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The risks and benefits of disclosing psychotherapy records to the legal system: What psychologists and patients need to know for informed consent

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ABSTRACT

When psychologists release patient records to the legal system, the typical practice is to obtain the patient's signature on a consent form, but rarely is a formal informed-consent obtained from the patient. Although psychologists are legally and ethically required to obtain informed consent for all services (including disclosure of records), there are a number of barriers to obtaining truly informed consent. Furthermore, compared to disclosures to nonlegal third parties, there are significantly greater risks when records are disclosed to the legal system. For these reasons, true informed consent should be obtained from the patient when records are disclosed to the legal system. A model for informed consent is proposed. This procedure should include a description of risks and benefits of disclosing or refusing to disclose by the psychotherapist, an opportunity to ask questions, and indication by the patient of a freely made choice. Both psychotherapist and patient share decision making responsibilities in our suggested model. The patient should be informed about potential harm to the therapeutic relationship, if applicable. Several recommendations for practice are described, including appropriate communications with attorneys and the legal system. A sample form, for use by psychotherapists, is included.

1. Introduction

When psychologists disclose confidential patient records (PHI)[2] to the legal system, it is common practice, consistent with legal mandates, to obtain the patient's signature on an authorization form. However, this process may occur so hurriedly or perfunctorily that clients may not fully understand what they have authorized or why, or may not realize that the consent is voluntary (Perlman, 2012, p. 136). Some may sign authorization forms against their wishes—due to of a variety of subtle and obvious pressures, or because no alternatives seem available (Damschroder et al., 2007; Greenberg & Shuman, 1997; Hamberger, 2000, p. 90; Knops, Legemate, Goossens, Bossuyt, & Ubbink, 2013; Koocher & Keith-Spiegel, 2008; McSherry, 2004; Rosen, 1977). Many patients simply blindly sign the documents and may view their signature more as a requirement to obtain coverage or services than a personal choice (Bemister & Dobson, 2011). Furthermore, guidelines regarding disclosures of PHI to the legal system are lacking, making it difficult for psychologists to determine what risks to discuss. Truly informed consent (for any aspect of medical treatment), widely accepted as a legal and ethical requirement by the psychology community, requires a more careful process than this (Sokol, 2009), and consent for disclosure of PHI should be no exception.

In this article, we begin with a short review of the foundation of informed consent, which arises from the concepts of privacy, psychotherapy, and individual autonomy. Although a required function of psychotherapy, there are a number of barriers to obtaining fully informed consent. Considerable vagueness and disagreement about the legal definition of informed consent subsists. Psychologists do not always effectively communicate the information patients need to make decisions. Even when they do, patients may not understand or remember that information. Informed consent is more difficult when it involves disclosures to the legal system, because the requirements for such disclosures are often conflated with the requirements for disclosures to nonlegal third parties. Furthermore, there is a greater need for informed consent regarding disclosures to the legal system, due to more serious consequences inherent in the legal system. Additionally, the legal system has different goals from those of psychotherapy, and it may not adequately protect the privacy rights of patients. We conclude the article by describing a number of risks and benefits of disclosing (or refusing to disclose) PHI to the legal system, and suggest some recommendations for practice. Appendix A contains a model form for use in an informed consent procedure when disclosure of PHI to the legal system is being considered.

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[2] In this article, we do not distinguish between records and testimony, as both concern the patient's private information. For the sake of brevity, we utilize the term adopted by the Health Insurance Portability and Accountability Act (HIPAA)–Protected Health Information (PHI).

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2. The requirement for informed consent, generally

It is well established that healthcare providers have an ethical and legal obligation to obtain informed consent prior to involving patients in any proposed services (Appelbaum, 2007, p. 1834). This practice is widely accepted as one of the key duties of any good health professional and demonstrates a respect for the patient's right to make informed choices (Doyal, 2001), consistent with most ethics codes. For example, informed consent is required by the ethics codes of every health care profession, including the American Psychological Association (APA, 2002, standards 3.10, 8.02, 8.03, 9.03, and 10.01), the American Psychiatric Association (APA, 2013, Section 2 standard 10 & 11), and the American Medical Association, (AMA 2012, Principles 2.015, 8.08, 8.082, 8.085, 8.121, 10.01, 10.015, 10.02). Most psycholegal commentators assume that the burden of securing consent falls on the evaluator (e.g., Foote & Shuman, 2006); it is such an important part of psychology practice that the current version of the Ethical Principles of Psychologists (APA, 2002) mentions the term no less than 37 times. Because psychologists are required to obtain informed consent from all patients, the documentation of informed consent is likely the first formal record of those services (Bemister & Dobson, 2011; Foote & Goodman-Delahunty, 2005).

The reason this requirement was taken on by professionals is due to the power imbalance between doctor and patient; doctors generally have vastly superior knowledge, whereas patients are very often made even more vulnerable by their illness. Providing information and opportunity for decision making on the part of the patient "will help to redress the power imbalance problems" (Hall, Bobinski, & Orentlicher, 2005, p. 200). Current understandings of informed consent may also (perhaps to the detriment of many patients) overlook non-Western cultural norms and values (see, e.g., Blackhall, Murphy, Frank, Michel, & Azen, 1995; Carrese & Rhodes, 1995; Gostin, 1995; Miller, 1992).

2.1. Privacy is the foundation of both psychotherapy and informed consent

The foundation of psychotherapy is the trust that is engendered by the confidentiality between the psychologist and the patient; it has been said to be "so essential … that psychotherapy is rendered worthless in its absence" (Paruch, 2009, p. 519, citing the APA brief in *Jaffee v. Redmond*). The need for confidentiality is critical, because "psychotherapy is the context in which, perhaps more than in any other, a person is most likely to reveal unflattering information about herself, as well as her fears, vulnerabilities, guilt, disappointments, doubts, and anxieties" (Smith, 2008, p. 79; see also Taylor v. United States, 1955). Effective psychotherapy demands "an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears" (*Jaffee v. Redmond*, 1996, at 10); the "mere possibility" of a breach of confidentiality could obstruct the development of the treatment relationship. "The mental health of our citizenry, no less than its physical health, is a public good of transcendent importance" (Paruch, 2009, p. 516, citing *Jaffee*).

These sentiments reflect a broad social policy (Perlman, 2012, p. 129) in support of treatment for mental disorders, based on the foundation that patients have a right to control the disclosure of their private information; this right is closely tied to the legal concept of personal privacy (Paruch, 2009). Shapiro and Smith (2011) note "…the importance of written waivers of confidentiality and that therapists should exercise the greatest caution when a waiver will not directly benefit the client" (p. 74). Thus, when confidential information is disclosed to third parties, informed consent should be a part of the process in the same way that patients consent to therapy itself (Nagy, 2011, p. 74).

2.2. Informed consent is also a legal requirement

Compared to privacy rights, consent rights are relatively new. For many decades, at least as far back as the 1800s, patient consent was limited to the right to refuse, called *simple* consent; operating on a patient without simple consent was governed by the law of battery. This was exemplified by the New York Court of Appeals in *Schloendorff v. Society of New York Hospital* (1914): "Every human being of adult years and sound mind has a right to determine what shall be done with his own body" (at 93). What made *Schloendorff* so memorable was not that the Court harshly rebuked the doctor (equating his actions with trespassing); it was having to remind physicians, as late as the 20th century, "of such elementary restraints on their professional authority in a democratic society (Katz, 1984, p. 52).

As ethical considerations developed further, the California appeals court in *Salgo v. Leland Stanford Jr et al.* (1957) introduced the term *informed consent* (but did not define it). In *Salgo*, the doctor performed a relatively new procedure that resulted in the patient becoming paralyzed. Although there were substantial risks of paralysis inherent in the proposed procedure, the doctor did not disclose those risks, relying on the tradition that the doctor could use their discretion about what information to disclose to the patient. *Salgo* did not ultimately resolve the question of what information should be provided to the patient, but it acknowledged that the interests of doctors and patients are not perfectly aligned, and stimulated a great debate about where that boundary should be placed.

Informed consent reached a watershed when a federal appeals court in *Canterbury v. Spence* (1972) completely rejected the doctor's professional discretion to withhold information from the patient. To *Schloendorff's* disclosure requirement, Judge Robinson added a requirement for free choice (Katz, 1984, p. 72). Free choice, theoretically anyway, requires that the patient obtain information sufficient to make that choice. The *Canterbury* decision, now using negligence law, focused significantly on the patient's decision-making process and the importance of the ability to weigh the risks and benefits (King & Moulton, 2006), now known as the "reasonable patient" standard (Boumil & Hattis, 2011).[3] *Canterbury* may not be the final word, however, because, although the court moved the needle, the decision it did not resolve the conflict between "the need for *medical knowledge* to elucidate the risks of and alternatives to a proposed procedure in the light of professional experience with the need for *medical judgment* to establish the limits of appropriate disclosure to patients" (Katz, 1984, p. 74).

Decisions continued to define the requirements for informed consent, making it a fiduciary duty (*Moore v. Regents of the University of California*, 1990) to disclose any and all information that is relevant to the patient's decision (*Cobbs v. Grant*, 1972), and courts recognize a constitutionally protected liberty interest to refuse treatment, even where such refusal might result in death (*Cruzan v. Missouri DOH*, 1990). Privacy, the ethical foundation of psychotherapy, is also a constitutional right (*Griswold v. Connecticut*, *1965*; *Roe v. Wade*, *1973*) that includes the right of self-determination. Thus, informed consent and confidentiality are parallel and corollary rights (Ebert, 2012; Winick, 1992).

2.3. Informed consent is also required in forensic contexts

Not only is informed consent a requirement for purposes of treatment (APA, 2002, standard 10.01), but consent is at least as important in forensic cases (e.g., Gold & Shuman, 2009)—particularly since patients may (wrongly) assume that their confidentiality will prevent compelled disclosure in court-related cases (Greenberg & Shuman, 1997). The American Psychological Association's Specialty Guidelines use the term eight times (APA, 2013). The American Academy of Psychiatry and Law requires consent via Guideline III (AAPL, 2005). Informed consent for forensic services may be the same as or may differ from the clinical context (Ebert, 2012). For example, a criminal defendant has a constitutional right to be warned how information obtained during a psychological evaluation may be used in the case (*Estelle v. Smith*, 1981). A multitude of

[3] A few states have adopted a "subjective" standard; disclosure of risks and benefits under this standard are those that are important to the particular patient making the decision (Berg, Appelbaum, Lidz, & Parker, 2001).