Under what conditions do lay people and health professionals accept a breach of doctor-patient confidentiality regarding a patient with signs of terrorist radicalization ?

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Introduction: Confidentiality is crucial to the establishment of a strong patient-physician relationship. However, certain situations create a dilemma for the physician who is faced with the choice of either respecting medical confidentiality or protecting others from a serious risk of violence.

Objective: This study aimed to observe how lay people and health professionals assessed the acceptability of breaching confidentiality when a physician is confronted to a patient showing signs of terrorist radicalization.

Method: 228 participants (174 from the general population and 54 health professionals) judged the acceptability of 54 scenarios which were constructed through the orthogonal combination of 4 factors frequently mentioned in the literature: presence of a "Psychiatric disorder"; "Signs of radicalization"; "Projects of violence"; "Collegiality". Variance and cluster analyses were performed on all the raw data.

Results: Results showed that all factors influenced the judgment of participants but that "Psychiatric disorders" had a weaker impact. Five clusters were identified: "Favorable if collegiality" (n=23); "Favorable to breach confidentiality" (n=77); "Unfavorable to breach confidentiality" (n=26); "Sensitive to all factors" (n=71); "Favorable if violence" (n=31), respectively with mean ratings of 5.87, 8.42, 3.64, 6.30, and 7.16, on an acceptability scale of 0-10.

Conclusion: The importance that the great majority of participants attribute to these factors indicates that they influence their judgments in this specific context.

Keywords: breaching doctor-patient confidentiality; terrorist radicalization; ethic.

Sous quelles conditions le grand public et les professionnels de santé acceptent-ils de rompre le secret médical face à un patient présentant des signes de radicalisation terroriste ?

Introduction : Le secret médical est crucial pour établir une solide relation patient-médecin. Toutefois, certaines situations peuvent créer un dilemme pour le médecin qui doit alors choisir entre le respect du secret médical ou la protection de tiers face à un risque sérieux de violence.

Objectif : Cette étude visait à observer comment des personnes issues du grand public et des professionnels de santé évaluaient l'acceptabilité de la rupture du secret médical lorsqu'un médecin est confronté à un patient présentant des signes de radicalisation terroriste.

Méthode : 228 participants (174 issus du grand public et 54 professionnels de santé) devaient évaluer l'acceptabilité de 54 scénarios construits grâce à la combinaison orthogonale de 4 facteurs fréquemment mentionnés dans la littérature : présence d'un « Trouble psychiatrique » ; « Signes de radicalisation » ; « Projets de violence » ; « Collégialité ». Des analyses de variance et de cluster ont été effectuées sur l'ensemble des données.

Résultats : Les résultats ont montré que tous les facteurs ont influencé le jugement des participants mais que les "Troubles psychiatriques" avaient un impact plus faible. Cinq clusters ont été identifiés : « Favorable si collégialité » (n=23) ; « Favorable à la rupture du secret médical » (n=77) ; « Défavorable à la rupture du secret médical (n=26) ; « Sensible à tous les facteurs » (n=71) ; « Favorable si violence » (n=31), avec des moyennes respectives de 5.87, 8.42, 3.64, 6.30, et 7.16 sur une échelle d'acceptabilité allant de 0 à 10.

Conclusion: L'importance que la grande majorité des participants attribue aux facteurs indique que ces derniers influencent leurs jugements dans ce contexte spécifique.

Mots-clés: rupture du secret médical; radicalisation terroriste; éthique.

Ethical conflict and legal framework

From the original Hippocratic Oath until today, medical confidentiality has been one of the fundamental rules of all health professions (Barthélémi, Meersseman & Servais, 2011; Mouneyrat, 2001). Its legitimacy is based on a simple principle: to offer the best care and the maximum therapeutic effectiveness while assuring the quality of care which depends on confidentiality and trust (Hoerni & Benezech, 1996). Besides being a fundamental value of the ethics code, medical confidentiality is protected by law.

At present, French law is quite strict: breaching confidentiality is only allowed if the practitioner reports abuse on a minor – or a major if he/she has given his/her consent – or if the practitioner knows that a dangerous individual possesses a weapon or manifests the intention to obtain one (Conseil National de l'Ordre des Médecins [CNOM], 2017). This legal framework varies from one country to another: legislators of certain countries have introduced more dispensations.

Despite this legal framework, doctors are faced with ethically problematic professional situations, leading to a debate on the limits of this confidentiality. The debate generally revolves around two opposing theses: a "relativist" one which tolerates a flexibility proportional to the severity of the threat, and an "absolutist" one that categorically refuses any impediment to confidentiality (Crook, 2011). Ambivalence arises when the two imperatives of individual interest and collective interest conflict (Mouneyrat, 2001).

Health professionals thus find themselves at the heart of many societal issues with which they must deal. The Tarasoff case, or the issue of protecting a close friend or relative from a patient infected by HIV, are major examples (Crook, 2011; Guedj, Muñoz Sastre, Mullet & Sorum, 2006). For several years now, to counterbalance the rise in terrorist radicalization, some governments have tried to introduce new measures that could involve the health sector. Mental health researchers are being increasingly called upon to notify the authorities of individuals undergoing violent terrorist radicalization (Aggarwal, 2018). Individuals with psychiatric disorders are sometimes pointed out as being more receptive to terrorist ideology (Speckhard, 2016). Some data in the literature suggests that isolated terrorists may suffer more from psychopathological disorders than terrorists belonging to a group (Schulten, Doosje, Spaaij & Kamphuis, 2019).

The following example presents a realistic situation highlighting the ethical conflict faced by the physician: "Dr. Burdin has known Ludovic, who is now 25 years old, since he

was a child. His mother had always described him as a young man with violent behavior. She had already reported many aggressive episodes since adolescence as well as the presence of a criminal record (mainly for robbery, fights, and possession of knives). Three weeks ago, during a consultation, his mother explained to the doctor that Ludovic had previously broken with his family several months ago: He isolated himself, no longer talks to his friends, and lives reclusively in a caravan. She said: "One day he will do something stupid, I feel it but I have no way to approach him. I'm ashamed to say it but I'm afraid he's become a terrorist!" The physician found out from her that he had converted to Islam, and that now, he wears only traditional Muslim clothing. When the doctor asked him about it during a consultation, he replied that he didn't want to talk about it. He responded: "I can no longer trust anyone." What should the doctor do? Should he warn the authorities or maintain confidentiality?

Governments' anti-terrorism projects

For some governments, the current climate concerning the fight against terrorism justifies a partial breach of laws relating to confidentiality.

In the United States, as part of the "Countering Violent Extremism" [CVE] strategy, various projects have been endorsed. For instance, the "Shared Responsibility Committees" in 2015 have allowed the FBI to call on many professionals from civil society to intervene in multidisciplinary groups directed at individuals who are vulnerable to radicalization in order to contain the process. According to Speckhard (2016), this necessarily involves the exchange of confidential data, although this is prohibited by law.

In the United Kingdom, new government recommendations *"Prevent"* were drafted in 2015. They exhort all health professionals to identify individuals undergoing terrorist radicalization and report them to the authorities (Secretary of state for home department by command of her Majesty, 2011). *Prevent* considers that the medical profession, by virtue of its direct contact with a large part of the population, encounters many opportunities to identify

individuals in the process of being radicalized. Over 700 nurses have been trained in this vein, and training will also be given to medical students (Dean, 2011).

In Belgium, the Flemish government also attaches importance to the prevention of radicalization. The Belgian Senator De Gucht (2016) argued that if professional confidentiality must be broken, it is necessary to consider a legal framework that would protect professionals, such as a specific derogation when radicalization is suspected.

This is what some French deputies (MPs) tried to do in 2016. A bill proposal to adapt professional confidentiality to tackle the evolution of radicalization was proposed, but it was not sent to a special commission (Dubby-Muller et al. 2017). However, following a recent decree (Ministère des Solidarités et de la Santé, 2019), the French authorities will now be warned – with the help of file-linking – as soon as a patient filed for "terrorist radicalization" is hospitalized to receive psychiatric care without his or her consent. Furthermore, the CNOM (2017) has published an interministerial guidance document of indicators of radicalization, which doctors can refer to in the event of worrying signs (Ministère de l'Intérieur [MI], 2015).

Health professionals' and the general public's attitudes

In October 2016, a study called *"Eroding Trust"* inventoried the numerous criticisms made against these new recommendations. It revealed that the Royal College of Psychiatrists [RCPSY] (2016) had serious doubts about the predictive value of the vulnerability factors on which *Prevent* is based (Middleton, 2016). Mohammed and Siddiqui (2013) contended that there is no medical solution to all these factors, which require instead to be dealt with on a socio-economic or political level. Conversely, Bhui and colleagues suggested that a public health message should be delivered to specify that violence may be the cause or the consequence of a poor general or mental state of health (Bhui, Warfa & Jones, 2014a; Bhui, Everitt, & Jones, 2014b; Kmietowicz, 2014). Thus, bringing forth the argument that public health can play a prominent role in preventing violence in order to fight against extremism

(Aggarwal, 2018). In one of their studies, Bhui et al. (2014b) observed that depression may be independently associated with greater tolerance for terrorist violence. Many French psychiatric federations are worried that psychiatric disorders and the process of radicalization are sometimes confused. According to them, this could stigmatize individuals suffering from mental illness even further (Beloucif et al., 2019). Witharana, Olumoroti and Larkin (2012) advocated a discussion to define whether terrorism can be considered as a mental disorder; and if so, what appropriate assessment tools should be employed in its diagnosis – tools that need to be scientifically validated and evidence-based (RCPSY, 2017). Currently, no clinical procedure or psychiatric tool can predict or detect the risk factors for terrorist radicalization (Davies, Elbe, Howell & McInnes, 2014; RCPSY, 2017).

For many health professionals, these recommendations mainly constitute a form of espionage that mostly targets Muslim patients (Summerfield, 2016), with the underlying risk of stigma that this could induce (RCPSY, 2017). The Council of American-Islamic relations [CAIR] (2015) criticized the fact that in some northern cities in the United States, programs related to the CVE's counter-terrorism initiative are used to “profile” Muslims (Aggarwal, 2018).

Many nurses have mentioned how uncomfortable they feel with making personal judgments about individuals (Dean, 2011). Other fears imply the consequences of reporting errors, and of being accused of racism (English, 2011).

Prevent insidiously targets only a religious group and could be called into question by anti-discrimination legislation (Mohammed & Siddiqui, 2013). At the European level, this report tends to violate the right to privacy of the European Convention on Human Rights. It exposes physicians to the risk of litigation (Middleton, 2016). According to Speckhard (2016), to waive confidentiality, we should refer only to the law. But health providers seem to be confronted with a major dilemma: on the one hand, no specific legal protection for

professionals who report a radicalized patient has been clearly established (Weine, Eisenman, Kinsler & Polutnik, 2016), and on the other hand they are worried about the threat of being prosecuted for not reporting a radicalized individual (Aggarwal, 2018). According to the RCPSY (2017), in the face of the pressure exerted by some governments, health professionals should respond by respecting their own guidelines and code of ethics. If a member of the medical community encounters a problematic situation related to terrorism, Jenkins, Mair, Lester and Khan (2016) advise having recourse to a collegiate decision. Breaching medical confidentiality on a permanent basis without strong justification could have a devastating effect on the therapeutic relationship, and could even hinder access to care (Aggarwal, 2018; Barthélémi et al., 2011; Jenkins et al., 2016; Middleton, 2016; Rizq, 2017; Samari, 2016). Indeed, since the implementation of these various anti-terrorism programs, some patients report that, for fear, they resort to self-censorship during their psychotherapy sessions (Rizq, 2017).

Generally, what patients fear if confidentiality is no longer respected is that it will hamper care and treatment (Jones, 2003; Lee, 1994). Jones (2003) asked 30 patients to assess the need to breach confidentiality in five different situations: when it came to protecting a third party, patients assumed more responsibility for breaching confidentiality. Guedj et al. (2006) compared the extent to which breaching confidentiality was acceptable for both physicians and the general public, in France. They observed that the general public was much more supportive than physicians. The French general public seems to be more in agreement with the Anglo-American laws than with the French laws when it is a question of breaching confidentiality to protect the wife of a potentially violent patient for example (Guedj, Muñoz Sastre, Mullet & Sorum, 2009). From one country to another, from one situation to another, opinions can diverge (Olivari, Munoz Sastre, Guedj, Sorum & Mullet, 2011; Olivari, Munoz Sastre, Sorum & Mullet, 2014). When laws and ethical guidelines differ, beyond the

professionals involved, the viewpoint of the public can also influence this kind of societal issue because as a patient, future patient, or potential victim, everyone is concerned (Bartholomew, Gundel & Scheel, 2016; Ormrod & Ambrose, 1999; Rubanowitz, 1987).

The present study

This study aimed to observe how a sample of the French population – health professionals and participants from the general public – evaluates the acceptability of breaching confidentiality by reporting to the authorities a patient with signs of terrorist radicalization.

As in previous research (Cantisano, Ferraud, Muñoz Sastre & Mullet, 2018; Mazoyer, Muñoz Sastre, Sorum & Mullet, 2017; Olivari et al., 2011), a methodology, derived from the functional theory of cognition (Anderson, 1981, 1996) and based on the construction of fictitious scenarios, was used. In our study, the various vignettes illustrate situations of ethical cases (or moral dilemmas) concerning medical confidentiality that can be experienced by doctors confronted with patients presenting various signs of radicalization. The scenarios were developed from factors frequently encountered in the literature: Signs of radicalization (Bénézech & Estano, 2016; Karagiannis, 2012), Projects of violence (Feddes, Mann & Doosje, 2015; MI, 2015), Psychiatric disorders (Bénézech & Estano, 2016; Bhui et al., 2014a; Bhui et al., 2014b; Schulten et al., 2019; Speckard, 2016), and Collegiality (Jenkins et al., 2016; RCPSY, 2017).

These factors can be considered as indicators affecting the threshold of acceptability during decision-making. Acceptability depends in part on the perception of the risk of "the judging individual". According to Anderson (1996), when an individual makes a judgment, he/she resorts to diverse mental operations. In particular, he/she attributes a subjective value to each item of information encountered, and gives it a specific weight depending on the meaning and the importance that it has for him/her.

The objective of this study was therefore to investigate on what grounds it is considered acceptable, or not, to report a patient who appears as radicalized to the authorities – implying a breach of confidentiality. In other words, we wanted to examine the thought path leading the participants in this research to make a decision. On the one hand by tracing how they combine the information given and, one the other hand, by observing if the weight attributed to each piece of information varies.

Hypotheses

Our first hypothesis was that participants would rely on all the factors - Psychiatric disorders, Signs of radicalization, Projects of violence, Collegiality - to assess the acceptability of breaching confidentiality. Secondly, we expected some factors to have more weight than others in participants' decision-making. More specifically, since the link between psychiatric disorders and terrorism radicalization mentioned several times in the literature (Bénézech & Estano, 2016; Bhui et al., 2014a; Bhui et al., 2014b; Schulten et al., 2019; Speckard, 2016), we presumed that the Psychiatric disorders factor would have considerable weight in decision-making. Thirdly, it was also hypothesized that sociodemographic variables – sex, age, professional status and level of education – would influence how participants position themselves on the acceptability scale. More especially, we expected that health professionals – in comparison to the general public – would give more weight to the Collegiality factor. This latter, is linked to the recommendations mentioned by health actors in the literature (Jenkins et al., 2016; RCPSY, 2017).

Fourthly, the fear of stigmatizing the Muslim community mentioned by several authors (Aggarwal, 2018; CAIR, 2015; Dean, 2011; English, 2011; Mohammed & Siddiqui, 2013; RCPSY, 2017; Summerfield, 2016) allowed us to suppose that patients' names' sound in the scenarios – French *vs* Arabic-sounding names – would modify the way in which the scenarios were evaluated.

Finally, in our last and fifth hypothesis, we envisioned that different groups of respondents would be observed based on their response profiles. In view of the data found in the literature (Jenkins et al., 2016; RCPSY, 2017), we assumed that a group containing more health professionals would rely primarily on the factor of Collegiality, while other groups would give more importance to Projects of violence or Signs of radicalization.

Method

Participants

Two hundred and fifty-six participants were recruited through word of mouth in France, mainly, in the Occitania region. Two hundred and twenty-eight (155 women, 73 men) agreed to freely participate and signed a consent form (estimated response rate was 85%, the estimated refusal rate was 12% and the estimated incomplete response rate was 3%). Participants were 18-95 years old (M = 39.56). One hundred and seventy-four were part of the general population (7 craftsmen/storekeepers, 33 executives and intellectual professions, 19 intermediate occupations, 38 employees, 3 workers, 44 students, 11 unemployed, 14 retirees and 5 unspecified professions) and 54 were health professionals (11 physicians, 7 psychologists, 5 paramedical professionals, 26 nurses, 5 nursing assistants). Seventy-nine percent of our sample had an educational level beyond high school.

Material

Fifty-four scenarios illustrating different situations that a health professional might encounter were constructed through the orthogonal combination of 4 factors frequently mentioned in the literature (following a factorial plan 3 x 3 x 3 x 2): “Presence of a psychiatric disorder” (No pathology; Major depression; Psychotic disorder) x “Signs of radicalization” (Change in physical appearance but non-violent language; Recent social isolation and use of conspiracy

theories; High social isolation and terrorist ideology) x “Projects of violence” (No established plan; Plan to leave France for Syria; Plan to acquire a weapon) x “Collegiality” (Individual decision to breach confidentiality; Collegiate decision to breach confidentiality). Systematically, at the end of each scenario, the doctor decided to breach confidentiality by warning the authorities. The following question was then asked: “How acceptable do you think the doctor's decision is?” Participants answered using an 11-point (0-10) scale ranging from “not at all acceptable” at the left of the scale, to “fully acceptable” at the right of the scale.

Here is an example of a scenario: “Mr. Mimoune came to see Dr. Pujol for sleep disorders. During the consultation, Dr Pujol discovered that Mr. Mimoune suffers from a psychotic disorder that alters his thinking and reasoning. Mr. Mimoune explained that he broke-up with his friends and family a long time ago. His speech was punctuated by expressions of hate linked to a terrorist ideology. He also revealed his intention to acquire a weapon in the near future. Worried by this change in his behavior and concerned that the potential safety of others may be at risk, Dr Pujol decided to warn the authorities. Dr Pujol took this decision alone. How acceptable do you think Dr Pujol's decision is?”

In each scenario, a fictitious name was attributed to the patient and to the doctor. The consonance of the patients’ names was introduced as an inter-variable with two modalities: for 128 participants, the names of patients were Arab-sounding and for 100 participants the names of patients were French-sounding.

Procedure

Following Anderson's recommendations (1982), the procedure comprised two steps. The “familiarization” phase enabled participants to discover the tool by training on seven scenarios, with the possibility of comparing, modifying and revising their answers. This step

allowed participants to acclimatize to and understand the material in order to be able to carry out the experimental phase. During this second phase called "experimentation", participants had to judge all scenarios previously mixed in a random order, but this time without being allowed to go back or modify their answers. These two steps lasted 35 to 45 min altogether. Experiments took places in quiet public places, mainly in libraries.

Results

An analysis of variance was performed on all the raw data. It was found that the factors with the greatest influence on acceptability judgments were, in decreasing order, "Projects of violence" (F (2, 414) = 215.97, p < .001, Eta^2_p =.51), "Signs of radicalization" (F (2, 414) = 178.28, p < .001, Eta^2_p =.46), and "Collegiality" (F (1, 207) = 99.88, p < .001, Eta^2_p =.32). Even if it had a lower weight, the factor "Psychiatric disorders" was also significant (F (2, 414) = 11.49, p < .001, Eta^2_p =.05). The results are presented on Table 1.

The results also showed a significant interaction between "Radicalization" x "Violence" (F (4, 828) = 25.04, p < .001, Eta^2_p =.11): the more extreme the "Projects of violence" and "Signs of radicalization" were, the higher the acceptability of breaching medical confidentiality. There was also a significant interaction between "Psychiatric disorders" x "Radicalization" (F (4, 828) = 18.96, p < .001, Eta^2_p =.08). Participants in this study appeared to take "Psychiatric disorders" into consideration more when "Signs of radicalization" were minimal.

Regarding the impact of some individual variables on how participants positioned themselves on the acceptability scale, results showed a significant effect of the level of education (F (1, 206) = 11.93, p < .001, Eta^2_p =.05). Participants who had a high school level or higher considered it less acceptable to breach confidentiality than subjects who had not completed high school. Age, sex and professional status variables had no significant effect, yet, a significant group interaction between "Professional status" x "Collegiality" (F (5, 196)

= 3.91, $p < .002$, $Eta^2_p = .09$) was found. Doctors and nurses, compared to the general public and other health professionals, judged the breach of medical confidentiality as more acceptable when the decision was made collegially. Lastly, the analyses also revealed a significant effect of the inter-name factor (F (1, 206) = 8.27, $p < .004$, $Eta^2_p = .04$): on average, acceptability was higher when patients' names sounded French.

A K-means analysis identified five clusters. ANOVA analyses were then performed for each of the five clusters. The results are shown on Table 1 and Figure 1.

The first and smallest cluster (n=23) was named *"Favorable if collegiality"* since the factor of "Collegiality" had the most significant effect (F (1, 20) = 234.34, $p < .001$, $Eta^2_p = .92$). The mean response (M=5.87) is positioned in the middle of the acceptability scale. This can be explained by a polarization of the answers: in the presence of a collegiate decision the level of acceptability is strong, otherwise acceptability is weak. Participants in this group also considered the factors "Signs of radicalization" (F (2, 40) = 7.90, $p < .001$, $Eta^2_p = .28$) and "Projects of violence" (F (2, 40) = 6.50 $p < .003$, $Eta^2_p = .24$) even if they had a lower impact. "Psychiatric disorders" is the only factor that had no significant effect on their judgments. This cluster contains individuals from the general population (n=15) and health professionals (n=8), but proportionately to these two samples of participants, there are more individuals from health professions (14%) than those from the general population (8%). It is composed mainly of participants who have a level of education beyond the high school level (n=19).

The second cluster (n=77) was named *"Favorable to breach"* since the mean response is 8.42 – the highest of the five clusters. The factor "Projects of violence" has a predominant effect (F (2, 132) = 86.82, $p < .001$, $Eta^2_p = .57$), followed by "Signs of radicalization" (F (2, 132) = 55.04, $p < .001$, $Eta^2_p = .45$), "Collegiality" (F (1, 66) = 39.03, $p < .001$, $Eta^2_p = .37$), and "Psychiatric disorders" (F (2, 132) = 9.22, $p < .001$, $Eta^2_p = .12$). This cluster is mainly

made up of participants from the general population (n=60) and includes the highest number of respondents who had not completed high school (n=27) – i.e. 56% of the sample of participants has the lowest academic level. Results also show that for more than half of this group (n=43) the modality of inter-name variable is "French-sounding" whereas, according to the expected value, it was predicted that this modality would be the smallest with 29 participants ($X^2 = 20.03$, $p < .001$).

The third cluster (n=26) was named *"Unfavorable to breach"*. Individuals in this group are the most reluctant to breach medical confidentiality, their mean ratings were the lowest on the response scale (M=3.64). They took into account the factors "Collegiality" (F (1, 24) = 32.36, $p < .001$, Eta^2_p =.57), "Projects of violence" (F (2, 48) = 26.83, $p < .001$, Eta^2_p =.53) and "Signs of radicalization" (F (2, 48) = 19.22, $p < .001$, Eta^2_p =.44). To assess each situation, this cluster's participants considered all factors except "Psychiatric disorders". Although they were generally unfavorable to breach confidentiality, they tended to find a breach of confidentiality more acceptable when a "Collegiate" decision (M=4.20) is requested and when "Projects of violence" (M=4.92) and "Signs of radicalization" (M=4.36) are the most extreme. This group is made up of participants from the general public (n=19) and health professionals (n=7) (with respect to the entire sample, 11% of the general population and 12% of health professionals). Almost all participants had a level of education beyond high school (n=24). Here, there were more scenarios with the modality of the inter-name factor "Arab-sounding" (n=17) than scenarios with the modality "French-sounding" (n=9).

The fourth cluster (n=71) was named *"Sensitive to all factors"* since it is similar to cluster 2, this group relies on all of them. However, contrary to cluster 2, acceptability is notably lower with an average score of 6.30. "Projects of violence" is the factor having the most important effect (F (2, 130) = 88.93, $p < .001$, Eta^2_p =.58), followed by "Signs of radicalization" (F (2, 130) = 77.73, $p < .001$, Eta^2_p =.54) and "Collegiality" (F (1, 65) = 48.91,

$p < .001$, $Eta^2_p = .43$). "Psychiatric disorders" had the lowest effect (F (2, 130) = 3.94, $p < .021$, $Eta^2_p = .06$). This cluster mainly includes participants from the general public (n=49), yet health professionals (n=22) are also present – i.e. 40% of the sample of health professionals. It was predicted that the two modalities of the inter-name factor would be evenly distributed in this group, however the "Arab-sounding name" modality predominates with 52 participants out of 71 ($X^2 = 20.03$, $p < .001$).

Finally, the fifth cluster (n=31) named *"Favorable if violence"* has a high response average of 7.16. In this group, the "Projects of violence" factor is the most important (F (2, 56) = 198.77, $p < .001$, $Eta^2_p = .88$), followed by "Signs of radicalization" (F (2, 56) = 40.23, $p < .001$, $Eta^2_p = .59$) and "Psychiatric disorders" (F (2, 56) = 5.36, $p < .007$, $Eta^2_p = .16$). This cluster is the only one where participants did not rely on the "Collegiality" factor, even though it contains 14% of the total sample's health professionals. Results show an interaction between "Projects of violence" and "Signs of radicalization" (F (4, 112) = 15.46, $p < .001$, $Eta^2_p = .35$). When there is no project of violence, acceptability gradually increases in response to signs of radicalization. As soon as a project of violence occurs, participants only take this factor into account and acceptability increases immediately and very strongly.

Discussion

This study on the acceptability of breaching medical confidentiality when faced with patients showing signs of terrorist radicalization has highlighted various elements.

Firstly, the analyses confirm our first hypothesis. All four factors have a significant effect in participants' decision-making. Participants tried to assess each situation by looking at all the elements. Their contextual sensitivity is therefore considerable. The importance that they attribute to the factors indicates that these factors are intelligible and meaningful for them in this specific context.

Nevertheless, the factors “Signs of radicalization”, “Collegiality” and “Projects of violence” have more weight in participants’ decision-making. Despite data in the literature about “Psychiatric disorders” (Bénézech & Estano, 2016; Bhui et al., 2014a; Bhui et al., 2014b; Schulten et al., 2019; Speckard, 2016), our results highlight that the impact of this factor is much weaker – which refutes the second hypothesis. It appears to influence participants’ judgment additionally when the “Signs of radicalization” are not strong. In light of these results, the presence of psychiatric disorders does not seem to be a sufficient argument for the general public and health professionals – or at least an argument sufficiently explained – to justify government recommendations regarding detection of radicalized patients by health professionals. Schulten et al. (2019) argue that it is tricky to use this factor as a statistical predictor since many individuals with a psychiatric disorder will not inevitably radicalize into violent terrorist extremism.

Therefore, the “Projects of violence” factor carries more weight than the “Signs of radicalization” factor, as if participants were mostly influenced by acts and facts, rather than by speech content or physical appearance. This is particularly noticeable if we look more closely at cluster 5: in scenarios where no “Project of violence” is established, respondents primarily focus on “Signs of radicalization” to evaluate the acceptability of breaching confidentiality, but as soon as a “Project of violence” appears they rely almost exclusively on the latter factor and to a marked degree. It is conceivable that these participants apprehend the process of terrorist radicalization on a bottom-up model ranging from the evolution of “Signs of radicalization” (from the least to the most consequential) to concrete “Projects of violence” (here, a project of departure for Syria or acquiring a weapon). In this study, the project of acquiring a weapon – corresponding to one of the legal derogations about medical confidentiality enforced in France – is the modality having the most influence. However, scores of the “departure for Syria” modality are also high, indicating a risk assessment that is

almost equivalent to that of acquiring a weapon. It is likely that the level of dangerousness associated with the departure to Syria result, partially, from collective beliefs built in recent years.

In support of our third hypothesis, we observed that less educated individuals appear to be more inclined to breach medical confidentiality. It would be relevant to study this point in more depth in future studies. Moreover, regarding other sociodemographic variables explored in the present study, professional status by itself did not significantly influence how participants position themselves on the acceptability scale as well as age and gender – which refutes part of the third hypothesis. Nevertheless, we observed that the "Collegiality" factor is very important for health providers, especially for nurses and physicians. This finding is certainly linked to the fact that these participants were more aware of the concept of collegiality given their educational and professional background. In their daily practices, they are used to employing collegial advice. In addition, since they are responsible for reports (or more broadly for decisions taken) they may prefer not to be alone when deciding. Similar results were observed in studies about of end-of-life decisions (eg. Guedj et al., 2005). However, in the present research, not all health professionals are concentrated in the "Favorable if collegiality" cluster; they are scattered among the five groups. The "Collegiality" factor by itself does not seem to define how they respond. It is conceivable, therefore, that the question of terrorism affects most individuals in a specific way, leading them to evaluate risk factors personally and independently from their professions – which counteracts part of the fifth and last hypothesis.

Lastly, in answer to our fourth hypothesis, results show that the inter-variable "Names" also influences participants' judgments: those who responded to scenarios where patients' names sounded French often evaluated the breaching of confidentiality as more acceptable than those responding to scenarios where names were Arab-sounding. It is possible

that the fear of stigmatizing a community, as mentioned in the literature (English, 2011; Mohammed & Siddiqui, 2013; RCPSY, 2017; Summerfield, 2016), may change the way in which each situation is evaluated. Participants responding to scenarios in which patients' names sound French do not seem concerned by stigmatization, and thus allow themselves to judge a breach of confidentiality as more acceptable. It is also possible that the "black sheep effect" explains their response behavior: according to Abrams, Palmer, Rutland, Cameron and Van de Vyver (2014), an individual may judge more harshly a deviant member in the in-group than in the out-group, in order to preserve and reaffirm a positive social identity in the in-group that is endangered by the deviant member. In the same way, Shaw and Skolnick (1995) observed in their study focusing on fictitious jurors, that white jurors judged white defendants more harshly than black defendants. They call this "the bias of reverse racism".

Finally, this study has certain limitations. Our sample is heterogeneous, with fewer health professionals, and individuals with a low level of education. In addition, the scenarios are not real-life situations (Froberg & Kane, 1989; Guedj, Sorum & Mullet, 2012; Ulrich & Ratcliffe, 2008). Although none of the participants complained about scenarios' unrealistic nature, it would be relevant in future research to carry out a pre-test beforehand, in order to verify the realistic characteristics of fictitious scenario.

Conclusion

Many participants find it acceptable to breach medical confidentiality, even in the presence of indicators that are not derogated by the law. It is plausible that health professionals' concerns relate to the injunctive nature of government recommendations associated to a legal uncertainty (Aggarwal, 2018; Weine et al., 2016) and to the lack of consideration regarding the possible negative consequences generated (Aggarwal, 2018; Barthélémi et al., 2011; RCPSY, 2017; Jenkins et al., 2016; Middleton, 2016; Rizq, 2017; Samari, 2016), rather than the breaching of medical confidentiality in cases of proven danger. Moreover, governmental

recommendations could be more specific regarding what each indicator of radicalization involves (Coppock & McGovern, 2014; Gill, 2015), particularly the psychiatric disorders factor. Many health professionals wonder what initiatives can be taken and are welcome to opportunities for discussion in order to respond independently to these important ethical questions (Lacour-Gonay, 2017). Discussions should be collegial and multidisciplinary. The general public's viewpoint, also concerned by this topic, could help health professionals to enlarge their reflections.

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Table 1

Main results of ANOVA and composition of clusters

	df	MS	F	p	Eta^2_p
Factors					
Violence	2	5166.6	215.97	.001	.51
Signs of radicalization	2	2356.4	178.28	.001	.46
Collegiality	1	4428.8	99.88	.001	.32
Psychiatric disorders	2	66.1	11.49	.001	.05
Radic x Violence	4	103.8	25.04	.001	.11
Radic x Psy Dis	4	58.2	18.96	.001	.08
Radic x Collegiality	4	10.9	3.42	.034	.02
Inter-variables					
Names	1	1220.9	8.27	.004	.04
Level of education	1	1730.2	11.93	.001	.05
Profession x Coll	5	161.3	3.91	.002	.09
Cluster 1: ***Favorable if collegiality***					
Signs of radicalization	2	29.02	7.90	.001	.28
Violence	2	43.36	6.50	.003	.24
Collegiality	1	8689	243.34	.001	.92
Cluster 2: ***Favorable to breach***					
Signs of radicalization	2	452.5	55.04	.001	.45
Violence	2	793.4	86.82	.001	.57
Collegiality	1	369.4	39.03	.001	.37
Psychiatric Disorders	2	29.2	9.22	.001	.12
Radic x Psy Dis	4	23.8	13.41	.001	.17
Radic x Violence	4	72.5	25.93	.001	.28
Radic x Collegiality	2	11.8	4.16	.017	.06
Radic x Psy Dis x Violence	8	4.2	2.75	.005	.04
Radic x Violence x Collegiality	4	7.2	3.50	.008	.05

Cluster 3: ***Unfavorable to breach***					
Signs of radicalization	2	297.68	19.22	.001	.44
Violence	2	803.53	26.83	.001	.53
Collegiality	1	427.85	32.36	.001	.57
Radic x Violence	4	12.30	3.72	.007	.13
Violence x Collegiality	2	12.91	4.59	.014	.16
Cluster 4: ***Sensitive to all factors***					
Signs of radicalization	2	1366.2	77.73	.001	.54
Violence	2	1392.5	88.93	.001	.58
Collegiality	1	997	48.91	.001	.43
Psychiatric Disorders	2	33.5	3.94	.021	.06
Radic x Psy Dis	4	27.7	7.70	.001	.10
Radic x Violence	4	24.6	5.96	.001	.08
Psy Dis x Violence	4	6.2	2.49	.044	.04
Cluster 5: ***Favorable if violence***					
Signs of radicalization	2	481.60	40.23	.001	.59
Violence	2	4043.17	198.77	.001	.88
Psychiatric Disorders	2	36.60	5.36	.007	.16
Radic x Psy Dis	4	31.71	7.12	.001	.20
Radic x Violence	4	90.66	15.46	.001	.35
Radic x Psy Dis x Violence	8	7.91	2.52	.012	.08
Radic x Psy Dis x Collegiality	2	7.78	3.81	.006	.12
Radic x Psy Dis x Violence x Collegiality	8	6.44	2.69	.007	.09

Note. The higher order interactions that were not significant are not reported here.

The following abbreviations “Radic”, “Violence”, and “Psy Dis” corresponding respectively to the factors “Signs of radicalization”, “Projects of violence”, and “Psychiatric disorders”.

Figure 1

Patterns of results for the five clusters

[“Insert the figure here”]

Note. On each panel, the y-axis corresponds to the degree of acceptability for breaching confidentiality; the x-axis bears the “Projects of violence” factor; the two curves correspond to the “Collegiality” factor, and the five panels correspond to the clusters.

Appendix

Two examples of scenario

Mr. Asmaa came to see Dr. Guitton for sleep disorders.

During the consultation, Dr Guitton discovered that Mr. Asmaa **doesn't suffer from any psychiatric disorder.**

However, Mr. Asmaa's **appearance recently changed**. **He grew a beard and dressed in religious clothes. His speech, however, is open and peaceful to others.**

He, nevertheless, revealed his intention to **acquire a weapon in the near future.**

Worried by this change in his behavior and concerned that the potential safety of others may be at risk, Dr Pujol decided to warn the authorities.

Before taking this step, **Dr. Guitton took the precaution of seeking the advice of Professor Umbert**, a specialist in the field.

How acceptable do you think Dr Guitton's decision is?

Not acceptable at all -0—0—0—0—0—0—0—0—0—0-Fully Acceptable

Mr. Mimoune came to see Dr. Pujol for sleep disorders.

During the consultation, Dr Pujol discovered that Mr. Mimoune suffers from a **psychotic disorder that alters his thinking and reasoning.**

Mr. Mimoune explained that he **broke up with his friends and family a long time ago. His speech was punctuated by expressions of hate linked with a terrorist ideology.**

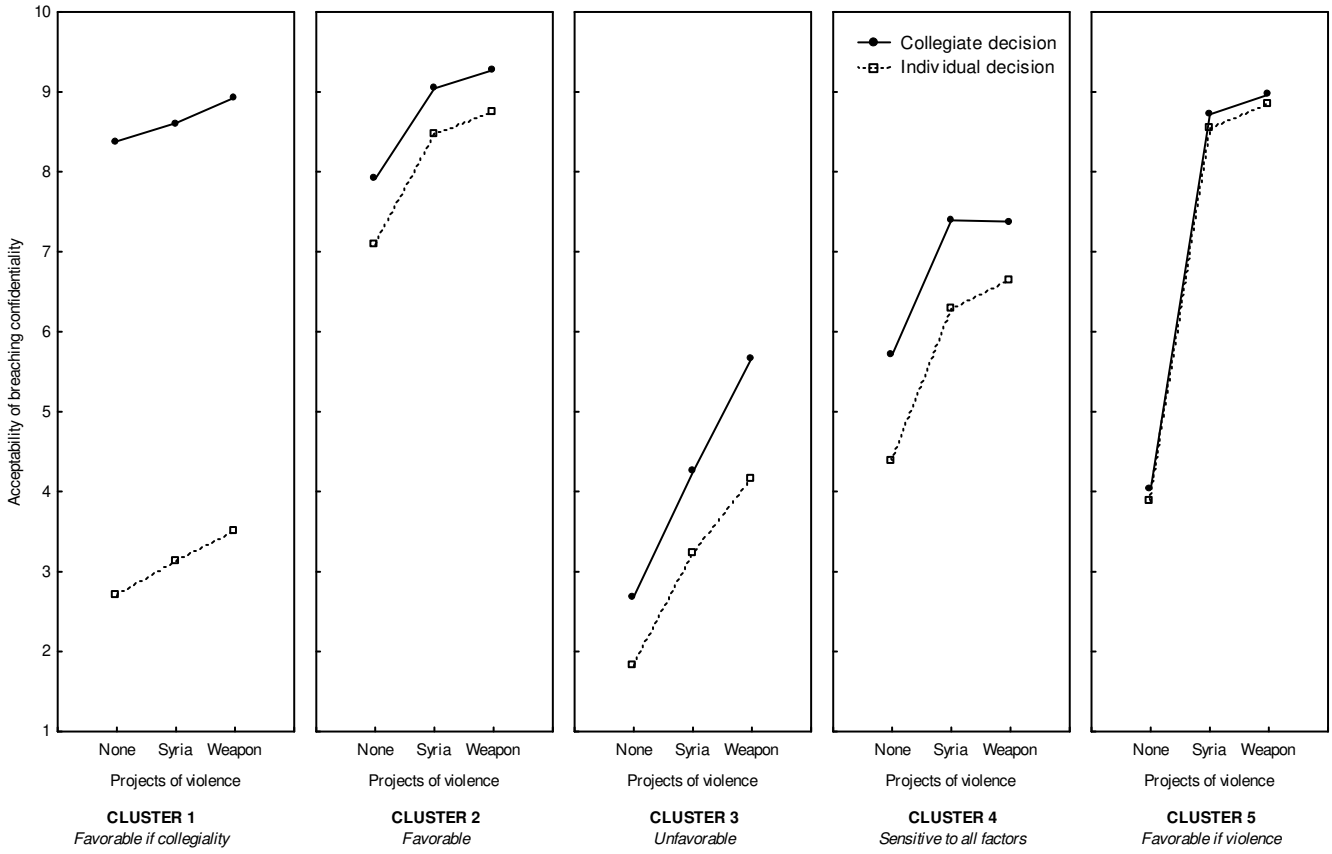
He also revealed his intention to **acquire a weapon in the near future.**

Worried by this change in his behavior and concerned that the potential safety of others may be at risk, Dr Pujol decided to warn the authorities.

Dr Pujol took this decision alone.

How acceptable do you think Dr Pujol's decision is?

Not acceptable at all -0—0—0—0—0—0—0—0—0—0-Fully Acceptable



Note. On each panel, the y-axis corresponds to the degree of acceptability for breaching confidentiality; the x-axis bears the "Projects of violence" factor; the two curves correspond to the "Collegiality" factor, and the five panels correspond to the clusters.