Does Sociodemographic Background Determine the Responses to Ethical Dilemma Vignettes among Patients?

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ABSTRACT

Background and Aims: Patients are important stakeholders in the care process and may have different viewpoints on clinical disclosure, which may be influenced by their sociodemographic and cultural background. Hence, the aim of this study was to assess whether age, gender, employment status, educational status, and other sociodemographic variables of persons with mental illness influence their views about ethical issues in clinical care. Materials and Methods: The study was conducted at the Outpatient Department of a tertiary care mental health/de-addiction center in North India. Patients aged ≥18 years and currently in remission of their primary psychiatric illness were included. Using case vignettes, their responses to ethical issues related to clinical situations were assessed. Results: The study included a total of 160 participants. The younger age group less frequently agreed on disclosure of a man’s Human Immunodeficiency Virus-positive status to other family members against his wishes. Women less frequently agreed on disclosure of marital strife to husbands’ parents. Higher educational status was associated with a less frequent agreement to disclosure of a man’s suicidal ideas to other family members, and those currently employed less frequently agreed to disclosure of marital strife of a female patient to her parents. Conclusion: Age, gender, education, and employment status might influence some of the responses to ethical dilemmas in the clinical setting. These factors may be considered while clinical decision-making faces ethical challenges.

Key words: Confidentiality, ethics, mental health, patient, sociodemographics

Key message: Ethical issues in health-care are important concerns, but are infrequently discussed. This paper explores whether demographic factors have an influence on the way patients and their family members discern and resolve ethical conundrums.

CASE VIGNETTE

A 30-year-old married male presents to a psychiatrist with an illness of 4 months, characterized by persistent pervasive low mood, loss of interest in previously pleasurable activities, getting easily tired both physically and mentally, inability to sleep at night, not feeling...
like taking food, forgetting things easily, and inability to focus on the task at hand. Later, he has also started thinking that he is a burden to his family and that he will not be able to overcome from his current situation and also has recurrent thoughts of ending his life, though he did not want his suicidal ideation to be revealed to his family members. Patient also requested the psychiatrist not to disclose his suicidal ideations to anyone. The family members, however, want to know the content of the discussion between the two. Should the psychiatrist disclose the patient’s suicidal ideations to his family members in spite of the fact that the patient does not want the same?

INTRODUCTION

Autonomy of an individual in society is usually culturally driven. When an individual comes in contact with the healthcare, his autonomy is influenced by his cultural heritage and society’s perceptual framework of illness, well-being, and accepted treatment modalities. Ethical issues, especially those pertaining to confidentiality, can bring a health professional at the cross-road of dilemma particularly in situations which involve disclosure of a sensitive information like informing a patient about his life-threatening medical condition like malignancy or making a decision for a terminally ill patient like taking away his life-supporting measures or maintaining confidentiality while dealing with the patients with substance use and sexual problems, and mental illnesses.

Studies have shown that patients who believe that their privacy will be respected are more likely to seek treatment, discuss problems openly, and return for follow-up care. It is interesting to note that physicians themselves may have differing opinions about how much information should be disclosed, to whom and when, particularly in the setting where a family is actively involved in the patient’s care and have their own apprehensions regarding the patient’s illness. Patient perspectives on ethical dilemmas and confidentiality can provide stakeholders insight into what could be the right course of action in a given ethically dilemmatic situation. Patients themselves are also an important party to the care process along with the healthcare providers, policymakers, and the caregivers and may have different viewpoints about what is ethically correct in a particular situation, especially those involving confidentiality; hence, their views about ethical issues in medical care need attention. However, patients themselves represent a heterogeneous population with varying sociodemographics and to understand whether selected demographic characteristics influence their thought process toward addressing clinical dilemmas would be helpful for clinicians to understand and anticipate their responses. In a previous work, we had highlighted patients’ and caregivers’ perspective on ethical issues in mental health care in terms of their agreement to the responses given for various ethical dilemma situations. In this work, we aimed to assess whether the sociodemographic characteristics, such as, age, gender, education, occupational status, etc., of persons with mental illness influence their responses.

MATERIALS AND METHODS

This study was conducted at the outpatient services of a tertiary care mental health/de-addiction center in North India. The hospital provides clinical services in the form of pharmacotherapy, psychotherapy, and rehabilitation. The study employed a sampling of convenience, and all the patients following up in the Psychiatry Outpatient Department (OPD) and fulfilling inclusion criteria of having age >18 years, in remission of their primary psychiatric condition, mostly mood or psychotic disorders, as assessed through clinical interview by a trained psychiatrist, and scoring less than eight on both Hamilton Depression Rating Scale (HAM-D) and Young Mania Rating Scale (YMRS) and less than four in all the items of the Brief Psychiatric Rating Scale (BPRS), were included. The participants were recruited after obtaining written informed consent. The study had approval from the Institute Ethics Committee.

The participants were presented with case vignettes. These vignettes were in the form of short sentences depicting clinical situations which require responding about whether a doctor should divulge sensitive information to spouse or family members or undertake coercive treatment. The vignettes, portraying six different ethically challenging situations in the Indian context, prepared after a discussion among the investigators, all of whom were psychiatrists (including two being assistant professors). The vignettes were presented in Hindi, and responses were sought in the form of yes/no. The interviews were conducted by qualified psychiatrists between February 2016 and January 2017.

Descriptive statistics were used for the demographic data. The responses of the participants to each of the vignettes (in the form of yes/no) were compared across various sociodemographic characteristics, using Chi-square test. A P value of <0.05 was considered significant. The analysis was done using licensed SPSS software (version 21.0, IBM Corp., Armonk, New York, USA).

RESULTS

In total, 160 patients were included. They had a mean (± SD) age of 35.6 ± 11.3 years. Sociodemographic
characteristics of the sample are presented in Table 1. Ninety-three (58.1%) were males, 81 (50.6%) were educated above the tenth grade, 73 (46.6%) were employed, 89 (55.6%) belonged to a nuclear family, 126 (78.8%) had urban residence (two missing data for employment status and residence), and the median per capita income was 5,000 Indian National Rupees (INR) (interquartile range from INR 2,400 to INR 8,000). The primary diagnosis was anxiety spectrum disorders in 56 (35.0%), mood disorders in 44 (27.5%), substance use disorders in 41 (25.6%), and psychotic disorders in 19 (11.9%). Male gender was associated with the patient being employed (Spearman Rho = 0.528, \( P < 0.001 \)), but gender was not associated with age or educational categories. Educational attainment did not have a statistically significant relationship with occupation status.

The tabulation of various sociodemographic parameters across the response to case vignettes is shown in Tables 2 and 3. Significant differences emerged only for four of the comparisons. Only those variables have been tabulated whose dichotomized categories have shown at least one statistically significant association with the responses on the vignettes.

To summarize the results, it was observed that younger age group less frequently agreed on disclosure of a man’s Human Immunodeficiency Virus (HIV)-positive status to other family members without his wishes (\( \chi^2 = 4.690, \ P = 0.030 \)). Females less frequently agreed on disclosure of marital strife to husbands’ parents when the wife was suffering from mild anxiety problems (\( \chi^2 = 4.055, \ P = 0.044 \)). Participants who were unemployed, less frequently agreed on disclosure of marital strife to wife’s parents when the wife was suffering from mild anxiety problems (\( \chi^2 = 4.612, \ P = 0.032 \)). Higher education was associated with a less frequent agreement of disclosure of a man’s suicidal ideas to other family members (\( \chi^2 = 4.586, \ P = 0.034 \)). No statistically significant association was found between sociodemographic variables, such as age, gender, or

| Table 1: Socio demographic characteristics of patients |
|-----------------------------|-----------------------------|
| Variable           | Mean (±SD) or median (IQR) or frequency (%) |
|-----------------------------|-----------------------------|
| Patients               |                             |
| Age in years            | 35.6 (±11.3)               |
| Gender                 |                             |
| Male                    | 93 (58.1)                  |
| Female                 | 67 (41.9)                  |
| Education              |                             |
| Up to 10th grade        | 79 (49.4)                  |
| Above 10th grade        | 81 (50.6)                  |
| Occupation\*           |                             |
| Employed               | 73 (46.6)                  |
| Not employed            | 85 (53.4)                  |
| Primary Diagnosis       |                             |
| Anxiety disorder        | 56 (35.0)                  |
| Mood disorders          | 44 (27.5)                  |
| Substance use disorders | 41 (25.6)                  |
| Psychotic disorders     | 19 (11.9)                  |
| Family type             |                             |
| Nuclear                 | 89 (55.6)                  |
| Extended Joint          | 71 (44.4)                  |
| Residence\*            |                             |
| Urban                   | 126 (78.8)                 |
| Rural                   | 32 (21.2)                  |
| Per capita income\*     | 5,000 (5,600)              |

SD = Standard deviation. \*Indian Rupees per Month (1 US $= approximately 68 Indian Rupees currently). \*2 missing data. IQR: Interquartile range

| Table 2: Responses in “yes” represented as n (%) to questions on clinical vignettes |
|-----------------------------|-----------------------------|
| Vignette                    | Age                          | Gender                          |
|                             | ≤35 years (n=86) | >35 years (n=74) | Male (n=93) | Female (n=67) |
| 1. Wife being told about suicidal ideas of a man without his consent | 82 (95.3) | 68 (91.9) | 88 (94.6) | 62 (92.5) |
| 2. Other family members being told about suicidal ideas of a man without his consent | 75 (87.2) | 66 (89.2) | 84 (90.3) | 57 (85.1) |
| 3. Admission of a patient with alcohol use disorder without his consent when brought by a family member | 65 (75.6) | 60 (81.1) | 71 (76.3) | 54 (80.6) |
| 4. Admission of a patient with unprovoked violence without his consent when brought by a family member | 78 (90.7) | 67 (90.5) | 84 (90.3) | 61 (91.0) |
| 5. Disclosure without consent of issues with husband to wife’s parents when the wife is suffering from mild anxiety problems | 53 (61.6) | 51 (68.9) | 65 (69.9) | 39 (58.2) |
| 6. Disclosure without consent of issues with husband to husband’s parents when the wife is suffering from mild anxiety problems | 53 (61.6) | 52 (70.3) | 67 (72.0) | 38 (56.7)* (\( P = 0.044 \)) |
| 7. Disclosure without consent about a man’s (who had been suffering from mild depression) extramarital affair to his parents | 59 (68.6) | 59 (79.7) | 64 (68.8) | 54 (80.6) |
| 8. Disclosure without consent about a man’s (who had been suffering from mild depression) extramarital affair to his in-laws | 42 (48.8) | 46 (62.2) | 50 (53.8) | 38 (56.7) |
| 9. Disclosure without consent of a man’s HIV-positive status to wife | 82 (95.3) | 72 (97.3) | 88 (94.6) | 66 (98.5) |
| 10. Disclosure without consent of a man’s HIV-positive status to other family members | 58 (67.4) | 61 (82.4)* (\( P = 0.030 \)) | 64 (68.8) | 55 (82.1) |

\*Significant at \( P<0.05 \)
educational and occupational status with the responses on the vignettes related to coercive admission for a person with alcohol use disorder, unprovoked violence, and revelation of a man’s extra-marital affairs. Further, residence, family type, or per-capita income were not found to be associated with responses to any of the ethical case vignettes.

**DISCUSSION**

The findings suggest that the responses of patients on various ethical dilemmas, especially those involving issue of confidentiality, are influenced by sociodemographic variables, such as age, gender, education, and employment status. Some differences in opinion were observed in the patients’ responses, based on their age, gender, education, and employment status, in regard to disclosure of information relating to suicidal ideation, marital issues, and HIV status of a patient to his family members, though generally, responses did not differ across the groups.

Putting our findings in context, a previous study had shown that those with older age and from low sociodemographic status tended to be opposed to disclosure and patient decision making; on the contrary, their younger, wealthier, and more educated counterparts agreed the right of a patient to know about their medical status. In this study, as compared with the older population, the younger participants did not agree on disclosure of HIV-positive status of a person by the psychiatrist to formers' family members. This finding is in consonance with another study conducted on Korean American and Mexican American populations, in which younger participants were more in favor of maintaining patients’ autonomy than their older counterparts.

According to authors of the current study, the driving factor for younger participants’ response favouring confidentiality could be their perceived stigma associated with HIV/AIDS and, hence not agreeing to disclose the HIV-positive status of the patient to family members, thereby respecting the right of autonomy of the patients, while for older participants, the response was primarily governed by the need of family member to know about the HIV-positive status of their family members, which is considered a severe condition, so that effective preventive and therapeutic actions could be taken. A previous study had shown that revelation of HIV positivity of an individual to his family members is not only governed by the stigma associated with it but also by a relative need of involvement of family member in the treatment of HIV/AIDS, which is considered a grave condition in various religious and conservative societies. That study observed that 81% of patients of Saudi Arabia (versus 37% patients from the United States) favored disclosing HIV-positive status of an individual in a hypothetical situation to a patient’s family members even if a patient is not willing for the same, which the authors explained using the aforementioned psychological understanding.

Women in the sample supported nondisclosure of a female patient’s issues related to husband to her parents without her permission. One of the possible reasons for this finding could be that the women are probably not very comfortable in discussing their problems with her in-laws as compared to their own parents and also not sharing marital strife with the in-laws can be an attempt to maintain the harmony of the family, though this finding requires further corroborative research. 

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**Table 3: Responses in “yes” represented as n (%) to questions on clinical vignettes**

| Vignette                                                                 | Education | Employment |
|-------------------------------------------------------------------------|-----------|------------|
| 1. Wife being told about suicidal ideas of a man without his consent    | ≤10th grade (n=79) | >10th grade (n=81) | Employed (n=73) | Not employed (n=85) |
|                                                                         | 76 (96.2) | 74 (91.4) | 70 (95.9) | 79 (92.9) |
| 2. Other family members being told about suicidal ideas of a man         | 74 (93.7) | 67 (82.7)* (P = 0.032) | 67 (91.8) | 73 (85.9) |
| without his consent when brought by a family member                      |           |           |           |           |
| 3. Admission of a patient with alcohol use disorder without his          | 61 (77.2) | 64 (79.0) | 56 (76.7) | 68 (80.0) |
| consent when brought by a family member                                  |           |           |           |           |
| 4. Admission of a patient with unprovoked violence without his           | 73 (92.4) | 72 (88.9) | 68 (93.2) | 76 (89.4) |
| consent when brought by a family member                                  |           |           |           |           |
| 5. Disclosure without consent of issues with husband to wife’s parents   | 55 (69.6) | 49 (60.5) | 54 (74) | 49 (57.6)* (P = 0.032) |
| when the wife is suffering from mild anxiety problems                    |           |           |           |           |
| 6. Disclosure without consent of issues with husband to husband’s parents| 54 (68.4) | 51 (63.0) | 53 (72.6) | 50 (58.8) |
| when the wife is suffering from mild anxiety problems                    |           |           |           |           |
| 7. Disclosure without consent about a man’s (who had been                | 59 (74.7) | 59 (72.8) | 51 (69.9) | 65 (76.5) |
| suffering from mild depression) extramartial affair to his parents      |           |           |           |           |
| 8. Disclosure without consent about a man’s (who had been                | 49 (62.0) | 39 (48.1) | 39 (53.4) | 47 (55.3) |
| suffering from mild depression) extramartial affair to his in-laws       |           |           |           |           |
| 9. Disclosure without consent of a man’s HIV-positive status to wife     | 76 (96.2) | 87 (107.4) | 70 (95.9) | 82 (96.5) |
| to other family members                                                  |           |           |           |           |
| 10. Disclosure without consent of a man’s HIV-positive status to          | 64 (81) | 55 (67.9) | 52 (71.2) | 65 (76.5) |
| other family members                                                     |           |           |           |           |

*Significant at P<0.05
Those individuals who were employed, less frequently agreed on disclosure of marital strife in a female patient with mild anxiety disorder to her parents. This may represent that higher socioeconomical strata of the society prefer maintaining privacy regarding marital issues and to resolve things by themselves, a finding which warrants further research.

Our findings strengthen the literature related to ethics, especially in terms of a person’s right to autonomy and maintenance of confidentiality in the context of the medical setting.

This study has some limitations which require the reader’s discretion while interpreting the findings. These include a single tertiary care treatment setting, categorization of age and education to two singular groups, responses based upon hypothetical situations instead of the actual experience of the participants, and the limited number of ethical situations that could be addressed. Moreover, the vignettes were brief, and the questions were close-ended. Such an approach might have overlooked the nuances of thought-process that lead to a particular response in these clinical scenarios. Further, we did not assess the role of primary psychiatric illness in determining the responses to ethical dilemma vignettes.

CONCLUSION

This paper assessed the relationship of patients’ age, gender, and educational and employment status and their views about ethical dilemma in the clinical setting. These selected sociodemographic characteristics may generally have a minimal role in determining the responses, though some clinical situations may be influenced by these characteristics. Further studies are required that might look into how sociodemographic characteristics might influence the actual decision making through in-depth qualitative inquiry. Studies should also be conducted to explore whether sociodemographic characteristics influence the opinions of the general population with regard to the ethical issues in the medical setting.

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Conflicts of interest
There are no conflicts of interest.

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