

To tell or not to tell? Physiotherapy students' responses to breaking patient confidentiality.

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ABSTRACT

Confidentiality is known to be a challenging aspect of physiotherapy practice. This paper explores current guidance available to the profession in New Zealand. Using a contentious real life case study from health care practice nine undergraduate physiotherapy students were asked to provide their responses to the ethically complex scenario using the Values Exchange web-based decision-making tool. In line with anecdotal evidence this small scale study found the students effectively confronted and worked through the inherent tension between autonomy and beneficence as they used the online technology to attempt to balance the right to confidentiality with their desire to protect the patient. Students also showed an appreciation of the complexity of their decisions and the Values Exchange facilitated a foundation for physiotherapy students to consider their professional role in contemporary physiotherapy practice. A larger study is needed to confirm and expand upon these findings.

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Key words: physiotherapy, confidentiality, ethics, decision-making

INTRODUCTION

The principle of confidentiality raises complex ethical issues in physiotherapy practice. Confidentiality is about respecting other people's secrets (Gillon 1985) and maintaining the security of information elicited from individuals in the privileged circumstances of a professional relationship (Reid cited Cross and Sim 2000). It is a foundational principle stemming from the autonomous right of individuals to make decisions about their personal information and essential to the trusting relationship between health professionals and their patients. There is an assumption that patients will need to divulge private information to receive the assistance they require, but that this information will be protected within the professional relationship (Brann and Mattson 2004). Failure to provide confidentiality may detrimentally affect a therapeutic relationship and deter patients from seeking help from health professionals (Jones 2003). But is confidentiality an absolute obligation?

BACKGROUND AND OVERVIEW

In New Zealand physiotherapists have both ethical and legal guidance. The Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct, section 3.2 states that physiotherapists should "not disclose identifiable health information about a patient/client without the patient's/ client's permission, unless disclosure is required or permitted by law" (p 2). The relevant law can be found within Part IV of the Privacy Act 1993, Rule 11 of the Health Information Privacy Code (HIPC) and s22F of the Health Act (1956) (Keenan 2010). While Rule 11 of the HIPC advises that, 'serious' or 'imminent threats' to a patient's life would justify breaching confidentiality, much is left to the interpretation of the physiotherapist. For example, will such a breach guarantee the prevention of the imminent threat? What are reasonable grounds? Is the disclosure necessary to prevent that imminent threat?

The commentary accompanying the New Zealand Physiotherapy Code of Ethics and Professional Conduct [Consultation Draft]

(2011) states that although there may be opportunities when information may be disclosed without consent (e.g. "when the patient/client poses a serious and imminent threat to themselves or someone else") these situations are rare and unlikely in the physiotherapy context (Section 3 p 8). However, Cross and Sim (2000) suggest that for physiotherapy "the issue of confidentiality is typical of 'everyday' ethical conflicts" (p 447). Regardless of the gravity of a breach of confidentiality, the ethical tensions remain the same. It is therefore worthwhile engaging students in the classroom so they are better equipped for practice.

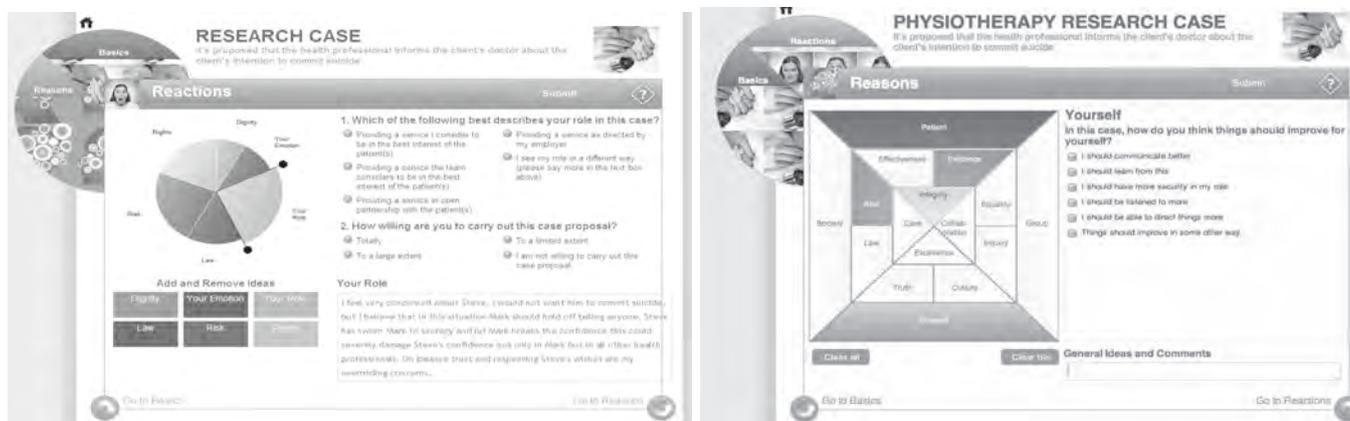
The authors have been delivering inter-disciplinary ethics programmes to undergraduate physiotherapy students for seven years. During that time the complex issues associated with confidentiality in physiotherapy practice have been regularly explored using an online decision making tool; the Values Exchange (AUT University Values Exchange 2011). A values approach underpins both our ethics education and the Values Exchange (Vx). While evidence based practice is necessarily central to decision making in health care, there is increasing acknowledgement that values play an integral role (Dickenson and Vineis 2002; Fulford et al 2002; Godbold 2007; Hope 1995; Lees 2011; Mills and Spencer 2005; Newcombe 2007; Petrova et al 2006; Seedhouse 2005; Seedhouse 2009).

The Vx is web-based technology that provides users with a framework for thinking and justifying decisions. An increasing number of universities, schools and health care institutions use it internationally, including AUT University (AUT University Values Exchange 2011). The Vx reflects a process orientated approach to ethics education and the view that a good decision is one that is robustly justified, rather than matching any desired right or wrong response (Seedhouse 2009). The tool incorporates traditional theoretical approaches, but remains accessible to students with little or no knowledge of ethics by using everyday terminology. Since this study, an updated version of the Vx with

greater interactivity is now being used within education and other institutions. Readers are welcome to view an example of this site at <http://aut.vxcommunity.com>.

The primary aim of the Vx is to make values transparent. Through a series of interactive screens; users are provided with a framework for considering ethically challenging clinical scenarios in depth and given opportunities to develop justified reasoning for their decisions. First, the user is asked to consider a case proposal and take a position on whether they agree or disagree. They are then required to choose what they see as the most important consideration and who matters most in the case. The software then requires the user to develop their initial response into an in-depth analysis using the interactive rings screen to reflect on their reactions to the case and the ethical grid to provide reasons for their position.

Figure 1: The Reactions and Reasons screens based on Seedhouses's Rings of Uncertainty and Ethical Grid



The Reactions and Reasons screens (presented in Figure 1) are an evolution of Seedhouse's earlier philosophical frameworks: the Rings of Uncertainty and the Ethical Grid (Seedhouse 2009). Upon completion of a case, users can access reports summarising their own responses as well as the responses of all others who have also completed the same case. These reports combine both quantitative and qualitative data, outlining rings and grid choices as well as free text entries.

The following case, which is possible in many different health care settings, has been regularly used in the Vx to provoke student thinking about the complex ethical tensions relating to confidentiality. *A patient has significant injuries following a car accident. After some weeks of rehabilitation, and swearing the physiotherapist to secrecy, the patient discloses that they are saving their medication to commit suicide.*

Anecdotally physiotherapy student responses have been mixed, but in line with students from other disciplines. They grapple with conflicts between autonomy and beneficence, a duty to protect the patient while wanting to protect themselves, as well as considering the wider implications for the patient's family and their profession. To explore their responses in a research context, the authors asked student physiotherapists to respond to this scenario using the Vx.

METHOD

A small, purposeful interpretive study invited physiotherapy students enrolled in a 12-week inter-disciplinary health care

ethics paper to use the Vx to consider the scenario. This qualitative approach acknowledges multiple realities, where the researcher explores and constructs subjective interpretations of the data (Merriam 2009). There were three male and six female participants with seven of those between ages 20 to 29 and two between 40 and 49. To avoid any conflicts of interest, students were recruited by a lecturer not involved in the teaching or assessment of the paper, and random passwords and logins were used by participants to access the Vx to protect their anonymity. Participants gave consent through responding to a series of questions at the beginning of the Vx case study response. The study was approved by AUT's ethics committee.

The case analyses from each of the participants were thematically analysed using Braun and Clarke's (2006) six step process. This involved "familiarisation with the data, the generation of initial

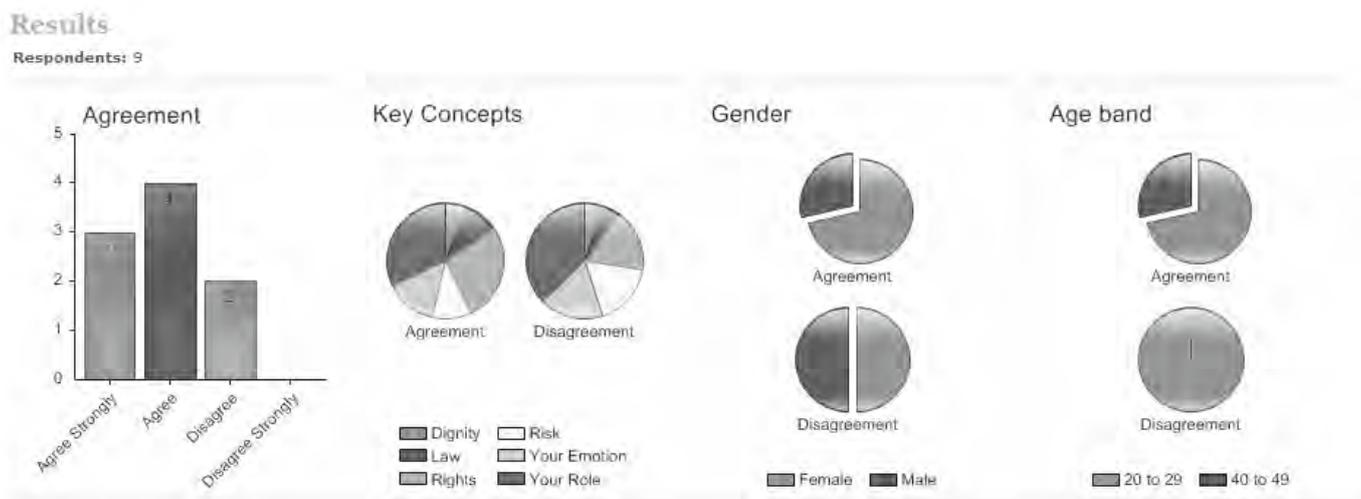
codes, searching for themes, reviewing, defining and naming the themes and producing the report" (p 87). To ensure validity, the responses were analysed separately by each researcher. No significant points of difference were identified. The analysis gave rise to three main themes; *balancing interests, the patient in a transient phase and seeking guidance*.

FINDINGS

To begin the participants were asked to consider a detailed version of the scenario to which they were asked to provide their initial response to the proposal: *that they would inform the doctor of the patient's intention to commit suicide*. Seven agreed, or strongly agreed, while two disagreed. This correlates with anecdotal evidence from the authors' teaching experiences using this case scenario over several years and are similar to the findings of Lees (2011). In that study, the same case scenario was used with a small group of health professionals. The majority agreed to inform the doctor even though it involved breaching the patient's confidence.

Having provided their initial response participants were asked to rate the importance of the following key ethical considerations in relation to the case: dignity, law, rights, risk, your emotion and your role (Figure 2). Despite differences in their initial positions of agreement, 'your role' was of greatest consideration for all participants. In fact, the degree of importance of all key concepts was similar irrespective of whether people agreed they should break confidentiality or not.

Figure 2 Results overview



BALANCING INTERESTS

That health professionals' actions will positively impact their patients' health outcomes is a fundamental goal of health care practice (Beauchamp and Childress 2001). Participants used the Vx to balance the risks and benefits of the situation and determine the most important outcome. All participants shared the common goal for the patient not to commit suicide. There was genuine concern for the wellbeing of the patient and participants felt a sense of responsibility to ensure suicide did not occur. Irrespective of their position on disclosure, participants expressed this duty in terms of acting in the patient's 'best interests'. For example those who agreed to breaching confidence, justified their decision in terms of wanting to preserve life. *I understand it would breach confidentiality of the patient, but when it is literally a life and death situation, surely taking action and overriding the confidentiality agreement would be deemed acceptable in this case?*

All study participants had a clear understanding of confidentiality and the duty to respect the information entrusted to them, as well as an awareness of the relevance of this trust within the relationship. Most recognised that by breaching confidence to protect the patient they were in fact betraying the promise given to them. Difficulties with professional role and breaking confidentiality in similar scenarios feature in the literature (Chaimowitz et al 2000; Kennedy 2008). Despite an understanding of confidentiality, most participants felt uncomfortable about their role and subsequent decision. For example, one reported that by telling the doctor they did not feel completely comfortable as it was seen to be breaking their professional relationship with their patient. Another felt concerned that *the professional should not have been 'sworn to secrecy' initially because that puts him in a compromising position.*

Feeling 'uncomfortable' is a common reaction to ethical dilemmas where there is no clear one right action. In this study participants voiced their discomfort in a number of ways: they felt confused, scared, bad, and had a desire to feel comfortable with their decision. These feelings of discomfort linked closely with the act of betrayal and going against the patient's wishes. /

don't want the patient to commit suicide but I feel if he knows I went against his wishes he will commit suicide.

When exploring responses to ethical issues by physiotherapists, Barnitt and Partridge (1997) found similar reactions. Their participants experienced "frustration, inadequacy and anger in the face of decisions which could not be judged as right or wrong, better or worse and for which there were no obvious actions to 'put it right'" (p 190). One participant proposed an alternative to speaking to the doctor, choosing instead to disclose the intention of the patient to commit suicide to the family. However this did not lessen the perceived severity of the betrayal. *I propose that I speak to his family, however it's impossible to know whether this would be considered more or less of a 'betrayal'.*

Only one participant felt that the obligation to respect confidence was absolute and as a result chose not to breach confidence. *The patient has a right if they said this in confidence to you, that you keep it between yourself and them.* However, the majority (seven out of nine) felt that betrayal was justified in terms of the severity of the situation. *I would feel bad for breaking a promise, but this is an exceptional circumstance where life and death is involved. It is unfortunate that it involves breaking the patient's trust in me...but some situations are worth that risk.*

The patient in a transient phase

The duty of confidentiality is extremely important to ensure a relationship of trust is created with each patient (Gabard and Martin 2003). This is evidenced in the prominence of confidentiality within professional codes. Despite this, only one participant acknowledged the negative potential impact of disclosure on other, future patients. *By breaking confidence with the patient, it is possible that other patients will not be honest with their own health care professional as they may fear their confidence will not be upheld. This may reduce the effectiveness of their treatments.* Using a classic utilitarian approach, which requires the chosen action to achieve the greatest good for the greatest number of people, participants argued instead that a short term breaking of the duty to maintain confidentiality was acceptable for other long term goals for the patient and

their family. *Breaching confidence and informing the doctor will provide the best outcome measures in the long term, ultimately putting the patient first.* A perspective shared by five participants was that the patient was in some sort of temporary phase, where recent circumstances prevented him from thinking in a rational way. This added weight to the argument in favour of overriding the patient's autonomous request.

While autonomy is a highly prized Western principle that underpins patient rights, including confidentiality, participants justified a beneficent, if paternalistic approach by the perceived transitory inability of the patient to make the 'right' decision. *The patient is progressing through the depressive stage of grief, therefore he has irrational thoughts. I do not believe people in that state of mind are thinking things through logically. After his depression has lifted he may be pleased that these steps have been taken.* This is in common with literature suggesting there is an assumption that any patient with suicidal tendencies is temporarily incapacitated or irrational and must be reported (Bostwick et al 2009). Further, the inability of patients to make 'correct' decisions has been seen as creating a special obligation on health professionals (Sherlock, as cited in Bernat 2008). The participants saw part of their role to help the patient move through this phase. Electing to disclose the intention to commit suicide was the physiotherapist's way of ensuring the patient was protected, as the patient had the *right to be safe from themselves, from doing harm to themselves.*

Seeking guidance

Guidance in relation to confidentiality issues is readily available from the Privacy Commissioner and professional bodies. Students were aware of this through their ethics education. However, when faced with the dilemma of whether to break confidence, the law was not considered as important as other key ethical considerations (see Figure 2). Rather than seeking guidance from the law, participants opted to seek advice from colleagues and other health professionals. Stevens and McCormack (1994) also explored student perspectives on confidentiality from a multi-disciplinary (medical) ethics course and similarly found that legal issues were not explicitly seen to be as relevant as other ethical factors. Their findings suggested that students elected to breach confidentiality because of the perceived beneficial outcome for the patient, rather than simply an adherence to rules. This study had similar findings. As one participant explained the law was not the reason for telling the doctor, *it is not out of fear of being in trouble...it would be out of fear of losing a patient to self harm.*

While concern for the health professional's legal responsibilities was a consideration for participants in Lees' (2011) study, our participants seemed more concerned with their specific role and where they would turn for help with their decision. For example, one participant used the law as a rationale for their decision and a way to possibly distance themselves from the patient: *The patient could be told that this is adherence to policy.* Another focussed on the decision being beyond their scope of practice *I propose that we should be able to listen to what they say and be able to refer them to the correct area as it most likely is out of the physiotherapy scope of practice to be dealing with such things.* The students are taught to seek advice from senior colleagues in their undergraduate programme. Seven participants discussed how they might obtain guidance from

colleagues but also from the patient's family and other health professionals. *I am not sure so would ask my manager, I would talk to other members of the team to try to decide, I propose to discuss this with a few colleagues, I was thinking maybe I could discuss with a psychologist, without revealing who my patient is.*

CONCLUSION

This small study has demonstrated the depth of analytical thinking possible by physiotherapy students when given a challenging ethical scenario, which they might face in practice. Using the Values Exchange they have grappled with the inherent tension between autonomy and beneficence as they attempted to balance the right to confidentiality with their desire to protect the patient. While the law has rightly contributed to their decision, this window into their thinking demonstrates the potential for ethical analysis beyond that of a solely rule based approach. Through the examination of an ethical dilemma, physiotherapy students have demonstrated thoughtful appreciation of the complexity of their decisions. The Values Exchange, as a tool for facilitating ethical decision-making has provided a foundation for physiotherapy students to consider their professional role in contemporary physiotherapy practice. A larger study is required to confirm and expand upon these findings.

KEY POINTS

- Confidentiality is known to be a challenging aspect of physiotherapy practice.
- When faced with a practice based confidentiality case, undergraduate physiotherapy students recognise ethical complexity, especially the conflict between the rights of the patient to confidentiality and a desire to protect the patient.
- Web-based educational technologies such as the Values Exchange may have the potential to facilitate in depth analytical thinking.
- The implications of such thinking for student education and future physiotherapy practice are potentially significant but will require further research.

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Appendix A Ethics

Ethics approval for this study was granted by the Auckland University of Technology Ethics Committee on 26 May 2011, Application number: 11/92.