

Patient confidentiality: changing the rules for modern duty to warn essay sample

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Every first year psychology student is taught that maintaining the confidentiality of the client is a prime concern in the development of a counseling relationship. As a practicing psychologist, members of the American Psychological Association are subject to guidelines for ethical behavior and sanctions for not maintaining patient confidentiality. However, the decision to protect a patient's divulences or even the fact that a person is a client can become a quagmire of ethical complications that few psychology students address in depth before they step into the counseling world. When does the duty to maintain a patient's confidentiality cease and where does it begin? From the legal guidelines of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the ethical guidelines of the APA, the practicing psychologist is faced with a multitude of situations in which the maintenance of client confidentiality becomes difficult or even potentially illegal. In this paper the writer will attempt to address some of the situations which can cause ethical dilemmas for the psychologist and some of the potential answers that are available.

Perhaps even more than the APA, HIPAA concerns regarding confidentiality are of primary importance to the practicing psychologist. In 1996, Congress adopted a law aimed at protecting patient privacy that has resulted in annual privacy notices to patients and new paperwork to prove that medical providers are ensuring the privacy of their patients. In theory, it also protects patient confidentiality. According to the United States Department of Health and Human Services, which oversees the law, " A covered entity must disclose protected health information in only two situations: (a) to individuals (or their personal representatives) specifically when they request access to,

or an accounting of disclosures of, their protected health information; and (b) to HHS when it is undertaking a compliance investigation or review or enforcement action," (HHS. gov, 2012). Of course, this immediately complicates the theory of patient confidentiality as the health care provider, in this case the psychologist, is faced with the duty not only of maintaining his or her ethical commitment to the patient and to society as a whole, but is also forced to attempt to interpret the law regarding when disclosure is permitted. High profile cases where mental illness is suspected to be a part of a patient's illegal actions, such as the 2007 shootings at Virginia Tech, further complicate the question.

From the perspective of the psychologist and the APA, the guidelines are no less confusing or complicated. The organization holds five general principles to be of the utmost importance to psychology practice. However, the principles are not necessarily clear what action the psychologist should take when the principles themselves require contradictory action. Principle five states the psychologist will show respect for people's rights and dignity. Specifically, the APA says, " Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making," (APA. org, 2012). The need to protect a patient's confidentiality has its roots in respect for the client.

It is intended to prevent patients from facing a social stigma related to their need for counseling and to promote absolute trust in the relationship between the patient and the provider. It gets messy when combined with the first principle, beneficence and nonmaleficence. " Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm," (APA. org, 2012).

The question then facing the psychologist is what action will result in the least harm to both the client and society. In the case of the Virginia Tech shootings, and indeed in the case of many mass shootings, the perpetrator has had previous mental health counseling and the focus of a terrified nation has focused not on the patient confidentiality principle, but on the psychologist's duty to warn. In the wake of the Aurora, Colorado, theater mass shooting this summer, the question of what can be done to identify persons capable of conducting these well-planned attacks against society as a whole becomes even more prominent and more important than assigning blame for the failure of Virginia Polytechnic Institute to identify and prevent the killing rampage of Cho Seung-Hui. Since the attack at Columbine High School, just 12 miles from the Aurora shooting, the nation's attention, and even the world's, has focused on the question of what makes young people

decide to plan these mass killings and why doesn't anyone notice their intention before it is too late to stop it?

Beginning with the Columbine incident 13 years ago, mass shootings have been a part of societal consciousness. Some people like to blame the "gun culture" of the United States, divisive politics, as in the case of the shooting of Arizona Congresswoman Gabrielle Giffords, or even movies and video games, but with incidents like the 2011 attack in Norway where 69 people were killed, the problem can no longer be identified as purely an American one. However, one of the unifying factors in each of these mass shootings was the age of the shooter; all except the Norwegian killer were young men just into their 20s. Obviously, not all young men who are depressed or bullied or mentally ill take the drastic step of becoming mass murderers, yet those who do often prompt society to look for clues, to wonder why the professionals did not identify these potential threats and do something to mitigate them. The nation, and the world asks, where was the duty to warn?

The risks associated with the mentally disordered are generally not a high priority in society nor should they be. "A scholarly review of the research literature by Cornell University indicates that 'none of the data give any support to the sensationalized caricature of the mentally disordered served up in the media,'" (Gabriel, 2000). High profile incidents like the shooting of former Arizona Rep. Gabrielle Giffords draw attention to violence by the mentally disordered, but they are the exception, not the rule. "[W]hile the data show that people with certain psychiatric problems do commit violent crimes at a higher rate than those who are seemingly healthy, the vast

majority of homicides, arsons and assaults are perpetrated by people who are not considered severely mentally ill," (Khan, 2011).

The mental disorders exhibited and in evidence for Cho Seung-Hui, the Virginia Tech shooter, may have been a factor in his killings, but probably were not the cause of it. However, the way that he was treated because of those mental disorders may have been a factor. Bullying and mistreatment as well as a general lack of social engagement could easily have been contributing factors, (Bartol & Bartol, 2011). The damning factor for psychologists, at least those involved in the Virginia Tech case, was that there had been no breach of patient confidentiality. In fact, not even the young man's parents were aware of his mental condition.

The question of responsibility then becomes a hazy mess of societal values and responsibilities. It was difficult not to notice that he was presented immediately as a foreigner and a loner. For a moment, reporters seemed lost as to what else to say about him beyond these characterizations, but by Wednesday, April 18 (two days after the incident) a New York Times article had the fundamentals of the basic story down: Cho Seung-Hui rarely spoke to his own dormitory roommate. His teachers were so disturbed by some of his writing that they referred him to counseling. And when Mr. Cho finally and horrifyingly came to the world's attention on Monday, he did so after writing a note that bitterly lashed out at his fellow students for what he deemed their moral decay'," (Song, 2008).

In the aftermath of the shootings, everything from the Virginia guns laws, which allowed Seung-Hui to purchase the guns he used legally, to the

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campus mental health programs were blamed for the shooting. With 33 people dead, including the killer, people wanted an explanation for the violence. They wanted to blame someone for not noticing how troubled the shooter was and to some justifiable extent; the blame lays within a system the labels the mentally ill, but fails to follow through in treatment for their illness. It was more than two years after the shooting when files from the campus mental health agency were finally made public, files that indicated some people were aware of Seung-Hui's troubled existence, but failed to follow up on it. The problem, at least to some extent, was a society that believes in individual rights and freedoms.

Whether due to misunderstanding of federal privacy laws, a lack of staffing or odd indifference, Seung-Hui's mental illness was not relayed to the proper people to help him. Indications that he might have been bullied as a child and teen are largely speculation and the educational assistance offered him in his primary education was never carried over to the university level because of privacy concerns. Mental health professionals treating the shooter much closer to the time of the shooting were hampered by the fact, that our society makes persons responsible for their own medical care when they turn 18 and there is no easy system in place for institutions like Virginia Tech to suggest that a young adult is incapable of that self-care.

Eighteen months before the shootings, Seung-Hui was referred to the mental health program by an instructor concerned about his writings. That was November, 2005. Perhaps it was the holidays and the killer's lack of desire for assistance that let him "crawl into the cracks and hide there," (Knaus, n.

d.). What happened was not even revealed until 2009. “ In the records from his initial telephone conversation, another triage counselor checked off ‘ Troubled: Further contact within 2 weeks’ under the portion of the form that rates the severity of the patient’s disposition. An in-person appointment was scheduled for Cho on Dec. 12, 2005, but when he failed to show up, another telephone consultation took place,” (Friedman, 2009).

While the therapist noted that Seung-Hui was depressed, anxious and had trouble concentrating, the counselor had no authority to force the killer to seek treatment. When he said he didn’t want to come in for an appointment, the subject was allowed to be dropped. Likewise, after a complaint from a roommate that Seung-Hui was suicidal, he was taken to a local mental hospital, but the triage counselor who was seemingly aware of his previous interactions with the counseling center did not deem the killer sufficient risk to himself or others to maintain at the hospital. ““ He denied any suicidal or homicidal ideation. Said the comment he made was a joke. Says he has no reason to harm self and would never do it.’

Even so, Conrad drew an “ X” through the portion of the medical chart that assesses a patient’s mental health, instead writing, ‘ did not assess — student has had two previous triages in past two weeks — last two days ago’,” (Friedman, 2009). While it is hard to assess ultimate responsibility to anyone other than the killer himself, the records point to glaring problems with the mental health system and the one at Virginia Tech in particular. Because of his age, despite indications of mental illness, Seung-Hui was considered responsible enough to make his own health decisions. Worse yet,

the counselors happily accepted his statement that his suicidal comments were a “joke” and that he had no intention of hurting anyone, including himself. Seung-Hui remained at the university for another 16 months, but there is no evidence that the counseling center or the mental hospital made any on-going attempt to help him seek treatment.

In general, this is an indictment of the rule of patient confidentiality. Whether the lack of a complete intake at the hospital could have prevented the tragedy is the subject of much debate. If Seung-Hui had been kept for more than 24 hours at the hospital, he might not have been able to buy the guns he used in his shooting spree legally or he might have gotten the help he needed and skipped the shooting altogether. So who bears responsibility, ultimately? Society does. We have somehow decided that personal liberties are more important than the safety of society as a whole. We rule that you can't open the laptop of a suspect in custody and miss plans to blow up a New York City landmark because of it. We rule that an 18-year-old with a history of mental illness is an adult and therefore his medical records cannot be shared with anyone else without his permission, even when, a few years later, those records tend to indicate he might be a danger to himself or others.

But the exception does not prove that there is an overall issue with patient confidentiality. The exception proves that more discussion is necessary and psychologists need a better education regarding when the principle of confidentiality must be set aside. “The concept of treatment boundaries developed primarily from psychoanalysis and outpatient psychodynamic

therapy. Ethical principles and legal duties have also defined treatment boundaries. Differences over what constitutes acceptable treatment boundaries go back as far as Freud's disputes with Ferenczi and Reich. Although no universally accepted boundary standards exist, broadly based boundary guidelines have received general acceptance among mental health professionals," (Simon and Williams, 1999). The rules may have been developed with good intentions, but they are hard to maintain in some clinical environments, especially when the therapist serves two masters or plays two roles. One particular study focuses on the post 9/11 role of military psychologists as co-workers and counselors (Zur and Gonzalez, 2002), but could easily have discussed small town relationships where a counselor is also a fellow church member, PTA associate or even the parent of a child who associates with the patient's family (Simon and Williams, 1999). The rule of maintaining confidentiality gets blurred. How can you as a psychologist protect the identity of persons who visit your office?

Patient confidentiality also takes a hit in the super specialized treatment areas of modern medicine where a patient may be seeing several different providers for related conditions (Rock and Congress, 1999; Wydra, 1994). Not telling a patient's other medical providers that he is taking an SSRI for depression is contradictory to the patient's overall health needs, but it could be considered a basic violation of the patient's privacy. Worse yet, some graduate students commit ethical transgressions while studying to become psychologists. " The highest percentages of violations reported involved confidentiality (25%), professional boundaries (20%), and plagiarism (15%). Fifty-four percent of graduate students committing ethical violations had

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taken an ethics course," (Tyron, 2000). These studies would tend to indicate that the question of client confidentiality is not necessarily something that students can simply learn.

At the heart of the discussion then is what needs to be taught and what practices need to be accepted with regards to these ethical principles. First and foremost, the concept of confidentiality needs to be balanced with the concept of minimizing harm. Whether or not counselors could have predicted the behavior of the Virginia Tech shooter or any other mass murderer is unclear, but students must be given guidelines for determining when to bring others into the counseling process. Perhaps via mentoring or working with more experience psychologists, beginners could more easily learn when to apply their duty to warn. Second, the APA should lobby Congress to amend HIPAA and lobby their states as well to offer protection for psychologists who choose to violate confidentiality for the protection of others. Right now, HIPAA and various state laws mean the psychologist could potentially face fines, loss of licensure and censure from the APA for violating that principle. Finally, psychologists need to be reminded that they are, ultimately, members of a greater community and should therefore seek assistance when a client is beyond their therapeutic capabilities.

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