Ethics in community mental health care: Confidentiality and common sense


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Abstract (Document Summary)

Backlar argues that we need to find ways to titrate confidentiality in a manner that enables one to maintain respect for a person's privacy but at the same time never permits the deference to the rules of confidentiality to override common sense.

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[Headnote]
Rights of privacy . . . are protections against unauthorized access to and reports about the person . . .

[Headnote]
-Tom L. Beauchamp and James F. Childress Principles of Biomedical Ethics (1989)

[Headnote]
Do our confidentiality laws still serve patients and society well? . . . One hopes that we never find ourselves saying, "Sorry, that's confidential," when common sense and good clinical judgement would have us do otherwise.

[Headnote]
-Judith B. Krauss
"Sorry, that's confidential" (1992)

Is confidentiality sacrosanct? In this day and age, some of you may think this is a silly question (Seigler, 1982). Discussions about confidentiality can become very heated. Consumers, families, healthcare providers, managed care entities, and employers often are very exercised about the limits of confidentiality; they may be both ambivalent and polarized about how access to and disclosure of consumer information should be managed.

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Most of us have experienced some invasion of our privacy. I still remember from my childhood school days, the rage and helplessness I felt when my "best friend" publicly divulged a private confidence I had shared with her. Weeping and stamping my feet, I told my mother, "But, I trusted her." The exposure of my secret was not my only loss. My friend had trivialized our relationship; in retrospect, as an adult, I would say my greater loss was that she did not respect me as a person. Respect for other people (respect for their autonomy), whatever their status, is both central to and a product of the instrumental value that we place on privacy: "[Privacy] is necessarily related to ends and relations of the most fundamental sort: respect, love, friendship and trust. . . . Privacy is not merely a good technique for furthering these fundamental relations; rather without privacy they are simply inconceivable" (Fried, 1968). Our right to privacy affords us a domain of liberty (the idiom, "A man's home is his castle," describes this well, it sends the message that in your own place you can do pretty much what you wish), freedom to make personal choices, and respect for confidentiality (Dworkin, 1994).

In Western medicine the requirement for safeguarding confidentiality has been accorded a grave regard for centuries. The Hippocratic oath demands that "What I may see or hear in the course of treatment or even outside of the treatment in regard to the life of men . . . I will keep to myself holding such things shameful to talk about." In almost all codes of medical ethics, even in disparate cultures and societies, there is some reference to rules about confidentiality; healthcare providers who have thought carefully about the fiduciary relationship between provider and patient usually agree that honoring confidentiality is a significant and powerful concern, "perhaps only subordinate to the main goal of the relationship, namely health benefits to the patient" (Beauchamp & Childress, 1989). And in psychiatric practice, the sensitive preservation of confidentiality is often the essential component to the therapeutic relationship. Without the maintenance of confidentiality the consumer and therapist may be deterred from undertaking treatment to the detriment not only to the consumer but possibly to society as well (Stone, 1976).

Despite the evident benefits that the preservation of confidentiality may provide, almost all the current literature concedes that the demand of absolute confidentiality is unrealistic (Seigler, 1982; Bok, 1983; Rachlin & Appelbaum, 1983; Appelbaum et al., 1984; Petrila et al., 1992; Krauss, 1993; Backlar, 1994; Beall, 1994). Fourteen years ago, Mark Seigler's article decrying confidentiality in medicine as a decrepit concept, advertised that 25 to 100 healthcare providers and administrative persons may have access to a hospital patient's record. Nowadays, with the proliferation of large networks of managed healthcare entities and the combination of ever more sophisticated computerization and communication systems, the opportunity for patient loss of privacy may be even greater and with far more serious ramifications for the patient.

Usually, discussions about medical confidentiality ponder tensions common for the healthcare provider that may result from conflicts between a patient's interests and a third party's interest. The boundaries of confidentiality are constrained when the health, well-being, and safety of identifiable persons, or society in general are threatened (in psychiatry, the Tarasoff case, 1976, has become an archetypal example of this). But the limits of confidentiality also may be constrained when the patient's personal stake in preserving confidentiality conflicts with her or his personal interest in securing adequate health care (Seigler, 1982). For mental health providers, a consumer's imminent suicide would be considered in this category. But also in this category, the routine limits of confidentiality become apparent when we consider some of the persons who may have a legitimate need to know portions of information contained in a consumer's chart. These persons may include healthcare providers (nurses, psychologists, physicians, social workers, occupational therapists, mental health technicians, residential care providers etc.), chart reviewers, financial officers, insurance auditors, quality of care assessors, and, with the advent of managed care, the catalog may swell to include at least-the employer/payor, and the mental health manager. Seigler's list of up to 100 hospital health professionals and administrative persons who routinely are privy to private information may have become a conservative count. In his 1982 article, Seigler proposed a number of remedies, suggesting that the patient record could be divided into discrete parts, that the 'need to know' should be scrutinized carefully, that patients should be informed about the limits of medical confidentiality, and that patients have the opportunity to review their medical record and to make informed choices whether certain portions of the record be made only accessible to their primary provider. However, nowadays this may be more complicated as there are a multitude of others, like computer hackers or even providers' secretaries, who clearly do not have a legitimate need to know and may have easy access to confidential information.

But, in the proliferating tally of persons with a legitimate need to know there appears to be a gaping omission: the informal caregiver. Only thirty years ago, many people with severe and persistent mental disorders were cared for in hospital or intermediary settings (Lamb, 1993, Grob, 1994), whereas nowadays-for the most part-the location of care for the majority of this population has shifted from long term custodial institutions to other facilities in the community (Carpenter & Buchanan, 1994), and to the informal caregiver. In the United States, even though there is no well-founded understanding of how informal caregiving is integrated into the practice of professional service providers, many of us are aware that our laws regarding the rules of confidentiality may present a barrier to the informal caregiver's ability to provide adequate care (Krauss, 1992).
The informal caregiver may be a consumer's relative or any person who has taken responsibility for the caregiving role. Evidently, informal caregivers provide a considerable percent of the care that entails housing services and case management (Beals, 1994). However, currently, mental health providers rarely share relevant information with the informal caregiver, nor do they ask families for information germane to treatment or legal decisions (Petriola & Sadoff, 1992). Often this may be deleterious to the health of the consumer. Conventional practice requires hospital treatment teams, at the time of hospital discharge, to share pertinent information about persons with severe and persistent mental disorders with staff in outpatient clinics and residential care facilities. Whether or not the consumer lives with the informal caregiver, I believe that appropriate information also should be disseminated regularly and routinely to the informal caregivers and should include data about medications and potential side effects, adequate explanation about the possibilities of decompensation and description of likely symptoms, and, if fitting, counselling about consumer's possible danger to self or others.

Recently, I have been both amused and concerned by a sign posted in the elevators of a local hospital that reads, "Remember Patient Confidentiality," as though 'confidentiality,' like an umbrella, might have been forgotten and I could go back and recover it from the hospital's "Lost and Found" office. Because we may have 'forgotten' the values that underwrite the reasons we honor a person's confidentiality, the admonition may be more apt than is the sign's obvious intention. On the one hand, we have relaxed our attentiveness to the rules of confidentiality. Of course, this is what the sign reminds us about, although it refers only to ' loose talk,' rather than to relaxed criteria that may provide a dubiously legitimate need to know to a disparate array of persons, or to the ease with which we are able to meddle into electronic communication systems and invade other persons' privacy. On the other hand, some providers may adhere so stringently to the rules of confidentiality that they impose a barrier to good patient care and defy common sense. Easy to point a finger at, but difficult and complex to resolve. The consumer, the informal caregiver, and the healthcare provider may comprise an interdependent triad that poses a web of conflicting requirements, conflicting interests, and conflicts of interest (Backlar, 1994). At all times there is a delicate balance between protecting a consumer's right to privacy and well-being, with the informal caregiver's need for accurate information, with the healthcare provider's need for accurate information, and with society's right to be protected.

Can we find ways to titrate confidentiality in a manner that enables us to maintain respect for a person's privacy, but at the same time never permits our deference to the rules of confidentiality to override our common sense? Our confidentiality laws have not been revised or altered since the 1970s (Krauss, 1992). Although there are risks both to legislating and to declining to legislate, I believe the competing perils must be considered and should not be disregarded.

[Reference]
REFERENCES

[Reference]


[Reference]


Lamb, H.R., & Shaner, R., (1993). When there are almost no hospital beds left. Hospital and Community Psychiatry, 44 (10), 973-976.


http://proquest.umi.com/pqdweb?index=14&did=10347430&SrchMode=1&sid=11&Fmt=3... 9/6/2005
78.
Tarasoff v Regents of the University of California, 17 Cal 3d 425; 551 P 2d 334 (1976).

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Ethics in Community Mental Health Care is a special section within Community Mental Health Journal designed to remind our readers about special problems which accompany the delivery of care to our clients.
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