The Limits of Confidentiality: Informed Consent and Psychotherapy

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Sound ethical decision making is essential to astute and compassionate clinical care. Wise practitioners readily identify and reflect on the ethical aspects of their work. They engage, often intuitively and without much fuss, in careful habits—in maintaining therapeutic boundaries; in seeking consultation from experts when caring for patients who are difficult to treat or have especially complex conditions; in safeguarding against danger in high-risk situations; and in endeavoring to understand more about mental illnesses and their expression in the lives of patients of all ages, in all places, and from all walks of life. These habits of thought and behavior are signs of professionalism and help ensure ethical rigor in clinical practice.

Psychiatry is a specialty of medicine that, by its nature, touches on big moral questions. The conditions we treat often threaten the qualities that define human beings as individual, autonomous, responsible, developing, and fulfilled. Furthermore, these conditions often are characterized by great suffering, disability, and stigma, yet individuals with these conditions demonstrate tremendous adaptation and strength. If all work by physicians is ethically important, then our work is especially so. As a service to *Focus* readers, this column provides ethics commentary on topics in clinical psychiatry. It also offers clinical ethics questions and expert answers to sharpen readers- decision-making skills and advance astute and compassionate clinical care in the field.

–Laura Weiss Roberts, M.D., M.A.

Informed consent continues to be one of the most important issues in biomedical ethics. Born from the atrocities of Nazi medical experimentation (1), the subsequent Nuremberg laws (2), and the Tuskegee Syphilis Study (3), informed consent has drastically affected the biomedical research landscape. Additionally, it has directed the practice of clinical medicine away from its traditional paternalistic roots toward a greater emphasis on shared decision making (4).

Informed consent is built from the biomedical ethical principle of autonomy, which emphasizes the importance of respect for persons (5). 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. In addition to the moral significance of informed consent, American case law has reinforced the legal relevance, establishing that physicians can be found liable for medical malpractice for failing to offer this information in certain circumstances (6).

However, challenges arise in certain situations where compelling, competing ethical reasons exist to withhold from obtaining fully informed consent. For example, should practitioners have the flexibility to choose not to obtain fully informed consent in scenarios where they determine the risk of serious harm to either their patient or third parties to be so high as to require an exception? That is, how should professionals operate when faced with serious conflicting ethics considerations related to obtaining informed consent? A practitioner must make judgments in certain situations that will have grave consequences for both their patient and third parties. These decisions, moreover, are not always simple or straightforward.

One method of resolving biomedical ethics dilemmas is dialectical principlism, an approach that balances conflicting ethics criteria to determine the most ethical course of action (7). The model strives to achieve this goal by first prioritizing ethics considerations according to an individual's specific professional role, with primary versus secondary duties. For example, a practitioner in a treatment role has a different set of primary duties than a practitioner in a research or forensic role, and thus a different calculus occurs. Next, the model uses the unique set of personal, cultural, and societal values, as well as the context of the situation, to assign weights to primary- and secondary-duty principles. Finally, these principles are balanced in a similar manner to the reflective equilibrium method of Rawls (8) to determine the most ethical action for that specific practitioner.

Informed Consent

Informed consent in the treatment context is defined broadly as the dialogue between a clinician and patient regarding the nature of a particular medical treatment (9). Generally, the legal requirement involves providing information that a reasonably prudent patient would need to know to make decisions about his or her medical care (10). The informed consent process encompasses multiple facets:

discussing the patient's part in the decision-making process, the treatment's indication, alternatives (including no treatment), inherent risks and benefits, and uncertainties, and then assessing the patient's understanding of the provided information and subsequent articulation of a choice (11). Studies suggest that informed consent, by enhancing doctor-patient communication, leads to improved patient satisfaction, better outcomes, fewer medical errors, and lower rates of malpractice claims (9). Although informed consent is often thought of in regard to more high-risk procedures, such as surgeries, chemotherapy, and radiation therapy, it is relevant to any situation in which the patient faces a medical treatment decision (12).

Informed Consent in the Psychotherapy Setting

The importance of obtaining informed consent may be overlooked in psychotherapy settings in which the likelihood of success of treatment or possible adverse outcomes is largely uncertain (4). That is, the risks of psychotherapy treatment at first glance are not as salient as for other interventions (13). However, there can be areas in which the risks are significant. One such relevant area of possible harm to patients undergoing psychotherapy treatment involves situations in which the psychiatrist breaches doctor-patient confidentiality because of mandated reporting or a serious risk of danger.

Some psychotherapists and ethicists might argue that a patient always has a right and ought to know the limits of confidentiality at the outset of any treatment. For example, disclosed information could be used to infringe on the patient's personal freedoms, which could lead to involuntary hospitalization, gun prohibition, legal and occupational problems, or other personal consequences. Although patient autonomy is a high priority, in this article, we address whether psychiatrists should or should not provide full informed consent in certain situations when the safety of the patient or third parties may be put at risk by this action.

Such scenarios include when patients may be considering dangerous actions, either to themselves or others. Ordinarily, practitioners might want to alert patients to the limits of confidentiality to respect their autonomy. When serious safety issues are concerned, however, it can be of such importance to obtain further information that the situation can warrant an exception. That is, psychotherapists might want to purposely not warn patients of all potential consequences when doing so might cause patients to minimize dangerous actions they are contemplating or to conceal them altogether. We make an effort in this article to lay out the various factors in conflict with each other in these situations and apply dialectical principlism to analyze and resolve such dilemmas to enable more ethical action.

The Challenges of Informed Consent Regarding the Limits of Confidentiality

In contrast to obtaining informed consent prior to prescribing medications or performing surgical or other medical procedures, there is no specific legal obligation to inform patients of the limits of confidentiality (4). However, most of the time there is an ethical duty to do so. Practitioners often advise patients at the outset of treatment as to situations in which confidentiality might be breached. These may include when patients present a danger to themselves or others as well as child and elder abuse reporting. In California, it also is now mandated that practitioners report patients who view child pornography (14).

However, patients often forget information provided during informed consent for surgical procedures as soon as three hours after signing consent forms, and in another study patients and surrogate decision makers were found to not remember relevant information weeks after the procedure (15, 16). Thus, details regarding the limits of confidentiality provided at the outset of outpatient treatment may be of limited utility. The practitioner may erroneously believe, however, that an initial advisement is sufficient to meet the ethical requirement of providing fully informed consent on confidentiality. In reality it is likely that the patients will not remember these risks, especially as more time elapses from the initial advisement.

Moreover, fully informed consent on the limits of confidentiality is not in reality advisable, because it would include a much longer list of situations. Reviewing these situations with the patient would be time prohibitive and unnecessarily frightening for rare scenarios unlikely to be relevant to the patient. Additionally, most practitioners are unlikely to be aware of all the legal limits to and permutations of confidentiality. For example, to give fully informed consent on confidentiality in California, a clinician would need to advise patients that information in their meetings might be used by the prosecution in capital criminal cases solely for pursuing the death penalty (17).

An option might be to inform patients when there is reason to think they might 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? Would it make a difference what kind of information you believe might be revealed? Would the decision to inform patients be shaped by how likely you thought it was that they were contemplating serious, dangerous actions? A risk of not informing the patient at the outset of treatment and waiting until the practitioner deems it to be relevant is that the practitioner may be unable to interrupt the patient in time to prevent him or her from revealing the nonconfidential information that could trigger consequences unbeknownst to the patient.

Dialectical Principlism

Dialectical principlism is an approach that addresses ethics dilemmas and that integrates and encompasses other theories and professional organizational guidelines. It is a method

of laying out, prioritizing, and balancing conflicting ethics considerations to help practitioners act most ethically (7).

Although it incorporates other theories, dialectical principlism distinguishes itself as a model by establishing a hierarchy of ethics considerations prioritized according to the specific role of the practitioner. Primary versus secondary duties are demarcated on the basis of the professional's role, and then the relevant ethics principles are weighed accordingly. *Dialectical* refers to the balancing of the weighted competing principles to arrive at a conclusion as to what is most ethical. The balancing process implements Rawls's (8) reflective equilibrium approach. The considerations being balanced are conflicting ethics guidelines, theories, and professional duties.

Case Illustration 1

A 43-year-old woman presents to her psychiatrist for ongoing psychotherapy treatment of her chronic depression. The patient has no history of self-harm behavior of any kind and no prior inpatient psychiatric hospitalizations. She comes into the psychiatrist's office complaining of worsened depressed mood, feelings of hopelessness, excessive guilt, insomnia, appetite suppression, and difficulty concentrating over the past two weeks. This increase in her symptoms was triggered by the major psychosocial stressor of filing for divorce from her husband of 10 years and a contentious child custody battle for her two daughters.

The psychiatrist is concerned about the severity of this depressive episode, because the patient has never appeared worse on exam than she presents at this visit. The psychiatrist wants to probe further whether the patient is at risk for self-harm or suicide. The patient has not been advised on the limits of doctor-patient confidentiality, and the psychiatrist believes the patient is unaware that divulging information such as suicidal ideation could lead to involuntary hospitalization and severely hurt her chances of being awarded the primary custodial parent in the divorce hearings, among other consequences.

1.1 Which organization has ethical guidelines that address the issue of advising potentially suicidal patients on the limits of doctor-patient confidentiality?

A. The American Psychiatric Association
B. The American Psychological Association
C. The American Medical Association
D. The American Academy of Psychiatry and the Law
E. None of the above

The answer is E. No medical, psychiatric, psychological, or forensic psychiatric organizational guidelines (e.g., American Medical Association, American Psychiatric Association, American Psychological Association, American Academy of Psychiatry and the Law), to our knowledge, provide guidance for this situation (18–23). With no relevant ethics guidelines, practitioners may draw on ethics theories and models, but they might be misguided in considering only one facet to the exclusion of all others. This narrowly focused approach can lead to unethical actions because it overlooks the harm of conflicting ethics considerations. However, a more thorough and complete ethical analysis would encompass all of these conflicting ethics considerations. To resolve the dilemma, dialectical principlism can guide decision making by laying out, prioritizing, and balancing the competing ethics principles.

1.2 What is the primary duty of the psychiatrist in this role?

A. Fostering legal justice
B. Advancing science
C. Ensuring societal welfare
D. Safeguarding the patient's welfare
E. All of the above

The answer is D. It follows in dialectical principlism that the psychiatrist in this hypothetical situation would start with the specific context to determine his or her primary duties as well as any relevant secondary ones. The role is a treatment one in this scenario. Under dialectical principlism, the primary duty of the psychiatrist in the treating role is to the welfare of the patient, with special emphasis on three of Beauchamp and Childress's (5) biomedical ethical principles: autonomy, beneficence, and nonmaleficence. Secondary duties are related to third-party safety and welfare; societal costs; and the individual psychiatrist's own personal ethics, values, and societal expectations of physicians. Fostering justice by answering the legal question honestly would be a primary duty for a forensic psychiatrist. Advancing science would be a primary duty for a psychiatrist in a research role.

1.3 Which ethics principle most favors advising the patient about the possible consequences of providing information that she is suicidal?

A. Autonomy
B. Nonmaleficence
C. Beneficence
D. Distributive justice
E. None of the above

The answer is A. The autonomy principle in isolation would favor advising the patient as to the possible consequences of providing information suggestive of suicidal thinking or imminent self-injurious behaviors. That is, according to the autonomy principle, the psychiatrist should obtain full informed consent of the limits of confidentiality to the maximum extent possible. Some practitioners and ethicists may believe that patient autonomy should always be the guiding principle in clinical situations and argue that more weight be given to this principle than others as a way to avoid paternalism. Beauchamp and Childress (5) clarified in

the latest edition of their book that they do not consider autonomy the most important principle, despite mentioning it first among their principles.

The argument for interrupting to clarify the limits of confidentiality is that this would maximally promote the patient's true autonomy in decisions related to her health. In the best case scenario, the patient, by fully being empowered, might withhold saying something provocative that she has no intent or plan to act on, because she was informed of the consequences. The patient would avoid suffering significant consequences, such as losing custody of her children, so this course of action aligns with the nonmaleficence principle in this context. Deontological considerations would be upheld because the rules for honesty and truthfulness are not violated. This position would also align with the individual psychiatrist's belief that physicians serve their societal role more by being "gatekeepers" to patient-centered care than by following the more traditional paternalism model of physicians.

Conversely, the argument for not clarifying fully the limits of confidentiality and probing further to assess dangerousness is that the psychiatrist would best achieve the primary-duty principles of beneficence and nonmaleficence by protecting the patient from self-harm and helping guide the most appropriate treatment for her depression, dependent on her risk for self-harm. The psychiatrist would be in the best position to obtain the most honest, truthful, and nonskewed assessment of the patient's risk of danger, because honest information is essential to a valid assessment in serious situations. This action would also be in the best interest of the patient's children, a secondary-duty principle. The psychiatrist would serve consequentialism considerations by promoting the greatest utility: protecting the patient from harm and potentially the children from neglect by a severely depressed and imminently suicidal parent. This position aligns with expectations of physicians serving a more traditional, paternalistic role in society in this limited respect, insofar as they use their expertise to do good and prevent harm.

The Case Continues. After further probing in the therapy session, the psychiatrist becomes less concerned about the possibility of suicide or potentially lethal self-injurious behavior. The psychiatrist now believes that the patient is contemplating nonlethal self-injurious behavior, such as burning herself with cigarettes.

1.4 Which answer best accounts for how this development would affect the psychiatrist's balancing of the relevant ethics principles?

A. The autonomy principle would be weighed less because the patient is not considering suicide.
B. The beneficence principle would be weighed more because the patient is not considering suicide.
C. The nonmaleficence principle would be weighed more because the patient is not considering suicide.
D. The nonmaleficence principle would be weighed less because the patient is not considering suicide.

The answer is D. A psychiatrist's opinion about what to do in these cases is contingent on the degree and severity of violence being contemplated. That is, dialectical principlism guides a different action depending on the context: whether there is suspicion of suicide versus nonlethal, minor self-injury. Now the psychiatrist is less concerned about suicide and instead suspects that the patient is contemplating nonlethal, self-injurious behavior amid a depressive state.

The weight of the nonmaleficence principle in favor of not disclosing the limits of confidentiality to prevent harm to the patient diminishes if the harm being considered is no longer suicide but a more minor self-injurious behavior. This may tip the scales in favor of the autonomy principle, which dictates that the most ethical action in this context is to appraise the patient's understanding regarding the limits of doctor-patient confidentiality. The context of the situation is used to assign weight to the primary principles. Therefore, dialectical principlism would favor not instructing the patient on the limits of doctor-patient confidentiality in situations when suicide is concerned (as a means to acquire more data to determine whether she is a serious danger to herself). However, if the danger is determined not to be serious, the autonomy principle could guide the psychiatrist to discuss candidly the potential consequences for the patient when the psychiatrist is mandated to breach confidentiality.

Case Illustration 2

A 33-year-old man has been seeing his psychiatrist in psychotherapy for more than a year for treatment of general anxiety disorder and alcohol use disorder. He walks into his weekly appointment visibly incensed and quickly divulges that his wife, whom he has previously suspected to be having an affair with a work colleague, is now filing for divorce. He proclaims, "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."

2.1 What is the most important secondary duty for the psychotherapist in this role and situation?

A. Legal justice
B. Third-party safety
C. Patient welfare
D. Distributive justice
E. None of the above

The answer is B. As before, the primary role of the treating psychiatrist centers on patient welfare, with secondary duties here being to public welfare and safety. Dialectical principlism maintains that primary duties be given greater weight in the balancing process, but in rare cases an unusually strong and relevant secondary duty can

trump primary-duty considerations. The relevant ethics principles are extracted from the narrative of the situation and prioritized on the basis of primary versus secondary duties.

In this example, the relevant primary-duty principles related to the patient's welfare include autonomy and nonmaleficence. The autonomy principle in isolation again would favor advisement of the patient as to the possible consequences of revealing homicidal ideation. The beneficence principle, conversely, would favor not disclosing limits of confidentiality, because the psychiatrist then would be in a better position to prevent the patient from suffering legal consequences of a violent action if the patient were forthcoming. This scenario also involves the strong secondary duty to third parties, to protect the safety of others when a serious concern for imminent violence exists. This duty alone might outweigh other considerations, including the primary-duty ones.

The Case Continues. The psychiatrist catches the smell of alcohol on the patient's breath as he talks, and although there is no evidence of prior violence, the psychiatrist knows that the patient has access to guns as a law enforcement officer.

2.2 In light of the patient being a law enforcement officer, which ethics principle is now weighted more heavily in favor of interrupting the patient and advising him on the limits of doctor-patient confidentiality?

A. Autonomy
B. Nonmaleficence
C. Distributive justice
D. Legal justice
E. None of the above

The answer is B. Nonmaleficence considerations would include the possible consequences related to an involuntary hospitalization and, for the patient in this hypothetical case, the possibility of losing his ability to carry a weapon and thus risking his employment. The arguments for and against interrupting to clarify the limits of confidentiality are very similar to the previous hypothetical case involving the potentially suicidal patient. That is, obtaining fully informed consent would maximally promote the patient's true autonomy in decisions related to his health. In the best-case scenario, the patient, when he is fully empowered, might withhold saying something provocative that he has no intent or plan to act on because he was informed of the consequences. The patient would avoid suffering unnecessary and significant consequences, such as firearm prohibition and the loss of his job.

However, by not informing the patient on the limits of confidentiality, the psychiatrist would best be able to promote the primary-duty principle of beneficence by protecting the patient from suffering legal consequences from acting violently. The psychiatrist would be able to obtain a more honest and candid report of the patient's risk to harm others. This action would also be in the best interest of third parties, including the patient's wife and her lover, a secondary-duty principle that, in the case of killing or seriously harming someone, can outweigh the primary duty to the patient.

2.3 Which factor in this situation should be weighed most heavily to be determinative of the psychiatrist's most ethical action?

A. Patient autonomy
B. The safety and well-being of third parties
C. Legal justice
D. Patient nonmaleficence related to the consequences of an involuntary hospitalization

The answer is B. In this hypothetical situation, the psychiatrist is faced with an ethical dilemma in which the primary-duty principles of autonomy and nonmaleficence to the patient conflict with the primary-duty principle of beneficence to the patient as well as the significant secondary duty to protect third-party safety. Beneficence to the patient is relevant because his violent act would lead to especially harmful consequences, such as a prison sentence or even a death penalty, far beyond the consequences of hospitalization, prohibition of firearms, and loss of his job.

This is a special scenario in which the secondary duty to the safety of others is so extreme and overwhelming that it trumps primary-duty-principle considerations of autonomy and nonmaleficence principles in its own right, even without the additional weight of the beneficence principle. The secondary duty to protect the safety of others when a strong concern for imminent, serious violence is suspected outweighs considerations of autonomy and nonmaleficence. The potential death or serious bodily harm to others in this example outweighs the other undesired consequences.

Psychiatrists can apply dialectical principlism to guide decisions to withholding obtaining informed consent regarding confidentiality when they encounter a patient who may act violently toward third parties. In the hypothetical case, not only would this be protective of the patient's wife and her lover but, again, it would protect the patient from grave legal consequences. It is possible that, after a thorough evaluation, the psychiatrist could assess the statement to be merely an expression of anger and not indicative of a plan of action; then there would be no need to violate confidentiality. To determine this, however, the psychiatrist might want to avoid interrupting the patient to clarify situations in which he or she is mandated to breach confidentiality.

Conclusion

Psychiatrists face competing considerations in many of their decisions, and it is important to understand how these considerations should be weighed or valued against one

another to guide action. In psychiatric practice generally and psychotherapy specifically, psychiatrists encounter conflicting duties that can give rise to serious ethical dilemmas. Beauchamp and Childress (5) laid out four biomedical ethics principles that should govern ethical decision making as it relates to the healer role. Three of these principles have a primary emphasis on doing what is best for the patient. However, the authors did not provide a method to analyze which principle is dominant when the principles conflict. They also did not address specifically the complexity of psychotherapeutic practice when psychiatrists have secondary duties to third-party welfare, which can, in extreme circumstances, outweigh primary duties. That is, in certain situations, the safety of others is sufficiently strong as to outweigh primary duties to the patient and become determinative of the psychiatrist's most ethical action.

Dialectical principlism addresses these problems by clarifying the competing factors and placing value on the principles on the basis of the context and specific narrative. Thus, autonomy may outweigh beneficence in the example of obtaining full informed consent from a patient who then declines a surgical procedure. However, beneficence to the patient and concern about serious harm to others outweigh autonomy in the examples of not obtaining informed consent on the limits of therapist-patient confidentiality to potentially suicidal and homicidal patients, respectively. It appears that Beauchamp and Childress (5) implicitly agreed with this, given their clarification that they do not believe autonomy should always trump other considerations.

These two hypothetical cases highlight the importance of professionals' specific role when they are determining how to prioritize conflicting ethical duties. Both cases take place in treatment settings in which the duties to the patient are primary and thus are given higher priority than secondary duties of ensuring societal welfare, fostering justice, and advancing science, among other considerations. In contrast, the welfare of the person is a secondary duty in forensic, research, or managed-care-reviewer roles.

The distinction between primary and secondary duties is helpful in that primary-duty principles outweigh secondary ones most of the time. However, with the emphasis on context-specific weighted principles, secondary considerations in scenarios of extraordinary significance may overcome the primary duty to the patient in a determination of the most ethical thing to do. One such example is captured by the potentially homicidal patient case, in which the secondary-duty principle to protect society overwhelms the primary duty to the patient's welfare.

The professional's opinion about what to do in these cases is contingent on the degree and severity of violence being contemplated. If the contemplated violence is minor and does not involve serious bodily harm, then the secondary duty to third-party safety is less significant and may no longer outweigh primary-duty considerations to the patient's welfare.

Informed consent as a method to enhance patient autonomy is a crucial ethical endeavor. It is generally advisable in most situations to respect the rights of patients and to improve patient care; however, this article underscores the problems that sometimes arise with obtaining fully informed consent on the limits of confidentiality. It is not practical to warn all patients of every possible contingency at the outset of treatment. Some scenarios are very unlikely to occur, and others are unnecessarily alarming to merit the consequence of damaging rapport, such as the practitioner potentially being compelled to testify against the patient in a death-penalty case.

Also, studies demonstrate that most patients do not remember pertinent information related to informed consent for surgical procedures soon after being advised (15, 16). It follows that informing patients on all confidentiality exceptions at the outset of treatment is likely also to be insufficient. As a result, psychiatrists may mistakenly believe that they are absolved of all future ethics dilemmas related to informed consent regarding confidentiality because they provided this initial warning.

Psychiatrists encounter the difficult dilemma of deciding what to do when a patient starts to reveal information that he or she mistakenly believes to be confidential and that has important medical and legal ramifications. Dialectical principlism provides a framework to analyze these ethics dilemmas and can guide the decision to withhold some aspects of the limits of doctor-patient confidentiality in certain complex situations, which might at the surface be counterintuitive to a psychiatrist's preconceived notion of optimal ethical care.

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