Research letters

Sharing confidential information of cognitively intact older patients: what do patients think? An exploratory study

SIR—Confidentiality is the cornerstone of the doctor–patient relationship. The General Medical Council (GMC) specifically notes that respecting and protecting confidential information are essential duties of a doctor [1]. GMC Guidelines of April 2004 elaborate on this aspect of clinical care:

‘... Doctors hold information about patients which is private and sensitive. This information must not be given to others unless the patient consents or you can justify the disclosure... Inform patients about the disclosure, or check that they have already received information about it...’ [2].

Good communication is another vital element in the delivery of effective care and there is much interplay between these two factors [3].

‘... You must respect patients’ confidentiality. Seeking patients’ consent to disclosure of information is part of good communication between doctors and patients...’ [2].

Sharing of patients’ confidential information within the multidisciplinary health care team is commonplace and widely accepted as being in the best interests of patients. GMC guidelines state that patients should be informed of this disclosure and that the disclosure should not occur if the patient maintains objections [3].

Doctors may tend to share patients’ confidential information with groups other than the multidisciplinary team for whom the case that they need to know is less clear (e.g. patients’ relatives). Balancing good communication with these groups against the duty to respect patients’ wishes for confidentiality is common in the care of the elderly.

In Scotland, there is a clear legal framework within the ‘Adults with Incapacity (Scotland) Act 2000’ for information to be disclosed to family and carers, etc. for patient benefit [4]. However, this does not apply to older adults who retain capacity. It is part of good practice to ascertain this as it is the duty of the doctor to obtain this information. However, little is known about what information cognitively intact patients in care of the wards for the elderly are happy to have disclosed and to whom. The GMC provides clear standards of care about this issue. We sought to perform an initial audit in our hospital to see how well medical teams were performing compared to these standards. We, therefore, ascertained patients’ views about this issue asking three specific questions:

1. Do patients wish us to share their information?
2. Do we ask our patients what they would like shared and with whom?
3. Do patients feel they should be involved in the decision to share information?

Methods

As this was an initial study we did not attempt a large-scale audit at this stage. A random sample of 30 patients (11 males and 19 females) was selected between May and July 2006 in a care of the elderly acute assessment and rehabilitation hospital. All patients were either inpatients or medical day hospital attendees. The foci of the inpatient wards included general assessment and rehabilitation of older people, orthogeriatric rehabilitation, movement disorders and stroke medicine. The patients involved in the study were required to be cognitively intact. This was accepted as an Abbreviated Mental Test (AMT) of 7/10 or Mini Mental State Examination of >24/30. Each patient gave verbal consent to participating in the study. The age range of patients was 63–96 years (mean age, 82 years). The patients involved had a typical wide range of clinical conditions including community-acquired pneumonia, congestive cardiac failure, cellulitis, stroke, fractured neck of femur, deep venous thrombosis etc. A doctor (JT) interviewed each patient and asked whether (s)he had ever been asked by a doctor what information about her/his current illness (s)he would be happy to permit being discussed and with whom. Patients were asked directly about disclosure of information about diagnosis, investigations, treatment, prognosis and resuscitation status. Patients were asked whether they felt it was important to be asked about the sharing of confidential information with others and whether they would have initiated such a discussion with their doctor. Please see Appendix 1 in the supplementary data on the journal website (http://www.ageing.oxfordjournals.org/) detailing the full structured interview.

Results

Only one of the 30 patients had been asked by a doctor what information about their current illness they would like discussed with their family, next of kin or others. All of the patients were happy for doctors to discuss their condition with some other person, especially close relatives (Table 1). Where discussion was approved, disclosure of most kinds of information about medical care was thought appropriate, though some patients indicated their preference for restricting discussion with third parties who were not close relatives (Table 2). Twenty-seven (90%) patients thought it was important for them to be asked about the sharing of their confidential information, but only six (20%) said that they would have initiated a discussion about this with their doctor if they had not been asked about it.

Discussion

This is a small study. Nevertheless, the results show that doctors do not frequently involve patients (with the capacity to decide) in decisions regarding sharing of their confidential information. The patients in this study were generally content for most of their confidential medical information to be shared with most groups (especially their
The issues of prognosis and resuscitation status may, however, be considered too personal by a proportion of patients to be shared with less close groups. This is germane, because patients believe it is important to be asked about, and involved in, any decisions regarding sharing of confidential information. Despite this, most of the patients in this study were reluctant to initiate such discussions with doctors.

Despite the fact that doctors share confidential medical information on a regular basis with relatives we could find no previous studies addressing this issue in the care of older people. A number of studies have examined the importance of communication in other settings. Nelson *et al.* [5] reported a qualitative study of intensive care unit survivors. They found that, given the poor outcomes for most patients and high costs and burdens of treatment, effective communication between clinician, patient and the patient’s family is essential when critical illness enters a chronic phase [5]. Hagerty *et al.* [6] examined the preferences of patients with incurable metastatic cancer with regard to the process of prognostic discussion. They concluded that the majority of patients preferred a realistic and individualised approach from the cancer specialist and detailed information when discussing prognosis [6]. Both of these reports support the trends revealed in our study.

The data in this study is limited by several factors. The sample size of 30 patients is small. Conclusions based on such small numbers must be guarded. Due to geographical location, the study population consisted predominantly of caucasian patients from a mainly Christian community. Older people of different ethnic and cultural backgrounds may present varying opinions regarding confidential information sharing. The patients included in the study were deemed cognitively intact on the basis of AMT >7/10 or MMSE >24/30. Psychometric tests are only a guide, not a substitute for a more detailed assessment of mental capacity. However, the cut-offs were chosen to be well above levels where patients’ understanding of talking to their relatives and others about their condition would be likely to be impaired [7, 8]. The cognitive status of patients included is germane to our reliance on patients’ reports of whether they had been asked about sharing of confidential information. Case note review revealed no documentation of any such discussions, though it remains a possibility that patients had forgotten them. Finally, the patients were interviewed directly by a doctor. This may have influenced their responses to the questions.

This study could be used as a basis for further work into the sharing of confidential information of cognitively intact older people. Any further work should have a larger sample size, incorporate patients from more diverse ethnic and cultural backgrounds, utilise more strict criteria on ensuring cognitive ability and consider the employment of health care professionals other than doctors to interview the patients.

Despite the limitations of this study, the general trend of results is clear. The patients in this study felt they should have been involved in decisions about sharing their confidential information. The overwhelming majority of these older patients stated that they had not been consulted about these decisions although most are content to share much of their confidential information with those closest to them. It is extremely important that doctors consider these views of cognitively intact older people and involve them more in the decision-making process. In particular, in view of the more sensitive issues of prognosis and resuscitation status, consideration could be given to the inclusion of an appropriately dedicated section in ‘Do Not Attempt Resuscitation’ forms. This could list those people that the cognitively intact older patient might wish to be kept informed of such a clinical decision.

**Conflict of Interest**

The authors have no conflict of interest.

**Key points**

- Doctors frequently fail to involve patients in decisions regarding sharing of their confidential information.

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<th>Treatment (%)</th>
<th>Outlook (%)</th>
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- Patients believe it is important to be asked about, and involved in, any decisions regarding sharing of their confidential information with people not involved with their health care.

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Supplementary data

Supplementary data for this article is available online at http://ageing.oxfordjournals.org.

References


doi:10.1093/ageing/asf020
Published electronically 27 April 2007

Prescription of paracetamol-containing medications as indicator of quality of prescribing

SIR—Paracetamol is widely prescribed for mild to moderate pain and pyrexia. It is available as a single ingredient and also in combination with opiate analgesics such as codeine and dihydrocodeine. The recommended dose of paracetamol for adults is 0.5 to 1 g every 4–6 h to a maximum of 4 g in a given 24-h period [1].

Hepatotoxicity is rare if doses of paracetamol <12 g (or 150 mg/kg body weight) are ingested [2] although it is described [3, 4]. Patients with poor nutrition are particularly at risk of hepatotoxicity even at doses within the recommended range [5]. This may be relevant for older people in hospital as the prevalence of malnutrition is known to be high in this population [6]. However, we are not aware of clinical trial evidence to suggest that older people should have a lower recommended dose. In fact, the current recommended dose is not based on randomised controlled trial data. Using a single intravenous dose of 500 mg of paracetamol, Wynne et al. showed paracetamol clearance to decrease with age and frailty [7]. Miners et al. showed that after administering a single oral dose of 1 g of paracetamol the total clearance and clearance by glucuronidation did not change with age although there was a reduction in clearance by sulphation and renal clearance [8]. Interestingly there was no age effect on the cytochrome P450 mediated clearance of the reactive toxic metabolite. This has also been seen in rat studies [9].

While deliberate overdose of paracetamol is well known, inadvertent, iatrogenic over-dosage is less well recognised. The National Sentinel Audit of Evidence Based Prescribing for Older People supported improvements in prescribing by measuring the quality of prescribing practice [10]. We report here on the prescription of paracetamol and paracetamol-containing preparations in 102 hospitals that participated in the audit and give an estimate of the risk of exceeding the recommended dose of paracetamol. The data were collected prior to the withdrawal of Co-Proxamol, dextropropanoxphene in combination with paracetamol, withdrawn in January 2005, because of poorly established efficacy and unacceptable risk of toxicity in overdose [11].

Methods

Hospitals in England and Wales were invited to volunteer to participate in the study in 1999 and 102 hospitals agreed. Prescribing data on paracetamol-containing medications were collected from drug charts of 100 consecutive medical inpatients aged 65 years or older on a selected day for each hospital. Data collected included the dose and frequency of all paracetamol containing medications prescribed. The total paracetamol content in milligrams prescribed to patients was evaluated over a 24 h period. We did not collect data on medications actually administered and nurses did not prescribe. Patients were considered to be at risk of overdose if there was the potential to be administered over 4 g of paracetamol in 24 h.

Results

Data were collected for 9,979 patients. Of these, 9,927 patients had one or more drugs prescribed. Among these patients 6,141 (62%) were prescribed 6,560 medications