

## Informed Consent, Confidentiality and Privilege in Psychiatry: Legal Implications\*

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There appears to be a need for understanding of certain basic legal concepts whenever informed consent, confidentiality, and privilege are discussed in medicolegal context.

Informed consent to treatment is based on an "intelligent understanding" by the patient. To attain to an intelligent understanding, the patient-client must be mentally capable of forming an independent opinion based on his awareness of necessary facts, implications, and information afforded him. Thus, an unconscious emergency patient is incapable of forming an intelligent understanding due to his unconsciousness. Therefore, the law, in such an instance, *implies* his consent to emergency treatment provided a life-threatening situation is indeed present. Furthermore, the courts have universally viewed with jaundiced eye the "disclosure" alleged, doubting that doctors give patients enough information, and have paid scant attention to the "consent" element involved because consent connotes the dual ingredients of *awareness* and *assent*. It thus becomes elementary that there must be understandable communication between the physician seeking the authority by consent and the person entitled by law to grant that permission. The patient must understand the vocabulary used by the physician, for he cannot consent to that which he cannot comprehend. So, too, deceit, fraud, or coercion in obtaining of the consent to treat will be just cause for such a consent to be vitiated by the court. Refusal to treat or to remain the patient's physician; belittling the side effects, the reactions, or the length of treatment; or stating that the chemotherapy or other treatment is something other than what it is in fact, are all examples of prohibited practice of coercion, fraud, and deceit.

*Confidentiality* arises out of ethical traditions of the medical profession because of the need for privacy in communication between the physician and patient. Thus, those matters of information obtained by the physician while acting in his professional capacity with his patient must be kept secret. This ethical tradition stems from the Hippocratic Oath and is a requirement of most medical licensing statutes.

*Privileged communications*, on the other hand, exist by virtue of statutes enacted by the various legislative bodies of the several states. Parenthetically, it should be noted, 36 states have privilege statutes in addition to case law in which confidential communications are recognized.

Whereas the attorney-client privileged communication was recognized at common law (by case decision), no such sanction appeared in the profession of medicine until 1776 in a bigamy trial involving the Duchess of Kingston. A surgeon who had attended the defendant Duchess was asked whether she had told him of a previous marriage, and the court ruled the question had to be answered, stating:

If a surgeon was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honor, and of great indiscretion; but to give that information to a

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court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever. *Duchess of Kingston's Case*, 20 How. St. Trials 355 (1776).

This example clearly illustrates the law's recognition of the existence of the confidential communication between physician and patient as a matter of "honor" and "great discretion." However, it is also a lucid example of how the courts have eternally viewed the right to attain to this information in order that justice might prevail.

By common usage, confusion, and semantics the terms "confidential" and "privileged" communications are used synonymously, interchangeably, and erroneously to describe communications between the physician and his patient.

Without describing or illustrating the variances of statutory privileged communication, it should at least be noted that some states confer the privileged status to professional communications in both civil and criminal cases, others in only criminal cases, some only to communications about venereal or loathsome diseases, others in only civil cases, and still others to communications only between psychiatrists and patients—as in Georgia. Texas, on the other hand, recognizes neither privileged nor confidential communications.

The scope of the application of any of the three legal concepts of informed consent, confidential communication, and privileged communications is immense. Several chapters for medicolegal treatises could be written concerning each. Due to limitations of space and time the foregoing should suffice for this discussion.

On one hand, the daily practitioner of law and psychiatry should be aware of the invasive tactics of governmental agencies, employers, insurance companies, and administrative bodies—to name but a few—into the constitutionally protected right of privacy which should exist between the physician and patient. On the other hand, the physician must also be aware of his duty and obligation toward the patient, since the patient has the right to be informed of all the following: the diagnosis; the choice of treatment which the physician has deemed appropriate; the physician's experience in rendering the treatment to others; the methods which will be used; the major and collateral risks involved; the contemplated length of hospitalization, if any; the usually expected results and benefits anticipated as the result of the treatment; the alternates for the treatment proposed; and the probable prognosis if treatment is, or is not, rendered.

On the one hand (as above), the practitioner must consider the propriety of divulging information to those seeking it. On the other hand, he must consider the propriety of divulging the required and necessary information upon which a patient will base his consent. Still a third consideration, however, is the propriety which the physician-psychiatrist must determine relative to the effect such divulgence will have upon the patient. These then, are the social, legal, and professional areas within which the concepts of informed consent, confidentiality, and privilege communication are operative.

It would further appear that a present need exists for legislatively determined parameters within which the psychiatrist could conduct his professional role. Assuming due regard for the protection of the right of privacy belonging to the patient, the right of the patient and society to be protected from imminent danger or harm, and the need for immunity for the psychiatrist divulging necessary information for such protection, such legislation could be meaningful. In addition, it would also seem that such legislatively determined parameters should establish qualified psychiatrist-patient privileges having meaningful application to the treatment of the patient and subject to the discretion of the physician rather than a third party—be the same an administrative agency, a governmental body, an insurance company, etc.—yet, constitutionally subject to the Court's determination.

Knowledge of existing legal guidelines should be promulgated so that the information sought may be restricted to the subject litigated. The court room should not be used as an excuse to engage in psychiatric research; nor should it be used for the purpose of embarrassment or the undoing of the progress in treatment of the patient.

The lack of communication and understanding between the medical and legal professions has historically been the basic cause of any present-day dichotomy between them. It is quite impossible for either professional to know of or care about the problems of the other when lack of information, knowledge, or concern is prevalent. Cross-pollination of the professions, whether by agreement or disagreement, by social amenities or by courtroom adversary encounters, can result in some stimulation of interest. Well planned and purposeful dialogue, however, would seem to be a more plausible means for interchange of ideas, adoption of mutual objectives, and mutual cooperative efforts. Thereafter, educational endeavors aimed at psychiatrists, practicing lawyers, and jurists might well be the only means of attaining achievements beneficial to the individual patient, societal interests, administrative agencies, and other interested third parties, while nevertheless maintaining, and resulting in, meaningful physician-patient relationships.

Since the law is the expressed will of the people, either through elected representatives or through jurists, its expression will ultimately reflect the morality and ethics of the present-day society and may be found either within the legislatively enacted statutes or within the common law as decided by the cases before a court. Everyone is subject to the law. The law is one of the guiding forces within our society, although, to some, it may well be the only guiding force. Our nation is a nation of laws—whether appreciated or not. Therefore, to accomplish change in the areas of informed consent, confidential communication, and privileged communications, laws must be altered or enacted, obliterated or applied, broadened or narrowed, but, in any event, they must exist. It would appear to be for the best interest of all if uniformity of definition, uniformity in interpretation, and uniformity in application could be achieved. Certainly, these pragmatic objectives cannot be attained within either a legal or a psychiatric vacuum, nor through paranoid reactions.

Present medicolegal guidelines would appropriately require the psychiatrist to assure himself, first, that the person informed, relative to any matter relating to his patient, is someone entitled to the information; second, that the information is not given by telephone or telegram; third, that the information is not misleading nor erroneous; and fourth, that if he has doubts then his attorney is to be consulted.

Without belaboring the issue, the reported cases are resplendent with language relating to the confidentiality between physician and patient. The cases are also indicative of the need for a re-evaluation of the present status of general law throughout the United States. While Robertson and Lifschutz have pioneered resolution by resistance against legal directives, they have not been successful in their endeavors, and it would appear that such protracted litigated confrontations leave much to be desired.

The Griswold Case of Connecticut [381 U.S. 479 (1965)], as one of the most notable landmark cases regarding the rights of privacy, together with other legal decisions, may yet, in the not too distant future, bode well for more definitive legislation in the area of psychiatric confidentiality and privilege. As stated in the Hammonds Case, decided in Ohio in 1965:

We are of the opinion that the patient's privacy is no mere ethical duty upon the part of the physician; there is a legal duty as well . . . it is axiomatic that the physician-patient relationship is a *fiduciary one*. The policy of the law is to promote a full and free disclosure of all information by the patient to his treating physician; *this information entrusted to the doctor creates a fiduciary responsibility in regard to that information*. Those confidences entrusted to the physician are entitled to the same consideration as a res in control of the trustee, and the activities of a doctor in regard to those confidences must be subject to the same close scrutiny as the activities of a trustee in supervising a res. (Emphasis supplied) *Hammond v. Aetna Insurance Company* 243 F. Supp. 793 (Ohio 1965).

Almost two decades ago, another jurist expressed the same thoughts in this manner:

The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins and his shame. Most patients who undergo psychotherapy know that this is what will be expected of them, and that they cannot get help except on that condition. . . . It would be too much to expect them to do if they knew that all they say . . . may be revealed to the whole world from a witness stand. *Taylor v. United States* 222 F. 2d/398 (D.C. Cir. 1955).

As 1975 approaches, it would seem that those of us interested in psychiatry and law must bring home to our counterparts within the professions the recognition that there are times when the cause of individual freedom, and thus the freedom loved by the whole of society, is best served by restrictive acts and limitations within our legal framework; times when such restrictions and limitations may well accomplish the prevention of injustice—which after all is the greatest accomplishment of law.