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Informing patients about limits to confidentiality: A qualitative study in prisons

Bernice S. Elger [a,b,*], Violet Handtke [a], Tenzin Wangmo [a]

[a] Institute for Biomedical Ethics, Switzerland
[b] Center for Legal Medicine, University of Geneva, Switzerland

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ABSTRACT

Aim: Confidentiality is important in healthcare practice, however, under certain circumstances, confidentiality is breached. In this paper, mental health professionals' (MHPs) practices related to informing imprisoned patients about confidentiality and its limits are presented.
Methods: Twenty-four MHPs working in Swiss prisons were interviewed. Data analysis involved qualitative thematic coding and was validated by discussing results with external experts and study participants.
Results: For expert evaluations and court-ordered therapies, participants informed patients that information revealed during these consultations is not bound by confidentiality rules. The practice of routinely informing patients about confidentiality and its limits became more complex in voluntary therapies, for which participants described four approaches and provided justifications in favour of or against their use.
Conclusions: Further training and continued education are needed to improve physicians' ethical and legal knowledge about confidentiality disclosures. In order to promote ethical practices, it is important to understand and address existing motivations, attitudes and behaviours that impede appropriate patient information. Our study adds important new knowledge about the limits to confidentiality, particularly for providers working with vulnerable populations. Results from this study reflect typical ethical and practical dilemmas faced by and of interest to physicians working in forensic medicine and other related settings.

1. Introduction

In healthcare, confidentiality ensures trust between the physician and patient. It is a cornerstone of the patient–physician relationship and an important component of patient privacy and thus safeguarded by law in most countries (Higgins, 1989). If this trust is not to be undermined, exceptions to confidentiality must not only be limited, but also be clearly defined and justified by law or medical ethics and known to patients (Appelbaum, 2002). Thus, both healthcare professionals and patients should be aware of the limits to confidentiality (Bok, 1983; Moodie & Wright, 2000; Rachlin & Appelbaum, 1983). While literature has examined the limits of confidentiality and duties to warn (Mills, Sullivan, & Eth, 1987; Pinta, 2010), discussions remain limited about how physicians should inform patients about these exceptions (Bok, 1983; Green, 1995; Moodie & Wright, 2000; Rachlin & Appelbaum, 1983).

It is accepted that confidentiality must be balanced against other interests such as the life and integrity of patients or third persons (Bok, 1983; Pinta, 2009; Rachlin & Appelbaum, 1983) and the 'public interest' (Bourke & Wessely, 2008; Kampf & McSherry, 2006) or the 'collective good' (Konrad, 2010). As the World Psychiatric Association (1996) states, '[b]reach of confidentiality may only be appropriate when required by law (as in obligatory reporting of child abuse) or when serious physical or mental harm to the patient or to a third person would ensue if confidentiality were maintained'. Likewise, the Royal College of Psychiatrists (2010) of the United Kingdom underlines that '[h]ealthcare professionals may have ethical duties to disclose confidential information, without consent, if serious and imminent dangers are present for a third party and they judge that disclosure is likely to reduce or eliminate the danger'. Ethically difficult situations may occur, however, if sensitive information about mental illness, psychiatric symptoms, thoughts and behaviours revealed during consultations are disclosed to third parties, rendering the patient vulnerable to stigma and social alienation. Thus, the World Psychiatric Association (1996) recommends that 'whenever possible, psychiatrists should first advise the patient about the action to be taken'. Although it is certainly important to inform patients directly before breaching confidentiality, it should be noted that this means informing patients at the moment when the patient has just disclosed the information to the physician. The question thus remains as to whether and how patients should routinely be informed at the beginning of any therapeutic relationship that confidentiality may be breached under certain circumstances in order to promote trust and to maintain a healthy relationship between patient and physician.

Confidentiality rules and its limit apply equally to prisoner-patients seeking mental healthcare services. Federal law in Switzerland provides

* Corresponding author at: Institute for Biomedical Ethics, University of Basel, Bernoullistrasse 28, 4056 Basel, Switzerland. Tel.: +41 061 267 1778.
E-mail address: b.elger@unibas.ch (B.S. Elger).

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strong protection of confidentiality. Its violations are punished by imprisonment or a fee. International *soft law* imposes the principle of equivalence for prisoner care ("Art. 321," Swiss Criminal Code, 2013; Council of Europe, 1998; UN, 1982). The professional guidelines of the Swiss Academy of Medical Sciences concerning "Medical practice in respect of detained persons" restate the importance of medical confidentiality and explain that "[m]edical confidentiality is to be maintained under the same legal provisions as are applicable for persons at liberty (Art. 321 Swiss Criminal Code)" (SAMS, 2002). Informing prisoner-patients about limits to confidentiality may be particularly important based on the crimes they have committed and their present mental conditions. If a prisoner-patient divulges past crimes or intentions of harming self or others, he may be unaware of the consequences of such disclosures made in confidence. According to a cantonal law in Switzerland, serious past crimes for which a prisoner was not incriminated must be disclosed by the healthcare provider (Gesundheitsgesetz Basel Stadt (GesG), 2012). Also, Art. 10 of the SAMS (2002) guideline states that in "exceptional cases, if the life or physical integrity of a third party is seriously and acutely endangered, physicians may themselves decide to breach confidentiality and directly inform the competent authorities or the third party at risk." Thus, informing patients at the outset of treatment about limits to confidentiality would enable them to think through decisions and possible consequences before revealing certain information to physicians. This is important because they may not be fully aware that exceptions to confidentiality exist such as their information being routinely shared with all team members involved in patient care or that information shared that could pose real and serious harm the patient self, identifiable third persons, or the general public (Moodie & Wright, 2000). Studies have also shown that individual thresholds about when physicians find it ethically appropriate to disclose information to third parties vary; and that patients', lay persons' as well as legal and health professionals' attitudes towards disclosure of confidential information also differ widely (Bruggen, Eytan, Gravier, & Elger, 2012; Elger, 2009b; Fennig et al., 2000, 2005; Schutte, 1995). These varying attitudes of healthcare professionals make it difficult to foresee when and whether the limits of confidentiality would be clarified to the patients.

A well-established practice, known by most physicians, in relation to non-therapeutic encounters (such as expert testimony for insurance companies or the justice system) is to inform patients at the beginning of the first meeting about limits to confidentiality. In order to be examined, individuals are made aware that confidentiality rules in these contexts differ from therapeutic relationships since information will be provided to the party who requested it. In contrast, recommendations for ensuring patients' knowledge about limits to confidentiality in routine clinical consultation are somewhat less clear-cut. Professional perspectives exist supporting the idea that information exchange should be two-way. For instance, the General Medical Council of the UK underlines that patients must be informed about confidentiality disclosures for purposes that patients would not 'reasonably expect' (General Medical Council, 2009). Therefore, health professionals must enquire that patients have already received information about such disclosures. Similarly, the Royal College of Psychiatrists (2010) reminds providers that clinical responsibility in psychiatry includes informing patients about how information is used: 'Particularly in the situation of multi-agency working, patients need to be made aware that, in order to provide optimal care, some information sharing will usually be desirable'. While healthcare professionals in general may face situations where they must balance confidentiality against other interests, in the context of prison healthcare such situations are more often likely to occur. As a consequence, sensitivity to the importance of informing patients about limits to confidentiality within prisons should be made clear.

Guidelines also exist as to the appropriate steps physicians should take when deciding whether they can breach confidentiality in regular medical practice. It could be assumed that similar guidelines apply to physicians working in prisons. However, prison is a unique setting and has a culture of its own. For instance, prisons are closed environments where it might be particularly challenging to ensure confidentiality because of the myriad of individuals involved in the care and security of the prisoners. Others who are directly or indirectly involved in prisoner care, particularly, non-healthcare staff members may be able to deduce something about a patient's health by simply observing which professional, i.e., nurse, general physician, psychiatrist, or specialist the prisoner is visiting.

To date, limited literature about how confidentiality is maintained in the prison environment is available. Thus, this study was designed to explore mental health professionals' (MHPs) experiences to ensure and/or beach confidentiality; and sought to understand their attitudes regarding confidentiality within the prison setting. Given the lack of previous research and the study's exploratory character, a qualitative methodology was used. This article examines the experiences of and approaches used by MHPs with regard to informing patients in prisons about limits to confidentiality, and highlights MHPs' justifications in favour of or against these approaches.

2. Methods

2.1. Participants

From 2008 to 2009,[1] face-to-face interviews were carried out with 24 MHPs working in Swiss prisons. Participants were selected using purposive and convenience sampling. Our goal was to ensure the greatest possible diversity among participants with regard to background, gender, professional experience, therapeutic orientation and cultural context. Thus, participants were selected to obtain maximum variation of opinions representing two major linguistic regions and varying levels of experience. Participants were not selected randomly as random selection is characteristic of quantitative or experimental study design, but not of qualitative study.

Board members of the Swiss Society of Prison Physicians (SSPP) assisted with participant identification. Since the SSPP notes that different approaches concerning confidentiality in prison occur in the French- and German-speaking parts of Switzerland, the sample was stratified to include similar numbers of participants from both language regions. After receiving approval from the appropriate cantonal research ethics committee, the senior prison or forensic physician responsible for the canton was first contacted and his/her consent and permission to approach MHPs working in prisons was obtained. Either all MHPs working in prisons or a selected sample of the most experienced MHPs were approached for an interview. Prospective participants were contacted by phone or e-mail and oral consent was obtained. The head physician was not informed whether members of his or her team did or did not participate. All interviews were conducted confidentially. After the interviews, participant names were deleted and any data that would permit identification of a person or particular situation were removed.

2.2. Interview guide

Based on previous experience with interdisciplinary qualitative studies (Manai, Burton Jeangros, & Elger, 2010), an interview guide was designed, starting with open-ended questions about participants' experience with and views on confidentiality. Interviewees were asked to describe their standards of practice as well as cases they found difficult. If the subject of informing patients about the limits of confidentiality was not raised spontaneously, probing questions were asked as to whether, how, and when patients were informed and whether this was an exception or reflected participants' typical approach. Towards the end of the interview, participants also were asked to consider four vignettes concerning confidentiality and the sharing of information. Interviews were carried out in French or German

[1] Although the interviews took place in 2008–2009, the attitudes described have been stable over the past 20 years. Through the interviews, we have been able to characterise the attitudes of the MHPs in Switzerland.