CONFIDENTIALITY AND PRIVILEGE

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1. What is confidentiality?

Confidentiality refers to the ethical duty of the physician not to disclose information learned from the patient to any other person or organization without the consent of the patient or under proper legal compulsion. The Hippocratic Oath describes the duty of confidentiality as follows:

Whatsoever I shall see or hear in the course of my profession as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.

This duty is described by the American Medical Association in Section 4 of the *Principles of Medical Ethics*:[5]

A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of law.

The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry elaborates in Section 4, Annotation 1, that:

Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern between the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard.[5]

2. Does the psychiatrist have a legal duty of confidentiality?

The existence of a legal obligation to protect the confidentiality of communications arising from the physician-patient relationship has evolved primarily through court decisions, although statutory regulations also may be pertinent. Successful lawsuits against physicians for breach of confidentiality have been based on the following legal theories:

- Implied contract to keep information confidential
- Invasion of privacy
- Tortious breach of duty of confidentiality
- Statutory regulations.

Courts have awarded damages for breach of confidentiality based on the **contractual relationship** between the physician and patient, which was determined to include an implied agreement that the physician would keep confidential any information received from the patient. Recovery also has been based on **invasion of privacy**, which has been defined as an unjustified disclosure of a person's private affairs with which the public has no legitimate concern in such a fashion as to cause humiliation and/or emotional suffering to ordinary persons. The nature of the physician-patient relationship has been determined to create for the physician a **fiduciary duty** (i.e., to act primarily for the benefit of another) to keep information obtained through such a relationship confidential. Therefore, a tort action can be used to recover damages. A tort is a civil wrong, other than breach of contract, for which the court will provide a remedy in the form of an action for damages. Finally, courts occasionally have allowed recovery based on **licensing statutes** that focus on issues of privileged communications.

3. When are physician's disclosures legally justified?

A **valid consent** for a release of information protects the psychiatrist ethically and legally. State law and/or relevant rules and regulations often specify the requirements for such a release. A valid consent minimally means that the patient was competent to provide such authorization and did so knowingly and voluntarily. It is recommended that *written* consent be obtained, specifying the purpose and scope of information to be released. Written consent often provides more clarity to the patient regarding the nature of the disclosure and provides documentation—a useful risk-management measure—for the physician.

Many **evaluations for medical/legal (i.e., forensic) purposes**, performed at the request of third parties to address issues such as impairment ratings for worker's compensation, disability insurance payments, and appropriateness of treatment, are not confidential. The *Ethical Guidelines for the Practice of Forensic Psychiatry*, developed by the American Academy of Psychiatry and the Law, state that

[t]he psychiatrist maintains confidentiality to the extent possible given the legal context. Special attention is paid to any limitations on the usual precepts of medical confidentiality. An evaluation for forensic purposes begins with notice to the evaluee of any limitations on confidentiality. Information or reports derived from the forensic evaluation are subject to the rules of confidentiality as apply to the evaluation and any disclosure is restricted accordingly.

Reports and/or information obtained from such examinations can be disclosed to the third party that requested the examination without risk of a successful lawsuit by the evaluee concerning breach of confidentiality. Consent is implied when the person proceeds with the evaluation after having been provided appropriate information concerning the nature of the evaluation and lack of or limits of confidentiality.

Disclosures without consent from the patient have been found to be permissible by courts when an **overriding public**

interest (e.g., public safety) was at issue. However, a careful risk-benefit analysis needs to be made prior to such disclosures. Consultation with a colleague and/or attorney should be part of the risk-benefit analysis process. Information released under such circumstances should be relevant to the potential public harm and provided only to those in need of the information.

Many state court decisions and/or statutes have adopted a psychotherapist's **duty to protect principle**, as described in the *Tarasoff II (Tarasoff v. Regents of the University of California*, 551 P.2d 334 [1976]) decision. This duty may, in certain circumstances, be legally discharged by warning of the patient's intended victim (whether or not the patient consents to releasing such information). However, jurisdictions differ concerning recognition and discharge of such a duty, and it is important for the clinician to be familiar with the law in his/her state concerning this issue. A physician could be liable for breach of confidentiality if a warning to a third party is provided without obtaining valid consent from the patient in states without such a duty.

State statutes often require physicians to report to various governmental agencies certain conditions such as **infectious diseases** (e.g., sexually transmitted diseases, tuberculosis), **suspected child abuse**, and **gunshot wounds**. States have taken very different approaches regarding confidentiality and reporting issues relevant to **HIV/AIDS infection**. Physicians need to be familiar with pertinent statutes in their own states concerning both the conditions that are to be reported and the threshold criteria for making such reports.

4. Are there any reporting requirements concerning patients who may have a medical or psychiatric condition that could cause impairments in their driving ability?

Most states clearly indicate in their statutes, and in the information they provide to motorists licensed in their state, that the driver is primarily responsible for his or her own safety and the safety of others. Ten states have clearly written guidelines under which drivers must inform their state of their medical conditions. However, few states have written criteria for determining driver safety, and physician reporting of unsafe drivers generally is not required by state law. There generally has not been a great impetus to interfere with the physician-patient relationship, although physicians are encouraged to report individuals who they feel would be unsafe behind the wheel to the Department of Motor Vehicles. Physicians generally are granted some form of immunity from liability when making such reports in good faith.

Physicians in Pennsylvania appear to have the strictest reporting requirements. Judicial decisions have held physicians liable for injuries in motor vehicle accidents involving their patients who drive. Several significant duty to warn and/or to protect third party cases involving psychiatrists arose from driving cases. Physicians should be familiar with pertinent statutes and case law within their jurisdiction concerning these issues.

5. Are there statutes pertinent to confidentiality other than the reporting statutes?

A number of states have enacted **mental health confidentiality statutes** that establish a rule of confidentiality and describe exceptions. For example, the Colorado statute which establishes procedures for involuntary commitment provides that "all information obtained and records prepared in the course of providing any services [for the care and treatment of the mentally ill] … shall be confidential and privileged matter" (C.R.S. 27–10–120). This law specifies a variety of exceptions such as peer review, communications between qualified professional personnel in the provision of services or appropriate referrals, releasing information to the courts as necessary to the administration of the provisions of this article, certain circumstances for releasing confidential information to family member(s) of an adult with mental illness, and appropriate research (C.R.S. 27–10–101, 102, 116, 120, 120.5 as amended).

Legislation often requires that rules and regulations be promulgated by the state's Division of Mental Health or equivalent agency concerning confidentiality. Physicians should be familiar with these rules and regulations within their own jurisdiction, because they vary significantly among states. There also are Federal rules and regulations regarding confidentiality applicable to **substance abuse treatment programs** that receive federal funds (42 C.F.R. Part 2). Records and information from such programs can be released only under conditions as specified in the regulations. These regulations provide detailed information concerning the nature of the written release required. Access to information concerning patients and records in the **Veterans Administration Hospitals** is determined by a variety of Federal laws and regulations, such as the Freedom of Information Act and Privacy Act.

6. How do the ethical guidelines address issues relevant to confidentiality?

The American Psychiatric Association (APA) has emphasized that:

[t]he continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy … Ethically the psychiatrist may disclose only that information which is relevant to a given situation. He/she should avoid offering speculation as fact …

It is good practice, both clinically and from a risk-management perspective, to provide the patient with a copy of the information (e.g., report, completed insurance form) to be disclosed *prior to releasing the information*. Generating the report in the presence of the patient and/or with direct input from the patient often can be therapeutic and contribute to good treatment planning. The most frequent request for information comes from insurance companies related to diagnosis, treatment progress, and planning, or issues relevant to disability and/or insurability.

Confidentiality may be breached ethically in the interest of **protecting the patient:**

Psychiatrists at times may find it necessary, in order to protect the patient or the community from imminent danger, to reveal confidential information disclosed by the patient.

Thus, it often is clinically and ethically appropriate for the physician to inform a patient's relative or roommate about a

depressed patient's suicide risk. The physician's legal liability under such circumstances is low if his/her assessment was reasonable. Physicians do not have a legal duty to warn others of a potential suicide attempt, although the physician does have a duty to provide reasonable care to his/her patients (which would include implementing appropriate steps to decrease the risk of suicide). Without patient authorization, a psychiatrist should not release information to family members or others, unless there is an overriding interest of protecting the patient. For example, do not give confidential information to a spouse who is requesting help concerning problems that may impact on the marriage unless the patient provides appropriate authorization.

7. How does confidentiality apply to the treatment of minors?

Until the 1990s, the general and forensic psychiatric literature was sparse concerning issues specific to confidentiality with children and adolescents. From a legal perspective, the psychiatrist generally can assume that a parent has a legal right to full information about the treatment of a minor if the parent is legally entitled to authorize treatment for a minor child. However, full implementation of such a legal principle often causes significant clinical problems. Such problems can be minimized by establishing **ground rules of confidentiality and exceptions** with patients and parents prior to beginning the treatment process. The ground rules generally are different for adolescents as compared to young minors due to both developmental differences and an increased right to privacy enjoyed by the older adolescent population.

State statutes often provide some guidance regarding issues of confidentiality in the treatment of minors. The American Academy of Child and Adolescent Psychiatry Code of Ethics and chapters by Macbeth, Benedek, and Weintrob provide detailed discussions concerning legal, clinical, and ethical considerations relevant to confidentiality and the treatment of minors. For example, the AACAP's Code of Ethics indicates that "it is necessary that the child or adolescent, within his/her capacity for understanding, be clearly apprised of confidentiality in regard both to his/her own communication and those of parents or guardians. He/she should also be informed of the limits to the general principle of confidentiality that the sharing of care-taking responsibility requires."

The AMA's Council on Ethical and Judicial Affairs indicated that "when the law does not require otherwise, physicians should permit a competent minor to consent to medical care and should not notify parents without the patient's consent … for minors who are mature enough to be unaccompanied by their parents for their examination, confidentiality of information disclosed during an exam, interview, or in counseling, should be maintained. Such information may be disclosed to parents when the patient consents to disclosure … confidentiality may be justifiably breached in situations for which confidentiality for adults may be breached … or when such a breach is necessary to overt serious harm to the minor… ."

8. What is the physician-patient privilege?

Most state legislatures have created a testimonial privilege that prohibits a physician from disclosing in a judicial or quasi-judicial proceeding, with certain exceptions, any confidential information learned during the course of treatment with a patient. Thus, **testimonial privilege** is an evidentiary rule, applicable to judicial settings and limited in scope, that is created by statute. The privilege belongs to the patient—not to the physician. A breach of privileged communication can result in a lawsuit against the physician. Physician-patient privilege statutes have enacted due to the recognition that confidentiality is needed to maintain the therapeutic relationship, which also may have benefits for the community (e.g., people receive necessary treatment for illness). The recognition of the importance of a patient's privacy interests also has been a justification for such statutes.

In 1996, the U.S. Supreme Court in its *Jaffee v. Redmond*, 116 S.Ct. 1923 (1996), decision held that federal law recognizes privilege protecting confidential communications between a psychotherapist and his/her patient.

9. What exceptions to privilege exist?

Exceptions to the privilege generally include:

- When a valid waiver of privilege is executed by a competent adult patient or his/her legal guardian
- The patient-litigant exception, in which the patient has initiated litigation when his/her mental or emotional condition is an element of a claim or defense in a legal proceeding
- Most court-ordered examinations involving a wide range of legal issues
- Malpractice proceedings initiated by the patient against the physician
- Involuntary civil commitment proceedings
- Will contest
- Certain criminal proceedings
- Reports required by various mandatory reporting statutes.

The above list is not inclusive, and the type of exceptions differs from state to state. For example, some state statutes allow for the waiver of a physician-patient privilege, at the discretion of the judge, in child custody disputes. Familiarize yourself with the appropriate law in your state.

Disclosures made to the physician for purposes other than obtaining treatment are not covered by the privilege. States vary regarding the presence of privilege if disclosure occurs when third parties (e.g., family members) are present during the course of the communication. Jurisdictions also differ whether communications arising in the course of couple's and/or group psychotherapy are privileged. Nonphysician providers supervised by physicians generally are not covered by the patient-physician privilege statute, although they may be covered by a statute specific to their profession.

10. How should the psychiatrist respond to a subpoena?

A **subpoena duces tecum** is a subpoena issued by a court, at the request of one of the parties to a lawsuit, to require a physician to bring (i.e., produce) pertinent medical records. A **subpoena ad testificandum** requires the attendance of the physician for testimony purposes. Neither subpoena *compels* the physician; ethical and legal principles may properly

prevent the psychiatrist from testifying and/or disclosing the subpoenaed medical records.

The psychiatrist may release medical records and/or testify when the subpoena is accompanied by a valid consent form signed by the patient. Reasonable attempts should be made to **inform the patient** or his/her attorney about the subpoena, to verify the validity of the consent and discuss relevant issues.

The psychiatrist should contact the patient or the patient's attorney when a signed consent form is not attached to the subpoena, to determine whether the patient has consented, explicitly or implicitly, to waive the privilege. Remember that *the privilege belongs to the patient*, and not to the physician. However, the physician has an ethical and legal obligation to withhold information obtained during the course of treatment as privileged from disclosure in a legal context unless it is clear that an exception exists (e.g., signed consent obtained) or a court directs the physician to testify and/or release the record.

The psychiatrist should discuss with the attorney, when appropriate, issues concerning disclosure of very sensitive information that appears not to be pertinent to the issues being litigated. The patient's attorney or the psychiatrist have the option of filing a motion to **quash the subpoena** or **limit the nature of the information** to be disclosed, based on protection under the physician-patient privilege and the duty to maintain confidentiality, when the patient has not consented to waive the privilege. A hearing will be held in which the judge will rule on the motion. The psychiatrist can ethically testify and/or release medical records when ordered to do so by the court, despite lack of consent from the patient. The psychiatrist should not rely on the statements or opinions of the attorney who has requested the subpoena concerning issues relevant to waiver of the privilege.

11. What are the principles of confidentiality following a patient's death?

The U.S. Supreme Court decision in *Swidler § Berlin v. United States*, 118 S.Ct. 2081 (1998), which held that the attorney-client privilege survives the death of the client, provides support that the physician-patient privilege also generally is maintained following a patient's death. The ethics committee of the APA has written that confidentiality ethically survives a patient's death unless disclosures are required by statute or case law. Some state statutes allow the executor or administrator of the deceased patient's estate or certain relatives to have access to the patient's medical record. Additionally, the physician-patient privilege may be waived in certain states following the patient's death. The psychiatrist should obtain guidance from legal counsel or the court concerning this issue when questions exist concerning the waiver of the privilege.

Similar issues arise which are not addressed by statute or case law. The psychiatrist may be questioned by the police during the course of an investigation involving the death of a patient, or may be asked specific questions by grieving family members. The psychiatrist should not disclose specific information obtained from the patient, although answering questions in terms of general psychiatric principles is appropriate. The psychiatrist's liability for breach of confidentiality is minimized by obtaining authorization from the patient's legal representative and close family members.

12. Is it a breach of confidentiality to use a collection agency or attorney in an attempt to collect unpaid bills?

There are no ethical principles that preclude psychiatrists from using the legal system or collection agencies for bill collection. The physician-patient privilege does not prevent a doctor from suing to collect proper fees. However, the legal and ethical obligations of the psychiatrist to protect the patient's confidentiality continue despite the breach of the treatment contract by the patient caused by not paying the bill. Patients may sue for breach of confidentiality when the psychiatrist discloses their *status* as patients to an attorney or collection agency. In general, the only information that needs to be disclosed to the collection agency or attorney is the patient's name, balance due, and dates of services. Confidentiality is best preserved by describing the dates of services as office visits in contrast to psychotherapy or medication management visits.

Due to issues of confidentiality and risk management, the psychiatrist should first use other methods of recovering fees. A matter-of-fact letter to the patient requesting either payment in full within a specified time frame or a proposal for a payment schedule is a useful alternative. If there is not a response to such letter within a reasonable period of time, another letter should be sent which requests a similar response within a specified time period and informs the patient that referral will be made to an attorney or collection agency for initiation of appropriate legal action if the patient does not respond.

Select a *responsible* collection agency or attorney—for professional reasons and to minimize the risk that the patient will retaliate by filing a counterclaim for malpractice, ethical complaint, or a complaint to the Board of Medical Examiners or equivalent agency. Learn about any pertinent laws within your state that specify procedures that must be followed before using a collection agency or attorney to recover unpaid bills.

13. What confidentiality issues are involved with new technology?

The availability of voicemail, cellular telephones, and fax machines can lead to unintentional breaches of confidentiality. **Voicemail messages** may be played back by persons other than the patient; cellular telephone conversations may be heard by other parties; and records sent via fax machines may be sent to the wrong number. Therefore, detailed voicemail messages should not be left for patients unless assurances have been given by them that other persons do not have access to their voicemail box. Patients should be told when a **cellular telephone** is being used and reminded that confidentiality is not guaranteed under such circumstances. **Fax machines** should not be used for routine transmission of confidential information, and procedures should be implemented to ensure safeguarding of confidential information that needs to be sent promptly.

The use of **computerized medical records** by healthcare providers and systems has increased rapidly. Medical data are being used for nontraditional purposes (i.e., other than clinical assessment or treatment) that are not governed by regulations, laws, or professional practices. The rapidly emerging infrastructure of healthcare information and its relation to patient privacy have been described in the literature. The advantage of these information systems for

the organization, delivery, and financing of health care is attractive to policymakers. Future electronic databases will contain a vast amount of personal information, including demographic, financial, medical, genomic, and social data. Unfortunately, there is significant potential for erosion of patient privacy in such systems.

The APA has developed resource documents for preserving patient confidentiality in the era of information technology and a guide to security relevant to computerized records.[3] These documents provide direction to policymakers, as they establish ground rules for the management of patient records in electronic form in new healthcare systems. A complete **medical record security program** should include policies, standards, training, technical and procedural controls, risk assessment, auditing and monitoring, sanctions for violations, and assigned responsibility for management of the program. Extra levels of security should be developed for information generally regarded as sensitive by tradition, or by agreement between the physician and patient.

The genetic revolution has taken a markedly clinical turn as evidenced by the work of the **Human Genome Project**, which soon will map the entire genetic code embedded in human DNA. This project and other research in molecular genetics raise new ethical and legal issues for physicians, who eventually will be able to accurately predict the risk of future onset of many genetic diseases as well as the likely current and future health status of relatives of the patient who share genetic material. Physicians will face a dilemma when a patient chooses not to disclose information that could be significant to genetic relatives. Berry summarizes issues that will need to be reviewed by legislative and judicial lawmakers to clarify under what circumstances may or must a physician disclose genetic information to interested third parties, and under what circumstances may or must the physician, instead, keep such information confidential.

14. I'm confused—can you give me some practical pointers regarding confidentiality and privilege?

The concepts of confidentiality and privilege often are confusing due to overlapping principles and the many exceptions, which have been briefly summarized. Confidentiality is an important element in developing a therapeutic alliance with patients. A breach of confidentiality can result in legal liability, ethical complaints, adverse actions pertinent to a physician's license to practice medicine, and criminal prosecution in certain circumstances.

Practical Pointers Concerning Confidentiality and Privilege
1. Follow the general principle to honor a patient's confidences unless a legally cognizable exception applies.
2. Have your own written "Authorization for Release of Medical/Mental Health Information" form that can be tailored to specific circumstances. If requested to release AIDS/HIV information, check with legal counsel or your state's Department of Health to ensure that the authorization you obtain is specific enough to meet legal requirements.
3. When in doubt about the validity of consent to release information, call your patient to discuss information and to verify consent.
4. When performing an evaluation (e.g., worker's compensation), clarify limits of confidentiality at the outset. Explain who will/will not receive a copy of the report.
5. Obtain competent advice before releasing information to anyone after a patient's death.
6. Apprise group therapy members about parameters of confidentiality.
7. When subpoenaed to testify/release records, seek advice from legal counsel. Generally, you will wish to ensure that the patient executes written, informed consent or that a court order is obtained.
8. Do not automatically assume that a managed care company has obtained patient consent to have information released to them. Try to discuss such authorization with the patient at the outset of treatment. Obtain written consent.
9. If using a collection agency or small claims court to collect an unpaid bill, make sure that you send the patient appropriate advance notice in writing and reveal the least amount of information necessary (Caveat: collections often lead to malpractice counterclaims.)
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