Secondhand effects due to alcohol among university students experienced at least once in the four weeks before being asked. Values are numbers (incidence; 95% confidence interval)

Secondhand effect	Sex of victim		Victim's tendency to drink heavily*			Total (n=1524)
	Women (n=881)	Men (n=643)	Never (n=253)	Monthly or less (n=602)	Weekly or more (n=669)	
Insulted or humiliated	294 (33; 30 to 37)	221 (34; 31 to 38)	70 (28; 22 to 34)	175 (29; 25 to 33)	270 (40; 37 to 44)	515 (34; 31 to 36)
Serious argument or quarrel	148 (17; 14 to 19)	136 (21; 18 to 25)	14 (6; 3 to 9)	81 (13; 11 to 16)	189 (28; 25 to 32)	284 (19; 17 to 21)
Pushed, hit, or otherwise assaulted	118 (13; 11 to 16)	114 (18; 15 to 21)	21 (8; 5 to 12)	63 (10; 8 to 13)	148 (22; 19 to 25)	232 (15; 13 to 17)
Property damaged	174 (20; 17 to 23)	130 (20; 17 to 24)	43 (17; 13 to 22)	110 (18; 15 to 22)	151 (23; 19 to 26)	304 (20; 18 to 22)
Had to take care of a drunk student	370 (42; 39 to 45)	239 (37; 33 to 41)	45 (18; 13 to 23)	227 (38; 34 to 42)	337 (50; 47 to 54)	609 (40; 37 to 42)
Found vomit in the halls or bathroom	201 (23; 20 to 26)	173 (27; 24 to 31)	41 (16; 12 to 21)	107 (18; 15 to 21)	226 (34; 30 to 38)	374 (25; 22 to 27)
Studying or sleep interrupted	571 (65; 62 to 68)	347 (54; 50 to 58)	135 (53; 47 to 60)	323 (54; 50 to 58)	460 (69; 65 to 72)	918 (60; 58 to 63)
Unwanted sexual advance	279 (32; 29 to 35)	151 (23; 20 to 27)	24 (9; 6 to 14)	146 (24; 21 to 28)	260 (39; 35 to 43)	430 (28; 26 to 31)
Sexual assault or date rape	8 (1; 0 to 2)	3 (0; 0 to 1)	0 (0; 0 to 1)	3 (0; 0 to 1)	8 (1; 1 to 2)	11 (1; 0 to 1)
Different crime on campus	11 (1; 1 to 2)	13 (2; 1 to 3)	4 (2; 0 to 4)	5 (1; 0 to 2)	15 (2; 1 to 4)	24 (2; 1 to 2)
Different crime off campus	26 (3; 2 to 4)	25 (4; 3 to 6)	5 (2; 1 to 5)	20 (3; 2 to 5)	26 (4; 3 to 6)	51 (3; 3 to 4)
Any	752 (85; 83 to 88)	524 (81; 78 to 84)	182 (72; 66 to 77)	476 (79; 76 to 82)	618 (92; 90 to 94)	1276 (84; 82 to 86)

*Six or more drinks (60 g ethanol) on one occasion.

preceding our survey, and one fifth of students had their property damaged.¹ Even non-heavy drinkers experienced several effects, some serious.

Strengths of this study include the random sampling, the high response rate, and using a computerised questionnaire, a method known to increase reporting of high risk behaviour.⁵ Limitations include imprecision—for example, the seriousness of “crimes” is unspecified—reliance on respondents to attribute responsibility for the effect, and our focus on students alone.

The needs of the many non-drinkers and moderate drinkers who are harmed by heavy drinkers should be considered when devising local and national alcohol policies. Universities and colleges should tackle environmental risk factors for hazardous drinking—for example, the availability and promotion of alcohol on and around campus—and should provide screening and intervention services for students with patterns of hazardous drinking.

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Privacy of patients' information in hospital lifts: observational study

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Respect for the confidentiality of patients' information is a basic principle of ethical and effective medical practice. It ensures individual patients' privacy, and, more broadly, it upholds public perception of the quality of the healthcare system and its professionals. Observational studies have shown that breaches of patients' confidentiality by healthcare professionals occurred in 3%-7% of lift rides in hospitals.^{1 2}

Even though most healthcare professionals know the limits of confidentiality well, they have trouble applying them to their behaviour, particularly in hospital lifts where discussions of patients' information may be overheard.³ To decrease the risk of compromising patients' confidentiality in public spaces in

hospitals, we investigated the number and nature of comments that compromise patient confidentiality in hospital lifts and the reactions of colleagues who witnessed these comments.

Participants, methods, and results

We instructed medical students in the information privacy policy of St Michael's Hospital, a tertiary care centre in Toronto, Canada. They recorded the date, time, duration, and location of every journey they took in a public lift at St Michael's Hospital during regular hours for two weeks in November 2002.

These observers excluded journeys where only their own healthcare team was present because no healthcare professional, patient, or visitor was present to witness a compromise of patient confidentiality. Observers, who were identifiable as medical students, recorded all breaches of patients' confidentiality by hospital staff and any reactions by witnesses to these comments.

Hospital caregivers made 18 comments deemed to compromise a patient's confidentiality on 13 out of 113 lift journeys (observers overheard multiple comments on some journeys). Doctors made the most comments (11), then allied health professionals (6), and then nurses (1). Most comments referred to patients by their initials or reason for admission, but names were used four times.

Reactions attempting to minimise breaches of patients' confidentiality happened only twice. Both times medical students naive to the existence of our study politely asked that the conversation be continued in another location. The students' interventions were successful.

Comment

Patient confidentiality was compromised on more than one in ten lift journeys, strengthening the evidence that public lapses in patient confidentiality are widespread.^{1,2} Most comments disguised patient identity, which shows awareness of the need for discretion in public spaces and the motivation to uphold it. But clarification of what constitutes a breach in patient confidentiality is needed.

The small number of reactions (to less than a tenth of comments) shows that other healthcare workers in elevators are either reticent or lack awareness. The silence of witnesses may even perpetuate the problem; on several occasions, breaches in confidentiality started conversations that further compromised patients' privacy.

Breaches of a patient's confidentiality compromise ethical health care and undermine patients' confidence in caregivers. Healthcare institutions must provide effective training to minimise these breaches. We hope that providers here and in all healthcare institutions will heed the call to improve discretion for the patients who entrust us with their care.

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Risk of suicide and spouse's psychiatric illness or suicide: nested case-control study

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Suicides cluster in families with histories of psychiatric disorders and suicides.^{1,2} Genetic and environmental factors may play a role in the familial aggregation of suicides but are inseparable in most studies. Because married couples are usually genetically unrelated, studying them can identify environmental factors and means of protection. Your spouse dying or your spouse having a psychiatric disorder is stressful; mortality is increased in the surviving spouse.³ I investigated the association between a spouse's psychiatric illness, suicide, and other causes of death and own suicide.

Participants, methods, and results

I got data by linking population based registers using unique personal identification numbers, which are assigned to all people living in Denmark. Until 1993, suicide was defined as ICD-8 (international classification of diseases, 8th revision) codes E950-E959; after 1994, ICD-10 codes X60-X84. I matched each person aged 25 to 60 years who had committed suicide during

1982-97 to a random subsample of 20 people stratified by sex and year of birth. I only enrolled people who had been living in Denmark for the past two years. I identified all spouses and children who were living with these people on 31 December two years before the suicide. I got admission and discharge dates and diagnoses from the Danish psychiatric central register, which has monitored all facilities for inpatients since 1969.^{1,2} I analysed the data with conditional logistic regression.

I identified 9011 suicides, 180 220 controls, and 111 172 spouses (table). People whose spouse had ever been admitted with a psychiatric disorder were at greater risk of committing suicide, particularly if the first admission had been recent (risk ratio 5.09; 95% confidence interval 3.53 to 7.35). People whose spouse had died, especially by suicide (21.69; 11.10 to 42.37), were also at a greater risk of committing suicide. An adjusted analysis found weaker associations, but a spouse's suicide remained indicative of own suicide ($P=0.01$).

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