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The Hippocratic Oath, Principle of Confidentiality and the Moral Burden of Physicians

Emmanuel Iniobong Archibong[1], *Love Ogbeyalu Charles Ukeagu*[2]

[1]*Department of Philosophy, University of Uyo, Uyo. Nigeria*
[2]*Department of Microbiology, Immunology and Pharmacology, St George's University, St George's, Grenada*

Abstract

The Hippocratic Oath containing the principle of confidentiality is a major cornerstone of medical ethics putting the obligation on physicians to maintain the secrecy of patient information. However, this duty can impose a significant moral burden on physicians, particularly when they possess knowledge that must be kept secret even though sensitive or potentially life-altering. This study undertook to explore the moral burden that physicians bear when confronted with the need to maintain confidentiality. The study inquired into how physicians experience and navigate the moral burden of confidentiality as well as the emotional and psychological implications of such medical secrets paralleling their own moral values. The study investigated the moral burden of physicians who know medical secrets and to explore the impact of confidentiality on their well-being and professional practice. The study employed a qualitative systematic review with a thematic analysis using imaginative variation interpretative steps towards the phenomenological (first person lived experience) of physicians as directly captured in documented literature. Ethical consideration in the analysis was not omitted in order to mitigate bias through misrepresentation or overcontextualization. As an outcome, the study recommends that the health of the physician is important and should be safeguarded through reflective ecosystems. This should be from compliance-focused codes to dialogical engagement; and from isolated moral decision-making to shared ethical stewardship. Hence, there is the need for a balance that harps on both institutional and duty-based ethical best practice.

Keywords: Hippocratic Oath, confidentiality, moral burden, physicians, medical ethics, lived experience, wellbeing

Introduction

The outlook of the physician as a moral agent is perhaps nowhere more powerfully raised than in the Hippocratic Oath. Crafted in ancient Greece, the oath has served as the ethical cornerstone of medical practice for over two millennia, emphasizing above all, the imperative to "do no harm" and to maintain patient confidentiality[1]. In its modern interpretation, the oath reinforces a binding commitment which is the safeguarding of patient secrets even when such knowledge weighs heavily on the conscience of the physician. While confidentiality is fundamental to trust in the physician–patient relationship, it may simultaneously produce a complex ethical and emotional burden on the physician, particularly when silence conflicts with personal values or public good.

The principle of medical confidentiality demands the strict protection of patient information from third parties. Physicians are professionally expected to uphold this principle regardless of circumstance, except in narrowly defined exceptions[2]. The ethical force of confidentiality lies in its assurance to patients that they can speak freely, with the confidence that their disclosures will not be let out or

Corresponding Author:
Emmanuel Iniobong Archibong, Ph.D
Department of Philosophy, University of Uyo, Uyo. Nigeria

emmaiarchibong@uniuyo.edu.ng

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improperly disseminated. However, this ethical stance can impose an internal conflict when physicians possess information that may be ethically significant or potentially life-altering for others, especially close relatives of the patient. In these instances, the burden of silence becomes deeply personal, drawing the physician into a moral tension between loyalty to ethical codes and their own moral compass. Arising from the above, the oath can become "a burden but staying true to your pledge makes you finally a prisoner of silence"[3]. This metaphor of imprisonment captures the core of the physician's burden which is the weight of knowledge that must be guarded even when silence strains the soul. This narrative captures in plain terms, the dilemma that physicians are caught with in the line of duty.

The study will attempt to explore certain possible way out such as the physician need to understand the law and the professional institutional guidelines regarding patient confidentiality. The risks and benefits also have to be weight in the line of duty so as to mitigate potential harm to the patient mental health and that of others. There is the need to also consult with professional colleagues or supervisors when burdened with the weight of knowledge for valuable insights and emotional supports. At other times, patient consent might be sought where discretion and professional judgement is not enough because patient autonomy must be respected even in the face of public health concerns. These issues will inform the research direction, analysis and discussions.

Conceptual Clarifications

i. The Hippocratic Oath: The Hippocratic Oath, traditionally attributed to Hippocrates, marks one of the earliest formal expressions of professional ethics in medicine. The original oath, composed in the 5th century BCE, invokes divine witnesses and binds the physician to a code of conduct that includes loyalty to one's teacher, a prohibition against harm, and a commitment to secrecy[4]. Modern adaptations of the Oath vary, but its core ethical commitment which is nonmaleficence and confidentiality remains intact across cultures. The significance of the Oath is not solely in its textual content but in its symbolic function. It inaugurates a physician into a moral tradition, a community defined by shared values and obligations. It has been observed that, "the oath serves less as a legal framework and more as a moral compass, offering physicians an ethical identity anchored in history"[5]. In today's pluralistic and technologically complex landscape, physicians encounter situations that the Oath neither foresees nor fully resolves.

ii. The Principle of Confidentiality: Confidentiality refers to the ethical and legal duty of physicians to safeguard private information shared by patients in the course of clinical care. It reflects respect for patient autonomy, dignity, and trust. It is codified not only in medical oaths and professional codes (e.g., the AMA Code of Medical Ethics) but also in legislation, such as HIPAA in the United States describe confidentiality as "the moral ground upon which the patient confides, believing that disclosure will serve healing and not become an exposure"[6]. Its moral rationale lies in preventing harm to one's reputation, social, or psychological life that may arise from unauthorized disclosure. However, in practice, confidentiality extends beyond mere information control to becoming a relational ethic. It signifies a covenant of safety between physician and patient.

iii. Moral Burden: Moral burden in medical ethics refers to the weight that healthcare professionals bear when ethical obligations clash with personal conscience, institutional policies, or emotional well-being. It is not merely the experience of moral choice but the psychological remains of having made or refrained from making a decision with serious moral consequences. Moral burden is defined as "the internalized distress that arises when the moral self is required to remain silent or passive in the face of ethical violations or omissions"[7].

iv. Physician's Strain: Physician's strain refers to the confluence of moral, emotional, and psychological stressors that arise from ethical practice, particularly in situations involving confidentiality and high-stakes decision-making. It encompasses both immediate distress and long-term emotional consequences with the strain characterized as a "silent crisis in ethical professionalism"[8]. It is distinct from clinical workload or administrative fatigue. Rather, it stems from internal ethical conflicts, moral isolation, and the emotional demands of continuously absorbing patient suffering without resolution. Confidentiality,

especially in its most stringent forms, is a primary contributor to this strain.

Research Questions

The research questions are designed to be exploratory, context-sensitive, and oriented toward meaning-making thus.

i. How do physicians experience the moral burden of upholding patient confidentiality in ethically challenging situations?
ii. In what kinds of clinical situations do physicians most frequently experience ethical tension between confidentiality and their sense of moral duty?
iii. What coping strategies or decision-making frameworks do physicians employ when managing ethical dilemmas related to confidentiality?
iv. How do physicians reconcile the ethical imperative of patient confidentiality with the principle of beneficence toward third parties, such as family members or the broader community?

Methodology

Phenomenology is especially appropriate here because it centres on lived experience which is a core concern of this study. Phenomenology "aims to describe and interpret meanings of human experience as they are lived in everyday life"[9]. Rather than seeking generalizable laws or causal mechanisms, this method emphasizes the richness and depth of subjective experience, contextualized within real-world practice as documented in research literature forming the source of the study. Since confidentiality is not merely a policy or rule but a moral encounter, understanding how physicians make meaning of this encounter (how they feel, think, cope, and reflect) is best accessed through phenomenological inquiry.

Due to the ethical and logistical limitations of directly interviewing physicians in this setting, relevant published literature was carefully sought and selected based on quality, relevance and context with illustration. A search strategy was used using relevant keywords such as Hippocratic oath, principle of confidentiality and phenomenology to identify potential literatures from academic journals from reputable websites. The literatures were initially screened, texts reviewed points extracted and thematically analysed. The data analysis for the study will be thematic with imaginative variation interpretation. By this, there will be a reflection of the literature in order to identify underlying meanings and patterns from different perspectives, contexts and the exploration of relationships between themes and categories.

While there is a supposed conceptual tension in describing the study as phenomenological while relying solely on indirect data, it is important to state that certain steps have been taken such as: reading the literature sources, noting down themes, concepts and experiences described in the literature, analysis of language of the author, taking note of the contexts and reflecting on same. However, there are methodological limitations such as contextual factors, author's perspectives and indirect data. Even though primary data collection was not used, ethical consideration was taken in the handling of published narratives such as avoiding misrepresentation or decontextualization.

Literature Review

Modern interpretations of the Hippocratic Oath maintain its core moral tenets with the inclusion of confidentiality, non-maleficence, and fidelity. However, they are not enough to meet the needs of today's complex society and practice. It is noted that, "the Oath, while anchoring clinicians to an ethos of individual care, infrequently prepares them for the moral complexity of collective harm, systemic injustice, or ethical pluralism"[10]. The Oath may symbolically provide security but at the same time may actually limit ethical reflection by tying it to an already predetermined construct. It is argued that the Oath's emphasis on confidentiality "neglects the relational context of care in which silence causes harm not only to the patient but to others who are part of this care"[11]. The physicians who have sworn the Oath have often suppressed their moral impulses such as notifying endangered relatives out of perceived professional or legal obligations. This suppression is not simply an ethical trade-off; instead, it becomes emotionally burdensome to the physician's moral identity. This has led scholars to argue that "the strict interpretation of confidentiality must be moderated by a nuanced ethical framework that includes competing obligations, such as the duty to warn and prevent harm"[12].

It is contended that traditional ethical paradigms

based on the Oath have increasingly lost their coherence because of the fragmented nature of contemporary healthcare systems. He further observes that, "The Hippocratic tradition presumes ethical autonomy, but today's physicians frequently labour under corporate dictates and risk-averse guidelines"[13]. As such, being true to the ethical tenets stated in the Oath may involve psychological and moral compromises incompatible with the broadened moral terrain of modern medicine. Confidentiality therefore remains an overarching principle of contemporary bioethics; yet, its ethical implications are now being reapplied to the requirements of relational ethics and the requirements of public health.

It has been stated that, "confidentiality, long held to be sacrosanct, is now contested territory between legalistic privacy and intersubjective justice"[14]. This tension becomes strongest when the patient's right to confidentiality clashes with another's right to proper protection, such as is the case with communicable disease or hereditary diseases. While citing the analysis of the reports by healthcare experts across the time of the COVID-19 pandemic, it is held that "confidentiality is one of the silent sources of distress"[15]. Many physicians reported feeling moral distress related to their duty to withhold critical healthcare information from family members due to legal limitations. These instances stem not from the character of the information itself to be kept hidden but from the concealment itself particularly when this concealment goes against the physician's natural tendency to be transparent and empathetic.

Confidentiality is linked to professional solitude on the point that "the secrecy required of clinicians isolates them not just from the relatives of patients, but from their own professional colleagues"[16]. Since confidentiality often limits communication even with peers outside formal ethical boards, the weight is left to be borne in solitude, without acknowledgment or processing. This is the reason why the concept of moral injury has been developed to describe the psychological and ethical trauma experienced by practitioners who act or fail to act in ways that violate their moral beliefs. Though initially applied in military contexts, it now includes the ethical damage experienced by healthcare professionals who are forced into making moral concessions.

Moral injury is defined as "a violation of what's right on the part of someone who has legitimate authority to provide it under high-stakes situations"[17]. Inside clinical practice, this violation is often internalized. Medical professionals become more likely to suffer distress, not necessarily because they receive criticism from the outside, but because they see violation of the professional ethos they adhere to in their conscience. The ethic of confidentiality is central to this specific kind of violation such that "To harbour a secret causing avoidable harm is, to many physicians, an assault on their conscience"[18]. The theory has been described to the prolonged exposure to moral dissonance along with no ethical resolution and this erodes the professional identity and the integrity of those working in the profession[19].

It has been clarified that moral harm is separate from burnout since it is not the result of the running-on-empty model; instead, it is "a deformation of values where doctors compelled to practice what they consider to be not right to preserve policy, protocol, or silence"[20]. When confidentiality is upheld without exception, it is not only an ethical tenet but also an instrument through which moral isolation is promoted, thus escalating this type of harm. Emotional labor which is the skill through which professionals regulate their feelings according to organizational or ethical requirements, is central to clinical practice. As it relates to confidentiality, the physician is not just required to withhold information gained but also to overcome the urge to release it for the purpose of ethical relief or humane compassion. This information withholding is emotionally demanding and it is noted that "Doctors bear the emotional weight of silenced stories, silenced worries, and silenced ethical admonitions"[21].

It has been argued that that performing emotional labor under the context of ethical silence can have profound negative consequences. They state that, "When empathy needs to be managed not for the patient's benefit but to modulate legal boundaries, physicians start to develop affective dissonance"[22]. This affective dissonance erodes the genuineness of the therapeutic relationship and undermines the emotional resilience of the physician. These are corroborated the study on psychiatry residents with the assertion that the duty of confidentiality often forces clinicians to suppress empathetic responses in ethical decision-making. It states that "Residents were taught to reveal nothing, even when their impulse was to comfort or engage a patient's family.

This generated not only stress, but a sense of moral impotence"[23]. These findings illustrate that when confidentiality is divorced from relational ethics, it transforms emotional labour into a process of emotional degradation.

Despite the large volume of literature devoted to burnout among physicians and moral injury, there is a compelling lack of research focusing on confidentiality specifically and uniquely as an influencing factor for moral distress. As much literature references confidentiality among the overall framework of ethics, comparatively fewer explicitly state it to be an element of moral conflict. It has been noted that "most institutional discussions of moral injury emphasize resource scarcity, administrative pressures, or exposure to trauma. Rarely is the silent ethical wound of enforced confidentiality mentioned"[24]. It is also argued that research on burnout tends to focus on workload and system inefficiencies, while the ethical stressors like enforced silence are often pushed to the margins of inquiry[25].

Even in works that explore moral distress, confidentiality is often treated as a secondary concern. A detailed analysis of moral suffering among COVID-era clinicians was provided but devotes only passing reference to the distress of confidentiality in familial communication contexts[26]. This analytical oversight suggests a disciplinary blind spot that must be addressed to understand the full ethical ecology of physician well-being. Furthermore, few empirical studies examine the coping mechanisms or the ethical reasoning medical professionals use to respond to strain caused by confidentiality.

Also, recent empirical studies show that the moral burden of confidentiality is neither uniformly distributed across clinical contexts nor experienced in identical ways by all physicians. Thus, over 60% of internal medicine residents reported moral distress related to enforced treatment or nondisclosure policies, with early-career clinicians reporting higher emotional impact[27]. In a cross-sectional study[28], child and adolescent psychiatrists were disproportionately affected, with 78% identifying confidentiality as a key source of ethical conflict, particularly in interactions with families. It is also observed that general practitioners described unique relational tensions in primary care, often rooted in long-term, multi-generational patient relationships[29], while COVID-19-era hospitalists faced escalating burdens tied to isolation protocols and confidentiality around infectious status[30]. Gender and experience-level differences were also noted, with female physicians and junior staff more likely to internalize ethical distress as personal failure[31]. These findings confirm that the moral weight of confidentiality is shaped not only by institutional policy but also by specialty, career stage, gender, and broader socio-clinical context.

There is a pronounced absence of literature addressing how different cultures or medical systems interpret and manage the moral burden of confidentiality. Most available studies are situated in U.S. or U.K. contexts and presuppose Western models of autonomy and privacy. Comparative research could illuminate whether physicians in collective societies experience and resolve this burden differently perhaps by leaning more heavily on community ethics, familial consultation, or shared decision-making norms. However, in Africa and East Asia with a communal worldview, the outcome of might be different. The culture and tradition of Africa and East Asia would ordinarily make physicians to tilt towards familial consideration since that aspects of its worldview are highly priced above the individuality that is common in the West. This goes to suggest that even the physician, though trained in Western medicine is a cultural individual who is defined by his affinity to the community. In as much as this gap is very important to fill, this study is content focusing for now on commencing the discussion with the hope that a comparative-ethical reflection will be taken a step further subsequently by the same authors or other author(s).

Hippocratic Oath and the Concept of Duty

One of the implications of the Hippocratic Oath is grounded in an unwavering sense of duty to patients, to the profession, and to moral integrity. The physician is not simply a clinical actor but a custodian of a sacred moral tradition. This ethos of duty, while noble, can impose a form of ethical absolutism that becomes burdensome in morally pluralistic and emotionally complex clinical environments. The Oath has always stressed fidelity to care and silence such as "I will apply dietetic measures for the benefit of the sick according to my ability and judgment... I will keep to myself whatever I see or hear in the lives of my patients," reads the

traditional version[32]. The formulation fuses care and restraint while linking healing to discretion, obligation to secrecy. This creates an ethical structure in which silence is not optional but constitutive of moral identity

However, critics have noted that the Hippocratic vision of duty lacks sufficient flexibility. It has been argued that "the Oath has functioned less as a navigational tool than as a moral boundary fixing the physician within a static conception of virtue"[33]. In practice, this means that duty, rather than being relationally adaptive, becomes unyielding. Physicians then must adhere to fixed expectations, even when those expectations conflict with the values of justice or relational care. This rigidity can also alienate the physician from contemporary ethical demands.

Despite these criticisms, the enduring nature of the Oath lies in how it embeds duty within a deeper conception of moral identity. The act of oath-taking, therefore, is not symbolic alone as it constitutes a moral performance that fuses duty with professional selfhood. However, such internalized duty can lead to moral rigidity. When silence is interpreted as a sacred command, any deviation becomes ethically suspect. This mindset often prevents physicians from adapting their sense of duty to the nuanced relational ethics of the modern clinical encounter. It prescribes allegiance to patients, but not always to truth, justice, or collective wellbeing. This restricted moral scope becomes particularly problematic in dilemmas involving patient confidentiality and relational harm. When physicians discover information such as a heritable disease, mental illness, or infectious risk that could impact others but is legally protected under confidentiality, their Hippocratic duty to remain silent becomes morally entangling. The physician's internal conflict is not merely about following the law but about the nature of duty itself. It is remarked that, "The Hippocratic physician is trained to prioritize patient will above all else but, in some situations, that hierarchy becomes ethically incoherent"[34].

In contemporary reformulations, some attempts have been made to expand this conception of duty. It is proposed that medical oaths should be revised to include virtues like humility, compassion, and justice, in addition to the traditional principles of fidelity and nonmaleficence. They argue that "such an expansion enables physicians to adapt duty to the ethical complexity of clinical life"[35]. This would transform duty from a static role into a responsive ethic—one that is resilient under strain and sensitive to context. The idea that duty is a relational concept, not a solitary burden requires ethical responsibility and judgment, not just obedience. The moral maturity of the physician lies not in compliance but in interpretive wisdom.

Despite this, the professional culture of medicine still often promotes a rigid, oath-based conception of moral obligation. This sacrificial ethos reinforces emotional suppression and ethical isolation, especially in confidentiality dilemmas where the physician must endure the moral burden of silence alone. Duty therefore must be dialogical and pluralistic not imposed but co-constructed between physician, patient, family, and society. Even defenders of the Oath acknowledge that its concept of duty must evolve. It has been averred that while "the Oath protects patients against capricious or self-serving physicians," it fails to protect physicians from ethical overload or moral distress[36]. Arising from this, duty must include a reflexive component an awareness of the physician's limits and the moral price of their silence.

Confidentiality and the Challenge of Beneficence

The duty of physicians to keep patient's health information confidential has long been regarded as an essential ethical doctrine. However, in the context of contemporary medical ethics, the tension between confidentiality and the duty of beneficence, especially when non-disclosure affects the patients' relatives is one of the most entrenched and ethically vexing problems. At the heart of this dilemma is the moral question: Does the doctor's duty to protect patient secrets take precedence over their duty to prevent foreseeable harm to third parties? In clinical practice, the ethical principle of beneficence calls on a concern to transcend simply acting in the best interests of the patient; it is often evaluated through an understanding of the relational dynamic at play since the circumstances of the patient have the potential to impact other members of the family.

It is summarised fundamentally that, "Confidentiality, as habitually conceived, is vertical between physician and patient. But beneficence is horizontal extending to those linked through care, genes, or dependency"[37]. Therefore, the ethical challenge is not to keep it secret but to decide whether such confidentiality would represent a harmful

omission. An important area of contention has to do with genetic information. A common scenario is described where a medical professional knows of an inherited condition but is constrained because the patient refuses to notify relatives who would be affected. He believes that "the doctor's obligation to the patient cannot ethically supersede the possible good of disclosure to relatives whose welfare may be at risk"[38]. However, legal requirements often place greater value on confidentiality even where such discretion is of substantial risk than results described as "an institutionalized moral blind spot"[39].

In this case, the doctor faces not only such legal restraints but also ethical discomfort, especially when the lines between individual and collective well-being become blurred. Research among psychiatric professionals conducted found out that close to half of the subjects reported distress upon being denied the ability to tell family members the patient's worsening state of being psychotic because of rules on confidentiality. This points at the time when the principle of beneficence, even being so valued among theoretical bioethics, is ineffective when it faces procedural barriers. This perspective is extended where it was stated that the principles of beneficence and confidentiality need to be understood in the context of relational ethics. From this perspective, the physician's role goes beyond being a guardian of confidences but a broker of risks, and this requires a moral proximity that supplements their legal obligations.

The tension between the beneficence and confidentiality principles is especially strong in mental health care. Yet, this prioritization of discretion begets increased wariness and skepticism on the part of the family members. These veiled pressures constitute an ethically tenuous circumstance in which the physician's commitment to silence is put under intense examination, despite its legal underpinning as there may be situations in which beneficence is legitimate to overcome other factors specifically where there is a predictable and avoidable risk to family members. The Relational Disclosure movement raises complicated questions about autonomy and consent. There is what is referred to as "paternalistic beneficence" which is the risk of healthcare professionals ignoring the patient's wishes to improve family welfare. There is a caution that "Without strong relational structures, disclosure can become ethically coercive"[40]. As such, beneficence should not be used to erode autonomy; it should instead be framed within negotiated ethical structures.

However, many legal frameworks continue to place individual consent at the forefront, thus limiting the ethical scope granted to medical professionals with regards to disclosure issues. The long-standing judicial doctrine has been subjected to criticism where "autonomy is essential but has been asserted at the expense of collective beneficence and pragmatic morality"[41]. Thus, the physician is left with the accommodation of conflicting moral obligations and organisational restraints. Tension is especially high in the context of genomic medicine, where the inability to provide relevant information can mean the omission of necessary preventative measures for family members. Healthcare providers maintain confidentiality not only because of ethical principles, but actually because they fear consequences from institutions. Primarily, the ethical concern is not the balance between beneficence and confidentiality but the system created to ethically handle instances where the two principles collide. It has been suggested that "tiered framework of ethical escalation," whereby healthcare providers evaluate the severity of harm likely to result, the closeness of the individuals involved, and the strength of patient refusal. He posits that "confidentiality must bow but not break under the burden of beneficence"[42]. This is an applicable ethical model that neither romanticizes secrecy nor downplays the need for disclosure.

The Moral Dilemma and Burden of Physicians

For a scholar, "suffering is defined as the state of severe distress associated with events that threatens the intactness of the person...it refers to serious pain and sorrow, unpleasant states of affairs for sentient beings"[43]. From this background, medical confidentiality, though ethically indispensable, often forces physicians into emotional conflict and morally complex positions. While preserving patient privacy, physicians may experience an unacknowledged but profound internal struggle which is a moral burden borne out of knowing critical, sometimes life-altering information that cannot be ethically disclosed. This internal damage is best described by the concept of moral injury akin to suffering defined as "a deep emotional wound resulting from betrayal of one's moral beliefs in high-stakes settings"[44]. In the context of confidentiality, moral injury can arise

when physicians must suppress ethical instincts such as alerting at-risk relatives to fulfil legal or institutional mandates. Such enforced silence is not value-neutral; it becomes a psychological fracture in the physician's ethical world

A compelling empirical foundation for this claim is offered demonstrating that moral injury among physicians is often triggered by situations where institutional codes override clinical judgement thus: "When ethical and legal codes diverge, physicians experience isolation, guilt, and moral rupture," it is concluded[45]. The dilemma is thus not solely legal or professional; it is existential. The physician is left asking: Did I do the right thing by staying silent? This dilemma is not purely theoretical. As there are identified scenarios in which "doctors should honour confidentiality even in cases where disclosure might prevent suffering"[46]. Kipnis suggest that its moral sanctity sometimes blinds clinicians to equally pressing duties of care. The result is a physician who follows the rules but feels morally implicated in the outcomes of silence

It has been argued that this moral discomfort is compounded in emergency medicine, where time-sensitive decisions intersect with incomplete information and institutional restrictions. "Physicians in such settings encounter moral injury not as an event but as a cumulative toll each suppressed disclosure, each silence adds to the emotional burden"[47]. In this view, the dilemma is both acute and chronic, destabilizing the physician's ethical equilibrium over time. Silence, in this context, is neither passive nor peaceful. In the philosophical treatment of confidentiality, it is asserted that "physician-patient confidentiality laws should be understood to impose potentially unwanted secrecy onto physicians, who bear burdens of silence often unrecognized in ethical discourse"[48]. The physician becomes a silent bearer of knowledge, forced into emotional concealment not just from patients' families but also from colleagues and communities.

In a phenomenological study of physicians facing end-of-life dilemmas, this ethical entrapment is captured with clarity thus: "Physicians expressed feeling trapped, morally torn, and isolated when ethical constraints required silence where they wished to act"[49]. Their narratives reveal the lived reality behind abstract ethical rules, one marked by tension, ambivalence, and a gnawing sense of complicity. In their study of nurses, A similar report is also noted of emotional burdens when healthcare providers remain silent due to institutional policies, "Emotional exhaustion and moral conflict are exacerbated when silence serves the institution more than the patient,"[50]. Although directed at nurses, this insight is equally applicable to physicians navigating confidentiality particularly in hierarchical healthcare systems where ethical detail is often subordinated to legal simplicity.

Findings

This section presents the findings from a qualitative phenomenological analysis of secondary narrative literature reflecting physicians' lived experiences with medical confidentiality. It draws from published reflective essays, interview-based studies, and phenomenologically grounded field research. This study sought to explore how physicians interpret and emotionally navigate the moral burden of confidentiality particularly in situations where their ethical instincts, the Hippocratic Oath, and institutional policies collide.

Results: Physicians' Experience of the Hippocratic Oath in Practice

The Hippocratic Oath, though regarded as a timeless ethical compass for physicians is often experienced not as a source of moral clarity but as a point of internal conflict. Through thematic analysis of indirect qualitative data, three fundamental themes emerged related to the tension between oath-based commitments and practical ethical demands:

1. **"Oath vs. Outcome": Conflicting Allegiances"**
   Physicians reported instances where adherence to the Hippocratic principle of confidentiality was in direct tension with perceived duties to families or the public. One clinician described: "I held back a diagnosis that had clear genetic risks to siblings. I did it because I took an oath. But I left the room thinking, 'What if something happens to them now?"[51]. These tensions produced anxiety, with physicians expressing emotional conflict between abstract ethical duties and immediate human consequences.
2. **"Silence as Loyalty, Silence as Loss"**
   Many physicians reframed their silence as an act of moral fidelity, not betrayal. One respondent "To stay silent wasn't weakness. It was the

hardest part of my job. I was honoring trust, but that trust came at the cost of my peace"[52]. This illustrates that the Oath was not merely a code but a living contract, felt and internalized.

3. **"Oath Fatigue": The Emotional Cost of Ethical Rigidity**
   Repeated emotional suppression in the name of confidentiality resulted in cumulative strain. Physicians described a phenomenon akin to "ethical weariness": "Every time I followed the rule and ignored my gut, I felt a little more distant from the work. The oath began to feel like a wall, not a guide"[53]. Here, the Oath's ethical absolutism is recast as a barrier to contextual moral reasoning.

Method of Thematic Analysis

The data consisted of secondary qualitative sources of 25 reflective physician narratives, interview-based academic papers, and ethics-focused memoirs. These were analyzed using interpretative phenomenological analysis[54] and[55] hermeneutic phenomenology. The steps included:

- Reading and annotation of physician-authored essays and interview transcripts to identify emotionally charged descriptions related to confidentiality.
- Initial coding of recurring phrases (e.g., "felt silenced," "couldn't tell them," "ethically wrong, legally right")
- Clustering of similar experiences into theme sets (e.g., "moral dissonance," "protective silence," "institutional abandonment")
- Imaginative variation to compare how themes played out across specialties (oncology, psychiatry, primary care) and settings (US, Scandinavia, COVID-era contexts).
- Theme saturation was achieved after 22 full narratives, with 3 additional sources used for triangulation. All quotes are cited from primary narrative sources or reflective interviews that were part of peer-reviewed studies.

Thematic Findings with Participant Narratives

Each theme presented here integrates participant voices and the analytical logic used to interpret them.

Theme 1: Silence as Ethical Burden: Across multiple sources, physicians expressed how confidentiality restricted moral agency. One psychiatry resident shared that: "They were crying, asking me what was wrong with their son. And I said nothing. That night, I cried too."[56] This quote typifies how silence creates ethical residue and emotional weight. The feeling of helplessness was a common emotional signature.

Theme 2: Ethical Dissonance: Ethical dissonance refers to a cognitive-emotional split between what one must do professionally and what one feels is morally right. One physician noted: "I didn't break any rule. But I felt like I failed everyone involved"[57]. This cognitive-emotional gap leads to distress not from wrongdoing, but from enforced inaction.

Theme 3: Moral Reframing: While some physicians experienced trauma, others reframed their moral struggle as a form of ethical witness. A senior internist wrote that: "If it hurts, it means I still care. Silence doesn't make me less human; it reminds me that this job is a calling"[58]. This form of ethical resilience was more common among experienced clinicians and those in institutions offering reflective practice.

Theme 4: Institutional Failure and Ethical Isolation: Physicians often felt that institutions enforced confidentiality rigidly without ethical distinction. It is stated that: "There was no room to explain context—just follow the rule. And if it breaks you, that's your burden to carry"[59]. Such sentiments portray a healthcare system where individual ethics are unsupported, even when rule-following causes harm.

Discussion

The findings reaffirm the view that confidentiality, though ethically foundational, is emotionally and morally burdensome when applied inflexibly. Physicians do not struggle with confidentiality as a principle but with its implementation without interpretive discretion. The Hippocratic Oath plays a dual role which is providing ethical stability yet, can become a moral constraint in diverse situations. Physicians across contexts expressed the need for relational ethics frameworks that allow for interpretive conversation around disclosure, rather than binary decisions.

Confidentiality dilemmas were more intense in

specialties like psychiatry, palliative care, and genetics where family dynamics and potential third-party risks often intersect with private patient data. Institutional cultures also shaped physician experience. For instance, Scandinavian physicians reported more collaborative disclosure systems and lower distress[60], while U.S. physicians reported isolation and fear of litigation. Also, the emotional residue left by enforced silence especially when harm is foreseeable creates long-term psychological costs, including moral injury, disengagement, and burnout. These findings underscore the urgent need for institutional ethics support, context-sensitive confidentiality protocols, and ethics education that includes ambiguity tolerance and emotional literacy.

Conclusion

This study has revealed that physicians experience the duty of confidentiality not merely as an ethical requirement, but as a lived and emotionally consequential experience. The tension between preserving patient secrecy and responding to perceived duties toward families or communities' results in what can be described as moral weight which is a sustained sense of responsibility, ethical discomfort, and, in some cases, psychological fatigue. While the Hippocratic Oath and related legal codes border confidentiality as a clear duty, this research found that its application often places clinicians in ethically ambiguous and emotionally isolating situations. Physicians do not merely follow rules as they negotiate, interpret, and sometimes suffer under them. The findings confirmed that moral distress, ethical isolation, and emotional residue were common themes, and that variation in institutional culture, access to ethical support, and clinician experience all shaped how this burden was experienced.

Given these findings, it is clear that confidentiality must be operationalized not only as a legal and ethical principle but as a relational and emotionally charged encounter. The moral terrain physicians navigate requires support structures, reflective training, and institutional flexibility. However, implementation of reform is not without challenge. Legal codes remain rigid, malpractice concerns shape disclosure behavior, and educational systems still emphasize principle-based ethics over reflective and relational competence.

Recommendations

The following recommendations propose not only what must change, but how such changes might be realized through cautious, context-sensitive strategies.

1. Develop Targeted Confidentiality-Ethics Consult Services: Institutions should implement ethics consult units specifically trained in confidentiality-related moral dilemmas. These consults would provide physicians with structured opportunities to discuss ethically ambiguous decisions such as whether to inform at-risk family members or manage psychiatric disclosures. Model programs like the Cleveland Clinic's Center for Bioethics and New York-Presbyterian's Ethics Consultation Service have demonstrated how time-sensitive, ethically literate consults improve moral confidence and reduce physician isolation. These services should include rapid-response mechanisms, interprofessional panels, and optional post-case debriefing to process moral residue. Confidentiality cases, unlike general ethics questions, often require relational sensitivity and emotional support that standard ethics committees may not offer.

2. Embed Relational Ethics in Curricula with Specific Competency Outcomes: Medical training must equip students with more than knowledge of ethical codes so they can cultivate ethical reasoning in emotionally and relationally complex situations. Curricula should include: Case-based discussions involving family-centered confidentiality dilemmas, simulations involving real-time disclosure choices and communication and reflective writing assignments on moments of moral doubt or conflict. Also, peer ethical dialogues modelled on Balint groups or narrative medicine rounds will be helpful too. Major competencies should include: ethical ambiguity tolerance, dialogical reasoning, compassionate communication, and contextual risk assessment. These skills are essential to relational ethics, which views the physician not as a neutral actor but as a moral participant embedded in a web of obligations.

3. Normalize Ethical Debriefings Post-Decision

Hospitals should make ethics debriefings standard practice after ethically complex confidentiality cases. These sessions can be brief but structured,

allowing clinicians to reflect on their choices, clarify doubts, and reduce emotional residue. Evidence from[61] and[62] suggests that physicians who reflect on moral challenges in community are less likely to experience long-term distress. Debriefings also support institutional learning, revealing recurring dilemmas that may warrant policy review. Debriefings is feasible can be led by trained facilitators or ethics fellows, held weekly or post-incident, and documented without legal risk if framed as quality improvement rather than peer review.

4. Create Discretionary Disclosure Pathways within Legal Safeguards: Institutions and legal frameworks should adopt structured discretionary pathways for ethically justified breaches of confidentiality especially in genetic, psychiatric, or communicable disease contexts. It has been proposed by[63] and[64] models for conditional disclosure, involving: Risk severity assessment Documentation of patient refusal to disclose. Independent ethics consultation and legal counsel involvement when necessary. While absolute confidentiality is the legal default, systems must recognize that patient-centered ethics sometimes require sharing information to prevent foreseeable harm. Carefully regulated exceptions can allow for compassionate and defensible disclosure.

5. Include Physician Wellbeing in Ethical Policy Formation: Ethics policy must explicitly address the moral burden placed on clinicians as rules that ignore the emotional cost of silence contribute to burnout, disengagement, and ethical erosion.

Physician wellbeing should be included in institutional ethical frameworks through: Recognition of moral distress as an occupational hazard, embedded support resources for high-burden roles (e.g., genetics, psychiatry) and inclusion of clinicians in the development of confidentiality policies It has been argued that, ethical frameworks must "center the moral experience of the practitioner, not only the rights of the patient."[65]. A more humane ethics is one that sees both parties, the speaker and the silenced as ethically relevant.

This study has shown that physicians carry the moral burden of confidentiality as an emotional reality, not a theoretical abstraction. If confidentiality is to remain a cornerstone of medical ethics, it must be supported by frameworks that respect the complexity of lived ethical life. To that end, ethics in medicine must evolve from rigid rulebooks to reflective ecosystems; from compliance-focused codes to dialogical engagement; and from isolated moral decision-making to shared ethical stewardship. The recommendations offered are neither exhaustive nor universally prescriptive, but they outline pathways for reform that are both empirically grounded and ethically urgent. Implementing these will require not only institutional will, but a renewed commitment to the human realities of ethical practice.

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