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Informed consent is a process, not a single moment in time. Information often has to be given to patients/clients over time if it cannot be absorbed all at once. Sometimes it takes time to build trust. Ask yourself how urgently the consent is required. And remember: consent is a two-way process! The doctor or nurse has to learn enough about the patient/client to make a decision as well. And in hospitals, you may need to view proxy consent in the light of hospital organisation.

Confidentiality

Nurses are required to 'protect all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent, where required by the order of a court or where you can justify disclosure in the wider public interest' (UKCC, 1992a).

Dimond (1995) lists exceptions to the duty of confidentiality:

- Consent of a patient
- Interests of patient
- Court orders
- Subpoena
- Supreme Court Act (1981)
- Statutory duty to disclose
- Road Traffic Act (1972)
- Prevention of Terrorism Act (1989)
- Public Health Act (1984)
- Misuse of Drugs Act (1971)
- Public interest
- Police.

Nurses are required to protect patient/client confidentiality, both by the terms of their employment contracts (usually), and through their duty of care. To trust someone else with private and personal information is a very important matter, and care should be exercised to make sure that the information is kept in the spirit of the relationship of trust in which it was given.

What must be kept confidential?

Sometimes, it can be difficult to determine what information should be confidential. Are patients'/clients' middle names or post codes confidential? Both of these are publicly accessible, easily gleaned from electoral registers in public libraries; however, in the nursing situation the information has been given freely to a nurse in the performance of their professional role and should be treated as confidential.

The easiest way to manage the dilemma of what is and what is not confidential is to treat all information as confidential. Check with the patient/client in your care about the more obvious information you might be asked to divulge, for example religious preferences. Is the patient/client happy for you to divulge these to a visiting minister of religion?

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In registered nursing homes only the registration officer has the right to access written records about patients/clients, as part of the registration process. All other requests for access to information (even from social workers and police) should be made in writing and have the written consent of the resident prior to release or, if the resident is unable, the written consent of the advocate.

Do you know the regulations which govern disclosure of information about patients/clients in your setting, for example to primary or community care practitioners? If you are unsure, find out from your line manager or mentor and ask him or her to clarify any points you are not clear about.

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Consider whether there are any situations in your own work where you might need to balance the need for patient/client confidentiality against legal considerations. How might you handle such a situation in order to protect both your patient/client and yourself. If you are unsure, discuss the issue with your line manager, mentor or tutor.

Issues of disclosure

A further dilemma can occur when a patient/client has been discovered to be suffering from a terminal illness or disease:

- Should the patient/client be told?
- Or should the relatives be told first, and then asked for their opinion as to what is disclosed to the patient/client?

This is not an uncommon situation. Nurses, doctors, relatives and almost everyone else close to the patient/client know the person's diagnosis and prognosis. Relatives and friends do not have the right to tell healthcare staff to

What price confidentiality?

In December 1999 Ruth Wyner, director of Wintercomfort day centre for homeless people in Cambridge, and the centre's manager John Brock were jailed for five and four years respectively:

'The prosecution said they were "knowingly permitting or suffering the supply of a Class A drug on the premises". Ms Wyner and Mr Brock are awaiting a date to appeal against their sentences.

'The case has serious implications for community psychiatric nurses (CPNs) and others who work with homeless people and drug users. Ms Wyner and Mr Brock were concerned that handing over the names of suspected drug dealers to police would put staff at risk of reprisals and undermine the principle of confidentiality that is fundamental to helping homeless people come off the streets. Judge Jonathan Haworth ruled that client confidentiality was not a defence.

'Some nurses have welcomed the decision. They see illegal drug use as causing serious harm to patients and communities, with all the resultant pressures on psychiatric inpatient units and A&E units. They believe that if staff turn a blind eye to drug dealing they get what they deserve.

'However, for workers in homelessness or drug projects who work alongside people who use illicit drugs it is part of everyday life. And people who have a drug addiction often sell small amounts as a way of financing their drug use.

'The ruling means that if a CPN is aware of the trading of drugs and does not take action to prevent it, they will be guilty of "knowingly permitting" the supply of drugs and could face a jail sentence. [...]

'So could CPNs find themselves in a similar situation to that of Ms Wyner and Mr Brock? Homelessness day centre staff usually act swiftly to bar anyone known to be selling drugs (as did the staff at Wintercomfort). But people who deal in drugs rarely draw attention to themselves. There may be suspicions but little else.

'The UKCC recognises the difficulties the issue of confidentiality raises, but leaves the decision with the nurse: "No exploration or elaboration by others alters the fact that the ultimate decision is that of the individual practitioner in the situation".'

Ms Wyner and Mr Brock were released on bail after seven months, pending an appeal. At the time of writing, they are awaiting the appeal hearing.

Simpson, 2000