

Informed Consent, Confidentiality and Privilege in Psychiatry: Practical Applications*

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Perhaps the most important ethical-legal consideration in psychiatry is the confidential relationship that exists between psychiatrist and patient. This relationship must be a trusting one in which the doctor is truthful, honest, open and considerate of his patient's needs. No doctor may trick, deceive, or take unfair advantage of his patient. From this confidential relationship emerges a number of other considerations of ethical import.

Informed consent, one of the essential elements in the relationship between physician and patient, is of equal significance to the psychiatrist and his patient. Informed consent has been variously interpreted and refers most commonly to that part of psychiatry which is akin to medicine; i.e., in which surgical or medical procedures are involved. The classical cases include psychosurgery, electroshock treatments and administration of medication. The patient has to know clearly what procedure he is receiving, what the risks are, what the goals of therapy are, and what could happen to him if he consents to the procedure.

These considerations hold true also for psychotherapy in that the patient must know what the psychotherapeutic scalpel will produce, what benefit it will be to the patient and what possible consequences or harm may occur by virtue of this medical procedure. This need may be more significant in behavior therapy with use of aversive techniques, but also occurs where transference phenomena are involved.

Another area in psychiatry in which informed consent plays a role is in the taking of information during a psychiatric interview for administrative, legal or employment purposes. When information taken from a patient during a psychiatric interview is to be transmitted to other individuals in summary or report form, the patient has a right to know what use will be made of this information and for what purpose, and what consequences may befall him owing to his revelation of this material.

The complexities of our society and of treatment methods in institutions have generally led to an erosion of confidentiality between psychiatrists and patients. The Statement of Principles of Medical Ethics cautions:

Growing concern regarding 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. Because of the sensitive and private nature of the information with which the psychiatrist deals, he must be circumspect in the information that he chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.¹

Then we may ask: "When is it beneficial and when harmful to release information about a patient and to whom?" The private psychiatrist sends a referring physician a

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report, outlining his consultation with the patient referred. The patient usually is told of this communication in advance and agrees to the transfer of information, but written consent is usually not obtained. In other instances, especially in the treatment of children and adolescents, of elderly people and of those requiring hospitalization, family members are told of the condition of their disturbed relatives. This communication is given in order to help the patient obtain the best possible treatment, whether it be hospitalization, family support or community care. More intimate details of personal conflicts, however, usually are not revealed.

In community mental health practice, information is collected and referred to a central file for record keeping. Hospitalized patients have records which may be observed by non-professionals. Psychotic patients who are in need of involuntary hospitalization and come before a judge for legal commitment cannot be treated with absolute confidentiality. Third party intervention often requires sending information to courts, lawyers, or insurance companies. Newer forms of family therapy, couple therapy and group psychotherapy also impose a modified approach to the traditional model of confidentiality.

When the confidential relationship is threatened by court action, i.e., when a court requires the psychiatrist to testify, the privilege doctrine comes into play. Privilege is a legal construct which belongs to the patient and keeps the doctor from revealing in court any information about the patient unless emergency situations exist or the court finds priority to disclosing the material over secrecy.

What does all this mean to the practicing psychiatrist? It means that he must be aware of what he puts into records, of what records he keeps, and of occasions when he may disclose information about his patient, with or without his patient's consent. The ethical statement for psychiatrists maintains: "A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion."¹ It also indicates: "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."¹ The statement of ethics does not specify whether or not the patient's consent is required when "danger is imminent." It leaves to the judgment of the psychiatrist to determine when the emergency exists and confidentiality must be broken.

The treating psychiatrist is in a much more difficult position than the examining psychiatrist, because the examining psychiatrist, no matter whom he represents, usually has set the *limits of confidentiality*; i.e., he tells the patient what he can keep confidential and what he cannot. He also enables the patient to give true informed consent to revealing certain material, by telling him what will be done with it and what consequences will befall him because of his disclosures.²

The treating psychiatrist usually does not set the limits of confidentiality with his patients. He usually has no reason to do so; he implies that all that is said will remain secret. Suppose, however, a patient in treatment reveals that he is involved in a criminal situation, either that he has committed a criminal act or that he anticipates committing one. This brings us back to the discretion of the psychiatrist in revealing any information about his patients. Most psychiatrists would probably continue treating people who are involved in minor crimes which relate to emotional disturbances, such as compulsive stealing, smoking marijuana, drug addiction or sexual offenses of a non-violent type, such as peeping or exhibitionism. They would hope to help the patient work out these problems medically rather than enter upon legal channels and destroy further chances of therapeutic resolution. When the offenses become violent, however, it is up to the psychiatrist to draw the line where he feels it necessary to prevent violence to others or to his patient.

Prediction of crime or violent behavior is much more difficult to assess than the validity of confessions of crimes already committed. Even confession, however, may pose serious problems, since the admission may be based on delusion rather than on reality. The wish to commit certain violent crimes may, but usually does not, lead to the actual commission of the crimes. The exception that is most often quoted is that of the young man in Texas who allegedly told his psychiatrist that he had urges to go up to the top of a tower and shoot the people below him. In fact, Charles Whitman eventually performed that very act. But how is the psychiatrist supposed to know when the wishes may actually be carried out? Our guidelines in this respect are quite limited and weak. Many people have such wishes, which they verbalize to the psychiatrist, and very few carry them out. Are we to detain preventively every patient who dares to utter such a wish or fantasy in the presumed sanctity of a therapeutic relationship?

Perhaps an example will serve to illustrate some of the practical difficulties involved in dealing with the interweaving nature of informed consent, confidentiality and privilege.

A twenty-seven year old married woman was hospitalized with a diagnosis of paranoid schizophrenia, manifested by hallucinations and delusions primarily of grandiosity but also of persecution. While in the hospital she demonstrated bizarre behavior and continued to hallucinate. Her husband was very concerned about her and asked about her diagnosis and prognosis. I felt it was appropriate to tell the concerned husband of a sick patient something about his wife. When he asked whether she was paranoid, I acknowledged that there were elements of paranoia in her illness. When he asked if she were schizophrenic, I agreed that she was and that it was an acute situation which should remit under proper treatment. Indeed she did recover quite rapidly, and upon doing so, decided that because her illness was related to the demands of her husband, who had been harrassing her and putting pressure upon her for several years, she wanted to separate from him and take custody of their four-year-old adopted daughter. When she left the hospital she went under the care of another psychiatrist, who continued to treat her. She separated from her husband and filed for divorce and custody of the child. In response to the legal situation, the husband called and asked whether or not I would put into writing what I had told him in the hospital; i.e., that she had been suffering from paranoid schizophrenia with delusions and hallucinations. I told him I would not do so and especially not without her consent. He could not understand why I would be willing to say what her diagnosis was at one time when she was in the hospital, and not be willing to put that statement in writing at a later time. I told him the difference related to the use to which this information would be put. In the first instance he was a distraught and concerned husband of a sick patient who required the information for future planning. Later, when he wanted the same information, it was to be used against his wife in a court proceeding. I felt that without her consent I could not give him this information that could be harmful to her.

To complicate the matter, I later received from a local attorney a request for information, a "release of information with authorized signature." The signature, however, was not the patient's, but her husband's. The document was obviously useless and I later confronted the lawyer with his fraudulent intent. He was embarrassed and agreed that he would not have submitted the information as requested, had he been asked for it in a similar manner. It surprised me that he did not subpoena the records if indeed he wished to have this information as he indicated. Certainly the hospital records with diagnosis and recommendations were available, as were my notes on the patient. The point of this example, however, is that the revelation of information may be appropriate at one time and not at another, depending upon the patient's informed consent and also upon the use to which the information will be put. I might add that at the time when I told the patient's husband of her diagnosis, she was present but could not give informed consent because she was incompetent and did not comprehend what we were discussing.

Suppose the patient did consent to my writing such a statement and also testifying about this information in court? There is a good possibility that I would refuse to do so unless I had a chance to discuss the matter with her at length. I would question why she should wish me to present this material which could be harmful to her and could work against her stated wishes to have custody of her child. I would want to discuss with her whether she was aware of what my testimony would mean to her and how significant it would be toward her legal goals.

Under most privilege statutes, when a person raises his state of mind in a civil matter in order to gain favor through the courts, either money or custody of a child, the patient may undergo an automatic waiver of the privilege and I may be forced to testify. In that case it may be essential for the best interest of the child in promoting society's welfare, that the information does emerge, so that if the patient is sufficiently ill, and would likely cause serious emotional damage to her child, then she may be denied custody. Thus, the balance of secrecy vs. society's right to know: which has priority? The judge must decide in each case. If required to testify, I would opt for the so-called "Lifschutz Compromise":* that the court could utilize only the relevant material from my testimony and not go on a fishing expedition in order to obtain excessive or irrelevant information which might be harmful or embarrassing to the patient.

An example of the harm that can occur from indiscriminate use of psychiatric records is the following:

A woman had been in analysis for several years and was undergoing divorce proceedings. The husband's attorney subpoenaed the records of her psychoanalyst, who allowed the notes of her free associations to leave his office, rather than merely a record of her attendance or a summary of the important areas of concern in her therapy. Homosexual fantasies were a part of these handwritten notes, and the judge, at his discretion, showed them to the husband's lawyer. For some reason, the notes, or information about the notes, went from the judge to the husband's lawyer to the husband, who, in his rage, went to his wife's home and beat her so severely that she was hospitalized with fractures and contusions. Who was at fault? Where should the blame be laid? Should the psychoanalyst have shown more discretion by keeping these notes in his office, or would such discretion have constituted an illegal act for which he might have been held in contempt? Should the judge have utilized only relevant information and forgotten about or not revealed the homosexual fantasies to the husband's lawyer? The judge showed poor judgment in my opinion. Next, should the lawyer for the husband have resisted the temptation to chuckle over these notes with the husband? Certainly, and I feel that the lawyer's action constituted negligence, poor judgment and poor professional practice. And what about the husband? He is the one who will have to pay the damages for his wife's battering. All this could have been prevented had the psychiatrist known enough to keep his intimate records away from the court, where they did not belong.

Many writers have advised the practicing psychiatrist to handle his records in a variety of ways. Some have advocated that he keep no notes at all except for income tax records. Others have suggested a dual record system, while a few have recommended keeping full and accurate records to protect one's self and one's patient. There is no single answer for everyone. Each doctor must decide for himself what suits him best in the care of his patients.

Perr⁴ has discussed the historical and legal development and philosophy of the privilege doctrine in psychiatric communications, and the Courts of Michigan have

* This compromise was delivered by the Supreme Court of California when Dr. Joseph Lifshutz, a psychoanalyst, refused to testify about a former patient of his who had waived his privilege of silence in a civil case involving damages.³

decided that the prisoner serving an indeterminate sentence is not able to give voluntary informed consent to experimental procedures (psychosurgery) that may help free him.

This paper will not cover these areas since they have been discussed so thoroughly elsewhere. I hope in this presentation to demonstrate the interdependence of the three ethical-legal concepts of informed consent, confidentiality and privileged communication in psychiatry. In order for a true confidential relationship to exist, there must be a strong privilege statute between psychiatrist and patient, and the limits of confidentiality must be set at the beginning of therapy to promote the possibility of true informed consent.

What guidelines can emerge from this discussion to aid the treating psychiatrist to adhere to ethical-legal concepts of confidentiality with his patients and still maintain responsibility to himself and his community? The following conclusions are offered:

[A] The guidelines on confidentiality, as proposed in the September, 1973, issue of the *American Journal of Psychiatry*,¹ should be studied and applied by each psychiatrist; in sum, the doctor must maintain a confidential relationship with his patient at all times except in an emergency or with danger imminent.

1. In the event of an urgent situation requiring breach of the confidential relationship,
 - a. the doctor should first try to encourage the patient to reveal the information himself if he feels it necessary for the patient's welfare.
 - b. Failing this, the doctor should reveal the information with the patient's consent or in the presence of the patient himself to a responsible family member or a responsible authority in society.
 - c. Finally, if the patient does not cooperate in revealing information which the doctor feels must be divulged, then the doctor must use his best judgment and discretion in deciding whether an emergency situation exists with clear and imminent danger to the patient or society, and reveal the information to a responsible authority, even without the patient's consent, if the act will result in prevention of violence or saving of life.

[B] *The doctor should set the limits of confidentiality* at the beginning of treatment whenever possible. The extent to which this is done depends on each individual patient. It must be at the doctor's discretion how much he will discuss the limits of confidentiality with his patient. Certainly in dealing with individuals who have acted out fantasies in the past or who have criminal records, the doctor should protect himself and alert his patient. In treating individuals on parole or probation, especially when mandated by the courts, or treating those in prisons, the doctor must discuss the limits of confidentiality at the beginning of treatment. For those in group psychotherapy, family therapy and other situations in which a one-to-one relationship does not occur, limits of confidentiality must be spelled out at the outset. Clearly, if there is a possibility of involuntary hospitalization, or if psychosis is evident, limits of confidentiality must be discussed both with the patient and with family members. In the treatment of adolescents, I always make it a point to spell these limits out very clearly at the beginning both to the adolescent and to his parents. All concerned know from the start how thoroughly I will discuss the case with the parents and what the adolescent can expect me to keep secret and what types of behavior he can expect me to reveal. Setting limits of confidentiality at the outset is to promote true informed consent in psychotherapy.

[C] If there is a need to testify about a patient, it is essential that the doctor give only pertinent information that cannot be of embarrassment or harm to other people, or even to the patient if not relevant to the case at hand. In this way we can help to protect our patients and also future patients who will have more confidence in the privacy of the psychotherapeutic relationship.

[D] Finally, we must push for changes in legislation and privilege statutes to insure a stronger doctor-patient and psychotherapist-patient privilege. Generally, the privilege belongs to the patient, but in Illinois the privilege belongs to the therapist working in

family and marital counseling in domestic relations cases. This type of privileged communication encourages people to discuss their family problems without concern that the information they divulge will be revealed subsequently in a court of law, either in divorce or in custody hearings. We must continue to help strengthen the privilege doctrine in psychiatric practice.

In summary, what I have tried to show is an interweaving of the three ethical-legal concepts of informed consent, confidentiality and privilege. They are all interdependent and necessary, one for the effective functioning of the other. The psychiatrist must ensure informed consent by setting limits of confidentiality at the beginning of treatment whenever possible, and maintaining the confidential relationship as prescribed in the Principles of Medical Ethics. This confidential relationship can be ensured only by strengthening the privilege statutes for psychotherapists.

References

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