Dilemmas on confidentiality of people with mental health problems

Ouzounakis P.[1*], Dalagozi P.[2], Frantzana K.[3]

[1] University Hospital of Alexandroupoli, Greece
[2] General Hospital of G. Gennimatas, Greece
[3] Department of Nursing, Technological Education Thessaloniki, Greece

ABSTRACT

It is a general principle that when so highly sensitive and personal information is shared by the patient with the therapist should be kept secret and confidential.

In this study is given a critical discussion about the significance of confidentiality by Mental Health professionals of mental patients "medical" secrets. The justification of confidentiality is based on deontologic principles such us autonomy and trust. Two theoretical frameworks provide a justification for medical confidentiality.

First, a principle-based ethic, as set forth by Beauchamp Childress, that explores the basis of confidentiality in terms of "the normal principles it expresses" as well as "the consequences it produces."

The second one, is a case-based ethic, as discussed by Baier, which is primarily concerned with interpersonal attachments and the moral decision-making that emanates from those relation-ships.

Key words: personal information, mental health, confidentiality

***Corresponding author:**
University Hospital of Alexandroupoli
Greece
Tel. 6984046770
E-mail: peterouzounakis@ gmail.com (Ouzounakis Petros)

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INTRODUCTION

It is general principle that when so highly sensitive and personal information is shared by the patient with the therapist should be kept secret and confidential [1]. Confidentiality remains an integral, a time-honored feature within the patient – psychotherapist relationship. A patient must be willing to make a frank and a complete disclosure of facts, emotions, memories and fears [2].

Although growing intrusion into the presumably private environment of the patient-provider dyad has raised ethical and legal issues for all health professionals, but particularly for psychiatrists and mental health nurses, whose clinical work is so dependent on atmosphere of trust [3]. It is therefore, important for clinicians to clarify in their own minds the limits of confidentiality and then articulate the standard to patients in an effort to optimally facilitate the collaborative work of therapy [4].

Confidentiality is implied by the various oaths undertaken by health professionals and consequently, can only be broken by practitioners when they feel that there are ethical claims that take priority over issues of confidentiality [3].

The famous ancient Greek physician, Hippocrates, was the first to mention in his Oath that "what I may see or hear in the treatment's course or even outside in regard to men's life which no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about" [5].

The medical confidentiality was for the first time one of the subjects studied in the 3rd Congress of the Society of French Psychiatrists in Blois (1st - 6th August 1982), a small town near Paris. On basic terms, it has been mentioned that quite often the problem of confidentiality presents itself in case of mental disease and marriage. Dr. Brouardel commented that the doctor does not have the right to disclose details of patient's illness, unless he has written permission from the relatives. However, the doctor has the right to disclosure the secret when he has to defend himself against accusations by their family [6].

On June 1966, the U.S. Supreme Court ruled that relations between a patient, and his or her psychotherapist are confidential and are protected from disclosure in federal trials. Previously, only attorney-client communications and communications between husband and wife were protected as privileged in federal courts [2]. Furthermore, on March 25, 1999 the Supreme Court of Canada profoundly changed the nature of confidentiality in forensic psychiatric practice in Canada and expanded the duty of all physicians to protect public-safety [7].

Confidentiality remains one of the greatest ethical issues for all Mental Health professionals. Surely, no genuine therapy can occur unless clients trust the privacy for their revelations to their psychotherapists. Dr. Harold Eist, president of the American Psychiatric Association, said: "The therapeutic relationship is poisoned from the outset when either the doctor or the patient fears eventual disclosure of confidential communications" [2].

According to Winslade, the concept of confidentiality is integrally linked to a cluster of issues including confidence, confession, trust, reliance, respect, security, intimacy and privacy [8]. Furthermore, confidentiality can be construed in narrow or board terms; the former perspective relates to protection of communications among persons in certain special relationships (e.g. patients and caregivers), the latter to a more general right to control information about one-self [4]. Health providers can interpret the concept of confidentiality at many points along this axis, which can significantly affect the degree to which patient's medical status remains private.

In general, lines two theoretical frameworks provide a justification for medical confidentiality:

First, a principle-based ethic, as set forth by Beauchamp and Childress, explores the basis of confidentiality in terms of "the normal principles it expresses" as well as "the consequences it produces" [9]. Their consequentialist arguments begin with considerations that echo Winslade's broader theoretical discussion of a world without confidentiality in which "no information about oneself would be treated as confidential… and relationships among persons would become fragmented and superficial… precluding the possibility of certain desirable forms of human interaction" [4]. According to them, the justification of confidentiality rests on deontological principles – autonomy and fidelity – which are concerned with instrict values, not the consequences of actions.

Autonomy broadly refers to the Kantian notion of a self-legislation will, self-determined direction, in contrast to control by others. Respect for persons as autonomous agent is the accepted norm of medical practice, as patients determine whether they wish to accept treatment. Furthermore, a principle of autonomy "carries over the idea of having a domain or territory of sovereignty for the self and the right to protect it'', which is closely linked to the right of privacy [4].

Fidelity is the obligation of health providers to keep all implicit and explicit promises to promote the welfare of patients. Assuming these consequentiality and deontological principles, Beauchamp and Childress conclude that confidentiality is not an absolute condition of medical practice, but rather a prima facie obligation subject to infringement in order to meet a "strong conflicting and normal obligation" necessitated by idiosyncratic clinical circumstances.

A second theoretical framework for defining the limits of confidentiality in medical practice is a case-based ethic. This approach is rooted in concepts of trust and mutual regard [4]. An ethic of care, as discussed by Baier (1985) [10], is primarily concerned with interpersonal attachments and the moral decision-making that emanates from those relationships. He objects to theories that seek to impose a general system of principles arguing that given the diverse moral traditions characteristic of a pluralistic society, none can claim primacy. Baier also objects to rationality as the exclusive basis of an ethical theory and argues strongly that human psychology or the moral emotions play significant roles in the conduct of moral agents. It finally believes that ethical decision-making is significantly affected by the context within which it takes place and, consequently, cannot be guided exclusively by the precepts of historical, broadly drawn theory [10].

Lip service to the concept of confidentiality in the past provided unscrupulous psychiatric hospitals the opportunity to overextend lengths of stay, since exploitative inpatient hospitalization could not be remedied without family support, which confidentiality prevented [11].

In modern psychotherapy practice, ethical therapists at the commencement of psychotherapy advice their patients who privilege is not absolute that there are legally defined exceptions, and in the modern era of multidisciplinary therapy and managed health care, persons other than the primary therapist will gain knowledge concerning the patient's contact with the primary therapist. Once given such information, just as surgical patients are informed of the risks of invasive procedures, mental health patients can disclosure confidential with the knowledge that absolute confidentiality is an enigma [11].

A paradigmatic example in psychiatric practice occurs when a patient report serious suicidal ideation, a circumstance that would likely cause a consensus of mental health workers to violate confidentiality assuming benevolent paternalism; however, that decision is found in judgments by the clinicians that are – at least to some degree-subjective [8].

Another frequently used exception is "the patient-psychotherapist" privilege which occurs [12]:

- In cases in which the patient relies upon his/her or her mental health condition as an element of a claim or defense.
- After the patient's death, in any proceeding in which any party lies upon the condition, as an element of a claim or a defense.

Likewise, in criminal cases, when the defendant pleads not guilty by reason of insanity, mental state is put in issue, there by waiving any privilege.

Some jurisdictions exclude the privilege in all criminal cases opening the door to the medical records of the defendant [4].

A more debated issue in psychiatric practice concerns infringements of a patient's confidentiality in order to protect the interests of identifiable third parties, a clinical circumstance that has become increasingly common [1]. Consequently, psychiatrists are increasingly faced with a difficult moral dilemma: they must choose between preserving patients' confidentiality and an obligation of beneficence to others, both known and unknown [13].

Nowadays, another used exception is "the solicitor patient/client" privilege, which is not absolute and is limited in public safety is at risk. Three factors must be considered and weighed in determining whether a concern for public safety. These are [14]:

a) clear risk to an identifiable person or group
b) risk of serious bodily harm or death
c) imminent danger

For example, the case of Smith V. Jones, an individual who was charged with aggravated sexual assault on a prostitute. Defense counsel retained a psychiatrist to assess the accused person for the purposes of preparing a defense and assisting in sentencing. The accused was informed that the consultation with the psychiatrist was covered by solicitor-client/patient privilege. In the course of the assessment with the psychiatrist, the accused described his plan to kidnap, rape and kill prostitutes. The psychiatrist informed the defense counsel that in his opinion the accused pepresented a threat to society. The accused pleaded guilty. Upon learning that his opinion was not to be used in evidence at sentencing, the psychiatrist commenced an action for a declaration entitling him to disclose the information in the interests of public safety [14].

The dissenting position agreed that in certain circumstances solicitor-client/patient privy-lege should yield to the interest of public safety. They added, however, that it is important to forest provide a climate in which dangerous individuals are more likely to disclose their disorders, seek treatment, and pose less danger to the public. If confidence is undermined, individuals will not disclose the danger they pose and will not be identified and public safety will suffer [14].

Further the minority opinion concerned this finding limits the ability of psychiatrists to assist the courts of mental health matters, as defense attorneys, will now be reluctant to allow clients access to psychiatrists for fear that it may jeopardize their case. This may undermine the intent of mental health diversion programs. In

addition mental health Professionals should have in mind the follow [4].

1) Confidentiality and public safety

During the initial evaluation, the mental health professional should usually make clear the general limits of confidentiality. If the mental health professional/nurse has reason to suspect that the patient is engaging in behavior that posses the others in danger, the professional should notify the patient of the specific limits of confidentiality.

2) Confidentiality and notification of third parties

In situations where mental health professional has advised and has worked with the patient to terminate behavior that places other persons at risk and the patient refuses to agree or is unable to comply with this agreement, it is ethically permissible for the professional to notify an identifiable person who the physician believes is in danger.

3) Confidentiality and disclosure to third parties

It is also ethically permissible for a physician to report to the appropriate public health agency the name of the patient who the physician has a good reason to believe is engaging in behavior that places other persons at risk.

Moreover there is precedence for this approach in resolving fundamental issues of medical practice. That is there is a high likelihood of concordance as the limits of medical confidentiality, whether determination of that standard derives from ethical decision-making based in care-based thinking or a principle-based method [15].

Virtually nothing is shielded by the shield. The exceptions and implied waivers are so many and so broad that is difficult to postulate a case in which the privilege applies [12].

Moreover, ethical dilemmas arise when the course of psychotherapy is altered in ways that would have been unimaginable a decade or so ago. That happens because of the advent of managed care into medicine which has not only altered the availability of traditional long term forms of psychotherapy, such as psychoanalytic psycho-therapy and psychoanalysis, but it has also caused out-patients' psychotherapy to be delivered by low-cost providers and to be used therapeutic techniques which are not always what would seem to be in the best interest of the patient. For instance, brief therapy, and even ultra-brief therapy may be all that is allowed by managed care organizations. Furthermore, frequent reauthorization has to be sought for the continuation of psychotherapy. This also result in a therapist being obligated to supply patient information to poorly prepared administrative personnel. The type of information requested is often highly sensitive, personal patient information that may break confidentiality even when the mental health patient is hospitalized where although such information is shared by the patient with the therapist as though it were to be held confidential, it is easily available to case managers and others with access to the managed care organization's patient-record system [15].

In addition according to Dr. Miller at hospitals more than 100 non-mental health care workers (e.g., office workers, radiologists, orderlies etc.) are not obliged to take the oath of confidentiality, and therefore they can disclose patients information [16]. The question becomes: will individuals, particularly high-visibility professionals and executives enter psychotherapy if extremely sensitive information about them is available to a larger audience than their therapist?

It worth also to mention that ethical dilemmas frequently arise for mental health professionals when:

a) Patients themselves can disclosure confidential information about them (their mental health state) over phone or internet (email). Confidentiality here is at issue cause of the availability to be known patient's information all over the world into the modern technology.
b) An out-patient declared cured decides to marry and information regarding the mental health of the patient is requested by the partners family. Information for which the professional is obliged to maintain secrecy; a secrecy that cannot be kept when partner's psychiatrist requests information by the other.
c) Mental health professional is accused of malpractice by the patient's family and confidentiality may be compromised.
d) Private insurance companies undertake the medical expenses of mental health patients posing in danger confidentiality.

From these dilemmas which were discussed some of them will become major "thorns" of concern for the mental health Professionals during their practice. Other will be less consequential. Of critical concern is [3]:

- that limitations by managed care on the technique and optimal length of treatment of psychotherapy can conceivably lessen its efficacy for some patients and could possibly eliminate this powerful treatment procedure for others'
- in all cases, civil or criminal in which a mental health patient is accused as guilty.

The confidentiality of a psychotherapist-patient communication is protected from disclosure only by showing that the communication is without relevance to the issues in the case or as a general principle, when other evidence is available and is

less onerous to obtain. Of course, what is relevant does not lend to an easy answer. It's a case by case decision to be made by the judge. Relevant evidence is evidence "having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less than it would be without evidence". So the federal rules should be in use in a way that would protect the rights of the mental health patients [16].

Mainly the practitioners should be fully cognizant of the moral underpinnings of confidentiality in order to guide their decision-making in varied clinical situations cause the management of confidentiality is much more a matter of professional ethics than of legal requirements [13].

Consequently, the justification of confidentiality is based on deontological principles such autonomy and trust. Respect for people as autonomous beings is the accepted norm of medical practice in psychotherapy.

CONCLUSIONS

1. Confidentiality is implied by the various oaths undertaken by health professionals, including nurses.
2. The justification of confidentiality rests on deontological principles, such as autonomy and trust.
3. Ethical and legal issues relating to confidentiality present themselves to all mental health professionals.

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