection of boundary structures and a rule-based management system. Boundary structures are erected as individuals attempt to maintain control over their private information because they realize that once they reveal that information, they become vulnerable to its subsequent release to others. There are four boundary structures that are salient: (a) boundary ownership, (b) boundary control, (c) level of boundary openness, and (d) boundary permeability.

**Boundary Ownership**

As an interaction unfolds, such as an initial consultation between a patient and health care provider, once information is presented, it becomes jointly owned, meaning that both parties share the responsibility of managing that information (Petronio, Ellemers, Giles, & Gallois, 1998). The communication boundary, thus, encompasses not only the confidential information, but also the health care provider and the patient and governs the revealing and concealing of that information (Petronio, 2000). In the managed care environment, these communication boundaries become sites of contention...
as various interests beyond the patient-health care provider dyad vie for access to and control of a patient's confidential information.

**Boundary Control**

Boundaries are regulated by rules that manage the tensions produced between privacy and openness. Rules governing the sharing of confidential information range on a continuum from loosely to tightly controlled (Petronio et al., 1998); control of the information varies along this continuum depending on to whom the private information is being disclosed, the nature of the interactants' relationship, and the sensitivity of the information discussed. With the advent of managed care organizations, the control of private information has shifted from the health care provider to the organization; what a health care provider once tightly controlled is now loosely controlled by the managed care organization.

**Levels of Boundary Openness**

Levels of boundary openness refer to the degree of accessibility allowed by the boundary keepers surrounding private information. Degree of openness, like boundary control, is situated along a parallel continuum ranging from primarily open to completely closed (Petronio, 1991; see also Petronio, Reeder, Hecht, & Mont Ros-Mendoza, 1996). Often there is consistency between the boundary control and the level of boundary openness. Compared to traditional medical systems, which usually kept tight control of patients' private information, in managed care environments, the boundaries of patient information are relatively open.

**Boundary Permeability**

According to CBM theory, more sensitive information is protected by a less permeable boundary and implies stronger sanctions for revealing that information. In contrast, if information is less sensitive, the boundary surrounding it is more permeable and sanctions for violating the privacy of that information are weaker (Petronio, 2000; Serovich & Greene, 1993; Serovich et al., 1992). Managed care systems seem to be challenging the permeability of privacy boundaries, and some patients are seeking legal sanctions and other remedies (e.g., paying for health care out-of-pocket) to protect these boundaries.

**Rule-Based Management System**

The functionality of the four boundary structures identified depends on the rule-based management system established by interactants who also are influenced by preexisting boundary structures and social norms. How the boundary structures function depends on four essential developmental concepts: (a) boundary rule formation, (b) boundary rule usage, (c) boundary rule coordination, and (d) boundary rule turbulence.

**Boundary Rule Formation**

First, the boundary rules must be created or formed by the interactants. Usually, boundaries around private information are protected through rules that guard against access. As Petronio et al. (1996) explained, "The perceived risk of boundary access may be influenced by the type of information being revealed and the extent to which confidentiality is assured" (p. 184). Access to such private information is often determined on the basis of four decision factors: (a) the person who receives the informa-
tion, (b) the content of the information, (c) when and where the information is disclosed, and (d) how much of the information is revealed (Petronio et al., 1996). Each of these factors influences whether private information will be disclosed to another person and, if so, how much of that information will be exposed. Other issues also are potentially relevant in regulating access to private information, including culture and interactants’ self-esteem, gender, and motivation or personal agendas (Petronio et al., 1996). For example, a patient may be more willing to reveal private information (a) to her or his health care provider, (b) if the information is relevant to diagnosis and treatment, (c) during an office visit (rather than in the grocery store), and (d) by telling the provider only that which is essential for obtaining care.

Consequently, in the complex managed care environment, the issue of access becomes much more complicated than in traditional health care systems, and the decision rules about privacy expand beyond the individual patient and physician to other members of the managed care organization and the external environment. Consider, for example, the utilization reviews, or audits of patient files, often demanded by managed care organizations before agreeing to pay for a patient’s course of psychiatric care (Edwards, 1995). Some scholars argue that such policies severely affect patient-health care provider interactions. For example, A. Allen (1998) suggested that managed mental health care is slowly pushing the patient-therapist relationship toward conversation that begins to resemble that of a police officer and a suspect. Psychiatrists speak of “Miranda-izing” their new patients—warning them that whatever they say may end up in an information stream to which the patient may have no easy access and over which the patient may have no control. (p. W10)

Furthermore, therapists contend that these intrusive reviews and audits are intimidating patients into deciding to pay for their care out of their own pockets rather than request payment from managed care organizations in order to regulate access and ensure the confidentiality of their sessions with the therapist. In reformulating the rules of access, complications such as these are created that may ultimately jeopardize patient care.

**Boundary Rule Usage**

Determining what boundary rules to use is the second concept of development in the rule-based management system and is decided by the interactants in one of two ways. First, boundary rules can be triggered by particular events (Petronio et al., 1998). For instance, a major event, such as a political campaign, may trigger using certain boundary rules. As an example, the psychiatric records of then Florida Governor Lawton Chiles and New York Representative Nydia Velazquez began circulating without their permission during their campaigns for reelection (A. Allen, 1998). In these cases, the boundary rule for candidates’ private medical information, as defined by the media and the public rather than the candidates, was open, unfettered access. Similarly, former Senator Bill Bradley (D-New Jersey) and Senator John McCain (R-Arizona) had their health records scrutinized by the public during their recent presidential campaigns (Dejevsky, 1999; Ferraro, 2000). However, these candidates maintained some control by issuing their medical records voluntarily and withholding the most private and sensitive portions.

Second, boundary rules may become routinized and difficult to change (Petronio et al., 1998). For example, it has become routine practice for drug manufacturers to buy patient prescription lists from managed care companies to market their products to consumers (Valentine, 1995). Prominent drug companies that practice using this
routinized rule include GlaxoSmithKline, Warner-Lambert, Merck & Co., Biogen, and Hoffman-LaRoche (A. Allen, 1998; Anderson, 1999). Consequently, the routine becomes the rule of practice and as long as an action is part of the routine, that action is considered acceptable. Overcoming these routines is, at the very least, a daunting task.

**Boundary Rule Coordination**

The third developmental concept, and arguably the most important from a communication perspective, is boundary rule coordination, which involves rules for sharing and regulating privacy boundaries. Those who share private information, either implicitly or explicitly, jointly determine what happens to that information through negotiation and renegotiation (Wilson, Roloff, & Carey, 1998). As the number of people or entities who have access to personal health information grows larger, the process of boundary rule coordination becomes more complicated and difficult to control. This occurs because the parties involved may have different commitments to or agendas for maintaining the privacy of the information revealed.

In traditional health care interactions, the patient and the health care provider jointly own the information that is shared during consultations. Although general boundary rules have been established for what is communicated in health care interactions, over time, those rules may be altered to allow for more open expression between a patient and a trusted health care provider. According to Petronio (1991), these “patterns of coordination may lead to increasing or decreasing relational quality and happiness” (p. 315). It is through boundary rule coordination, then, that patients learn to trust their health care providers and, ultimately, begin to share more private information, which may lead to better quality health care (Cline & McKenzie, 2000; Parrott et al., 2000). However, in the age of managed care, the coordination of boundary rules becomes more complicated and contested, which may disrupt the delicate balance between maintaining personal privacy and disclosing relevant health information.

**Boundary Rule Turbulence**

The fourth concept of development in the rule-based management system occurs when the privacy boundaries of each participant invade one another (Petronio, 2000). For example, A. Allen (1998) described a Navy officer who refused to be tested for a gene mutation linked to breast and ovarian cancers; from which her three aunts had died. Although the officer was aware of the risks of not being tested, she decided to maintain the privacy around her health information to protect her employability and insurance benefits. Boundary rule turbulence arose when the mother of the officer disagreed with her daughter’s decision and tried to impose her more open communication boundaries on her daughter’s private, medical information by demanding that the daughter talk with her physician and consent to the test even though the test results would become part of her daughter’s medical record and could jeopardize her future employment. This example illustrates that privacy functions in concentric circles, ranging from society to self; each of the parties in between also manages boundaries around private information. It is when these boundaries invade each other or overlap uncontrollably that boundary rule turbulence occurs and may be harmful to participants.

To address the complex paradox of managed care and patient confidentiality, an extension of CBM theory is employed after presenting a case in point. The analysis of this case study illustrates the importance of considering macro-level boundaries cur-
rently absent from the micro-level focus of CBM theory. By expanding this theory, a better understanding of the paradox of managed care and patient confidentiality emerges along with practical recommendations for patients, health care providers, and managed care organizations.

**CASE STUDY METHOD**

A case study “comprehensively describes and explains the variety of components in a given social situation using multiple sources of evidence” (Arneson & Query, 2001, p. 154). The case study approach is especially constructive when the boundaries between context and phenomena are not clearly evident and when researchers and research participants need to design practical strategies to cope with the blurring of these boundaries (see Deetz, 1990; Kreps, 1990; Mier, 1982; Yin, 1993, 1994). In addition to being cognizant of these conditions, we developed our case study following the conceptualization and process proposed by Stake (2000), which asserts that an *instrumental case study* is selected to advance understanding of a related issue by seeking patterns of triangulated data that challenge and extend what is known about the phenomenon. We have been interested in the implications of confidentiality breaches on health communication and extending this interest into the realm of managed care seemed timely and important. Hence, we looked to relevant literature for theoretical and methodological guidance.

Our search of the literature revealed that although confidentiality breaches were discussed, mostly in popular literature, no comprehensive, theoretically guided studies of a managed care environment were evident. Thus, to begin constructing a web of evidence, we observed the communication of health care providers, patients, and staff in a managed care hospital. Similar to reports in the media (e.g., A. Allen, 1998; Inlander, 1999), we witnessed various types of confidentiality breaches and created a typology (Brann & Mattson, in press). In this study, we chose to apply CBM theory using a case study method because of the strength of the theory in addressing interpersonal privacy issues and the advantage of case studies in foregrounding communication processes within an actual situation from which insight can be gained to refine theory (see Patton’s, 1990, discussion of instrumental case studies). Our report and interpretations of the case extend the scope of CBM theory into the realm of macro-level privacy issues. We also sought to expand the methodological implications of the theory by studying a text-based case that revealed several layers of communication boundaries.

The case narrative that follows is based on a true story. Data for the case and subsequent analysis were gathered from a variety of sources, including previous observations (Brann & Mattson, in press), newspaper accounts (A. Allen, 1998; Bowling, 1997), and legal case records (Warner v. Lerner, 1997, 1998). Attorneys involved in the case were contacted to provide clarification in interpreting the published literature and the legal documents, but cited attorney-client privilege as a reason for not discussing the case further. The plaintiff (i.e., patient) in the case was interviewed and his comments served as both a source of evidence and as a member-checking function of our interpretations and report of the case (Yin, 1989).

**(UN)MANAGED CARE OF PATIENTS’ CONFIDENTIAL INFORMATION: A CASE IN POINT**

In 1990, the U. S. Senate passed a bill to protect the confidentiality of medical records and to strengthen the privacy rights of patients. Legislators passed this bill
because they understood that harm might come to patients if the sensitive information in their medical records was disclosed. On the basis of this bill, the State of Maryland enacted the Confidentiality of Records Act to protect patients' privacy and encourage trust between patients and health care providers. However, part of the bill read, "A health care provider may disclose a medical record without the authorization of a person in interest to any provider's legal counsel for the sole purpose of handling a claim against any provider." Although this bill may have offered some sense of protection of confidence to patients, its obscure language ultimately created an illusion of confidence for William S. Warner.

In 1992, urologist Dr. Horst Schirmer treated Mr. Warner for medical problems of a very personal and sensitive nature. During his treatment, Mr. Warner discreetly disclosed potentially embarrassing information about his urological problems to his physician, believing that the information was essential to his medical care and that it would be kept confidential. However, 3 years later, Mr. Warner's prostate surgery became the focus of an open court hearing involving another urologist who was being sued by a different patient for medical malpractice.

Dr. Brad Lerner, who was charged with medical malpractice by Leo Kelly, Jr., obtained the pathology report of Mr. Warner, a patient he had never met, from Union Memorial Hospital's computer system. Union Memorial Hospital was a member of MedStar Health, the largest managed care system in Maryland. As physicians who practice at that hospital, Drs. Schirmer and Lerner were members of this managed care organization, as was the patient Mr. Warner. Dr. Lerner acquired Mr. Warner's medical records without requesting or receiving permission from Mr. Warner or his physician. Although Mr. Warner harbored a legitimate, albeit dubious, expectation of the confidentiality of his medical records, his records were published without notice, his consent, or an opportunity to challenge the disclosure. Dr. Lerner used this information as part of his defense against Mr. Kelly's malpractice charge.

Mr. Warner's medical condition was exposed while his physician, Dr. Schirmer, was being questioned as an expert witness for the plaintiff's malpractice case. Dr. Lerner's attorney used Mr. Warner's records to question Dr. Schirmer about his own use of a procedure known as a transurethral resection because earlier in the case Dr. Schirmer had claimed that Dr. Lerner violated a required standard of care when he performed a similar operation. Dr. Schirmer was so shocked at hearing his patient's confidential pathology report revealed in open court that he refused to comment on it. Even more surprised was Mr. Warner, who did not know his records had been opened to the public until his physician contacted him after the court hearing (W. Warner, personal communication, October 29, 2001).

Upon learning of the disclosure, Mr. Warner filed a complaint against Dr. Lerner for violating Maryland's Confidentiality of Records Act by procuring and using his medical records without his consent or authorization. Mr. Warner claimed that Dr. Lerner obtained the pathology report "wrongfully, willfully, and in violation" of the Act. However, the Circuit Court for Baltimore City upheld the managed care organization's and the urologist's decision to take and use the confidential records in his defense, which they argued, was in keeping with the terms of the Act.

In 1996, Judge Cathell, speaking on behalf of the Court of Special Appeals of Maryland, upheld the Circuit Court's decision and stated,

One's right to privacy in his medical records falls within the ambit of constitutional protection. . . . Although the Act attempts to fortify the privacy interests and rights of patients, it lacks clarity as to the precise circumstances under which a provider's attorney may obtain medical records. . . . While
we surmise that the drafters may have intended that the terms of discretionary disclosure should be applicable to a legal action in which the patient has a direct interest, and that the basis of this action accrued within the scope of the subject provider's practice, this intent stands in diametric opposition to the language used in the Act. We must accept the law as it is written, not as we would like it to be. (Warner v. Lerner, 1997, pp. 5, 8)

In 1997, however, the Court of Appeals of Maryland overturned all previous rulings in the case citing the need to safeguard the confidential information of patients and keep intact the initial integrity of the Confidentiality of Records Act. All the judges agreed that the hospital or its managed care organization were not required to reveal Mr. Warner's records, and that without Mr. Warner's permission, the organization could not lawfully divulge his confidential information. The judges also claimed that the Act did not support managed care organizations or their health care providers' attorneys obtaining any patient's medical records, even if those records may aid in an actual or potential lawsuit.

The case of a confidentiality breach by a physician not even associated with the patient whose confidential information was revealed (i.e., third-person disclosure) has particular theoretical significance because it reveals multiple layerings of privacy boundaries within macro and micro levels of context that previously may have been obscured by focusing on micro-level dyadic interactions. In addition, the practical implications for improving the standard of patient care and patient integrity in the managed care environment become evident through an analysis of the case, to which we now turn.

AN ANALYSIS OF THE CASE FRAMED BY COMMUNICATION BOUNDARY MANAGEMENT THEORY

What is most interesting about the case in point is that the breach of confidentiality did not come from the patient's primary physician; instead, the managed care organization allowed a physician in its network to access the patient's private information without the permission or knowledge of the patient or his primary physician. In turn, the other physician's attorney revealed the information in open court. Consequently, a CBM theory analysis of this case cannot focus exclusively on the patient-physician dyad. Instead, a confidentiality breach by another physician within a shared managed care organization can only be understood by considering the complicated interplay of factors and communication boundaries involved in this breach. In particular, this example exemplifies the multi-layered nature of privacy boundaries and the recursive relationship of micro-level and macro-level forces in the disclosure of medical information in the managed care environment. In the next sections, we extend CBM theory to the complex paradox of managed care and patient confidentiality using specific examples from the case as evidence.

Creating and maintaining Boundary Structures in the Managed Care Environment

The four dimensions of privacy boundary structures emerged in this case, but teasing them out was complicated by the multifaceted nature of managed care systems. Consequently, each dimension was reconceptualized to incorporate this integrated sense of micro-level and macro-level complexity (Table 1).

Contesting Boundary Ownership

In the case in point, the patient and his physician clearly established joint ownership of the medical information that Mr. Warner shared during their interac-
PARADOX OF CONFIDENTIALITY IN MANAGED CARE

TABLE I
BOUNDARY STRUCTURES, DEFINITIONAL QUESTIONS, AND ILLUSTRATIVE CASE EXAMPLES

<table>
<thead>
<tr>
<th>Boundary Structures</th>
<th>Questions to Consider</th>
<th>Case Study Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contesting Boundary Ownership</td>
<td>Who owns the private information?</td>
<td>Mr. Warner and Dr. Schirmer assumed joint ownership of the shared information about Mr. Warner's urological condition until the interests of other parties (e.g., another physician or managed care organization) were revealed in court.</td>
</tr>
<tr>
<td>Expanding Boundary Control</td>
<td>Who controls the private information?</td>
<td>Dr. Schirmer mistakenly thought he controlled Mr. Warner's medical information, when, in fact, the managed care organization exercised its ultimate control by releasing the information.</td>
</tr>
<tr>
<td>Multi-Dimensionalizing Boundary Openness</td>
<td>How open is the boundary surrounding the private information?</td>
<td>Because of multiple boundaries, there are varying degrees of openness. Dr. Schirmer and Mr. Warner maintained relatively closed boundaries, whereas the managed care organization was more open with its boundaries.</td>
</tr>
<tr>
<td>Challenging Boundary Permeability</td>
<td>How permeable is the boundary surrounding the shared information?</td>
<td>As the case escalated through the court system, the information became more permeable and the sanctions for releasing the information became more severe.</td>
</tr>
</tbody>
</table>

Mr. Warner disclosed personal information to Dr. Schirmer under the commonly accepted assumption that his urological problems would be kept confidential. Dr. Schirmer, in turn, maintained the privacy of the sensitive information shared. However, Dr. Lerner, the urologist being sued by another patient, violated the implicit ownership agreement established between Mr. Warner and Dr. Schirmer when he accessed Mr. Warner's medical records in the managed care organization's computer system.

This incident raises the question of who actually owns private medical information once it is revealed—the patient and his or her health care provider, the health care organization, and/or even the larger managed care organization? Most patients naively assume that the managed care organization does not own their personal information. As Mr. Warner explained in an interview, "We assume the information is private. You know, my father was a doctor and [he taught me] that [patient] information is private. You and I, we assume that the information will be kept confidential, so never assume!" (personal communication, October 30, 2001). However, under managed care and through the use of complicated consent forms (K. Allen, 1998), the ownership of health records and personal health information is transferred from the patient and the physician to the organization. This multiple ownership of patient information blurs the boundary perimeter of patients' privacy and may cause bound-
ary confusion and personal harm (Allman, 1998). As this case clearly illustrates, the concept of privacy boundaries must be further expanded to include the intersection of macro-level and micro-level boundaries.

Expanding Boundary Control

In this particular case, although Dr. Schirmer thought he had control of Mr. Warner’s medical records and that this private information was, therefore, safe, the exposure of Mr. Warner’s pathology report in open court during a lawsuit involving two other parties demonstrates that the managed care organization actually superseded Dr. Schirmer’s control of Mr. Warner’s information. Within the managed care environment, control of patients’ confidential information has shifted along the continuum from being tightly controlled by a health care provider’s staff to being loosely controlled by a large integrated organization that potentially shares patient information both internally and externally. In other words, legitimate access to patients’ confidential information has become a site of contest by the many interested parties involved in the system.

Multi-Dimensionalizing Boundary Openness

This case demonstrates how the same information can be situated at different places on a continuum of openness/closedness because there are actually multiple overlapping boundaries involved and multiple people to whom the information might be revealed. Using concentric circles, Figure 1 graphically represents the situation in this case by illustrating the overlapping communication boundaries of the interested parties involved. Although Mr. Warner was fairly open with the boundaries of his information when talking with Dr. Schirmer, Dr. Schirmer closed the boundaries around Mr. Warner’s medical records and did not intend to reveal his patient’s private information. Upon realizing that the records had been breached, he refused to discuss Mr. Warner’s file. However, the managed care organization was more open with the boundaries of Mr. Warner’s records in that it allowed Dr. Lemer and his attorney access to the information. Once Dr. Lerner gained access to Mr. Warner’s health records, he openly shared the confidential information within the court boundaries of admissible evidence. In other words, as boundary control surrounding patients’ confidential information expands, so too does the level of boundary openness.

Challenging Boundary Permeability

As privacy boundaries become less controlled and more open, those boundaries also are more permeable. However, challenging the permeability of the boundary surrounding a patient’s confidential information carries the risk of sanctions. In this case, a state court of appeals ultimately determined that Mr. Warner’s medical information was sensitive and should have been kept confidential via a less permeable boundary. Although we could not determine the exact sanctions imposed, due to a confidentiality agreement signed by all parties to the lawsuit (W. Warner, personal communication, October 29, 2001), violation of Mr. Warner’s confidentiality likely carried a strong legal action against Dr. Lerner and the managed care organization because they inappropriately revealed Mr. Warner’s confidential information. Unfortunately, it seems that managed care organizations and their members may continue to contest the boundaries of confidential information until sanctions are made public and laws are enacted that further define the appropriate level of permeability of these boundaries.
Creating and Maintaining a Rule-Based Management System in the Managed Care Environment

As with the development of boundary structures, the functionality of those boundaries were evidenced in the case through the four developmental concepts, which led to a more complex conceptual understanding of the rules that govern patient confidentiality in a managed care system (Table 2).

Contextualizing Boundary Rule Formation

Boundary rules are shaped through interaction but, as is indicated in this case, in the managed care environment, as shown below, the four access decision factors governing private information become more complicated, less transparent to the interactants in the initial conversation (i.e., physician and patient), and more constrained by the interests of the larger organization.

Access decision factor one. Relative to the first access decision factor concerning who receives the information, Mr. Warner believed that Dr. Schirmer was the only person who, unless he gave permission, would have access to his personal medical records; consequently, he felt comfortable confiding in his physician. However, if Mr. Warner knew that the rules of the managed care organization permitted his information to be made available to others, it is clear from his lawsuit against Dr. Lerner that he would
not have revealed his private information. As he told us during an interview, "It was a breakdown in the hospital security. . . . I don't think it is anyone's right to reveal my private medical history. . . . I don't think anyone should have a right to this information without my permission and so that is why I decided to sue" (personal communication, October 29, 2001).

Access decision factor two. The second decision factor determining access to information is the content of the information. Traditionally, no one other than the primary physician (and maybe the physician's staff members) had access to information regarding a person's private health data; hence, revelation of the content discussed was not usually a concern for the patient. Under managed care, however, numerous individuals can acquire the contents of a patient's medical records ("Association Cites Confidentiality Problems," 1999; Munson, 1996; Rock & Congress, 1999).
Davidson and Davidson (1996) noted that before managed care, health care organizations, even those with several levels of bureaucracy, had much stricter rules for the release of confidential information to interested parties. In the current managed care environment, however, the information systems used to collect and communicate confidential information (e.g., unregulated computerized databases and telephone reviews) offer the potential for many unauthorized users to access patients' private information. Essentially, anyone with knowledge about how to navigate an electronic query may be able to easily access patients' confidential health information. In addition, more patients are at risk of confidentiality breaches because managed care systems feature extensive networks of personal information created through access to medical data (Wynia, Cummins, VanGeest, & Wilson, 2000). In the present case, if Mr. Warner had known that others would be allowed access, he may not have revealed as much information and Dr. Schirmer may not have included all of Mr. Warner's sensitive medical information in his medical record.

Access decision factor three. The third decision factor regulating access to information is when and where the personal information is disclosed. Under the assumption that he and Dr. Schirmer shared both the information and the responsibility for keeping it confidential, Mr. Warner disclosed his potentially embarrassing urological problems in a private office visit. However, beyond that office, the managed care organization enabled his personal information to be revealed under a variety of circumstances without the knowledge of the primary physician or the patient. Thus, the boundaries of information revealed during an office visit now stretched beyond the door of the physician's office.

Access decision factor four. The fourth decision factor determining access to information is how much of the information will be revealed. It is possible that Mr. Warner may not have objected to part of the information he shared with Dr. Schirmer being revealed outside their patient-physician relationship. In fact, Mr. Warner told us,

I don't think anyone would have objections if they were a patient to use their case in a matter of research without using the name. ... If my medical information is needed for medical research that might be okay, but they should never know any personal information about me. (personal communication, October 29, 2001)

However, his entire medical record was made accessible without his permission, not only to another specialist in the field but also to Dr. Lerner's attorney and, by law, to all involved in the open court proceedings. It seems that, in this particular case, motivations of self-interest were a definitive factor in breaching the confidential information of a patient in that Dr. Lerner's interests and the interests of the managed care organization became paramount in their decision to access Mr. Warner's records and use the information contained therein to defend themselves against a medical malpractice lawsuit.

Reconsidering Boundary Rule Usage

The use of boundary rules can be triggered by particular events and/or established routines; the case in point illustrates both these boundary rules of use. As was routine in traditional patient-physician interactions, Mr. Warner and Dr. Schirmer had agreed implicitly on tight boundaries around their private communication and also negotiated usage rules on the basis of their trusted patient-physician relationship. As Mr. Warner told us, "I have never had that kind of conversation with any of my
doctors [about confidentiality]. I think we all assume that the information is privileged”  (personal communication, October 30, 2001). However, Dr. Lerner violated these rules, whether knowingly or not, by requesting the confidential health records of another physician’s patient. The managed care organization also violated these rules in an effort to protect one of the physicians in its network. The event that triggered reconsideration of the boundary rules was the legal action brought by Mr. Warner against Dr. Lerner.

Making Boundary Rule Coordination Explicit

Explicit coordination of privacy boundaries becomes essential in managed health care settings as interactants attempt to manage the confidentiality of the information shared. The rules of privacy boundary coordination have changed with the implementation of managed health care. As Davidson and Davidson (1996) noted, “Client information is now shared in a much less discriminate manner than traditionally occurred in fee-for-service delivery systems” (p. 209). These boundaries are now being negotiated and coordinated not only between a patient and health care provider, but also with the encompassing managed care organization and various relevant audiences (e.g., drug companies, legal community).

With the addition of more participants in the health care process, specific requirements for boundary rule coordination can be challenging to determine. Unfortunately, in this case, boundary rule coordination beyond the patient-physician dyad became a contested matter. Allman (1998) claimed that “disclosure is not always of the physician’s own choosing” (p. 191), and this was evidenced in this case. Even though Dr. Schirmer did not participate in the release of his patient’s information, members of the managed care organization released the private medical records of Mr. Warner to parties outside the patient-physician relationship and, eventually, the managed care organization itself. Instead, explicit coordination of information ownership should be accomplished within the initial patient-health care provider interaction to ensure that the rules regarding the protection of patients’ confidential information in the managed care environment are mutually understood. As Mr. Warner warned, “Never assume!” (personal communication, October 30, 2001).

Acknowledging Intersecting Boundary Rule Turbulence

In this case, the intersecting boundaries of the parties involved (i.e., Mr. Warner, Dr. Schirmer, Dr. Lerner, and the managed care organization) affected each participant due to the relatively small area of boundary rule coordination that existed for the parties (Figure 1). Mr. Warner and Dr. Schirmer established a viable boundary within the managed care environment. However, when Dr. Lerner, supported by the managed care organization, invaded that boundary by gaining access to and using Mr. Warner’s private information for his own purposes, complications arose. According to Petronio et al. (1996), differences in the status of a patient and health care provider often create problems in defining ownership of information and determining appropriate rules for disclosing confidential information. However, the status of the other participants may also lead to such turbulence. In this case, the two urologists bitterly disagreed about who owned the patient’s confidential information, the relevant rules governing the confidentiality of that information, the appropriateness of disclosure of that information, and to whom the information may be disclosed.

By considering this particular case from a communication boundary management perspective, it is evident how the confidentiality of Mr. Warner’s private health
information was breached because of overlapping boundaries. Complications arose because of the conflicting needs and interests of each party involved. By having varying ideologies of ownership, control, permeability, and openness, Mr. Warner's private information became the focus of a heated debate when those competing confidences were exposed. In negotiating how to form, use, and coordinate rules around the boundaries of that private information, each party focused on its own concerns. This led to boundary rule turbulence that became chaotic and was only manageable through a legal decision.

DISCUSSION

This case study suggests that there are serious concerns regarding the communication of confidentiality breaches in the managed care environment. In addition to the previously existing possibility that the primary health care provider may breach the confidentiality of a patient, there may be increased risk of other health care providers and the integrated staffs of managed care organizations disseminating confidential information simply by virtue of the increased number of people who can gain access to patients' records. In addition, as this case illustrates, even attorneys not affiliated with a patient may obtain her or his medical records and present the information to all those present during a public court hearing. Thus, the confidentiality breach in this case highlights the paradox of maintaining patients' private information in the complex web of communication in the managed care environment; it also points to important theoretical implications and practical recommendations for health communication despite some study limitations and the need for further research.

Theoretical Implications

In analyzing this case from the perspective of CBM theory, it is evident that privacy boundaries were established and maintained between Mr. Warner and Dr. Schirmer; these communication boundaries protected Mr. Warner and the information he shared with his urologist. Problems seemed to arise when Dr. Lerner, working through the managed care organization, violated the previously established boundaries by gaining control of Mr. Warner's medical information and disseminating it without the permission of the patient or his physician. Although boundary rules had been formed between the physician and patient, the managed care organization created different rules without considering the already established rules. Because boundary rule coordination is essential to effective health communication in the patient-health care provider relationship, all parties need to be involved in the developmental concepts of boundary rule management leading up to and including explicit boundary rule coordination.

Theoretically, then, this research supports the application of CBM theory to study both text-based cases and health communication concerns, but we also argue for an extension of the theory that recognizes the existence and influence of multiple macro-level and micro-level organizational and interpersonal boundaries that need to be managed to protect information that interactants deem private and want kept confidential. Furthermore, in addition to highlighting the paradox of maintaining confidentiality in the complex communication web of managed care, this extension of the theory also problematizes the notion of boundary rule coordination by viewing it as a contested site of information access and, in doing so, suggests practical recommendations to manage the paradox. That is, in recognizing and emphasizing that multiple
boundaries exist, there is also a need to expand the area of boundary rule coordination to include all parties whose boundaries intersect (Figure 1).

**Practical Recommendations**

The findings of this study point to a few practical recommendations that can aid in the coordination of privacy boundaries for patients, health care providers, and managed care organizations. First, health care providers and patients need to become better educated about confidentiality issues in the managed care environment. One way to foster this education is for managed care organizations to train staff and patients to increase their awareness of all parties that may have access (i.e., authorized and unauthorized) to medical records. For example, Georgetown University law professor Lawrence Gostin (in A. Allen, 1998) astutely argued that the public may need to be plainly and clearly told that absolute privacy does not exist in the brave new world of managed health care. This awareness might then foster the need for caution on the part of patients, health care providers, and the managed care organization because of the complexity of the system regarding patients’ confidential records.

Second, patients need to participate more proactively in determining how much of their private information is available for dissemination. For example, patients need to more consciously read medical consent forms and ask questions to clarify anything they do not understand or do not agree with before signing the forms; this is the only way an informed decision about the confidentiality of one’s medical records can be made before consent is given.

Third, patients will benefit from continually negotiating their privacy boundaries with all their health care providers (e.g., during the initial appointment and whenever a new provider is introduced to the patient), including the managed care organizations in which they participate (e.g., through consent forms and with staff). Patients must also be aware of the ramifications of these negotiations (e.g., private information may be revealed to a source for whom consent has not been granted).

Overall, patients, health care providers, and managed care organizations need to recognize from the onset who owns and controls patients’ medical information, how permeable the boundaries of that information are, and what level of openness characterizes that information. In other words, it is our contention that legitimate access to patients’ confidential information should occur only on a need-to-know basis for relevant health care staff members and that these parties, including the patient, need to negotiate and renegotiate the rules regarding confidentiality of medical information, use those negotiated rules in their ongoing interactions, coordinate the relevant rules across privacy boundaries, and know how to handle any turbulence associated with the agreed rules (e.g., confront and sanction rule violations). Using these recommendations, the paradox of patient confidentiality in the age of managed care has a better chance of being successfully managed.

**Limitations and Future Directions**

Although this study has revealed important findings about boundary negotiation in the health care setting, it is not without limitations. Three limitations are particularly germane. First, this case may not be representative of typical breaches of patients’ confidentiality, which more often involve interpersonal conversations between health care providers (A. Allen, 1998) and computer breaches (K. Allen, 1998; Anderson & Brann, 2000). The case chosen was quite visible in the media and in legal circles and may represent an exception in patient confidentiality breaches rather than the rule.
Emphasizing this case also may suggest that only major confidentiality breaches deserve attention whereas minor breaches should be ignored. We attempted to address these limitations by referencing a variety of confidentiality breaches reported in the literature to support our choice of theory for analyzing the selected case. We chose this particular case because it reveals several intersecting dimensions of patient confidentiality (e.g., interpersonal issues, organizational issues, and legal issues; see Figure 1), which also may be involved in more common cases.

Second, this case was gleaned primarily from existing literature rather than from more direct observation and interaction with relevant parties. Although pertinent parties were contacted to clarify and respond to the case report, the information that could be shared was limited due to a confidentiality agreement at the resolution of the lawsuit. To address these limitations, our future research will triangulate the case study method with other methods—including observations, interviews, and surveys—to better understand, both theoretically and pragmatically, the paradoxical communicative process of boundary management involving patients’ confidential information in the managed care environment.

Third, we would be remiss not to mention the irony of sharing a specific case about a confidentiality breach to address the issue of confidentiality. That is, by writing about this case, we bring even more attention to the patient involved, who would have preferred that his medical information not be the focus of attention. In doing so, it seems that we have created yet another paradox, or at the very least another communication boundary system, that needs to be considered in the realm of communication boundary management—that is, others in the larger environment who may further disclose private information after learning about it through media, literature, or other sources. Certainly, this is another important issue to ponder in the future of confidentiality research.

NOTES

1The names in the case were not changed because they were part of the public record.
2The management of clients' confidentiality likely involves similar complications in a number of other contexts, such as financial institutions and law offices.
3By our definition, legitimate access to confidential patient information includes only relevant parties and does not encourage access by health care staff not relevant to the case, other patients, attorneys, employers, and insurance companies.
4When we asked Mr. Warner what he thought about others, like us, writing about his case, he said, "Oh, I think it is fine for you to write about this." He may consider it to be within the realm of medical research that he deems acceptable.

REFERENCES


