As a midwife 'you must respect a woman's right to confidentiality': A Northern Ireland perspective

Abstract

Within the role of a registered midwife, the issue of maintaining confidentiality is complex. A midwife's responsibility is outlined and governed by laws such as the Human Rights Act 1998 and the Data Protection Act 1998. The ideology of confidentiality is further reinforced by the Nursing and Midwifery Council, and should not cause the midwife undue pressure or stress; however, it often becomes a cause for concern. Midwives in Northern Ireland may carry out their role in environments that are not well suited for preserving confidentiality or sharing sensitive information. Conflict may arise for midwives in maintaining women's confidentiality while also having a duty of care to protect the public. In today's climate, many midwives experience a fear of litigation, so the importance and complexity of confidentiality must not be underestimated.

Keywords

Midwife | Confidentiality | Legal | Professional obligations

There are professional standards of practice and behaviour to which a registered midwife must adhere, which are set out by the Nursing and Midwifery Council (NMC). One such obligation is confidentiality, which extends to women and their families throughout their care (NMC, 2015). A woman's right to confidentiality is identified in the NHS Constitution and is part of creating and maintaining therapeutic relations (NHS, 2015). This is arguably one of the most sensitive and challenging aspects for a midwife to manage. The Human Rights Act 1998, Data Protection Act 1998 and common law principles result in the midwife being legally bound to confidentiality until it becomes clear that information needs to be disclosed (Peate and Hamilton, 2008). This article explores the role of the midwife relating to confidentiality, its significance within midwifery in Northern Ireland, and the difficulties and challenges it brings. It will identify when and why trusted information is shared, why the right to confidentiality is not absolute, and the consequences when a breach of confidentiality arises. Examining the systems in place in midwifery, the article evaluates their success in protecting sensitive information and providing a platform for woman-centred care. Ultimately, the aim of this article is to highlight the importance of trust between a woman and midwife, the determining factor being confidentiality.

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Defining confidentiality

Confidentiality is defined as an 'ethical principle in which information about individuals is made available only to those who need it' (Tiran, 2012: 49). The NMC (2015) adds that every person has a right to confidentiality, and it is a midwife's duty to ensure each person in his or her care receives it. Reinforcing this, the Data Protection Act 1998 serves to protect a person's confidential information and controls how this can be used by organisations (Jones and Jenkins, 2004). This is further strengthened by the Human Rights Act 1998, whereby each woman has a right to professional midwifery care, thus a right to informed consent and privacy of personal information (Clarke, 2015). The right to privacy and life is a basic right (Macdonald and Magill-Cuerden, 2011), but the state has the power to override privacy rights for various reasons, one of which is public safety (Rainey, 2015). It is, therefore, essential for a midwife to know the rights to privacy for individuals, in order to fulfil his or her duty to women and their families—in addition to protecting himself or herself from legal or disciplinary action.

Importance of confidentiality in midwifery practice

Confidentiality is one of the most important issues to consider during a consultation between midwife and

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woman (Edwards, 2010). For a midwife to successfully fulfil the role of caring for a woman holistically, s/he must obtain a substantial amount of personal information from the first appointment. To provide optimal individualised care to every woman, the midwife must work to build a rapport with women, enabling them to feel safe, unjudged and at ease. This is key in midwifery practice; when a woman feels safe, she will feel confident to start the information-sharing process with her midwife, together ensuring the best possible start to pregnancy for her. This process of sharing information aids in building a strong, trusting relationship, with the woman feeling well supported and unjudged (Peate and Hamilton, 2014). The midwife is, therefore, able to facilitate disclosure and provide specific support to each woman (Mauri et al, 2015). Research has shown that a woman needs to be asked numerous times about domestic violence before she feels ready to disclose, so should be asked a minimum of three times throughout her care (Stonard and Whapples, 2016). To gain a woman's trust, the midwife must follow the rules set out in the framework for moral reasoning from the first contact (Yap, 2014). Firstly, the midwife must practise with veracity and the duty of candour to always tell the truth. Secondly, there is the issue of confidentiality; and finally fidelity, which means to always do as one has promised (Hodkinson, 2013). These rules are the basis on which a trusted relationship may be formed. This, in turn, allows the woman to feel that her private information is safe in the hands of her midwife, who can use it to provide specific care and support. The importance of confidentiality to the woman–midwife relationship must not be overlooked.

Maintaining confidentiality in midwifery practice

There are systems in place to aid confidentiality in midwifery. In Northern Ireland, domestic violence—sadly, an ever-growing concern for midwives—is now recorded under 'routine enquiry' in the maternity handheld records (MHHR), in such a manner that only health professionals understand its meaning. This encourages women to be honest about domestic violence as it is not being clearly documented for anyone else to see. Midwives in all Health and Social Care Trusts (HSCTs) in Northern Ireland use an asterisk to indicate other sensitive information that the woman does not want documented in her MHHR. In such cases, another health professional will know to ask what the asterisk indicates (Public Health Agency for Northern Ireland, 2015).

Using such discreet methods reflects the importance of confidentiality, which will increase a woman's trust in her midwife. When presenting women with their MHHR, the responsibility of safekeeping and confidentiality should be enforced; each woman should be advised that the records must not be left in a place where information could be accessed by other parties. If any aspect of the care provided is called into question, the MHHR will be essential to any investigation (Beach and Oates, 2014). When the postpartum period is over, the records are returned to the HSCT where the birth took place and stored for 25 years before being destroyed (Public Health Agency for Northern Ireland, 2015). It is vital to adopt systems that allow the provision of woman-centered care, keeping women feeling safe and well cared for; to aid the preservation of safety for both the woman and midwife, accurate record-keeping is key. In a case where a woman has been told that her information will be recorded and used for the purpose of delivering effective health care, the midwife may share information with other members of the clinical team caring for that individual; disclosure must be restricted to the clinical team only (Griffith, 2015).

Challenges to maintaining confidentiality

Despite the importance of confidentiality, there are a number of systems in midwifery that could be argued to hinder it. The booking appointment is one of the first meetings between a woman and her midwife; during this 2-hour appointment a vast amount of personal and often sensitive information is shared. Current practice allows husbands or partners to attend this appointment; however, a woman being asked about previous pregnancies, past sexual health and social worker involvement may not wish to answer honestly in the presence of her partner (Bacchus et al, 2010). This practice could, therefore, hinder a midwife's ability to provide woman-centred care, and may be detrimental to women who feel especially vulnerable. Midwives should exercise caution during joint consultations, as there is a risk of accidentally breaching confidentiality (Edwards, 2010). This can be prevented by ensuring the computer screen is blank while the midwife is not in the room, not leaving maternity records where others can read them, and not discussing confidential details in public places (Beach and Oates, 2014). Likewise, it could be argued that the MHHR—structured, standardised, national maternity records that were formed to improve multidisciplinary communication (National Institute for Health and Care Excellence (NICE), 2016)—may actually be detrimental to a woman's confidentiality. As the records are held by the woman, all detailed information is effectively available for her partner or relatives to view. Each woman should, therefore, be advised on the confidentiality and safekeeping of her MHHR.

The process of information-sharing based on trust between a woman and her midwife is enhanced with continuity, when the woman receives care from the same midwife at every appointment (Jenkins et al, 2015). That

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said, the philosophy of each woman receiving all her care from the same midwife may be seen as an unrealistic ideal. An increased emphasis on service modernisation, reform and the delivery of midwifery-led models of care, requires a highly trained workforce delivering care 24 hours per day, 7 days per week (Department of Health, Social Services and Public Safety, 2011). Such models of care, although commendably promoting continuity, inevitably warrant more than one midwife delivering care to particular women; therefore, the need to share information about women is essential for optimal care within this model. This presents two main problems with confidentiality: firstly, should a woman require additional appointments, the risk of an accidental breach of confidentiality is increased. As a result, midwives must ensure that all documentation concerning each woman is transported safely and, where appropriate, disposed of as confidential waste. Secondly, when a number of midwives are involved with a woman's care, the decrease in continuity may mean trust is reduced, leaving the woman feeling unable to confide in her midwife. Continuity is best practice for woman-centred care and, where possible, should be implemented to encourage information-sharing between the midwife and woman.

The disclosure of information

The UK Department of Health (DH, 2003) has identified exceptions allowing disclosure of information to appropriate sources without consent. These may be useful when making a judgement about disclosing information. Disclosure to appropriate sources would be allowed in cases of suspected abuse of dependents, under vulnerable adult and child protection procedures (DH, 2003; Department for Education, 2015). Exemptions include:

- Disclosure in the public interest
- Disclosure in the interest of justice
- Disclosure for the public good
- Disclosure to protect a third party
- Disclosure to prevent or detect a serious crime.

Given that midwives will face sanctions from their employer, professional regulatory body, and the law for an unwarranted breach of confidence, it is essential that any disclosure of information is undertaken appropriately, within the requirements of the duty owed to the woman in question.

If a midwife is unsure whether a disclosure of information is justified, advice should be sought from a senior colleague or manager (Griffith, 2015). Policies on the use and disclosure of patient information should be followed (all NHS establishments are required to have these), along with the advice given in the *NHS Code of Practice* on confidentiality (DH, 2003). In addition, midwives must consider the requirements of the NMC *Code*, which endorses that midwives must promote professionalism and trust at all times by personal commitment to professional standards and behaviour. This model of integrity should lead to confidence in the profession from women and the public (NMC, 2015). Having a duty of confidence to the woman generally requires that disclosure of confidential information for purposes other than care and treatment must only be made with the explicit consent of the woman, unless an exception to that duty applies or the information can be disclosed in an anonymised form (NMC, 2015). Where confidential information must be disclosed without the explicit consent of the woman, there is a need to carefully consider whether an exception to the general duty of confidence applies (Griffith, 2015).

Ensuring appropriate sharing of information: Caldicott guardians

Each NHS organisation has a guardian of person-based clinical information, known as the Caldicott guardian, overseeing the use and sharing of such information. This person ensures that patient-identifiable information is only shared for justified purposes, and that only the minimum necessary information is shared in each case (NHS, 2015). The Caldicott guardian plays a key role in ensuring that the NHS satisfies the highest practical standards for handling patient-identifiable information. He or she should appropriately facilitate and enable information-sharing, and be a source of reason on the lawful and ethical processing of information to ensure appropriate information-sharing.

Protection of confidential information is crucial in midwifery; however, there are instances when confidential information shared will result in a midwife referring a woman to other services, such as social services, in the interests of both the woman and the infant. In order to maintain a trusting relationship with women, NICE guidelines recommend that the midwife should address women's fears about the involvement of children's services by providing information and reassurance (NICE, 2010). This referral, known as Understanding the Needs of Children in Northern Ireland (UNOCNI), should not be viewed by the woman as negative, but as a step being taken by the midwife to help support her and her family; this is an example of disclosure with consent (Edwards, 2010). The process of sharing information between the woman and midwife helps to build a strong, trusting relationship, with the woman feeling well supported and unjudged (Peate and Hamilton, 2014). The midwife is able, therefore, to facilitate disclosure and provide specific support to each woman (Mauri et al, 2015).

Good practice and the midwife

One area of confidentiality that is sometimes difficult to control is unavoidably disclosing information (Edwards,

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2010). This may happen in a situation where voices are overheard through closed doors becuase the midwife raises his or her voice when a woman has hearing difficulties or when there is a language or learning difficulty barrier (Harrison and Willis, 2015). The risk of information being overheard can be reduced by ensuring consultations happen in secure, private rooms out of earshot of others. Interpreters, like midwives, are legally bound to confidentiality, and consent will have previously have been obtained from the woman regarding this (Dhami and Sheikh, 2008). The NHS Constitution states that every patient (or service user) should have the right to privacy (NHS, 2015). In addition, the Human Rights Act 1998 and common law policies enforce an obligation of confidentiality on individuals who may receive or hold personal information about a service user (Wheeler, 2012). However, while health care brings positive benefits to many people, persistent faults regarding areas such as informed consent and confidentiality, as well as more deliberate violations, still arise (Talbot, 2013). Disclosure without consent is just that—the woman has not consented to the information being shared. If, for example, a woman has attended to have vaginal swabs taken, it is not acceptable to release the results to anyone other than that woman. Should a concerned husband telephone, explaining that his wife is in an important meeting and therefore unable to call herself, it must be reiterated that the information being requested is confidential to the woman (Edwards, 2010). If a midwife breaches confidentiality, s/he will be referred to the NMC, subjected to a fitness-to-practise investigation for misconduct, and may face the severe sanction of being struck off the professional register. It is estimated that 80% of referrals to the NMC in 2014/15 were attributed to misconduct and may have involved a breach of confidentiality (NMC, 2015). This reinforces the need for good record-keeping and adherence to standards and guidelines (NMC, 2012). Following an investigation by the midwife's employer, the midwife could lose his or her employment status, and may also face litigation in common law from the woman herself.

Ethical issues regarding confidentiality

Although preserving confidentiality is essential, it cannot be ethically justified to withhold information that could prevent serious harm to others if shared (UK Caldicott Guardian Council, 2012). There are instances where the duty to safeguard clashes with the duty to maintain confidentiality; in such a case, the benefit to the wider public must outweigh the individual's right to confidentiality (Talbot, 2013). For example, should a midwife have knowledge of a vulnerable person at risk from another individual, the information must be disclosed to the relevant parties as protocol dictates to protect the vulnerable individual and possibly the wider public. This utilitarian theory is commonly used in public health, whereby the midwife is acting for the greater good. This highlights the hazard that midwives find themselves facing when confronted with a confidentiality issue: to share or not to share. A certain amount of clinical judgement must be used; however, this often leaves midwives open to condemnation and disciplinary procedures (Higginson, 2009). It is essential that midwives know the Trust and local policies and procedures surrounding confidentiality and safeguarding, to ensure safety for all parties.

Confidentiality is a serious matter. The Department for Education (2015) recognises information-sharing as a fundamental part of every practitioner's role. To identify the correct time to share information, it has compiled seven rules for sharing information, which can be summarised as (Department for Education, 2015):

- Do not perceive the Data Protection Act 1998 as a barrier, but as a framework to ensure information is shared correctly
- Be open and honest from the outset, unless it is unsafe to do so
- If in doubt, seek advice without revealing the individual's identity, if possible
- Where possible, share with consent, and always respect the wishes of the individual who does not wish to share
- Be aware that even if information is based on facts and the midwife's own clinical judgement, it may still constitute sharing without consent
- Consider safety for everyone concerned and decide whether what you are about to share is necessary and appropriate
- Finally, record everything in detail and accurately.

Conclusion

Clear guidance on confidentiality is provided, yet the subject continues to cause considerable problems for midwives. It may appear to be simple, in theory; in reality, however, it can be extremely challenging. The NMC provides a benchmark to which midwives must uphold standards, but this often leaves little room for professionals to make their own clinical and ethical judgements (Higginson, 2009).

Simple practices to help maintain confidentiality include ensuring the computer screen is blank when the midwife is not in the room, not leaving patient records where others can read them, and not discussing confidential details in public places (Beach and Oates, 2014). However, this article has outlined areas where safeguarding confidential information is difficult with the systems in place within midwifery. A midwife should recognise the importance of confidentiality for the women in his or her care, as well as the importance

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Key points

- Maintaining confidentiality is a complex issue for midwives
- The midwife's role is governed by the law and the Nursing and Midwifery Council's professional code
- Conflict arises in maintaining confidentiality while also having a duty of care to protect the wider public
- A balance can be reached by using effective professional decision-making maintaining both women's right to have their confidences respected and the need to share confidential information

of protecting him- or herself. Confidentiality is key, not only to provide woman-centered care but to the midwife–woman relationship, which is based on a foundation of trust formed at the very first appointment (Lewis, 2015). A midwife's role is to be 'with woman'—to afford her the safest, most relevant care possible, not only physically but holistically. Without confidentiality, this is not possible, as confidentiality is essential to trust.

Midwives must balance their legal and professional duty to maintain confidentiality against the exceptions to that duty allowing disclosure. Although there are certain circumstances under which the courts can require disclosure, it is left largely to a midwife to exercise his or her professional judgement when deciding whether to reveal confidential information to others. This leaves the midwife open to a charge of breaching both the professional and legal duty of confidence, and risks sanctions that could include losing his or her job and professional status.

Midwives must inform their professional decision-making by adhering to the guidance of courts, their code of conduct, and the *NHS Code of Practice* on confidentiality in resolving the dilemmas that arise from the burden of keeping confidence. In this way, a balance will be reached in maintaining both women's right to have their confidences respected and the need to share confidential information. BJM

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