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Communication Privacy Management Theory in the Context of the COVID-19 Pandemic: Case Studies from the Philippines

EDNA T. BERNABE*
DIVINA T. PASUMBAL
MAMERTO S. BERNABE JR.
LEIA REYNA T. PASUMBAL
Polytechnic University of the Philippines

ABSTRACT

Information management during the COVID-19 pandemic ranges from personal to institutional level of agencies. This was highly observable at the onset of the national health emergency in the Philippines when most Filipinos who had symptoms did not know what to do. They, as well as their relatives, were in a fearful situation, and so were the government and private agencies involved in health care services. When in need of medical attention, will they tell the truth about their travel history or their exposure to anyone who is infected? The researchers studied the turbulence that occurred when mutually held rules by a community were breached by its members through concealment and gatekeeping during national health emergencies. The study elucidates how the management of private information prevents boundary turbulence and maintains personal relationships, but results in uncontrolled social turbulence during the pandemic. Applicability of the system and principles of Communication Privacy Management Theory such as privacy ownership, privacy control, privacy turbulence, and information stakeholders were studied qualitatively through data generated from nine participants of varying points of view - a) patients and/or relatives who managed their private information; and b) patients, their relatives, and health workers such as doctors, nurses, and medical staff who were adversely affected by such management of private information.

Keywords: *COVID-19, communication, privacy, ownership, control.*

INTRODUCTION

Communication Privacy Management (CPM) Theory by Sandra Petronio indicates 42 years of theory testing and development. A brief status report on CPM discusses its application in varying communication contexts which includes family communication focusing on parental privacy invasions, social media, health, and relational issues (Petronio, 2013). It also projects the varying utilization and weaving of the theory's concepts such as privacy boundaries, privacy rule regulation, and privacy turbulence, as well as the future of CPM, emphasizing "the fluidity in what constitutes the meaning of private information", that the "conditions of private information can change across ownership of information, life span, the simplicity, complexity or confidentiality of information, and more" (Petronio & Child, 2019).

The Theory

"People believe they own and have a right to control their private information" (Petronio & Durham, 2015). Petronio presupposes that information is owned solely by the one who has control over it. To illustrate, a person may choose to keep the information to himself to prevent possible intrusion from gossip and eavesdropping.

*Corresponding author: bernabe.niniedna@gmail.com
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The theorist also purports that "…the more eager people are to take on the role of the confidant, the less control they have over what they hear" (Emory et al., 2019). The confidant becomes liable for whatever information it has received and therefore must be careful in handling that information.

Retelling or sharing information with another person means making that next person a co-owner of the information. This co-ownership lays the foundation for the next principle, an agreement on privacy rules and control of this privacy (Petronio & Child, 2019). Deciding to tell someone means making that person co-owner of the information (Petronio & Child, 2019). Part of being such is agreeing on shared privacy rules, although that would not always be set in stone. Thus, once the rules are breached, turbulence occurs.

CPM and COVID-19

The Philippines has a constitutional provision on disclosure of health conditions in Section 9(e) of Republic Act 11332 (UP College of Law, 2020). However, this provision is more often being neglected and violated specifically during the time of the pandemic. Narrated incidents revealed that patients who withheld information about foreign travel for assurance of hospital admission have caused infection and even death of health workers.

One such case is that of Dr. Israel Bactol who died of coronavirus because "he had a patient who lied about travel history" (Romero & Cayabyab, 2020), and had come to the hospital with a cough and fever and lied along with the family members when asked about travel history. This claim was supported by a statement of Department of Health (DOH) Spokesperson Maria Rosario Vergeire who said some doctors died because "their patients were not able to disclose their full information, thereby giving them increased risk that's why they got infected and eventually died" (Romero & Cayabyab, 2020). The unnecessary concealment of information as an option for the management of private information resulted in unwanted turbulence beyond familial situations amid the COVID-19 pandemic.

CPM posits that turbulence occurs between co-owners of private information involved in interpersonal relationships and studies employing the theory were limited to personal or familial relationships. Extending the theory's applicability from personal concerns of information management to greater public concerns in the context of the COVID-19 pandemic is novel. This study investigated the turbulence that occurred when mutually held privacy laws being invoked by citizens were breached during national health emergencies. Thus the question: "Will the principles of CPM remain valid in the context of the COVID-19 Pandemic?"

LITERATURE REVIEW OR RESEARCH BACKGROUND

The literature focused on the application of CPM concepts and principles about health concerns as well as recent studies on COVID-19 involving information and communication privacy.

Applications of CPM Concepts and Principles

Petronio considered CPM a practical theory because it aims to solve everyday problems and is easy to apply (Petronio, 2004, Petronio & Child, 2019). In recent years, the most explored concepts were disclosure and concealment. Hall (2017), examined women's fibromyalgia disclosure in the workplace while Mueller (2019), compared self-disclosure and disclosures of co-owned private relationship information in the workplace focusing on comfort, frequency, and motivations for disclosing. Camacho, Reinka, and Quinn (2019) on the other hand,

examined disclosure and concealment in people with concealable stigmatized identities and faced the dilemma of deciding whether, when, and to whom to disclose stigmatized identities. Related to this is an analysis of disclosure and concealment as two contrasting motives and behaviors theorizing that perplexing, seemingly self-destructive disclosure behavior can go hand in hand with the simultaneous activation of the desires to reveal and conceal (John et al., 2019).

Boundary turbulence was also examined from different knowledge-generating lenses in an interpersonal level of interactions. In 2015, studies established that message clarity was a preferred strategy in dealing with boundary breaches concerning private and sensitive information, whether in the form of truth-telling or sheer falsification (Bello et al., 2016). McLaren and Steuber (2013) used CPM as a guide in examining how people's emotions and communicative responses to boundary turbulence correspond to relational outcomes. Moreover, it was considered important in the recalibration process after a privacy violation situation. Mc Lauren and Steuber (2015) in another study have found that people in confrontation after the privacy turbulence have been more forgiving and are open to conversation, thus, bordering on a relational improvement than that of relational damage (2015).

Pandemic and Privacy Management

A study in 2011 (El Emam et al., 2011) revealed that as early as the 1990s, privacy management by medical professionals had always been a decision-making problem on whether to disclose patient information or not, even if a notifiable disease reporting was mandated. An example was the H1N1 influenza outbreak in 2009 where physicians were not willing to share data with public health units because of trust issues and protection of their patients' health information.

On health privacy and its preservation, an assessment of disease exposure risk with location looked into the worldwide implementation of digital contact tracing solutions through the use of GPS location histories which were transformed and encrypted (Berke et al., 2020).

With the observation that the pandemic poses problems for the healthcare system, another study by Lenert and McSwain (2020) was aimed at balancing health privacy and information exchange in the context of COVID-19. Similar investigations on privacy management include one on consumer privacy during and after the COVID-19 pandemic; (Brough & Martin, 2020), and another on the responsible use of digital data to tackle the same issue (LInca & Vayena, 2020). Research by Blose et al. (2020) tracked the incidence of self-disclosure on Twitter datasets about COVID-19 from March to April 2020.

Given the foregoing, this study claims to be one of the first to explore the applicability of CPM principles at the time of COVID-19 from a perspective that radically extends its application from solving everyday life problems to societal, once-in-a-lifetime global problems.

METHODOLOGY

The study aimed to describe the applicability of the principles of Communication Privacy Management Theory in the context of the COVID-19 Pandemic. A collective case study by Creswell (2013) was used as a research methodological tradition.

Participants who were selected through snowball sampling and crowdsourcing were categorized into: 1) patients/relatives who chose to conceal information on travel history or exposure to someone infected; and 2) individuals who had first-hand experience of an incident of private communication management. Another category of participants was not carried out because of circumstances that were beyond the researchers' control. Crowdsourcing became useful in "obtaining geographically and demographically diverse groups of participants in a short time frame" (Edgar et al., 2016). Snowball sampling followed, where participants were generated through referrals of previously identified participants (Tracy, 2013). Since it was a pandemic, snowball sampling became useful as it helped the researchers locate participants who hid themselves and did not want to be interviewed. This method relied on referrals from initially sampled respondents to other persons believed to have the characteristic of interest (Johnson, 2014).

Qualitative data were generated through online interviews and online written responses. A semi-structured interview guide (Mcintosh & Morse, 2015) was conducted to ensure smooth expression of thoughts and insights on their privacy management experiences relative to COVID-19. Participants were assured strict confidentiality and anonymity and consent forms were also accomplished.

RESULTS AND DISCUSSION

The interviews went through verbally and in writing, whichever was available and preferred by the participants. They were asked the same open-ended questions and were free to choose which questions to answer and how. The following questions or issues are addressed in Table 1.

Table 1: Questions and issues directed towards the participants

Principle	Questions and Issues
Ownership of Information and Right to Information	Why do patients lie about their COVID-19 circumstances and efforts to know these reasons? Outcomes of lying about COVID-19-related circumstances Concurrence on the withholding of COVID-19 patient information and why? Who owns the information about COVID-19 test results and why? Who owns the daily COVID-19 data and why?
Privacy Control and Privacy Rules	Why do patients withhold information about their COVID-19 circumstances or information? Reaction upon discovering that someone lied about COVID-19 information or circumstance Opinion and reason about disclosing travel history or possible exposure Who should know the following information and why? Details of who should undergo COVID-19 testing, daily details about COVID-19, and any other related issues
Co-ownership of information	What obligation or responsibility does a receiver of COVID-19 patient information have?
Negotiation of agreeable privacy rules	To whom should a COVID-19 patient confide about information and why?
Turbulence	Consequences of a Patient Withholding COVID-19 Information The personal impact of current government management of COVID-19 information

Case Profiles

Participants came from Quezon City and Lucban Province, with ages ranging from 23 to 48 years, with a male-female ratio of 2:7. Consent was documented in writing, audio, or video. All asked for anonymity.

a. Case 1

39 years old, female from Quezon City, and a Category 3 participant. She worked as an information officer. During the pandemic, she was scheduled for surgery after a very long waitlist that took years. On the day of the surgery, the procedure was canceled due to stringent health protocols, which were breached by a patient, who was publicly blamed for the eventual spread of COVID-19 and the death of one person.

During the early stages of the COVID-19 pandemic, hospitals did not have all the information to address the public health problem. As the identified Patient 37 had kept relevant details of travel in her clinical history, she also failed to trigger judicious measures to prevent her communicable and deadly disease. Her doctor got sick. A chain of infection began to cascade among health workers and other contacts. When she was discovered and others got sick, the hospital disinfected its premises, canceled all its services, eventually locked down, and had all its employees tested. The procedure was necessary to protect its mostly immunocompromised patients and vulnerable stakeholders.

At this consent, the participant was in that hospital with her husband, and due for surgery on that day. The canceled procedure would have sent them home right away, but pandemic protocol at that time required their quarantine and testing. Her children were left alone at their home for some time.

She believes that patients would lie about their COVID-19 condition due to fear. Fear of the unknown, uncertainty and stigma are considered possible as the patient in consideration might have thought of misgivings from the widespread ignorance and management of COVID-19, discomfort with the uncertainty of care, and dislike of isolation from family, kin, and community.

She considered that the lie of patient 37 resulted in the paralysis of hospital services, shelving of plans, compromise of physical and psychological health of people, and anxieties in the family. She maintained that she understood the patient and admitted having the same fear.

However, she did not agree that patient 37 was correct or defensible in lying because other patients got affected, like the indefinite cancellation of her needed surgery. If placed in the same situation, she would not lie, because that would put others in difficult circumstances, compromise her family and others in the community, and her health condition would not be addressed properly. In her words, “There will be a domino effect. With one lie, a lot of people die”.

For her, the Department of Health (DOH) and health facilities, the community, and the Barangay Health Emergency Response Team own the information about COVID-19 data because key people in the community should know. She noted that guidelines in the local government units were available but have not been seriously acted upon.

She cited the conflicting views between the Philippine Department of Health Undersecretary Vergere and the tourism authority. The former said there was no local transmission, thus no reason to worry, while the latter mentioned, *“Kawawa ang tourism*

industry" (The tourism industry is pitiful). People will lose their livelihoods if tourism is paralyzed.

She also thought that information was not available due to the unknown. Her reactions to the concealment included fear due to the unknown extent of the spread of the disease, and fear because of the depleting funds for COVID-19.

The desperation in her voice marked her sarcasm as she absolved the concealer of information from obligation or responsibility, while the entire system of Philippine health care collapsed. She still pitied the patient who lied because she died, because she felt that her needs were more important than the responsibility to tell others. Meanwhile, she felt the urge to tell others because of that. She felt the obligation to tell and warn the people.

She said the patient should have told the truth to the healthcare professionals, but at the time she was adamant and even colluded with her companion to lie and reveal the story only after her death and this companion turned out to be infected, too.

b. Case 2

Another 39-year-old female from Quezon City, also an information officer, was interviewed live on Zoom. Her story started in a breakout session with a public official, who was later quarantined due to exposure to a resource person in the Senate. She felt anxiety for her family and her immunocompromised father. She worried about the requirement of hospitalization if found positive, and agonized while waiting for the result of her test. She said the public official turned out to be negative, but she nevertheless stayed at home because the Enhanced Community Quarantine (ECQ)was enforced in Metro Manila.

She also told the story about their purok leader (community leader), who worked as a driver at a funeral home. This neighbor was asymptomatic as well as his family, but five in their household tested positive for COVID-19. The second respondent thought that the purok leader lied because he feared that his Local Government Unit position would be taken away from him. Because he lied about his COVID-19 result, two other neighbors died, and their children got infected. She considered this lack of leadership. She did not agree that the purok leader had the right to withhold information. She felt that if the person knew he was positive but asymptomatic, then he should have been more responsible.

She believes the people own the information, especially about COVID-19. *"Kasi doon lang naman tayo makakagawa ng informed decision, kung alam natin yung mga totoong nangyayari. 'Yung walang tinatago sa atin, 'yung hindi nila finilter yung gusto nilang ipaalam sa atin, kasi ang hirap po 'yung hindi mo alam 'yung lahat ng bagay, baka magkamali ka sa mga gagawin mong desisyon"* [Because that is the only way we can make an informed decision, if we know what is happening. When they (government) don't hide anything, when they don't filter information, then the difficulty of not knowing a lot of things may prevent you from making a wrong decision]. "Those things that can affect Filipinos should be known to all." She attributed wrong decisions as emanating from a sense of false security.

Regarding privacy rules and controls, she was frustrated feeling toyed around by information and courses of action. She felt that the gatekeepers of information assumed that every Filipino was ignorant and would accept everything they said. "Our audience includes the youth, and information officers of various government agencies in the whole country, then you feed them this garbage?"

For her, the purok leader acted without any obligation. This would not be true for her. She ranted that she would not mind if the leader was COVID-positive but harmless, however, he had an obligation to the community. She noticed that there are many COVID-19 cases in her community including the elderly and the vulnerable. Most of them were asymptomatic, and they were lucky. But "What if they infect others who were not as lucky?"

c. Case 3

Case 3 participant was a public health nurse and a diseased surveillance officer. She met a COVID-19-positive patient, who denied her status until her child needed to be checked for admission a few days later. She rationalized that the mother feared discrimination and lying is a maternal instinct. She said the mother might have feared the community reaction and discrimination towards her child - she did not want gossip to circulate about them, friends to avoid them, and her family to suffer from stigma. She added the mother would justify that it was a maternal instinct to protect the child.

The information initially withheld by the mother caused fear that she might have spread the disease to other contacts. With this situation, the barangay (a small territorial and administrative district where the participants reside) statistics would be jeopardized. Nevertheless, she understood the patient as a mother, even though this conflicted with her work.

In her opinion, the proper gatekeepers of information were the Rural Health Units (RHUs) of the municipality, the Barangay Health Response Teams (BHERTS), provincial Local Government Units, front liners, and DOH. In her experience, she must protect the privacy of her stakeholders. She was happy to say that barangay captains in her area understood this importance. She felt that it was right that such information be told to members of RHU like her.

d. Case 4

Case 4 said her daughter was COVID-19 positive. She could not believe the text message informing her of the same. She did not tell anyone initially because she was in denial. She tried to understand when her daughter lied to her, but she could only have pity.

What offended her was the laboratory result of her asymptomatic and pregnant daughter being broadcast via two-way radio by the barangay workers themselves. Neighbors started leaving their area, talking about the condition of her daughter.

She felt that whatever rules the Local Government Unit (LGU) was following violated their privacy and resulted in a stigma. She strongly felt they owned the information and that she and her daughter should be the ones to tell anyone about what happened. She plans on filing a complaint against barangay workers who did not act discreetly and did not respect their rights as owners of such private information.

e. Case 5

A 23-year-old participant from Quezon City who was pregnant claimed that she never left her home but she visited the health center when she had a cough. She was asked to have a COVID-19 test, which turned out positive. During the interview, she intimated that she was in denial. *"Kasi po, ano, eh, parang di po talaga ako naniniwala. Parang, parang yung naiisip ko po, hindi. Negative ako. Parang gano'n po. Saka natatakot din po akong malaman ng mga kapitbahay namin. Gano'n"* [Because I cannot believe it myself. I thought, no, I am negative.

Just like that. Also, I fear that my neighbors will know the situation]. In hindsight, she deemed that barangay health workers should have informed her family first when she became positive.

f. Case 6

Case No. 6 saw fear as a reason for a person's concealment of infection. Being a health worker, her reason for concealment was also the fear of risking health workers and frontline. She was initially irritated by patients who would lie about their COVID-19 circumstances, but she believed that these people needed understanding. She did not agree that those lies were necessary because other people may be harmed.

She believed that COVID-19 information should be owned by DOH and front liners, and they were the people who would be most affected and would benefit from protecting themselves and other health workers. For questions under privacy controls and rules, the participant thought that the obligations are for health workers and front-liners like her so they can protect themselves, and their families. She also believes that COVID-19 information should be given to health workers so they can give help more effectively.

She exhibited conviction in her views as to how the government handles COVID-19-related information, saying that rapid and swab testing was not publicly posted so as not to conceal the non-adherence to protocols like prioritizing the high-ranking officials, and projection of itself as being under complete control of the crisis. She saw these as causing an increase in positive COVID-19 cases.

Later, she tested positive for COVID-19 but could not be accommodated at the government hospital where she was working. Instead of going to a health facility where she was sent, she chose to stay in the boarding house with two other health workers who were also positive.

g. Case 7

A male physician working in Quezon City gave written responses to the interview. He believed that patients lie due to fear or discrimination. However, he believed that concealing such information could cause the problem to spread. This made him sad, but he could not justify such lies.

He identified healthcare workers and the people who could be exposed, to be the owners of information about COVID-19. The results of the COVID-19 test should be told to all possible contacts. His professional obligation included understanding and the ability to explain to a COVID-19 patient. All front liners and community workers who could be exposed should be told of necessary COVID-19 information.

h. Case 8

Another male physician from Quezon City chose to respond to questions in writing. Similarly, he thought that patients lied in fear of discrimination, and the patient's justification could include lack of symptoms or being asymptomatic which was another form of denial. These lies, he said, could worsen contact tracing and could cause additional anxiety to people around the patient. He also could not justify why patients would lie, but he believed that data privacy would not include information that could affect the whole population.

He believed that information about COVID-19 should be owned by the government, the DOH, and the hospital because of their healthcare responsibilities. The obligation to protect privacy would also be important, just like caring for his health. He also identified the same owners of information to be the same people to receive COVID-19 information.

i. Case 9

A female physician and owner of a private primary care facility also answered the interview in writing. She said patients lied about their COVID-19 condition because they feared they might not receive the right medical services. They also feared discrimination. They also lied due to a lack of knowledge, like believing that wearing a mask would be enough to protect other people. The patient might also unwittingly lie if he or she did not know his or her COVID-19 condition immediately.

Such lies could result in harm to doctors, nurses, and allied medical professionals who would provide care to a COVID-19 suspect. If all patients are considered potential COVID-19 positive, health costs would increase. A culture of lying among patients and suspicion among healthcare workers could lead to more telehealth consultations, which were not the best practice.

She did not agree with any justification that a patient should lie. She believed the patient's right to medical privacy should stop when public health is in danger. She added that patients should accept and submit to triage procedures and should properly fill out the COVID-19 declaration form and consent.

The doctor identified the DOH, Inter-Agency Task Force (IATF), and LGUs to own the information about the details of mass testing. She believed this information need not be publicized because it would only be relevant to chief implementers. Nevertheless, details of the daily data about COVID-19 must be shared with the public because it is the people's right. The people need to know if the Philippines was doing good or bad against COVID-19. This would help them to be vigilant and prevent them from being nonchalant about this public health dilemma.

She said it is her obligation as a doctor to report to DOH if a patient is COVID-19 positive. DOH shares this information with LGU and the LGU cascades this to the smallest LGU for contact tracing. However, she was cognizant of her duty to protect the patient's medical privacy to people who were not affected by the problem.

Further, she said that frontliners should be told of COVID-19 circumstances and information. This is more than a show of respect to healthcare workers. The healthcare system would collapse if healthcare workers go down with an illness for 14 days. COVID-19 information should also be shared to all contacts of a COVID-19 patient.

Ownership, Co-ownership, and Right to Information

The varied personal stories of the participants showed five health professionals, two information officers, an office employee, and a housewife. No one denies ownership of the information, but the information depends on the participant's degree of involvement in the issue of being infected. In the context of the pandemic, the information officers and health workers who had first-hand experience with the sad and fearful result of concealment saw ownership as those of the community and other stakeholders and those who were affected by another person's lying. This is contrary to the point of view of the COVID-19 positive patient who concealed her condition from her mother and was also threatened with contracting the

virus because of exposure. In the context of CPM, they were managing the private information that they alone own, not the barangay or the government health workers.

Participants were against withholding relevant, helpful information. They cited fear and implied or directly stated isolation, discrimination, and/or stigma as the primary modifiers of behavior (Mental Health Foundation, 2021; Sheehan, 2015; Camacho et al., 2020). A participant mention the fear of expense or denial of perceived necessary medical attention.

Everyone believed that lying or withholding vital information about their COVID-19 status or circumstance would have an untoward consequence on the personal, family, kin, community, institutional, and national levels. The lying or malingering person might not receive appropriate care. The infection may spread to family, kin, or neighbors. Hospitals or healthcare facilities may lock or shut down. The nation might not get over this pandemic, and the healthcare system might collapse.

No one would concur or justify enough the withholding of COVID-19 patient information. Nevertheless, understanding ranged from the recognition of denial to affective transference. Patients in the acute phase of the disease would expect to be in denial. A mother listening to another mother, who endured the seemingly no-choice scenario, felt the dilemma of valuing one's child against the welfare of others. Lying could not be justified, especially if its ill effects were known, palpable, and real, but it would always happen. People around liars would have to be protected. Universal protection, due to lies, would increase health care costs.

Participants also identified patients as owners of the information on their COVID-19 test results. Some may argue that the buyer owns the product bought, and a Philippine government agency even supported the patients to be more careful in verifying the validity of their test results (Research Institute for Tropical Medicine, 2021). If test results were free from the government, or the government was paying for the tests, arguably the government would own the results and the consequent information. Consent for this was implied when the public would submit to the free tests (Content Team, 2016). At best, the patients would be co-owners of the test results and information with the government. Private practitioners in litigious countries, which had sweeping laws about privacy, would be uncomfortable. Specific laws to remedy this for certain diseases, like AIDS/HIV positive (acquired immunodeficiency syndrome, human immunodeficiency virus-positive), were passed to protect privacy and prevent stigma and discrimination. No such law has been discussed and passed in the Philippine law-making bodies yet.

Moreover, participants said the public would own the daily COVID-19 data because the people deserve to know, be informed, act responsibly with vigilance, and avoid complacency or nonchalance. One said that the government owns these data and the public does not need information that is best used by authorities for its strategic management (IPM, n.d.; Osborn, 2018). The front liners in the roster of interviewees disclosed their obligation to protect medical privacy, but also the legal requirement to report their data to concerned government agencies.

Privacy control and Privacy rules

Patients control their privacy by withholding information. Medical information privacy is a basic tenet in medical ethics. Patients withhold information (McCarthy, 2014; Hlavinka, 2018; Crist, 2018), to protect themselves (Health Day News, 2018), career, livelihood, business, or

corporate strategy (Nogrady, 2019), political power (Braddock III, n.d.), relatives and relationships, and self-worth. The last two were evident and recognized in the interviews. Anger and fear towards self and others were natural responses to liars and malingerers. This pandemic, however, added agony and anxiety. People would not just be angry with the liar but fear for the lives of people around the liar. The highly infectious disease and hypermedia-induced fear as theorized by Debrix in 2001 and the investigation of mediated effects of fear of COVID-19 as studied by LIn, Brostron, Griffiths, and Pakpour (2020), have one thing in common – the hypermedia environment had induced worries about waiting for the result, about seeing a positive result and about hospitalization, death, or being alone. The moral damage ranged from the personal to the interpersonal. Blaming and pointing fingers were not addressed in this paper.

Personal travel history and exposure to a COVID-19 patient was very important before widespread community transmission. No significant comment was made on this question primarily because of the non-availability of participants who would give data on such information. It could be extracted from the quasi-expert opinion of the professional participants that concerned agencies and healthcare facilities should know who should undergo COVID-19 testing, but a common theme generated by participants showed the public as major stakeholders in knowing the daily details about COVID-19.

Negotiation of Agreeable Privacy Rules

Those who answered consider that healthcare providers should receive the patient's confidence to give COVID-19 information, to provide proper care to the patient, and adequate care to prevent the spread of infection to self and others. Risk reduction would be the vocation of professionals. Also identified were relatives, family, and contact persons to be deserving of the information.

Turbulence

The known consequences of a patient withholding COVID-19-related information included improper care, inadequate health response to an undisclosed risk, unchecked spread of the disease, difficulty in contact tracing, unnecessary morbidity and mortality among contact persons including family, relatives, neighbors, and healthcare workers. Defensive and expensive healthcare services, the continuing pandemic, exhaustion of government resources, and possible collapse of the healthcare system were identified as the worst consequences.

During the interviews, there was a vague public dissatisfaction with the government's management of COVID-19 information. The University of Philippines exposed the weakness of existing data (UP COVID-19 Pandemic Response Team, 2020). Strategic management within the government became more difficult (Beltran, 2020). Public data became less comprehensible (UP COVID-19 Pandemic Response Team, 2020) for other planners and businesses. Government policies and strategies ranged from the wild, consultative, and socially democratic, to the experimental with trial and error. All of these would still be contingency management (European Centre for Disease Prevention and Control, 2020), which could be a strategy in a less informative crisis (Shaw, 2020).

CONCLUSION

COVID-19 privacy management of information, even in the paucity of these nine interviews, exposed turbulence that endangered the public, its healthcare management, and the person through stigma or death, not just an individual interest. Turbulence happened while the boundaries between wielders of information were vague, sharing was undefined, and many consequences were unclear.

People would die from the pandemic and more so if the agents of change, the healthcare people, government leaders and administrators, and other front liners were uninformed. They would need information from the patients to institute care. They would need information from the public to implement proper quarantine. Professionals need more reliable data to understand the disease and the pandemic. The complicated dilemma in the higher echelons of government would be beyond this paper.

The current lack of legislation would keep the stigma unchecked. Although not discussed by the participants, the stigma of the disease can affect social and personal lives and careers, such as HIV. Legislation could also address the lack of science in the country that brought our dependence on foreign products and ideas. The undiscussed fallibility (false positive and false negative results) of current tests had prevented improving the tests and merely enriched the early developers of fraudulent tests. Nobody questioned its development. Reliable tests were usually developed in years or decades (Kosack et al., 2017). False-positive results would increase the rate of stigma.

While medical practice had addressed the issue of malingering patients, it would benefit the public to diminish the incidence of malingering. Even though nearly impossible, malingering was drastically reduced immediately at the beginning of the Bayanihan Act (University of the Philippines Diliman, 2020). Healthcare was made free if COVID-19 was the diagnosis. It was almost short-lived when PhilHealth funds could only last about 30 days (Nonato, 2020). The government made new promises (Aurelio & Ramos, 2020), and extended the scope of the facilities (Rita, 2020).

The unabated pandemic in the Philippines reflected a conflicted message of hope and despair. The positive words from the government spoke to people either placated the unwary or inflamed the dissatisfied. Local governments tried to scramble for the right information with more tests. The local and regional political efforts would pale as travel policies remained vague and contrasting with the real purposes of lockdowns and quarantine. The crisis spreading to the countryside was a woe of contingency to reduce numbers and data in the Metropolis.

While the information was vague, Presidential Spokesperson Harry Roque admitted in one public pronouncement in June the failure of the government in the early stages (Geducos, 2020). Putting that behind now, the government could be less defensive and more forward-looking, as efforts are palpable to listen and implement a more functional society, as the measure of a truly winning public health management.

BIODATA

Dr Edna Tormon-Bernabe is a former dean at the College of Communication at the Polytechnic University of the Philippines (PUP)- College of Communication and currently an associate professor. Email: bernabe.niniedna@gmail.com

Dr. Divina T. Tormon-Pasumbal is a former PUP College of Communication dean who recently retired as an associate professor. Email: divine.pasumbal@gmail.com

Dr. Mamerto S. Bernabe Jr., is a physician and an associate professor at the PUP College of Science. Email: mamertosb@yahoo.com

Ms. Leia Reyna T. Pasumbal is a former faculty of the PUP College of Communication and now owns a start-up video company. She is also finishing her Master's degree at the Academy of Art University in San Francisco, USA. Email: leiapasumbal03@gmail.com

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