The Essence of Regulated Behavior: Ethical & legal dilemma as professional issues in global mental health initiatives. Part II

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Abstract
Psychologists, as a clinician in mental health settings, often work with vulnerable individuals in sensitive situations. The information these people divulge or disclose to psychologists is very private and in many conditions. An important step in centers on the totality of individual's life. Therefore, becoming a mental health professional or consumer of psychological services is to be aware of the ethical issues faced by psychologists. As a provider of psychological services, you are obligated to remain informed regarding ethical standards or issues that are pertinent to the practice of psychology. A clinical psychologist without deep-rooted foundation in ethical practices, is not only dangerous to the profession of clinical psychology, but also to the entire society. So, for universities or institute of professional studies to graduate a student without adequate background in professional issues, is the great harm anyone can inflict on a nation. The issues of professional ethics centre on competency, privacy, confidentiality, informed consent, are at the core of clinical practices, which provide a broad outline of ethical practice in psychology. Specific courses elaborate on these issues, and help students and clinical practitioners identify situations in which they can be applied. This paper is to create awareness of the importance of training Nigerian clinicians on professional ethics, and the specific ethical issues in psychology that will broaden the view of students on the meaning of ethical behavior as it applies to any endeavor. In fact, whether you studying politics, education, business, manufacturing, law, medicine, or any other vocation, you most certainly need ethical background and understand the implications of unethical behavior to professions, consumers of services, and the entire nation.

Key Words: competency, privacy, confidentiality, informed consent

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Introduction

Clinical psychologist are health care practitioners, with an important role to promote mental health wellbeing, aiming at reducing psychological distress and increasing functional, productivity and mental or physical illness (NHS, 2014; Routledge, 2015). Clinical psychologists mostly work in the health-related settings such as hospitals, health centers, in community health as well as in social services (APA, 2002). The route to becoming a clinical psychologist in many developed nations like USA (APA, 2010) or United Kingdom (UK) involves the completion of a compulsory examination on ethics approved by State or federal government (Bearse, McMinn, Seegobin & Free, 2013; APA, 2002). This mandatory examination and regulatory system enable the a future and practicing clinician to have a sound basis of psychological knowledge, ability and skill needed to become a competent clinician (Clearing House for Postgraduate Courses in Clinical Psychology, 2014a/2014b; APA, 2010). The requirement needed to register for ethical examination is that the individual must complete supervised work experience within mental health or in a relevant charitable sector.

Privacy as a personal attribute

The concept of privacy in health care system is contained in the code of conduct (Giordano & Schatman, 2008), which is a set of rules outlining the responsibilities or proper practices in diagnose, treatment and prevention of diseases, disorders and injuries (Lakhan et al, 2008). According to DeCew (2008), privacy is the right for a person to be free from unwarranted publicity of information, discussion or thought. The essential element is of privacy is in human rights (UN, 1948) which is inherent in the pursuit of freedom and liberty (Etzioni, 2007). The basic elements of privacy include:

- the right of individuals to decide about how much of their information should be shared with others (Solove et al, 2006);
- to prevent unnecessary governmental interference in intimate personal relationships or activities (DeCew, 2008); and
- the freedom of individuals to make fundamental choices involving themselves, their family, and whom to communicate their thought, experience, and beliefs to (Black, 1979; Gavison, 1980; Sieber, 1992; Smith-Bell & Winslade, 1999).

In this perspective, privacy presupposes a constitutional right to individual and collective freedom and liberty, which further gives an individual the right to decide who to talk to, when and how much to reveal and under what circumstances. In strictest sense of the words, people do not lose the inalienable rights to privacy because of physical or mental illness or infirmity. It suffices to say, therefore, that whether an individual is a patient or a
participant in a scientific research program he or she carries alone the inalienable right that limits others from direct and unrestricted access to his or her private information, thought, and matters (Smith-Bell & Winslade, 1994). Furthermore, privacy right involves freedom to decide whom to share one’s dreams, fantasies, feelings, thoughts, beliefs, joy, sorrow, and personal data, and the right to restrict one’s information from unauthorized publicity (Rothstein, 2005; Folkman, 2000; Seiber, 1992). The right to privacy, therefore, can be summed up into two main features. First, the right to “pick and choose the time and circumstances under which facts about a person…[and] extent to which his or her attitudes, beliefs, behavior, and opinions are to be shares with or withheld from others (Folkman, 2000, p. 49). The second is the right not to disclose information that an individual wants to keep out of unwarranted circulations (Smith-Bell & Winslade, 1994).

**Manifestations of Right to Privacy**

Using the United States’ concept of privacy (Lessig, 2006), it is recognized that the constitutional right to privacy is first implicated in the case of Grisworld v. Connecticut (1965). In this case, the statute of State of Connecticut that prohibited the use of contraceptives by married couples, which struck down by the United States Supreme court (Loewy, 2007). The Supreme Court maintained that even though the word privacy is not mentioned in the actual text of the constitution, there is undisputed clarity that the right to privacy is implied in all the general declaration of human right and other amendment thereafter. The Supreme Court, therefore, opined that if the constitution implicitly included individual right as part of pursuit to freedom and liberty, then right to privacy is the formidable pillar on which the concept of liberty takes meaning (Smith-Bell & Winslade, 1999). The implicit right of the individual to privacy is also the fundamental basis for patient’s right and professional confidentiality. It is evident, however, that such privileges granted to and enjoyed by individuals in the United States or in parts of Europe are yet to be made global. For this reason, health care providers in each country are required to advocate for health care laws that will empower individuals to seek health care, especially mental health care with ultimate confidence (Behnke, et al, 2000).

In this way, the right to privacy can be categorized under four general classes:

1. **Appropriation**: It is wrong for medical and mental health doctors to appropriate patient’s information as their own. When a patient gives information about his or her life, the information is by no means, the clinician’s property. Therefore a clinician does not have the right to exercise dominion over a patient’s information to the extent, and for the purpose, of making him or her (patient) subservient for his own propose use or pleasure. For example, a clinician cannot lay extra financial burden on a patient because of the type of information he or provided
during clinical consultation or interview and neither would the clinician threaten to report the patient to Internal Revenue Service (IRS) or Immigration as a way to stop patient from pursuing malpractice law suit. In other words, the clinician will not be motivated by general curiosity, financial gain and other considerations to divulge patient’s information inappropriately (Blocki et al, 2011; Blocki et al, 2011b; Weitzner et al, 2008).

2. **Intrusion**: This is a situation where clinicians, knowingly take wrongful possession of a patient’s information (Blocki et al, 2011b). Example of this may be situation where a clinician refuses to testify to the court or release information to a designated person or agent even though the patient has given his or her permission. Another side to this situation can be referred to as professional discretion or good-judgment position, which gives clinicians the right to act under a professional vantage point or good faith, to prevent an eminent mental or emotional problem emanating from the disclosure. In this situation, intrusion may be justified, but the clinician must be prepared to prove beyond every reasonable doubt, that the release of such information will present mental or emotional consequences to the patient.

3. **Public disclosure of private facts**: The public disclosure is when a clinician divulges information, which patient refuses to waive privilege. For example, reporting sex or physical abuse on a minor, even though the client would not want it reported.

4. **False light in the public eye**: This is a malicious disclosure (Blocki et al, 2011b), where clinician places his or client in a ridiculous and unreasonable position in the public eye. The summary of ethical principle is, in all situations, do no harm. If a medical or mental health professional must testify against his or her patient, still effort must be made to protect the patient against embarrassment or causing situations that may cause the patient a greater harm (Weitzner et al, 2008).

**Privileged communications and Human Right**

Patient’s rights entail the exercise of “privileged communication” and it is a legal concept that protects patients/clients from having their clinical information to a health care professional revealed during legal proceedings without their informed consent (Jacob & Powers, 2009; APA, 2010). The concept of privileged communication pre-empts privacy and confidentiality. In many instances, privilege and confidentiality are often muddled up because they are seemingly identical and at times used interchangeably. The attempt to understand their difference will certainly help immensely in effective interpretations of their ethical and legal demand on a health care professional (APA, 2002). As right to privacy puts constraint on government or intruders to stay clear of the individual’s legitimate activities, privilege, on the other hand, puts legal constraint on medical doctors and psychologists to respect and conceal information obtained in the course of professional relationship (Blau, 1998; Koocher, 1999). Even though, privilege flows from the same stock and values with confidentiality (i.e., it protects and promotes individual
the value of privacy and autonomy), there is remarkable distinction between them (Curtis et al, 2006). Let us examine each.

Privilege: Privilege is a property (i.e., right, immunity, or benefit) granted by law and it is solely controlled and enjoyed by the patient or client who has entered professional relationship with a physician. Remember, privilege is not absolute. It is rather governed by situation and circumstance and inasmuch as the individual works under the laws and regulations that govern privilege, he or she is entitled by law to enjoy all or some of the privileges embedded in the relationship. For example, marital privilege, professional privilege, priestly privilege, etc.

Privileged communication can be defined as statements made by certain persons within a protected relationship, like doctor-patient, attorney-client, priest-penitent, wife-husband, and psychologist-patient (see Jaffe v. Redmond, 1996) that enjoys protection from forced or unwarranted disclosure (Behnke, et al., 2000; Black, 1987; Blau, 1998; Domb, 1991; Folkman, 2000; Sieber, 1992). Communication is considered privileged if individuals in certain relationships are prevented by law from using intimate conversations or information as evidence against the other person or persons involved in the relationship. In a therapeutic relationship, privileged communications invokes the patient’s right to keep his or her information confidential and the right to present any part of it from unwarranted circulation. Blau (1998) remarks that the “ethical constraint against revealing confidential information is almost absolute” (p. 396). When a person in a legally binding relationship decides to regulate the flow of his or her information or refuses to disclose any part of his or her information to a third party, the person is said to invoke privilege (Taube, &Elwork, 1990).

Relatively, when a patient invokes privilege, it is absolute that under no circumstances would a psychologist or medical doctor discuss or disclose any part of the information or records in a legal proceeding (Behnke, et al., 2000; Koocher& Keith-Spiegel, 1998). On the other hand, a patient who voluntarily authorizes a health care provider to release information to a third part or the court, such authority is referred to as waived privilege.

When a patient waives his or her privilege, the clinician is relieved from the bonds of confidentiality and therefore has no legal and ethical responsibility. But if privilege is waived by a patient (Aronson, 2001), psychologists are bound by their professional obligation to diligently and prudently quantified such waive before divulging any information. This is because waive of privilege in one circumstances may not automatically apply to another case and the amount of information to disclosed must be quantitatively commiserate with the purpose and the need of a given demand. Even though privileged communication is guaranteed by the statutes as an indelible right of every citizen, and sometimes conceived as absolutely binding, but in reality or when
applied to practical laws, it is limited in horizon and structure by the laws and by the common-law rules. Legally, privilege is defined as a “protection”, a “benefit”, or an “advantage” a person enjoys under a specific condition (Behnke, et al., 2000; Blacks, 1987).

The specifications or conditions under privilege can be interpreted is determined by the law, statutes, and by the court. In real world, there is often tension between the values attached to the exercise of privileged and the pursuit of fairness, equity, and the truth enshrined in legal system. The tension arises because of the power many states devoted on privileged communication, which favors concealment of information that might help in fostering justice and fairness (Glosoff, 2000). This is because when an individual invokes privilege, information that would be relevant to the pursuit of justice and truth may be considered inadmissible, and therefore justice may be suppressed or aborted (Dailor, 2007). Since the pursuit of truth, justice, and equity is very essential in any civilized society, the extent to which privileged communication can enjoyed by citizens is regulated by the common-law rule and legislation. With such regulation, a health care provider who is not well exposed to the details of the law and legal and ethical obligations is prone to unethical practice, which may subsequently expose him law suits or even jeopardize the health of his or patient (Jacob & Hartshorne, 2007).

**Confidentiality**

Confidentiality prohibits divulge or disclosure of privileged (nonpublic) information received in a fiduciary, professional or contractual relationship (Allen, 2008; Majumder, 2005). Confidentiality is achieved through silence, discretion and data security. Expectations of confidentiality surround many professional relationships. Both personal and professional relationships demand confidentiality. Everyday ethics treat friendships and marriages as confidential relationships of trust in which information can be safely shared. Relationships with providers of professional services are governed by written rules of confidentiality. In the same manner the doctor-patient, attorney-client and clergy-penitent relationships are good examples of confidentiality. The definition and explanation of confidentiality is more complicated than privilege. Whereas confidentiality concerns matters of professional obligations that are ethically and legally binding, privilege protects patients from disclosure in judicial proceedings. Thus, privilege is narrower in scope than confidentiality, and statutes provide exceptions to privilege that can seriously hamper its effectiveness for therapeutic purposes. Therefore, confidentiality is a professional seal imposed on health care professionals by law and professional codes of ethics to prevent patient’s information from unnecessary disclosure (APA, 2002) or usage against the patient in legal proceeding without explicit permission from the patient (Brakel, Parry, & Weiner, 1985; Sieber, 1988).
Confidentiality is an integral aspect of both privacy and privileged communication. It is also the cornerstone of both clinical and research processes. In clinical context, confidentiality refers to the general standard of professional conduct imperative in clinical relationships. The practice of confidentiality obliges the physician not to disclose any part of clinical information from a patient to a third party without proper authorization (Koocher, 1999). The fundamental intent of confidentiality laws is to protect a patient's right to privacy by ensuring that information disclosed to health care providers is not mismanaged or used against the informant (patient). In discussing confidentiality, therapists also hope to encourage communication. For a reliable and effective medical and mental health treatment to take place, patients must be guaranteed a protection of their information communicated during the course of therapeutic relationship (APA, 1985/1992). In general, during the course of treatment, situation may warrant a health provider to disclose part or whole of patient’s information, especially if there is a need to refer patient to another health care provider or if the information falls contravenes the profession’s duty-to-warn law, which supersedes Privileged communications, privacy and confidentiality.

The duty-to-warn law refers to an ethical considerations and legal responsibility that requires a health care provider to breach confidentiality if a patient or other identifiable person is in clear or imminent danger (Tribbensee&Claiborn, 2003). In such situation, the health care provider must determine the degree of seriousness of the threat to the individual or the public and notify the person in danger or competent authorities who are in a position to protect either the individual or the public from harm. In mental health, where the mentally ill are known for their violent tendencies, the duty-to-warn law requires a clinician who has reasonable grounds to believe that a patient may be in imminent danger of harming himself or others to warn the possible victims (Tribbensee&Claiborn, 2003). In this way, the physician or clinician is mandated by law to divulge only the part of information that conveys imminent danger of harm, no more, no less.

This is a dilemma to the practice of confidentiality. Even though the duty to warn law is among the few exceptions to a patient’s right to confidentiality, physician’s ethical obligation to maintain confidential information related in the context of the therapeutic relationship conflicts with his or her legal obligation. Therefore, in the United States, the therapist’s duty to warn is implicitly contained within the guidelines for disclosure of confidential information without the consent of the patient. Even though the law requires a physician to report some patient information, yet the physician cannot disclose confidential information without the full consent of the patient. But prudence must be
exercised by health providers in negotiating with patient about the possibilities of divulging his information. For example, if a patient who has a history of mental disorder and known for his violent behavior informs a doctor that he is a member of a terrorist group that plans to attack the public in coming three days. He came to the doctor because he is conflicted as to whether to go ahead with the group in executing the planned attack. After treatment, the patient changed his mind not to continue with the group, but warned the doctor not to disclose the information to police and threatened attacks on him and his family if the information is divulged.

It will be imprudent for the doctor to ask the patient consent to disclose such information. He must, however, work out other means to protect the patient, himself and his family or others from harm (APA, 1992). But the law required that the doctor must breach confidentiality to warn the identified victim/third party about imminent danger (Corey et al, 2007). Even though the ways of responding to this situation may vary from country to country, especially in countries without any defined guideline or with a poor and corrupt legal or police systems, the general rule is the danger must be imminent and the breach of confidentiality should be made only to someone who can reduce the risk of the danger (Tribbensee&Claiborn, 2003). People who would be appropriate recipients of such information would include the intended victim and the law enforcement. In countries with corrupt law enforcement agents, health care providers must be careful so divulging of such information to them (corrupt law enforcement agents) may not be used against you and your family.

The next obstacle or dilemma to confidentiality is when minors (children under 16 years) are the patients. Confidentiality in relation to children has both ethical and legal issues (Koocher& Keith-Spiegal, 1990), and it is very limited (Querido, Eyberg, Kanfer, &Krah, 2001). According to Querido and colleagues, practice of confidentiality in relation to information provided by a child is tricky. The manner to which such information is handled ant treated depends greatly on both the age of the child, circumstances and the purpose of the interview. In general, however, a preschool or preadolescent child has limited confidentiality. For this reason, important information received during treatment section must be communicated to parents, foster parents, and legal custodians (Boggs &Eyeberg, 1990).

The ethical guidelines here are that health providers are expected to report information that have a negative effect on the child or others. In the case of children, however, it is expected that the health care provider should disclose the information without revealing the identity of the child and such information must be reported to the appropriate responsible authority. Like in the cases of adult patients, health care providers are called to use prudence in divulging information provided by minors since “irresponsible” disclose
of information may further hurt and traumatize the child. So, it is left to individual clinicians to decide the limit of information to disclose, what circumstances and what in clinical terms constitutes a negative effect that is serious enough to require reporting.

Confidentiality under clinical or medical research: Confidentiality under clinical or medical research can be referred to as an agreement between the researcher/clinician and participants as to what may be done with their data (Folkman, 2000; Levine, 1986; Sieber, 1992). It is known fact that the advancement achieved in modern health care came from medical research and in many countries, especially in developed countries, it has enjoyed good public support. In order to maintain this public support, confidentiality must be taken seriously and violation to the laws and guidelines are seriously dealt with. Even if the research is not necessarily linked to clinical care, there is a legal and a moral impetus to ensure that research is conducted with the maximum respect for participants and their privacy (Lowrance, 2002). The most important aspect of research that links to confidentiality is are requirement at that the researcher must obtain explicit consent from participants, identifying personal data that is required and how, where and when the information provided will be used. In a way, many research is multifaceted, meaning that it could involved many layers of studies and analysis which also involve different people in difference circumstances. In other words, it means that people who are not involved in the collection of the initial (original) information (data) may need access to the data. It is advisable that the original consent stipulate these circumstances and all potential scientist or research who may have access to the data will be held to confidentiality through anonymization. Researchers and clinicians must strike a careful balance between their pursuit of health improvements for all and their obligation to maintain the privacy of individuals participating in research (Kalra, et al, 2006; Kalra et al., 2005).

Professional confidentiality can be discussed under three dimensions, namely: legal, ethical, and interpersonal (Behnke, et al., 2000).

- **Legal perspective:** medical and mental health clinicians have a professional obligation to ensure that a patient’s information is guided and protected against unwarranted publication of written and verbal information.
- **Ethical perspective:** confidentiality, which includes privacy and individual autonomy, is a highly prized and valued by many societies, in many societies; the integrity of an individual is tested on the ability to keep this secret. A society without a measure of confidentiality is opened to ruin because national security is in jeopardy. Confidentiality, on the other hand, assures individual’s liberty, privacy, and security, and highlights the freedom to decide for oneself who share one’s intimate information with, and the right to decide how to use it. It is therefore a moral imperative that health care professionals treat and handle their
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patient and information collected in the course of clinical relationship with uttermost respect and cordiality.

- **Interpersonal perspective:** confidentiality is at the core of every human and professional relationship. In therapy, protecting the sanctity of the patient’s communication provides a safe haven for the patient to share the most intimate aspects of life experience, without fearing that it may be divulged to unwarranted persons. Such confidence will help to promote effective and productive health care treatment and intervention.

The recognition that confidentiality to the patient’s information as well as an explanation of its limits is a milestone in modern health care system have expanded the horizon of how health care is conceived and practiced. Not only it is an essential part of quality health care, it also establishes physician-patient trust which is important in effective treatment procedures (Dekraai, et al, 1998). To keep communication confidential is to treat patient with dignity and respect, which further builds up confidence, security, and subsequently trust. Trust is the foundation that creates and defines the space where two people may work together toward a mutual goal. The promise of privacy and confidentiality is thus the foundation of a successful relationship, and thus the essential features of health care (APA, 1994; Behnke, et al., 2000).

Despite the fact that confidentiality is not specifically recognized in the constitutional law of the United States, it forms bedrock under which many governmental and professional enterprises extol their operational strength. In mental health profession, for example, its importance cannot be compromised. In many cultures and societies where biases and stigma about mental illnesses exist, one cannot overestimate the importance of keeping and maintaining mental health records and information with uttermost privacy and confidentiality (Domb, 1991; Smith-Bell & Winslade, 1999; Sosfin 1985) because many people prefer to keep their mental health records private. The truth of this statement can be ascertained by the effort many people take to keep their mental health history out of public scrutiny or circulation. For example, in North America and Europe where health care is covered by health insurance companies, some people would prefer to pay directly for mental health therapy instead of filing for an insurance claim. But as more and more develop confidence in the system, they have relied on confidentiality laws that are well protected, defended and enforced.

**Distinction between Confidentiality and Privacy**

Both confidentiality and privacy are related in the sense that information is restricted from unwarranted divulge or access to individuals who have no right to the content of the information. In most part, both are often used loosely or interchangeably to stand for
secrecy or concealment. The concepts, privacy and confidentiality are opposed to publicity, and vary in their meanings and interpretations when used in a clinical context. In a clinical setting, for example, it is generally believed that individuals who have mental and emotional problem release their intimate and private thoughts, beliefs, feelings, and experience to the mental health professionals in exchange for treatment, tests, and assessment. The information received from a patient in exchange for mental and emotional treatments cannot be used for another purpose. Any attempt aimed at using a patient’s information other than to improve his or her health condition may be considered as a breach of professional confidentiality. The very nature of mental health therapy suggests that psychiatrists, psychologists or mental health therapist have direct access to the most integral and exclusive secrets of their patients. In most part, no profession has such a control over a patient’s innermost and secret information than mental health professionals. It makes sense, therefore, for mental health profession to adopt stricter ethical and legal regulation that will reassure patients that their secret or private information cannot be used against them. This is to say that, confidentiality makes patients less vulnerable to clinicians who may use their position to victimize patients.

On a broader spectrum, confidentiality does not stop with the professional obligation to conceal patient’s information from undue publicity, rather it encompasses the clinician’s responsibility to conceal and block the identity of his or her patients from recognition. Mental health professionals as well as other health care providers that control patient’s intimate information, must not create undue situations where a third person knows that therapeutic relationship exist with their patients. For example, social intimacy with patients like, exchange of gifts or invitation to social gathering may jeopardize confidentiality. Furthermore, the site and location of mental health clinic may compromise patient’s confidentiality therefore, mental health clinic should be strategically located and sited in order to avoid third parties identifying a patient moving in and out of the clinic. It is imperative that health care professionals should be guided by the following guidelines:

1. The statutes that govern privacy, confidentiality, and privileged communication are based on presumption that the therapist’s foremost obligation is to protect the right and integrity of his patient. The first instinct is to defend the patient’s privileged communication and to protect it from unwarranted and malicious circulation, but at the same time, not to compromise the public safety. For example, it is in the best interest and safety of a child and an elderly person that abuses, neglect, abandonment, and exploitation against them be disclosed to competent authority. The same goes in a situation where a third party is in a proximate risk of harm or in danger of death if confidentiality is not divulged. Some state laws determine that the interest of the general public must outweigh
the right to privacy of a patient and automatically waives off the responsibilities of confidentiality. In this way, a mental health professional may disclose confidential information only in a situation the law explicitly creates an exception to the general presumption of confidentiality. If a psychopath has a detailed plan to commit homicide or suicide, this plan is not covered under privileged communication. If a medical doctor treats a patient with a gunshot wound or other injury believed to be armed robber related case or other violent crime, he/she is bond by hypocritical oath to safe the patient’s life and required by civil obligation and safety of the public to report the patient to competent authorities. The same thing goes with psychologist who during the course of treatment knew that his or her patient is a fugitive for a violent crime.

2. The mental health professional is not totally free of his or her obligation to protect the patient’s privileged communication, even in a situation where the law allows his or her to divulge confidential information. In releasing a patient’s information, a psychologist must be meticulous and sensitive to a number of the following issues: a) Law of no surprises: Whatever may be the case, never give out patient’s information without first consulting with him or her. b) Parsimony principle: While divulging a patient’s information, never give out more information than asked or required. c) Consultation: Do not jump into action if in doubt, rather suspend action and consult colleagues or resource books.

Confidentiality Law and Patient Right in Global Health

For this reason, Global Health Initiative (GHI) focuses on improving the health care programs in areas like infectious disease, nutrition, maternal and child health, personal hygiene, safe water, and community participatory initiative (CPI). This is aimed at reducing burden of diseases and disorders and to empower individuals and group to become personally involved in the health and well-being, which transcends the mere emphasis on medical treatment methods, but emphasizes coordinating activities across agencies and sectors (Etches et al, 2006) that promote and empower people be involved in health care programs. Two important elements stand out here, namely, people’s direct involvement in health care and assurance the existing health system is not hostile to individual personhood. These are contained in the Universal Declaration of Human Rights on health care (1948). Unfortunately, the World Health Organization (WHO) has not succeeded in making the case that global health initiatives cannot be successful without enhancing patient’s right. When patient’s right is promoted, it leads to health literacy, minimizes superstition, which is the major hindrance to quality health and promotes community participatory initiative and trust in health care system.
Fundamentally, professional confidentiality laws guarantees patient’s right because it sanitizes health system, making it trustworthy, respectful, and congruent.

With exception of countries in North America and Europe, where laws that promote and enforce patient rights are meticulously followed, many countries, especially in development countries of the world, do not have established laws and regulations directed to promoting and enforcing patient rights and professional confidentiality. Where they exist, they only exist in published papers, but never implemented or enforced (Richards, 1998). The universal declaration of human rights on health care recognizes the “inherent dignity” and the “equal and unalienable rights” of all peoples and opens the basic understanding of the rights of each individual patient.

Depending on prevailing cultural and socioeconomics of any country, there are different models of the patient-physician relationship that can be adopted which should inform a particular right entitled to a patient. For example, in North America and Europe, about four patient right and confidentiality law models which streamline that “normal” physician-patient relationship have been used to study confidentiality in global healthcare system (Mead & Bower, 2000). They are: a) the paternalistic model; b) the informative model; c) the interpretive model; and d) and the deliberative model (Kaplan et al, 2009). Each model suggests different professional obligations a clinician has toward his or her patient and how information gather in the course of clinical relationship can be handled to prevent abuse of patient’s right and general well-being. With the exception of paternalistic model, other models are based on the principle of parsimony, which deals with the required balance in clinical relationship (Carr, 2002).

**The paternalistic model:** In paternalistic model, also called the priestly model, the health provider has full control of every clinical decision and assumes that he/she knows what is best for the patient. Here the best interests and right of the patient is solely determined by the clinician who is valued above the provision of comprehensive medical information and decision-making power to the patient. In this model, which is an offshoot from the biomedical-hippocratic model, the patient’s right is whatever is invented and decided by health care providers with a belief that patients are only passive participators in their own care (Emanuel & Emanuel, 1992). Currently, this model is very common in developing countries where most patients lack the basic poor understanding of the science of human body and are known to be low-information health consumers.

**The informative model:** The informative or engineering model is a shape departure from the biomedical-hippocratic model to patient empowerment to take a more active role in their healthcare by becoming the protagonist of their own health can well-being. As the concept of health changed, a new paradigm in which patients are
encouraged to assume more personal responsibility own what happens to their body and mind. The clinicians were to treat the patients as consumers with right to their body and how it will be treated. This model resulted in patient-centered integrative model thereby replacing the biomedical-Hippocratic model. The physician-patient interaction is a professional relationship in which the physician provides relevant information to patient and allows the individual to decide how to be treated and how his or her clinical information will be used (Mansell et al, 2000). Practically, the physician is there to serve the interest of the patient by providing necessary information about the state of the patient’s disease, the possible diagnosis and therapeutic procedures to be used, the risks and benefits of the procedures and any uncertainties of knowledge. Here the obligation of the physician is to provide the patient with necessary professional opinion and knowledge, and it is the patient’s right to decide what treatments are to be given or how the patient’s information should be used (Beaver et al, 1996). Some clinicians still entertain some apprehension on the effectiveness of this model, especially in countries where most of the patients have low education or a total lack of education as well as patients with mental problems. The growing international consensus, however, is that regardless of the situation of a given country, all patients have a fundamental right to privacy, to the confidentiality of their medical information, to consent to or to refuse treatment, to make decision about their treatment and to be informed about relevant risk to them of medical procedures (Kaplan et al, 2009; Mead & Bower, 2000).

**Interpretive/Collegial model:** This model depicts the physician as occupying a friendly and counseling position in his or her clinical relationship with patients. The patient is believed that the devastating nature of some illnesses can make, even well informed and educated patients, to be confused or uncertain about values or options of their treatment. So, physician can play the role of a counselor or friend in assisting the patient in his or decision-making responsibilities because the physicians’ medical knowledge and the patients’ personal values contribute to balanced medical decision-making. The “interpretive”/“collegial” model acknowledges that physicians have full access to better and reliable medical or health facts, but with subjective or limited knowledge of the patient’s values. In this arrangement, the physician is expected to provide medical or health care expertise, and is capable of counseling patients as friends to make decisions that best realize the patient’s own personal values. This approach strictly upholds patient’s autonomy, right and privilege without undermining the physician’s duty as a professional, expert and a caring friend.

**Deliberative model:** According to Emanuel and Emanuel (1992), deliberative model is a better model that balances the rights and privileges of the patient and at the same time maintains that professional position of the physician as an expert. They believed that
other models have outlived their usefulness and therefore requires justification before adopting them. While recognizing the professional ability to the physician to objectively know and prioritize a patient’s medical and personal values, the physician and as a matter of fact, the society understands the immense right of each patient and therefore treats his or her visit to the hospital or clinic as noble decision. This type of relationship helps physicians persuade patients that some health-related values are more complicated than some of their personal values and rights (Mansell et al. 2000). As such, the model enables physicians to normatively assess their patients’ personal values and exert enormous influence over not only what patients can but also what they should do. The physician mentor’s grip on decision-making is more relaxed than the physician-parent/priest, but the “fact-value” dichotomy remains with the physician and many autonomy-conscious patients find it unsatisfactory (Hui, 2005).

What is a breach of confidentiality?

A breach of confidentiality takes place when patient’s medical/clinical record is disclosed to a third party without patient’s informed consent or whoever the patient appointed. Disclosure can be oral or written, by telephone or fax, or electronically, for example, via e-mail or health information networks. The legal basis for imposing liability for a breach of confidentiality is more extensive than ethical guidelines and the source of unwarranted disclosure could be linked to physician-patient relationship or the patient himself. Therefore, the impetus of confidentiality laws lies on federal and state legislation and regulation governing both health care records and professional licensing, and specific federal and state legislation designed to protect sensitive information (e.g., HIV test results, genetic screening information, mental health records, and drug and alcohol abuse rehabilitation information). As noted above, enforcement of these laws takes precedence over their enactment.

Informed Consent

Informed consent is a willful and voluntary agreement entered by a clinician and patient in exercise of individual’s autonomy and freedom. The terms “willful” and “voluntary” connote power, competency, and reasonable mental disposition to act on one’s behalf (Grisso, 1992). According to Fischman, 2000, Koocher (1998) and Grisso, (1992) clinicians and researchers are bound by law and ethics to get the consent of their patients or participants before commencing treatment or research. In fact, health care providers must not only obtain patients’ consent before commencing treating or releasing clinical information, but they must also take steps, through a process of disclosure and dialogue, to ensure that the consent they obtain is "informed" (Richardson & Nash, 2006).
Informed consent is invalid if, at the time of the agreement, the person who authorized and endorsed the agreement is below the normal intelligence ability and reasonable mental awareness (Fins & del Pozo, 2011). For example, for an informed consent to be legally binding, the level of comprehension, assertiveness and autonomy, rational reasoning, anticipation of future event, and judgment in the face of uncertainty or contingencies must be at a legally and clinically accepted normal function.

Koocher (1998) observed that, “competency is the prerequisite for informed consent.” It follows, therefore, that a patient with a serious mental, a person with developmental problem, and minors may not directly qualify to give a treatment or research consent (Behnke, et al., 2000, Folkman, 2000, Fischman, 2000; Koocher, 1998 & Grisso, 1992). Koocher believed that under the law, “a person’s competence is conceptualized as a specific functional ability” (p.466). What it means is that children under the age of 18 are considered legally incompetent, adults with mental problem and developmental incapacitation cannot authorize treatment consent without adequate permission and assent from a qualified person (APA, 1992; Koocher, 1998; Peterson, Clancy, Champion, & McLarty, 1992). There are discrepancies here. For example, in juvenile detention facility, offenders who are sentenced as adults are still legally minor and therefore incompetent to give consent to treatment contracts. Here the question is, how would mental health clinicians in prison facility get permission or assent for these minors?

The general rule regarding release of a patient's health record to a third person is that information contained in a patient's record may be released to third parties only on three major circumstances, including, a) patient’s consent to such disclosure, danger to third parties and/or the public; c) statutory requirement to disclose information. In order to release patients clinical records to a third party, the patient must give his or her express authorization (Fins & del Pozo, 2011) before any part of his or her clinical information is disclosed to a third party. By authorization, we means that the patient must be the one to permit the disclosure of part or whole of his or her clinical information to a third party. In many countries, mental health records are not subject to release even if the patient has authorized the release (Richardson & Nash, 2006).

Due to their mental instability and cognitive impairment, people with mental problems be easily influenced and manipulated into agreeing to releasing information without understanding their ramifications on them. In this case, patient’s health care provider (especially psychiatrists and psychologists) must be trained on issues relating to releasing patient’s medical/clinical records to another health care provider (in case of further health care needs), attorney, insurance company, patient's employer (unless a worker's compensation claim is involved), member of the patient's family (where the family member has been appointed the patient's durable power of attorney for health care),
government agencies (under subpoena or disability proceedings). It means, therefore, that once the patient has given consent to release his or her record(s) to a third party, the health care provider in question has no right to withhold part or whole of the record, except where it is determining that the patient is not in a right frame of mind to make such discussion. So, patient’s medical/clinical record disclosure requirement may be mandatory or merely permissive.

An adult who is clinically considered incompetent to stand trial in court may not qualify to authorize an informed consent provided he functions as a custodial parent, takes care of himself, or manages his financial affairs (Appelbaum, Lidz, & Meisel, 1987; Peterson, et al., 1992). Strictly speaking, to determine incompetence in adult can be difficult, therefore must be considered on a case-by-case basis. It behooves the clinician to assess the mental ability patients before a release or informed consent is signed. The following must be considered: a) the ability to understand all relevant information about the nature and potential future consequence of the informed consent; the ability to make or maintain a decision; the value (rational) and quality (coherent) of the decision made; and, d) whether the decision is lawfully acceptable (Richardson & Nash, 2006; Koocher, 1998). Identified whether the patient is a minor or an incompetent adult or whether the parent, guardian, or personal representative should sign on behalf of patient. Such mandate is called permission. Permission is conceived as a release or informed consent signed another on behalf of a minor or an incapacitated adult (Folkman, 2000; Grisso, 1992; Koocher, 1998), and the awareness that it is the minor or the incompetent adult is the person who benefits from therapy is called assent.

Generally, authorization to release health care record must be committed in writing, indicating what has to be in the release. Basically a valid release should include the following elements:

- Patient's name and identifying information;
- Address of the health care professional or institution directed to release the information;
- Description of the information to be released;
- Identity of the party to be furnished the information;
- Language authorizing release of information;
- Signature of patient or authorized individual; and
- Time period for which release remains valid.

Some state laws add other elements, such as specifying on the form the reasons for disclosure or a caveat that the authorization may be revoked. In United States and Europe, releasing or divulging patient’s clinical information without following
appropriate release procedure may have serious results. Punishment ranges from revoking a physician's license to practice, suspension, penalty or litigation.

According to Koocher (1998), Informed consent or releases “should be drafted for highly specific purposes, addressing each of the key elements….” (P.467), the following issues should be addressed; a) Identifying the person or persons to who the consent and release apply; b) Indicate what is being authorized; c) Indicate the reason and purpose of which the duty of confidentiality can be releases without patient’s permission. For example, treatment emergencies, public and personal safety, referral and consultation, subpoena and legal system, research program, mandatory reporting statutes; d) State who is granting or signing the release, state if he or she is different from the patient. (In case of permission or assent of the minor or incompetent adult); e) In case of a minor or an incompetent adult, identify the grantor and his or her relationship with the patient to who enters into therapeutic relationship; f) Indicate the duration of each release (i.e., if a patient wants information or records to be given to his or her parents, primary doctor, or insurance, indicate how many times or circumstance in which the information will be released; and, g) Include a valid signature of the grantor.

According to Corey (1995) informed consent must be applicable to group therapies. He formulated list of information clients deserve to know before joining a group (see, p.27), although he did not project the idea of signing a consent form. Lakin (1999), on the other hand, maintained that the APA ethical standard (4.02) did not put credence on group informed consent, because “therapist working with groups cannot always define the anticipated course of therapy or answer all of the clients’ questions as mandated in the standard on structuring the relationship” (p.368). Since marriage and family therapies are conceived as special group of individuals, Margolin (1999), believed that “informed consent be conducted with all persons who participate in therapy, including those family members who join therapy at a later time” (pp. 362-363). Invariably, Solso, Johnson, and Beal (1998) believed that informed consent must be entered and signed by all subjects participating in an experimental research group (see, p. 123,). Allen (1995) believed that, “both subject and the researcher sign the consent form” (p. 36).

**Confidentiality and General management safeguards and security**

Even though professional confidentiality is between the clinician and the patient, the breach of confidentiality by health care supporting staff employed by a hospital, clinic or community health centers or the spouses of the health providers could be directed to the physician that is treating the patient. Physicians, hospitals, and health centers have the primary responsibility to prevent unwarranted and unauthorized release of medical/clinical information. All persons associated with patient’s records, support staff,
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vendors, consultants, and all health care providers participating in a data repository reviewed of patients must be covered by comparable confidentiality and security policies, including:

a) implement security controls over sensitive patient information (e.g., HIV status, pregnancy termination, and history of mental health problems or drug and alcohol abuse)

b) maintain good system security by equiring those who access the health information sign appropriate user agreements.

c) train staff and secure agreements concerning confidentiality and security; and

d) periodical assessment of the clinical data repository by security experts.

Physicians/clinicians who operate private clinics should set up office procedures to prevent the release of health care records without a copy of the patient's release. To make it as simple as possible, the release form would have a checklist indicating date of receipt of the request, date of receipt of the copy of the patient's release form, and date that the medical records were authorized to be sent to the requester.

**Obstacle and Exceptions to Confidentiality**

It is noteworthy that privileged communication is not absolute, and therefore confidentiality, which protects privilege communication, is limited. In spite of the great values attached to confidentiality, communications to psychologists do not enjoy absolute confidentiality. In some case, situation may exist where confidential information may leak in spite of the therapist’s professional ethical effort to protect his or her patient’s information. For example, in group therapy, family or couple therapy, confidential information may leak through the members of the group. In this situation it will be difficult for the clinician to control dissemination of privileged communication since members of the group are not professionally bound by the ethical and legal obligation of confidentiality.

In order to insure that such situation does not exist, clinicians must make it a point of duty to instruct the members of a group therapy on the importance of confidentiality. Furthermore, members of the group must be advised not to discuss intricate and sensitive issues with the group until the clinician in charge of the group reviewed them. Other areas of concern for information leakages are through the insurance agencies, court, and governmental agencies. In light of these obstacles, psychologists must be cognizant of the fact that they owe their patients the professional duty of explaining to them the limitations of confidentiality before entering treatment session. In the face of these discrepancies and limitations, clinician must have written and signed informed [release]
consent before starting any psychological treatment, testing, research and group therapy sessions.

Conclusion

The principles of professional ethics and ethical conduct in health care are the fundamentals of quality health care. Once taken away, the whole process is in shambles and meaningless. This is because encapsulated in these ethical principles are the essence of human decency, rational and intellectual abilities and moral fortitude. The basis of these (ethical) principles is the natural law and human right. In natural law, humans aspire for a social order in which reason transcends instinct. From this framework, humans can grasp and enter into relationships, first with their Creator (eternal relationship) and second relationship with others (to love and be loved). Due to their reasoning abilities, rationality, and their capacity to understand what is ultimately good and be motivated to altruistically (selflessly) pursue goodness out of their free will, humans can indeed behold justice and benevolence, rights, duties and responsibilities.

This mental and intellectual ability ultimately thrusts humans to know and understand what is good (right) and what is bad (evil/wrong), aspire for truth, and motivated by free will to consciously choose what is good (right) over what is bad (wrong). It can be said therefore that natural law and human right are diametrically opposed to teleological ethics (focuses on the outcomes or ends of actions or ‘the ends justifies the means’), but conform to deontological ethics that demands both ends (outcomes) and means (actions) to be ethically sound and justifiable. Since natural law endows all humans with inalienable right, the pursuit of this right must be infused with transcendent ethical norms and truths that are universally applicable to all humans regardless of persons, color, gender, race and creed. There is no shortcut to attaining this right than to develop principles that evaluate dignity and integrity from a holistic perspective. Under this concept, action and outcome are inseparable because actions can be immoral or unjust regardless of their outcomes. The most important thing is that ‘the means must justify the ends.’ This is the essential principle of natural law, human right, patient’s right, confidentiality laws and informed consent.

The “Nuremberg Doctors’ Trial,” 23 senior medical officials of the German government during World War II were indicted of crimes against humanity (natural right). They were charged with and convicted of performing medical experiments, without the subjects’ consent, on prisoners of war and civilians of occupied countries. In the course of these experiments, the defendants (doctors) were accused of committing murders as well as acts of cruelties, brutalities, tortures, atrocities, and other inhuman acts. Also planning and performing the mass murder of prisoners of war and civilians of occupied countries, stigmatized as aged, insane, incurably ill, deformed, and so on, by gas, lethal injections, and diverse other means in nursing homes, hospitals, and asylums during the Euthanasia program. The doctors were convicted because of absence of informed consent from participants as well as depriving patients their natural and human right.
The infamous Tuskegee syphilis experiment was another landmark in human and patient rights initiative, where a clinical study conducted between 1932 and 1972 in Tuskegee, Alabama by the United States Public Health Service was discovered to violate participants’ human rights. Without due process, lack of information and deceptive plot, researchers (mis) Informed participants that they were being treated for “bad blood,” when their doctors had no intention of curing them of syphilis at all. Rather the participants were used as guinea pigs and were deliberately left to die under a false hope that they were being treated for tertiary syphilis—which can include tumors, heart disease, paralysis, blindness, insanity, and finally death.

The patient, regardless of his or her physical, mental and socioeconomic conditions, participates and shares the inalienability of natural and human right and must not be taken away from one person for the benefit of another without his or his informed and express permission. The Nuremberg is is make   While are human legitimate and legislative means of enforcing human right and the conscientization (consciousness raising) of the natural law. For example, the ethical principle, “do no harm,” covers both human right and natural law, “thou shall not kill.” While human right element gives the patient the legal right to be treated fairly by physicians or clinicians, the natural law aspect puts moral and legal responsibilities on health care providers to do everything in their power to do nothing but save life. The reason why the two components (human right the natural law are necessary in piloting ethical conduct is that emphasize in one aspect may not bring a good result. With rationalization, human element in health care, will always find a loophole to circumvent their ethical responsibilities. We can see that in places where human rights are respected or enforced by their government, the only ethical compass left to protect the interest of patients is the natural law   is But such justification is not strongly supported by the principle guidelines of professional confidentiality. As pointed out above, clinicians must draft informed consent to include persons, agencies, and groups the patient wishes to send information. The content and detail of information to be released must be clearly ascertained.

Furthermore, the law of no surprise mandates the clinicians to inform their patients about exceptions to the rules of confidentiality before treatment (Behnke, et al., 2000). Clinicians must not disclose information without first consulting with their patients even though it is stated in the informed consent that information should be released. During this period, the clinician will review with his or her patient what the demands are and their implication to mental and emotional stability (Canter, Bennett, Jones, & Nagy, 1994). In order to minimize the possibility of surprise, any type of disclosure must be done with patient’s knowledge. Furthermore, the parsimony Principle puts limit to what clinicians can disclose in at given time. For example, a psychologist who received a call from emergency room about his patient will provide only information that will help the physician in his treatment. In referrals for psychological testing or assessment, clinicians must share only those aspects of the patient’s problem that help the referring psychologist interpreting the test results (Anastasi, 1988). There is no reason why clinicians should share information that is unrelated with a case in point. Therefore, clinicians should
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determine what information is necessary and sufficient to address the need of the
disclosure and disclose only that information. The Law of No Surprise and the Parsimony
Principle are guidelines for all mental health professionals when they must disclose
confidential information.

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