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Ethical Considerations of the Limits of Confidentiality in the Psychotherapeutic Setting:

When Doing No Harm Means Avoidance of Informed Consent

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Informed consent continues to be one of the most important issues in biomedical ethics. Born from the atrocities of Nazi medical experimentation (Meisel and Kuczewski 1996), the subsequent Nuremberg laws (Gonorazky 2015), as well as the Tuskegee Syphilis Study (Corbie-Smith, 1999), informed consent has drastically impacted the biomedical research landscape. Additionally, it has directed the practice of clinical medicine away from its traditional paternalistic roots of physicians describing only what they thought best towards a greater emphasis on providing information regarding possible consequences of treatment as well as alternatives (Appelbaum 1997). American case law has reinforced the relevance of informed consent, establishing that physicians can be found liable for medical malpractice for failing to offer this information in certain circumstances (Harnish v Children's Hospital Medical Center, 439 NE2d 240 [Mass 1982]).

Informed consent is defined broadly as the dialogue between a clinician and patient regarding the nature of a particular medical treatment (Cordasco 2013). The informed consent process encompasses multiple facets: discussing the patient's role in the decision-making process, its indication, alternatives including no treatment, inherent risks and benefits, uncertainties, and lastly assessing a patient's understanding of the provided information and subsequent articulation of a choice (Braddock et al. 1997). Informed consent is built from the

biomedical ethical principle of autonomy, which emphasizes the importance of respect for persons (Beauchamp and Childress 2013). The purpose is to empower patients to have control in making health-care related decisions that reflect their true desires established by a unique set of personal values.

Although informed consent is generally thought of in regards to high-risk procedures like surgeries, chemotherapy, and radiation therapy, it is relevant to any situation in which the patient faces a medical treatment decision (Whitney et al. 2004). This is true in health-care decisions in which the risks or consequences of a treatment may not be as readily recognized. For example, direct-to-consumer personal genome tests may on the surface appear to have no down-side. But many consumers likely fail to realize the potential psychological, physical, and social harms that may occur as a result of obtaining this information (Bunnik et al. 2014). It is also true in cases in which the likelihood of success of treatment or possible adverse outcomes are largely uncertain (Appelbaum 1997).

Studies suggest that informed consent, by enhancing doctor-patient communication, leads to improved patient satisfaction, better outcomes, less medical errors, and lower rates of malpractice claims (Cordasco 2013). Despite the growing focus on patient autonomy following the abuses of the last century, the question remains whether informed consent is always best for patients or whether in certain extreme scenarios informed consent may prove sufficiently detrimental to their care to require an exception.

Psychiatry is a field of medicine in which the relevance of informed consent may be overlooked, and particularly with the practice of psychotherapy the risks of treatment are not

likely salient and predicting outcomes is difficult and largely variable as it is dependent on the unique doctor-patient relationship (Jain and Roberts 2009). One area that may be especially important to consider related to patient autonomy in the psychotherapeutic setting is whether and when to give a patient fully informed consent as it relates to confidentiality and specifically the limits of confidentiality. It could be argued that a patient always has a right and ought to know at the outset of treatment the limits of confidentiality. For example, disclosed information could be used to infringe on their personal freedoms or liberties leading to involuntary hospitalization, gun prohibition, or legal and professional consequences. Yet, as will be presented in this paper, not giving full informed consent in certain situations may be the most protective action of the patient and/or third parties, thus trumping patient autonomy.

Such scenarios include when patients may be considering dangerous actions, either to themselves or others. Ordinarily, practitioners may want to alert patients to the limits of confidentiality in order to respect the patient's autonomy. But when safety is concerned, it can be of such importance to obtain the information that it warrants not warning patients in ways that might discourage them from sharing the dangerous actions that they are contemplating. An effort will be made in this paper to lay out the various factors at conflict with each other in these situations and apply a method developed to assist psychiatrists in analyzing and resolving such dilemmas to enable us to act more ethically.

In contrast to informed consent in other medical and surgical scenarios (Appelbaum 1997), there is no legal obligation to inform patients of the limits of confidentiality in psychotherapy. Many practitioners advise patients at the outset of outpatient treatment as to situations in

which confidentiality might be breached. These may include when a patient presents a danger to themselves or others as well as child and elder abuse reporting. However, studies of recall of informed consent information for surgical procedures demonstrate that patients and surrogates for pediatric patients are more likely than not to forget most relevant factors as little as 3 hours after signing consent forms and weeks after the procedure (Hekkenberg et al. 1997, Lashley et al. 2000, Finch et al. 2009). It therefore is at least as likely that psychiatric patients would also not remember such risks as the need to violate confidentiality when clinicians describe this information to them prior to initiation of therapy. Moreover, full informed consent on the limits of confidentiality would in reality not be advisable, as it would include a much longer list of situations that would be time-prohibitive, unnecessarily frightening for scenarios unlikely to be relevant to the patient, and most treating psychiatrists are unlikely to be fully aware of all the legal limits and permutations to confidentiality. For example, in order to give full informed consent on confidentiality, a psychiatrist would have to advise clients that information in their meetings may be used by the prosecution in capital criminal cases for the sole purpose of pursuing the death penalty (People v Wharton 809 P 2d 290 [Cal, 1991]).

In the People v Wharton California (1991) case, a patient told his psychiatrist and psychologist that he feared killing his girlfriend when intoxicated from alcohol. This information was used to prove premeditation (a necessary factor for first degree murder and the death penalty) when he did in fact kill her while under the influence of alcohol. The California Supreme Court ruled that there was no legal privilege that the patient could use to prevent such testimony because of a statutory dangerous patient exception to privilege, which almost certainly was never intended to be used for such a purpose. As a result, if a patient in therapy

asks for help not to act on an angry impulse to kill someone but later in fact kills that person, then the therapist could be compelled to testify against the patient to demonstrate premeditation in order to obtain a death penalty sentence. Would you want to alert every patient to such a possibility at the outset of treatment regardless of how unlikely the situation would arise and despite its likely chilling effect on treatment?

An option might be to inform patients when there is reason to think they may begin discussing material that might not be confidential. Should they be interrupted at this time and informed of the limits of confidentiality? Would it matter if they were previously counseled on this information at the outset of treatment? And would it make a difference what kind of information you believe may possibly be revealed?

The practice of psychiatry, more than any other medical specialty, operates at the intersection of humanities and science leading to complex situations that can present serious ethical dilemmas when differing ethical principles conflict. A psychiatrist must make judgments in these situations that will have grave consequences for both their patient and third parties. And these decisions will not always be simple or straight-forward. How can psychiatrists analyze and resolve ethical dilemmas in these complex situations in which they face conflicting obligations?

To address this problem, dialectical principlism (Weinstock 2015) was developed. It is a method of laying out, prioritizing, and balancing conflicting considerations to help psychiatrists analyze dilemmas and make the best ethical decisions in difficult and challenging scenarios. The method involves considering various relevant principles like patient and society welfare,

autonomy, justice, beneficence, non-maleficence, and honesty that may arise and conflict with one another.

Under this model, principlism refers to the emphasis on principles in the broadest sense of the term. Principles include meeting duties as prioritized in specific role and context, professional ethics principles, personal ethics principles and values, societal expectations for physicians and mental health professionals, as well as culturally based principles.

Dialectical principlism places weighted value to these principles that may have different priorities based on the specific psychiatric role as well as the context. That is, the primary duty is dependent on the role of the psychiatrist. Clinical psychiatrists have a primary duty that centers on patient welfare with secondary duties to public welfare, society, hospitals, and allocation of resources, among others. Forensic psychiatrists have primary duties to promote justice, to answer legal questions truthfully and honestly while showing respect for persons, with secondary duties to the person evaluated, to the retaining attorney, and to the psychiatrist's personal ethics and values. Research psychiatrists have conflicting duties related to advancing their studies, the safety of their research subjects, and the danger of patients overly trusting their doctor despite conflicts of interest. Managed care psychiatrist reviewers have a realistic primary duty to save money with secondary duties to patient welfare.

Primary duties have special weight in the balancing process leading them to outweigh all secondary duties most of the time. But unusually strong secondary duties in relatively rare contexts and narratives can outweigh primary ones and become determinative. The competing principles are balanced in order to arrive at a synthesis of these considerations to direct action.

This method can help psychiatrists resolve complex dilemmas when faced with conflicting ethical guidelines. The goal is not merely to avoid professional or legal consequences, but also to have a systematic approach to resolve ethical dilemmas with the safety of our patients and others in mind. Dialectical principlism can help psychiatrists lay out the relevant issues, prioritize them, and balance these factors against one another to determine what is the most ethical or the "right" thing to do in situations in which there may not be a general consensus.

The following examples can help illustrate how the dialectical principlism model can guide action regarding the decision to provide informed consent on confidentiality limits in various therapeutic settings.

The Potentially Suicidal Patient

As a treating psychiatrist you are seeing a patient with a history of depression. You have adjusted her antidepressant regimen over the past 2 years. She has no history of self-harm behavior of any kind and no prior inpatient psychiatric hospitalizations. She comes into your office, complaining of worsened depressed mood, feels hopeless, has constricted affect, has not been sleeping or eating much for the past week or so, and has increased her alcohol intake. You are concerned about the severity of this depressive episode, as she has never looked worse and want to probe further whether she is at risk for self-harm or suicide. Should you advise or remind her at this point of the limits of confidentiality prior to further questioning including potentially using information to involuntarily hospitalize her in the event you determine that she is danger to herself?

This example likely is straight-forward and almost all psychiatrists would come to the same ethical conclusion without utilization of dialectical principlism. However, it can be helpful to demonstrate how the model functions to guide our ethical decision-making in this relatively simple situation since it will become less apparent what the most ethical conclusion is on the more complex examples to follow. So to begin, the primary duty of the psychiatrist in the treating role is to the patient. Beauchamp and Childress describe four biomedical ethical principles: autonomy, beneficence, non-maleficence, and justice. Dialectical principlism holds that these principles among others should be weighted based on their significance in the specific context. Autonomy would require advisement of the patient as to the possible consequences of providing information suggestive of suicidal thinking or imminent self-injurious behaviors – that is, to provide full informed consent of the limits of confidentiality to the maximum extent possible. Beneficence (to do good) and non-maleficence (to not do harm), on the other hand, in the case of a suicidal patient would clearly favor not clarifying confidentiality limitations before proceeding with further questions. The risk is that informed consent at this point could discourage truthful answers from the patient and that the patient would mask symptoms in a way to avoid hospitalization. The potential good (beneficence) of appropriately addressing the patient's depression as well as the potential for preventing suicide or bodily harm (non-maleficence) clearly outweigh considerations of the patient's autonomy in this scenario.

Acting to not give informed consent on the limits of confidentiality in this situation would be consistent with an extension of the therapeutic privilege concept. The therapeutic privilege established in American case law (Canterbury v Spence, 1972) allows that the physician may

withhold information from patients in circumstances to prevent them serious harm, generally applied to withholding disclosure of risks of a particular medical or surgical treatment. The idea is that providing this information in certain situations would cause serious psychological and emotional harm with subsequent worsening of their physical condition and impairment of their ability to make health-care related decisions (Hodkinson, 2013). Thus, in the example of the suicidal patient, the potential serious harm of committing suicide as well as the inability of the patient to fully appreciate the implications of this danger, appear to qualify as reasons to extend the therapeutic privilege to withhold information on the limits of confidentiality in the therapeutic setting.

How would the balance of these principles change, though, if it were discovered that the patient's decompensation was in the setting of a recent divorce and contentious custody battle over her son and daughter? Now, the ramifications of an inpatient hospitalization could have devastating consequences for the patient as this information could be used in court to award custody to her partner as an indication that she was a less fit parent. The patient's right to make fully informed decisions regarding what information to reveal in therapy, that is respect for her autonomy, involves in this case whether to share the extent of her depression and thoughts of self-harm or suicide. This principle would be weighed more heavily now that the stakes of losing custody of her children is on the table. The harm of losing her children, however, pales in comparison to the potential that the patient could kill herself or hurt herself in a serious manner. Thus, the balance, although less one-sided than the first example, would again favor not instructing her on limits of confidentiality as a means to acquire more data to determine if she is a danger to herself.

Although we cannot know this in advance, it is possible she will reveal only less serious suicidal thoughts that do not necessitate further action or direct treatment changes by us but could hurt her in the child custody battle. As such, obtaining this information may in fact end up doing her harm and not much good. But all we can do is make the most ethical decision we can with the information at hand. Because of the serious potential harm from suicide it can be most ethical to obtain this information regardless of the fact that we cannot know what will be revealed. That is why our intent to do the "right" thing is determinative of what action is most ethical and not what the actual consequences, which can be unpredictable, may be.

The Potentially Homicidal Patient

Another situation in which dialectical principlism guides ethical action as it relates to whether or not to advise a patient on the limits of confidentiality in the therapeutic setting relates to concern of violence towards third parties. For example, a 33 year-old Caucasian male who you have been seeing for over a year for treatment of general anxiety disorder and alcohol use disorder, walks into his weekly appointment visibly incensed. He quickly divulges that his wife, who he has previously suspected to be having an affair with a work colleague, is now filing for divorce. While he curses her name, he utters, "I'm not going to let her get away with this; if I can't have her, I'll make damn sure no one else will either." You catch the smell of alcohol on his breath as he talks, and while you have no evidence of prior violence, you know he has access to guns as an avid hunter. Before allowing him to continue further or probe with more questions to ascertain risk of violence to his wife or her presumed paramour, do you inform

your patient that this information might need to be revealed by you to others and used for purposes of involuntary hospitalization, gun prohibition, or other legal consequences? If he in fact killed her, much like in the People v Wharton case you could even be required to testify against him in court called by the prosecution for the sole purpose of sentencing him to death.

Again the primary role as the treating psychiatrist centers on patient welfare, with secondary duties to public welfare, society, hospitals, allocation of resources, among others. Dialectical principlism maintains that primary duties be given greater weight in the balancing process, but that is not to say that in rare cases an unusually strong and relevant secondary duty cannot overcome and trump the primary duty consideration. For example, the primary duty to a patient can be outweighed by secondary duties to third parties in child and elder abuse reporting to protect the most helpless in our society.

So in this situation, with the primary duty being to the patient, the most relevant principle regards respect for the patient's autonomy, that is, that he be informed of information that could be shared outside the therapist's office with consequences of involuntary hospitalization, gun prohibition, and legal penalties up to and including the death penalty to name a few. But also salient in this scenario, is the secondary duty to the third parties, namely their safety thus invoking principles of beneficence. While the primary duty has special weight in the balancing process leading primary duty considerations to outweigh secondary duty ones most of the time, the secondary duty to protect safety of others when a serious concern for imminent violence is suspected overcomes the patient's autonomy. Moreover, in this example it could be argued that primary duty principles of non-maleficence and beneficence would also favor not

disclosing limits of confidentiality, as the therapist would now be in a better position to mitigate and prevent violence at the hands of the patient that would lead to even greater legal and other problems for the patient. Preventing the patient from the consequences of carrying out the violence would likely be most protective of the patient as well.

How would the balance of these principles change if the patient is a law enforcement officer? The consequences would now include losing his ability to carry a weapon and his job. This would give greater weight and significance to his autonomy to recognize the ramifications of possibly threatening his wife or her presumed lover. But again, even with greater weight to the autonomy principle as one of the primary duties to the patient being seen, the potential death or serious bodily harm to others in this example would exceed the undesired consequences of the patient losing his livelihood. The other primary biomedical ethical duties of beneficence and non-maleficence would compete with autonomy and outweigh it. Not only would this be protective of his wife, but again also most protective of the patient who would face grave legal consequences of murder or attempted murder.

Conclusion

Physicians face competing considerations in many of their decisions, and it is important to understand how these considerations should be weighed or valued against each other to guide action. This is particularly the case within psychiatry, where practitioners have conflicting duties that can lead to serious ethical dilemmas. Beauchamp and Childress lay out four biomedical ethical principles that should govern ethical decision-making as it relates to the

healer role with primary emphasis on doing what is best for the patient. But they do not provide a method to analyze which principle is dominant when their principles conflict. They also do not address specifically the complexity of psychiatric practice with secondary duties that sometimes may not be related to the well-being of the patient and in certain situations can be sufficiently strong as to be determinative of our most ethical action. Dialectical principlism addresses these problems by clarifying the competing factors and placing value on the principles based on the context and specific narrative. That is to say that any one principle may dominate for certain but not all scenarios. So the autonomy principle with respect for informed consent may outweigh beneficence in the example of giving informed consent to a patient who then declines a surgical procedure or a medication that could help them live longer. But this paper demonstrates how beneficence and non-maleficence outweigh autonomy in the example of not giving informed consent on the limits of therapist-patient confidentiality to a suicidal person. Beauchamp and Childress, in the last edition of their seminal book, agree with this notion, clarifying that they do not believe autonomy should always trump other considerations.

And the final example of the potential homicidal patient highlights the important distinction of primary versus secondary duties, which varies depending on the role of the psychiatrist. That is, the primary duty of a treating psychiatrist differs from that of other psychiatric roles. The primacy of the conflicting duties as a clinical psychiatrist is different from that of the forensic psychiatrist which is different from the researcher or managed care reviewer. The differing weights given to competing duties dependent on the specific role will lead to a unique balance and often to different determinations of the most ethical action. Dialectical principlism holds that primary duties be given special weight and should be more important than

secondary duties most of the time. So in the clinical psychiatrist role, duties to the patient are primary and should be given higher priority than fostering justice, advancing science, conserving resources, and societal welfare. However, with the emphasis on context-specific weighted principles, secondary considerations in situations of extraordinary significance such as preventing violence or abuse of others can overcome the primary duty to the patient in a determination of the most ethical thing to do.

Informed consent as a method to enhance patient autonomy will generally be advisable to respect the rights of patients and to improve patient care; however, this paper illustrates the problems of providing informed consent on the limits of confidentiality in the psychotherapy realm. It is not practical to warn all patients of every possible contingency at the outset of treatment. Some are unlikely to occur and others unnecessarily frightening to include such as the psychiatrist potentially being compelled to testify against them in a death penalty case. Also, studies suggest that most patients will probably not remember confidentiality exceptions mentioned at the outset of treatment. So we are left with the difficult dilemma of needing to decide what to do when a patient starts to reveal information they mistakenly believe to be confidential and that have important ramifications on their lives like being used for involuntary psychiatric hospitalization and reason a patient may be a less fit parent in a child-custody battle or gun prohibition and subsequent loss of a law enforcement job. Dialectical priniciplism provides a framework to analyze these ethical dilemmas in psychiatry such as deciding to withhold informed consent in certain situations, which may at the surface be counter-intuitive to our preconceived notions of optimal ethical care.

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