CONFIDENTIALITY PRINCIPLES IN PSYCHIATRY

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CONFIDENTIALITY PRINCIPLES IN PSYCHIATRY (Abstract): Confidentiality stands out in psychiatry through its multiple connotations as an intrinsic necessity in the ethics of professional relationships. Thus it represents an important characteristic of this profession and at the same time a stringent request which, through its specificity, implies a direct contact with persons in need for help. Despite being inserted in professional codes and legislative systems, confidentiality in psychiatry is far from being considered a clarified matter and does not stand aside from ethical controversy. Keeping the professional secret is often a hard task due to the pressure of the law or of other professional groups who can bring multiple justifications, including that of action for the benefit of society. The therapist is often submitted to a tension caused on the one hand by the promise of keeping the professional secret and on the other hand by multiple requests of breaking the confidentiality. So the problem of confidentiality in Psychiatry deserves special attention because in this profession, more than in other branches of medicine, the gain of the patient’s trust is essential in the psychotherapeutic relationship. Keywords: ETHICAL CONTROVERSY, PROFESSIONAL GROUPS, GAIN OF TRUST, PSYCHOTHERAPEUTICAL RELATIONSHIP

The idea of protecting the confidential character of communication between physician and patient was first expressed in the Hippocratic Oath, while the guarantee of confidentiality through law appeared in the English legislation as early as the 17th century. Moreover, the ethical principle of confidentiality was at the core of Percival’s Code of Medical Ethics, representing the starting point for both the American Medical Society and the British Medical Society. From a legislative viewpoint there are, however, significant differences regarding the limitation of medical confidentiality within the legislative systems of different countries. Consequently, despite being inserted in professional codes and legislative systems, confidentiality could hardly be regarded as a clarified matter and often makes the subject of controversy. Keeping the professional secret is often a difficult challenge due to the pressure coming from either the legislative system or from certain professional groups that could provide a whole range of justifications, including that of action for the benefit of society (1, 2). The psychiatrist is thus challenged by an ethical tension caused, on the one hand by his engagement to keep the professional secret and on the other hand by the multiple requests of breach of confidentiality that she/he constantly receives.
THE DOCTOR - PATIENT RELATIONSHIP

Confidentiality essentially defines, beyond any legislative aspects, the professional relationship between doctor and patient. More specifically than in any other branch of medicine, confidentiality is essential in psychiatry firstly because it helps the patient engages in the psychotherapeutic relationship. Only that patient who fully trusts his/her therapist will reveal his/her most intimate thoughts, intentions, doubts or states of mind. In the Hippocratic times, although doctors had very few therapeutic means, they were able to offer the patients trust, hope and inspiration that helped them recover. These less tangible approaches can be hardly found in the over-technologies medical practice of the present day. The therapist’s role is limited, according to the reductionist model strictly based on biological dimensions, to correcting certain organic and functional deficiencies by means of pharmacological and surgical methods. Being guided by these aspects, some voices even claim that Hippocratic medicine would be out-of-date and unable to overpass its symbolic condition. However, from an ethical point of view, the Hippocratic tradition is a key element in medicine and defines the human context necessary for the application of all these new technologies.

The relationship between the psychiatrist and the patient, on the one hand, as well as between the psychiatrist and the patient’s family is crucial in achieving efficient psychotherapy, in increasing the patient’s trust in the therapist’s competence and his/her belief that the condition can be either improved or cured. Nowadays, due to the new technologies and paraclinical investigations possibilities, patients show an increased tendency to believe that the diagnosis and cure of a certain condition depend mainly on complicated tests and investigations and the miraculous effect of sophisticated treatment schemes. The therapist’s intervention and contribution seem to be regarded as secondary and less important (3). This results in a state of tension and concern, as the patient searches for and requires more and more tests and treatments, the psychotherapeutic contact between doctor and patient being thus negatively impacted. In this context, the relationship between the therapist and the patient should be reconsidered, by trying to re-establish an affective contact and increase the role of psychotherapy, which should be mediated by means of other investigations. As well as this, hospital conditions should be improved, the trauma produced by hospital commitment and by the implications of psychiatric diagnosis should be reduced to a minimum and the best possible social and family integration should be constantly attempted. In this context, the psychiatrist’s duty is to protect the patient, to keep the professional secret and treat the diagnosed condition with competence, resoluteness and optimism. Such an attitude is meant to increase the patient’s confidence in the therapist’s competence and expertise, the moral support offered to the patient motivating the latter to cooperate in regaining his/her hope of recovery and reintegration in his/her social, family and professional life.

Confidentiality is philosophically founded and supported by arguments and justifications belonging to various theoretical concepts. Regarded from the medical ethics perspective these concepts are related to ethical and philosophical dimensions faithfully mirrored by social and community elements.
THE UTILITARIAN THEORY

As far as the utilitarian theory is concerned, breach of confidentiality is only permitted when the respective breach results in producing a better effect or a less harmful effect upon the society as compared to keeping the professional secret. Any society is interested in ensuring health benefits for all its members, and guaranteeing the confidentiality of the medical act is meant to encourage the population in requiring health assistance. This particular aspect is more obvious in the case of a psychiatric condition, as the nature of the condition itself can label the patient in a socially stigmatizing manner. This is why psychiatric conditions are regarded with more conspicuous caution and prejudice by the rest of the population.

It was repeatedly noticed that the society’s attitude towards the psychiatric patient and his/her condition directly impacts upon the psychiatric assistance (4). Depending on the hesitations and the prejudices influencing the community or the patient himself/ herself, the patient postpones his visit to the psychiatrist, psychiatric hospital or even the ambulatory medical unit. Unconventional treatments are often preferred, which leads to wrong diagnosis or inaccurate evaluation of the physical suffering, delays the administration of adequate therapy and hides the sometimes very severe evolution of the condition. This situation is mainly due to the reticence of the social environment towards the patient who was committed to a psychiatric hospital and received a psychiatric condition diagnosis (5). This is why the patient should feel safe under the shelter of confidentiality so that he is able to reveal certain information and help the therapist decipher his/her suffering. On the other hand, the therapist must maintain confidentiality of all information and data received from the patient and not only of that information that is relevant for diagnosis or therapy.

THE THEORY OF AUTONOMY

The theory of autonomy focuses on the mandatory dimension of confidentiality supporting the notion of individual autonomy that include every person’s right to privacy and secrecy as far as personal data and information are concerned. The obligation to respect confidentiality can be reinforced by the doctor’s promise to the patient to treat all information as confidential. In this case, as opposed to the utilitarian theory, there is no motivation whatsoever for breaking the promise of confidentiality. Some modern approaches of this theory state that confidentiality may be broken in situations in which keeping the information secret would result in causing harm to other people or the patient himself/herself. The justification of such an action is based on the principle that no right is absolute as long as the one who benefits from that specific right would infringe other norms or regulations that would cause harm to other people or to that individual himself/herself.

However, other approaches argue and plead in favor of the absolute right to confidentiality motivating that this would bring infinitely more benefits than any breach of confidentiality required by particular cases and situations. Immediate benefits can be followed by negative long-term consequences and especially by a decrease in medical assistance consumption that would in turn have a negative impact upon the general health of the population (6). Another argument would be the improper situation a therapist would put him-
self/herself into when revealing confidential information for political and legal reasons rather than medical ones.

THE SOCIAL CONTRACT THEORY

Another theory to be considered is the social contract theory that states that any traditional generally accepted practice can be formally protected by the law. This can also be applied to confidentiality, which represents an ancient medical tradition. The obligation to keep the professional secret and confidentiality is part of the social contract concluded between the doctor and his/her patient.

PARTICULAR SITUATIONS

As far as dilemmas raised by particular situations are concerned, the therapist finds himself/herself in a very delicate position: on the one hand s/he must value and respect confidentiality in his/her relationship with the patient and on the other hand s/he must act in compliance with the provisions of the law respect his/her duty as a citizen. There are cases in which breach of confidentiality as required by the law is only performed after the person involved formally consents. This category includes situations of legal obligation to reveal information on an individual’s state of mental and physical health, such as medical reports or examinations required for hiring in a new workplace, obtaining a driver’s licence or a handgun carry permit.

As opposed to the situations mentioned above, there are countless cases where evaluation is controversial. The necessity to break confidentiality is often motivated by the need of social protection (7). First of all there are frequent cases of degradation of family relations in which usually the wife, although physically and/or emotionally abused does not want to press charges on her violent husband, although her suffering is evidently perpetuated. Equally controversial are children abuse cases. Although it is generally accepted that these cases be reported once they are discovered, it is yet unclear if reporting the case actually solves the problem. Experience sadly shows that limited resources within the family is the most common cause for which children are required participate in certain activities while their school attendance drops or their access to education is limited. In such cases, simply reporting the situation to relevant authorities does not solve the issue. As well as this, children might consequently become victims of physical and psychic violence or even sexual abuse, especially when parents are alcoholics or drug addicts. In these cases besides reporting the situation to authorities, parents should be taken into social care and receive specialized assistance.

SPECIAL CASES

Drug users are one of the special cases. As far as they are concerned, in many countries the law stipulates that the therapists should report them, for their own protection. That is why the drug users give up medical help altogether, so their addiction is not revealed. Drug or alcohol addiction should consequently be entitled to strict confidentiality, mainly due to the stigmatizing character of the addiction, of which the patient is fully aware. The patient’s desire to remain anonymous often prevails over his/her desire to get help. This is the very reason for which various associations dealing with the protection and rehabilitation of alcoholics are called Alcoholics Anonymous Associations (8).
Another special case would be that of a psychiatrist who finds out from a patient that the latter has committed a crime. Any supporter of the absolute right to confidentiality would plead in favor of keeping the professional secret in this specific case. This is actually one of those instances in which the relationship between therapist and patient resembles the one between priest and parishioner under the confession oath (9). Supporters of the utilitarian theory would most probably argue against this position, as, according to their belief, doctors’ duty is to contribute to the wellbeing and protection of society, as any other citizen.

On the other hand, breaking confidentiality every time a therapist senses a potential danger would only estrange and keep at a distance the patients who, feeling their trust betrayed, would no longer require the psychiatrist’s help. One should not disregard the strictly therapeutic aspect of working off one’s tensions by means of free and uncompromised expression of all thoughts, feelings and imagination that a patient frees himself/herself of during therapy. More than that, the absolute trust and reliance a patient has towards his/her therapist determines that patient to respect all therapeutic indications; when confidentiality is uncertain the patient would not be motivated to follow therapeutic indications properly. Thus, the only chance the psychiatrist has for intervention in particularly difficult and potentially dangerous cases, namely hospital commitment and treatment acceptance, would be totally compromised (10, 11, 12).

**CONCLUSIONS**

Many psychiatrists are revolted against this pressure to become defendants of public order rather than therapists, especially since violence prediction is not a very exact coordinate. Potential dangerousness may or may not turn into violent behaviour, and it can be manifested in so many various ways. Most legal systems do not state clearly the situations in which the psychiatrist shall warn the authorities. This attitude would probably be justified only in obvious and extreme cases where a person’s or a private property’s integrity would be endangered. If we also take into account the possibility of a relative identity of the potential victim or a vague identification of that victim, the next question arises: How should the therapist act in order to prevent an event? The rightest attitude from a medical and ethical viewpoint would probably be to simplify the compulsory commitment procedure.

In psychiatry, confidentiality arises thus, due to its multiple connotations, as an intrinsic necessity within professional relations ethics. This principle represents an important characteristic that governs many other professions and an undeniably essential demand in professions that imply a direct contact with people who seek some kind of professional help. In psychiatry, confidentiality and keeping the information provided by the patient secret become thus an implicit condition of professionalism, representing at the same time a guarantee for the confidence of the patient in the respective professional service.

**REFERENCES**


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**NEWS**

**EZETIMIBE/STATIN COMBINATION THERAPY TO TREAT PATIENTS WITH TYPE 2 DIABETES**

Diabetes mellitus is the most common serious metabolic disorder and it is considered to be one of the five leading causes of death in the world. Patients with diabetes present a cardiovascular risk two to four times higher than non-diabetes population. An important factor in cardiovascular complications is hyperlipidemia. Diabetic dyslipidemia is characterized by the so-called atherogenic lipid triad. The aim of this study was to investigate the efficacy of add-on ezetimibe therapy in cholesterol lowering for patients with type 2 diabetes and not controlled by statin therapy. The results of this study showed that adding ezetimibe to statin in add-on trials provided a relative decrease in LDL-cholesterol from baseline of 23.4% compared to statin monotherapy. This fact suggests that patients who poorly respond to statins may be more responsive to cholesterol absorption inhibitors such as ezetimibe. The study supports the hypothesis that an high effect of cholesterol-lowering can be achieved by administration of a minimum dose of statin with ezetimibe, a higher response to that obtained by administration of statin monotherapy maximum doses. Ezetimibe decrease the postprandial elevations of chylomicron cholesterol and triglycerides; after combination therapy with atorvastatin it induced a greater decrease in post-prandial TG levels. These favorable effects have been observed also in association with simvastatin, a good influence on fasting and postprandial triglyceride-rich lipoproteins in patients with type 2 diabetes, by favoring the production of less atherogenic cholesterol-poor chylomicrons and VLDL particles. Ezetimibe alone or in association with simvastatin had favorable effects on the removal of radio labeled chylomicron-like emulsions from plasma in patients with coronary heart disease. It can be concluded that ezetimibe therapy, in combination with statins, provide greater biological beneficial effects, compared to statin monotherapy, in patients with type 2 diabetes (Farnier M, Ezetimibe/statin combination therapy to treat patients with type 2 diabetes. *Atherosclerosis Supp*, 2015; 17: 2-8)

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