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When Doctors Divulge: Is There a "Threat from Within" to Psychiatric Confidentiality?

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ABSTRACT: Psychiatrists, as a profession, have always asserted the central importance of confidentiality. The American Psychiatric Association (APA), in its recently released "Guidelines on Confidentiality," reaffirms this position. In an age of progressive erosion of the traditional psychiatrist-patient confidentiality, the threat to confidentiality is invariably perceived as *exogenous*, emanating from external sources such as the legal system, third-party payers, and peer review organizations. In rare instances, there appears to be a *threat from within*, when the psychiatrist (or nonpsychiatrist physician dealing with a psychiatric patient) deliberately chooses to divulge the patient's confidential communications in the absence of any clearcut legal requirement to do so (and against the express wishes of the patient). Four case examples of these unusual breaches of confidentiality are presented. The author concludes that although significant assaults on patient confidentiality are occurring from without, it is quite rare for such violations to come from within the profession itself.

KEYWORDS: psychiatry, privacy, doctor-patient privilege, confidentiality

> Whatsoever things I see or hear concerning the life of man, in any attendance on the sick or even apart therefrom, which ought not to be voiced about, I will keep silent thereon.
>
> HIPPOCRATIC OATH

Confidentiality has long had a venerable place in the practice of medicine. Its sanctity in psychiatry is perhaps even more critical because of the inherently intimate nature of the patient's communications, which cover his or her innermost thoughts, feelings, and fantasies [*1*]. To discuss such matters candidly, the patient requires an atmosphere of unusual trust, confidence, and tolerance. Patients will be helped only if they can form a trusting relationship with the doctor. The American Psychiatric Association (APA) has emphasized that "Confidentiality is essential to psychiatric treatment" [*2*] and in the recently issued "Guidelines on Confidentiality" [*3*] has warned of the sanctions that may be imposed in cases of unwarranted disclosure [*3*]:

> Keeping patients' confidences is part of a psychiatrist's ethical and legal duty. Any breach of such confidence . . . may lead to admonishment, reprimand, suspension, or even expulsion [from the APA]. . . . [B]reach of confidentiality may also be judged to be unprofessional conduct and grounds for suspension or revocation of the psychiatrist's license to practice medicine. It can even be a basis for civil litigation or criminal action against the psychiatrist (pp. 1522-1526).

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In recent years, the confidentiality of the traditional psychiatrist-patient relationship has been under increasing pressure from outside sources. There has been a steady erosion of the limits of confidentiality in the post-*Tarasoff* era, with an emphasis on guarding against public peril at whatever cost to patients' protective privilege [*4,5*]. In addition, third-party payers and peer review organizations have required detailed information about treatment; courts and legislatures have repeatedly sacrificed confidentiality when judicial or governmental access to information is at stake; and, computerized records of psychiatric patients are stored in (and retrieved from) proliferating data banks [*6–9*].

In the face of these new and escalating external pressures and threats to confidentiality,[2] psychiatrists have continued to champion the cause of confidentiality and to attempt to avoid or minimize the scope of disclosure to protect patients' interests and promote successful treatment. As Rachlin and Appelbaum [*10*] observe,

> Although only a foolhardy therapist would guarantee patients absolute confidentiality, most therapists can legitimately say that they will do all in their power to protect patients' privacy.

Although it is true that in the overwhelming majority of psychiatric patient contacts, no breach of confidentiality occurs, there have been exceptions. This paper presents a number of such cases wherein confidential information regarding psychiatric patients was *deliberately divulged by their physicians,*[3] *against the patient's express wishes.* These disclosures were not compelled by court order, reporting statutes, concerns about the duty to protect third parties against a potentially violent patient, or other clearcut legal requirements.

Case 1: Divulgence in Order to Promote Professional Medical Education

Eight years after the termination of a lengthy psychoanalysis, Dr. A published a book which reported verbatim and extensively the patient's biography, most intimate personal relationships, thoughts, feelings, emotions, and sexual and other fantasies. The former patient brought a lawsuit against Dr. A, seeking an injunction and monetary compensation for emotional injuries incurred as a result of the public exposure and humiliation she suffered. The action was predicated on invasion of privacy and the breach of an implied covenant to keep all of her disclosures in confidence [*11*]. The Court rejected Dr. A's claims that the patient had consented to publication of such a book (the Court disparaged the value of an alleged oral waiver of confidentiality by a patient to a psychiatrist during the course of treatment) and that the book was of such scientific merit that the professional need which it fulfilled transcended the patient's right of nondisclosure (the Court said "[i]n no case, however, has the curiosity or education of the medical profession superseded the duty of confidentiality" [*11*]). Further publication of the book was enjoined and the former patient was awarded $20 000 in compensatory damages. In its opinion, the Court stated [*11*]:

> Every patient, and particularly every patient undergoing psychoanalysis, has such a right of privacy. Under what circumstances can a person be expected to reveal sexual fantasies, infantile memories, passions of hate and love, one's most intimate relationship with one's spouse and others except upon the inferential agreement that such confessions will be forever entombed in the psychiatrist's memory never to be revealed during the psychiatrist's lifetime or thereafter? The very needs of the profession itself require that confidentiality exist and be enforced.

[2]Additional situations requiring disclosure of otherwise confidential information would include various reporting statutes (for example, in cases of actual or suspected child abuse) and a duty to report certain contagious diseases (for example, AIDS infections in certain jurisdictions).

[3]Cases 3 and 4 involve psychiatric patients in situations where information about their prior psychiatric treatment or details about their psychiatric illness, or both were divulged without their consent (and against their express wishes) by nonpsychiatrist physicians.

Case 2: Divulgence in Order to Share Information with a Patient's Spouse

A former patient sued his psychiatrist, Dr. B, alleging that during two extended courses of treatment, the psychiatrist revealed intimate details about him to his wife without justification and without consent. As a consequence of such disclosure, the patient claimed that his marriage deteriorated, he lost his job, suffered financial hardship, and was caused such severe emotional distress that he required further psychiatric treatment. The Court noted that such a cause of action was rare because confidentiality is a cardinal rule of the psychiatric profession, "faithfully adhered to in most instances, and thus has come to be justifiably relied upon by patients seeking advice and treatment" [*12*].

While recognizing that there is an exception permitting disclosure of confidential information by a psychiatrist to a spouse whenever a danger exists to the patient himself, the spouse, or a third person, the Court held that otherwise information should not be disclosed without proper authorization.[4] The Court emphasized that a stringent standard should apply to disclosure of psychiatric information in such cases because [*12*]

> [o]ne spouse often seeks counselling concerning personal problems that may affect the marital relationship. To permit disclosure to the other spouse in the absence of an overriding concern would deter the one in need from obtaining the help required.

Case 3: Divulgence in Order to Respond to a Governmental Inquiry

A civilian employee of the U.S. Air Force was discharged from his job following the receipt of a letter from his medical doctor, Dr. C, disclosing that the patient's excessive absences from work were due to alcoholism. Dr. C had alerted the patient that the Air Force requested the letter because the underlying cause of the patient's illness had not been set forth in prior medical certificates the doctor had previously submitted (at the patient's request) to excuse the absences. In other words, the patient had previously requested that Dr. C make what amounted to incomplete disclosures to his employer as to the nature of his illness; however, now when the Air Force requested additional and more specific information from the doctor, the patient expressly ordered him not to comply. Over his patient's objection, nevertheless, Dr. C decided he had an overriding duty to make full disclosure of the patient's diagnosis when requested by the Government to do so (especially because he had previously supplied incomplete information). As a result, the patient was discharged from his job and brought a lawsuit against Dr. C, charging that in mailing the letter the doctor had committed malpractice by divulging a confidential communication.

The Court held that there was no malpractice on the grounds that Dr. C had an overriding duty to make full disclosure and that the patient had in effect waived confidentiality in the first place. The Court said [*13*]:

> The delicate balance of conflicting duties must thus be weighted . . . to determine the doctor's paramount duty. Was the duty to divulge the employee's weakness which, conceivably could be used to rid the government of a worthless servant and thereby save public funds, greater than the duty to maintain a confidential professional communication? Had the disclosure risen to the level of a need to safeguard the security of the government or the safety of the public, as in a case of a disclosure of a communicable disease . . . it would, of course, be quite simple to find that the doctor's duty to disclose overrode his duty to remain silent. In view of the prior incomplete medical certificates requested by the plaintiff and supplied by the doctor . . . it may similarly be said

[4]The APA recognizes that in some cases involving seriously disturbed patients, psychiatrists may need to work with the relatives involved in the patient's care and should not inadvertently use confidentiality as an excuse to avoid doing so. It is not clear whether this "seriously disturbed patient" exception to confidentiality should apply in this case, because few details are offered about the patient's clinical status beyond the fact that he was being treated as an inpatient for an unspecified psychotic illness at the time. Similar exceptions to confidentiality may apply under certain circumstances when the patient is a minor.

> that his right, if not duty to his government, to make a full disclosure of the facts superseded his duty to the patient to remain silent. This leads directly to the issue of waiver. . . . Having placed the doctor in the position of telling but part of the truth, he [that is, the patient] is estopped from preventing his divulging the remainder. In the circumstances, there could be no qualification, limitation or termination of the waiver.

Case 4: Divulgence in Order to Prevent Deceiving or Misleading a Legal Tribunal

A former patient sued her doctor, Dr. D, for breach of confidentiality after he revealed communications from her to the patient's adversary in a personal injury lawsuit. Dr. D had been her treating doctor after she was injured in an accident. In the original lawsuit, while Dr. D was being prepared for his testimony at trial, he suddenly (and for reasons that are not spelled out) indicated he would not testify in his patient's behalf and requested the name of the opposing counsel. At this point, he was warned by the patient's lawyer that all communications made to him by the patient were privileged and should not be divulged to any third party. Nevertheless, Dr. D contacted opposing counsel to divulge information to him regarding the patient's prior psychiatric history, her abuse of medication, and his opinion that the accident had been caused by the aforesaid medication abuse. Upon learning of the other side's intention to call Dr. D as well as the original psychiatrist as witnesses at the forthcoming trial, the patient reentered settlement negotiations and settled the case for a sum which was considerably lower than the original estimated value of the case.

The issue before the Court was whether a cause of action for a breach of confidence lies against a doctor who reveals communications between himself and the patient to the patient's opponent in a personal injury lawsuit (in which the patient's physical and mental state are at issue). The court found in favor of Dr. D, holding that when a plaintiff brings a personal injury action in which his physical or mental condition is placed in issue, he thereby waives any privilege. In this case, the plaintiff waived the privilege by virtue of bringing the original lawsuit. Having already waived the privilege, the patient belatedly tried to reinstate it by instructing her attorney to caution Dr. D not to divulge certain confidences to any third party. Such an attempt to limit the waiver of privilege was held to be ineffective. As in Case 3, the Court held that there could be no qualification, limitation, or termination of the waiver once it had been made.

While holding that Dr. D was not *legally* liable, the Court went on to note its strong disapproval in the following terms [*14*]:

> the conduct of the defendant [doctor] herein, although outrageous, unprofessional and improper . . . was not a breach of confidence since the privilege of confidentiality was waived by the commencement of the original lawsuit. . . .[5]

The Court's censorious language seems unwarranted if (as the report of the case suggests) Dr. D presumably was acting to prevent his patient from offering false or misleading evidence (or omitting to introduce material evidence) in the original lawsuit. Under similar circumstances, a lawyer would have an ethical obligation to rectify such a situation by disclosing his client's deception to the tribunal or to the other party, if he could not persuade his client to take remedial measures [*15*].

Although psychiatrists (and other physicians) are not bound by the ethical code of the legal profession (or vice versa), it appears that the physician in the case at bar was attempting to act in an honorable fashion in order to prevent his patient from deceiving or mislead-

[5]The court went on to observe that the doctor's "unprofessional behavior," although not actionable, was reportable to the licensing authorities (that is, although there was no basis to hold him civilly liable, his conduct might still be grounds for suspension or revocation of his medical license).

ing the Court.[6] Candor towards the tribunal is generally viewed as a duty of major significance that our system goes to great lengths to safeguard. The Court here appears to be saying that when a conflict arises between a physician's duty to keep his patient's revelations confidential and a duty to the court, that his paramount obligation is to maintain confidentiality.

Conclusion

Psychiatrists, as a profession, have championed the cause of confidentiality. The APA has issued specific "Guidelines on Confidentiality" [3] reaffirming its central importance in psychiatry, outlining the possible sanctions that may apply in the event of a breach, and setting forth the special situations under which the psychiatrist may be compelled to (or have a duty to) divulge otherwise confidential information. Although the threat to confidentiality is invariably perceived as *exogenous*, with the psychiatrist staunchly refusing to divulge information unless pursuant to a court order or some equally compelling legal duty,[7] in rare instances there appears to be a *threat from within.* In such cases, the psychiatrist (or nonpsychiatrist physician dealing with a psychiatric patient) deliberately chooses to divulge the patient's confidential communications in the absence of a clearcut legal requirement to do so (and against the express wishes of the patient). Four case examples of these unusual breaches of confidentiality are presented. Although significant assaults on patient confidentiality are occurring from without, it is quite rare for such violations to come from within the profession itself. Psychiatrists maintain a strong allegiance to confidentiality and are rarely sued for impermissibly breaching it.

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[6]It may be that Dr. D believed that he was in danger of participating in a fraud or committing perjury, unless he took the action which he did. It is not clear whether he acted on his own or after seeking consultation with a senior colleague or a knowledgeable attorney.

[7]Some members of the profession have taken it one step further. In 1969, Dr. Joseph Lifschutz went to jail, asserting that as a practicing psychoanalyst he had a professional obligation not to violate the confidentiality of the analyst-analysand relationship. He argued unsuccessfully that the therapist should be accorded the privilege of silence independent of the patient's privilege. (The privilege belongs to the patient and, in Dr. Lifschutz's case, the patient had voluntarily consented to a release of information, which the court subsequently ordered Dr. Lifschutz to release.) As a result of tenaciously adhering to his position, Dr. Lifschutz was briefly jailed for contempt of court [16].

[11] *Doe v. Roe*, 400 N.Y.S.2d 668, 676, 677 (1977).
[12] *MacDonald v. Clinger*, 446 N.Y.S.2d 801, 805 (1982).
[13] *Clark v. Geraci*, 208 N.Y.S.2d 564 (1960).
[14] *Fedell v. Wierzbieniec*, 485 N.Y.S.2d 460 (1985).
[15] *Model Rules of Professional Conduct*, Rule 3.3 (Candor Toward the Tribunal), American Bar Association, 1983.
[16] *Matter of Lifschutz*, 467 P. 2d 557 (1970).

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