Correspondence

EDITED BY MATTHEW HOTOPF

Concerns over confidentiality

We recently received our copy of *Good Psychiatric Practice 2000* (Royal College of Psychiatrists, 2000). On reading it there was little one could disagree with and much to commend it. However, there was one matter regarding confidentiality which raised our concern: "the psychiatrist will . . . respect the confidentiality of sensitive third-party information and only divulge such information either to the patient or others with the consent of that party" (p. 19).

At face value this sounds reasonable, but it is questionable whether this advice is always justifiable and legal. This is particularly the case when third-party information involves an accusation about the patient or his or her behaviour.

We have recently been involved in a case where sensitive third-party information was given about a patient who was detained under section 37/41 of the Mental Health Act 1983. The information was thought to be believable and related to prior actions of the patient unrelated to factors involved in their current hospitalisation. If the information were believed, then this would profoundly affect issues around risk management and thus the likely future care of the patient. The informant refused to inform the police of the allegation despite encouragement and refused to give us permission to disclose it to the patient. This placed us in a difficult position. It was unclear how we could take note of the informant's opinion if it was not fully investigated. There was also the question about the right of a patient to be aware of a factual matter which was taken into consideration when decisions were made about his/her care and discharge. In view of this we took legal advice, which would appear to contradict the advice given by the Royal College of Psychiatrists (2000).

There are three points which seem worth mentioning. First, the European Court of Human Rights (Convention for the Protection of Human Rights and Fundamental Freedoms, article 6: http://conventions.coe.int/treaty/EN/Treaties/html/005.htm) states that any person who is charged with a criminal offence is entitled to a fair hearing by a tribunal, and has the right to be informed promptly of accusations against them. This may well have implications for detained patients who appeal for a mental health review tribunal where all allegations regarding their behaviour or mental state are 'accusations against them'. Second, doctors have a clear and overriding duty to their patients. Psychiatrists have a duty to act in good faith and in the patient's best interests. This involves informing them of any information which will affect clinical decisions and is likely to include any information discussed with the Home Office in the case of a restricted patient. In short, our duty to the patient and the public interest outweigh any duty to the informant. Third, if an allegation involves sexual abuse, it raises our responsibilities with regard to child protection legislation and the public interest. Enacting this may lead to investigation and hence to the patient being aware that information has been given and being able to identify the informant.

We would suggest that the College reviews its recommendations over third-party information, and recommend that any advice take account of the fact that, in certain circumstances, the rights of a patient may outweigh the rights of an informant to confidentiality.

Royal College of Psychiatrists (2000) *Good Psychiatric Practice 2000*. Council Report CR83. London: Royal College of Psychiatrists.

J. Sandford, A. Lee, A. James Avon and Western Wiltshire Mental Health Care NHS Trust, Blackberry Hill Hospital, Blackberry Hill, Stapleton, Bristol BS16 1ED

Whose consent is it anyway?

We were interested to read the editorial by Pinner (2000). In particular, the significant advocacy role we have traditionally accepted of relatives, which may conflict with the views of elderly people in general. It has become accepted good practice in clinical situations and research to seek and be influenced by the opinion of carers and relatives acting in this role.

The issue of consent among mentally incapacitated adults is a complex problem. We have been studying the views of elderly patients with mental health problems towards cardiopulmonary resuscitation (CPR). The study was confined to an acute in-patient population. Part of this enquiry required us to ask patients with a dementing illness "If your heart was to stop now, would you want us to bring you back to life?" and "If you were suffering from an incurable illness, would your answer be the same?" Other than completing a severity rating scale and depression inventory nothing else was required of the patient.

Relatives were asked for permission to approach patients. Considerable effort was made to recruit support by lengthy discussions and written material but to no avail. Eleven consecutive relatives refused, saying, in all cases, that the question would upset the patient too much.

There is evidence that relatives' proxy consent does not necessarily reflect the wishes of individuals and where divulging the diagnosis of dementia is concerned relatives wish this information to be withheld from the patient when they would expect to be told if they were affected (Maguire *et al*, 1996). This double standard also seems to affect psychiatrists (*Hospital Doctor*, 16 July, 1997). Denial has been reported as a means of coping by Alzheimer's patients (Bahro *et al*, 1995); is it possible that carers' decisions are influenced more by processes of denial and emotional self-protection than the needs of the patient?

Although there have been concerns that discussions about CPR with elderly patients might be distressing, the evidence indicates that elderly people are grateful for the opportunity to discuss this subject, which they consider important and upon which they wish to make their views known (Morgan & King, 1994). It is also clear that decisions and policies about CPR are usually absent or unclear and decisions are frequently left to junior staff in an emergency. Moreover,

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