If Truth Be Told: Paternal Nondisclosure in Neonatal Herpes Simplex Virus Infections

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ABSTRACT

An infant is treated for a suspected neonatal herpes simplex virus (HSV) infection. The mother requests that the father not be informed of his child's diagnosis or treatment, as the father is not aware of the mother's possible HSV infection or her extra-relational sexual encounter. The obligation to inform the father of his child's treatment is in conflict with the obligation to protect the confidentiality of the mother's sexual history. While outright deception of the father is unethical, options exist to limit disclosure of the mother's sexual history, since those details are not directly relevant to the father's ability to make informed medical decisions about his child's care. The careprovider should inform the mother of the complex and recurrent nature of HSV infections and empower her to select an option that will inform the father of the concern for HSV infection and the need for treatment in a manner that she feels will best protect her confidentiality. Objections to this method are evaluated and countered.

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CASE

A mother brings her 10-day-old male baby to the emergency department with a fever. The child is irritable, but without a clear source of infection. He was born full term via vaginal delivery with no documented complications during the pregnancy, delivery, or newborn period. Through further questioning, the mother describes a history of genital lesions in the second trimester consistent with herpes simplex virus (HSV) and is unsure if she has had similar lesions in the past. She was sexually active with the father of the infant throughout the pregnancy and had an extra-relational, unprotected sexual encounter during the pregnancy. The parents are not married, but cohabitate and parent the child together as legal guardians.

Due to concerns for serious viral or bacterial infection, the patient is admitted to the hospital, a full workup is performed, and broad-spectrum antimicrobial therapy is initiated, including treatment for HSV. The mother requests that the careprovider not tell the infant's father about the treatment for HSV, as he does not know about her extra-relational sexual encounter, and she is concerned that this knowledge will damage their relationship.

HSV-1 and -2 are common viruses that spread between individuals by direct contact, often through

oral or genital contact during kissing or sexual intercourse. Mother-to-child transmission during or shortly after birth is responsible for neonatal HSV. Neonatal HSV can cause a spectrum of disease from mucocutaneous involvement of the skin, eyes, and mouth; central nervous system involvement; or dissemination to multiple organs. Without prompt treatment, neonatal HSV has a high rate of mortality and disability. HSV is difficult to diagnose clinically, as a child may not have typical vesicular lesions, and the mother may not recall any symptomatic infections during pregnancy, requiring viral cultures and a PCR (polymerase chain reaction) assay to confirm diagnosis.[1]

TRUTH-TELLING IN PEDIATRICS

The importance of truth-telling has changed throughout the history of medicine. In the 19th century, medicine was highly paternalistic. Doctors believed it was acceptable to withhold information or lie outright to "protect" their patients, at least in part due to a common belief that giving a poor prognosis was harmful to patients.[2] With the evolution of medicine to more highly value patients' autonomy and patients' preferences to hear the truth, regulations requiring informed consent for research and treatment have also evolved. As diagnostic information provides more reliable data, truth-telling has become fundamental to medical practice in the United States.[3] Today, the argument for truth-telling is rooted in the principle of respect for patients' autonomy, because patients' knowledge of their condition is a prerequisite to their being able to make informed decisions regarding their health.[4]

The application of truth-telling in pediatrics is less clear because the principle of respect for patients' autonomy does not directly apply to children.[5] In pediatrics, careproviders' primary moral obligation remains with the patient, but the primary legal obligation is with the patient's parents or legal guardians. Additionally, a child's ability to process information depends on her or his development. Infants are incapable of understanding any information, young children may have minimal understanding, and adolescents may process information similarly to adults. According to the American Academy of Pediatrics, communication with families should be family-centered, frequent, clear, and honest, but hopeful whenever possible.[6]

The application of these principles in specific situations may be controversial, in part because the interests and rights of parents and children may be in conflict. For example, the pediatric ethics literature discusses the nuances of when to withhold information about a grave diagnosis from a child at the request of parents,[7] or when to withhold information about an adolescent's social behaviors from her or his parents.[8] However, the literature regarding nondisclosure of medical information from a child's parent at the request of another parent is sparse.

ETHICAL OPTIONS

Any level of deception of parents that compromise the care of their child is unethical. In this case, the child will receive the needed treatment regardless of the father's knowledge of the child's diagnosis or treatment. The mother's desire to keep her sexual health history confidential and the father's legal right to access his child's health information represent a potential ethical conflict for the careprovider. The ethical question centers around whether the confidentiality of the mother outweighs the right of the father to be informed about his child's medical care.

The father has a legal and a moral right to access his son's medical information. Specifically, he should be informed of the treatments his son is receiving, the pending tests, the diagnoses being considered, and possible prognosis. Furthermore, the father should be included in any decisions to be made about the care of his child.

The mother has a right to keep her personal sexual history confidential. Revealing her extra-relational sexual encounter may have a wide range of effects on the relationship she has with the child's father. The environment in which the child grows up may be negatively affected. Weighing the risks and benefits of disclosing the sexual encounter to the father is not the physician's role. Aside from the obvious stress that disclosure may place on the relationship, the stigmatization of HSV makes disclosure particularly challenging, including the risks of psychological and social trauma.[9] In addition, the mother's extra-relational encounter may have further cultural and religious implications. These could be severe, including abandonment by her family and exclusion from her community.

The benefit to the mother of nondisclosure may outweigh the possible harm to the father. Based on legal obligations, generally held ethical standards, and the consideration of the patient and family members, an outright lie to the father about the care of his child is ethically unjustifiable.[10] The "reasonable patient" principle considers what most reasonable patients would want. Applying this principle

to pediatrics, one can expect that most fathers would want to know the diagnoses and treatments concerning their child.[11]

Given the complexity and recurrent nature of HSV infection, disclosing medical information to the father and protecting the mother's confidentiality are not mutually exclusive. The mother's HSV infection could be from a relationship that preceded the current relationship with the father, and although a secondary recurrence of an infection is much less likely to be transmitted to an infant, this is possible.[12] Additionally, it is entirely possible that the HSV infection was transmitted from the father to the mother, and that he acquired it either from a prior relationship or a concurrent extra-relational encounter. One option would be to discuss these nuances with the mother, and develop a plan to inform the father regarding the child's need for treatment while protecting the mother's confidentiality to the highest degree possible.

Another option would be to place the responsibility for informing the father with the mother. This would allow her to inform him on her own terms. The mother should be warned that if the father asks a direct medical question, it will be answered truthfully. A third option would be to give the father general information about the prevalence and severity of neonatal HSV without stating that it is sexually transmitted. This would leave open the possibility that if the father asks a direct medical question, it will be answered truthfully.

A more controversial option would be to wait until the PCR assay returns, which typically is in 24 to 48 hours, before telling the father about the HSV infection. If the assay is negative, which is the most likely result, since the child has no lesions, acyclovir would be discontinued.[13] This approach would be morally questionable because the father would not be informed about the multiple doses of antiviral medication and related testing, and runs the risk, if the test is positive, of telling the father about the diagnosis and that the child is being treated.

One option would be to discuss these nuances with the mother, and develop a plan to inform the father of the child's need for treatment while protecting the mother's confidentiality to the highest degree possible. Another option would be to place the responsibility for informing the father with the mother.

OBJECTIONS CONSIDERED

The careprovider may not actively deceive the father to protect the mother by citing therapeutic privilege. Therapeutic privilege is a controversial concept that is used to justify deceiving a patient for the benefit of that patient.[14] For example, a careprovider could claim therapeutic privilege to mislead a child who has end-stage metastatic cancer to convince her that she is not dying, because the knowledge of her condition may cause her serious psychological harm. Therapeutic privilege cannot be used in this case for two reasons. First, it in not the patient who is being deceived. Second, it is not the patient who receive primary benefit from the deception, but the mother. Deceiving the father may protect the mother, which may benefit the child in some situations by keeping the family intact or protecting the mother from abuse. But the likelihood of keeping the family together through deception is not easily determined by the careprovider, and concerns about a possibly abusive situation warrants discussion regarding the involvement of child protective services.

A second objection to deceiving the father is that it is immoral to not provide him with all of the medical facts known to the mother. On the other hand, the moral obligation to disclose information is tied to the relevance of the information;[15] disclosing all medical information is impractical and often impossible. A careprovider could spend hours discussing the epidemiology, pathophysiology, and management of HSV infection. Instead, a reasonable careprovider will narrow the information presented to what is relevant to the family. In this case, the concern regarding neonatal HSV infection is relevant to the father's ability to make medical decisions for

his son, but the sexual history of his partner is not. While any attempt to deceive the father about his child's possible neonatal HSV infection is morally indefensible, specific information about the mother's sexual activity is not relevant to the child's care. Although withholding this information may appear to be deceptive, the benefits of withholding the mother's sexual history could outweigh the benefits of revealing that information to the father.

A third objection is that the father deserves to be informed of his risk of contracting HSV from the mother. This objection is problematic for multiple reasons. First, the mother does not have a confirmed HSV infection. Second, the child is the patient, not the father or the mother, and the careprovider's obligation is to the child. Third, a careprovider generally does not have a duty to inform an adult patient's sexual partners about their risk of contracting HSV from a patient, although the careprovider should encourage infected individuals to disclose their status to exposed partners.[16]

CONCLUSION

In this case, an obligation to inform the father about his son's medical care is in conflict with an obligation to keep the mother's sexual history private. This ethical dilemma appears to challenge the careprovider to choose between protecting the mother's confidentiality and involving the father in decision making for his son. The relevant medical information the father needs to make informed decisions about his son does not include information regarding an extra-relational sexual encounter his partner had during pregnancy. Given the complex and diverse clinical presentations and transmission of HSV, the careprovider should suggest multiple ways to inform the father of the concern for neonatal HSV, and empower the mother to select an option that she feels will best protect her confidentiality. While requiring additional attention and time to balance the interests of both parents, this approach ensures that the careprovider allows both parents to participate in the care of their child and does not force the careprovider to deceive the father or betray the mother.

PRIVACY

Details of the cases have been altered to protect the identities of patients and family members.

NOTES

1. S.H. James and D.W. Kimberlin, "Neonatal Herpes Simplex Virus Infection," *Infectious Disease Clinics of North America* 29, no. 3 (2015): 391-400.

2. B. Sisk, R. Frankel, E. Kodish, and H. Isaacson, "The Truth about Truth-Telling in American Medicine: A Brief History of Disclosure in Medicine," *Permanente Journal* 20, no. 3 (2016): 74-7.

3. Ibid.

4. J. Pugh, G. Kahane, H. Maslen, and J. Savulescu, "Lay Attitudes toward Deception in Medicine: Theoretical Considerations and Empirical Evidence," *AJOB Empirical Bioethics* 7, no. 1 (2016): 31-8.

5. J.D. Lantos, "Should We Always Tell Children the Truth?" *Perspectives in Biology and Medicine* 40, no. 1 (1996): 78–92.

6. M. Levetown and American Academy of Pediatrics Committee on Bioethics, "Communicating With Children and Families: From Everyday Interactions to Skill in Conveying Distressing Information," *Pediatrics* 121, no. 5 (2008): e1441-60.

7. Lantos, "Should We Always Tell Children the Truth?" see note 5 above.

8. E.D. Berlan and T. Bravender, "Confidentiality, Consent, and Caring for the Adolescent Patient," *Current Opinions in Pediatrics* 21, no. 4 (2009): 450-6.

9. P. Caulfield and D. Willis, "Herpes Simplex Virus: 'To Disclose or Not to Disclose.' An Exploration of the Multi-Disciplinary Team's Role in Advising Patients about Disclosure When Diagnosed with Genital Herpes Simplex Virus," *International Journal of STD and AIDS* 0, no. 0 (2016): 1-6; J. Melville et al., "Psychosocial Impact of Serological Diagnosis of Herpes Simplex Virus Type 2: A Qualitative Assessment," *Sexually Transmitted Infections* 79 (2003): 280-5.

10. Levetown and American Academy of Pediatrics Committee on Bioethics, "Communicating With Children and Families: From Everyday Interactions to Skill in Conveying Distressing Information," see note 6 above; Pugh, Kahane, Maslen, and Savulescu, "Lay Attitudes toward Deception in Medicine: Theoretical Considerations and Empirical Evidence," see note 4 above.

11. C.L. Cox and Z. Fritz, "Should Non-Disclosures Be Considered as Morally Equivalent to Lies within the Doctor–patient Relationship?" *Journal of Medical Ethics* 42 (2016): 632-5.

12. James and Kimberlin, "Neonatal Herpes Simplex Virus Infection." see note 1 above.

13. Ibid.

14. Pugh, Kahane, Maslen, and Savulescu, "Lay Attitudes toward Deception in Medicine: Theoretical Considerations and Empirical Evidence," see note 4 above.

15. Cox and Fritz, "Should Non-Disclosures Be Considered as Morally Equivalent to Lies within the Doctor–Patient Relationship?" see note 11 above.

16. Caulfield and Willis, "Herpes Simplex Virus: 'To Disclose or Not to Disclose," see note 9 above; Melville et al., "Psychosocial Impact of Serological Diagnosis of Herpes Simplex Virus Type 2," see note 9 above.