Ethics in Psychiatry

The Five C's of Confidentiality and How to DEAL with Them

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According to Section IV of the *AMA Principles of Medical Ethics,* "A physician...shall safeguard patient confidences and privacy within the constraints of the law."[1] The clinical import of "confidentiality" is often confused with the legal concept of "privilege." Briefly stated, the term *confidentiality* involves the ethical duty of the clinician not to disclose information about a patient without authorization. As it applies to healthcare information, the term *privilege* involves a legal rule of evidence that gives a patient the right to exclude from a legal proceeding certain communications made by the patient to a clinician. While the ethical duty of confidentiality is universal, the legal concept of privilege is not uniformly recognized or applied in all jurisdictions. Some jurisdictions, including the federal courts, recognize a psychotherapist-patient privilege to cover communications made by patients to psychiatrists and other mental health professionals.[2]

Our colleague Tom Gutheil, MD, teaches a useful mnemonic to distinguish confidentiality from privilege. Paraphrasing Dr. Gutheil, *confidentiality* ("co") is the *clinician's obligation* not to disclose confidential information about a patient, while *privilege* ("pr") deals with the *patient's right* to exclude from a legal proceeding communications made to a treating clinician.[3]

Although the parameters of confidentiality may vary according to jurisdiction and clinical setting (e.g., in military, correctional, forensic, or substance recovery settings), there are five generally recognized exceptions to the duty of confidentiality that clinicians may wish to keep in mind.[4] A mnemonic device to remember the exceptions to the duty of confidentiality is the "Five C's." The Five C's are:

- **Consent—**A clinician may release confidential information with the consent of the patient or a legally authorized surrogate decision maker, such as a parent, guardian, or other surrogate designated by an advance medical directive.
- **Court Order—**A clinician may release confidential information upon the receipt of an order by a court of competent jurisdiction. (Note: Unless issued by a judge, a subpoena should not be considered the equivalent of a court order in many jurisdictions.)
- **Continued Treatment—**A clinician may release confidential information necessary for the continued treatment of a patient. (This exception is also recognized by HIPAA, subject to the "minimum necessary" rule of limited disclosure.[5])

- **Comply with the Law**—A clinician may reveal confidential information in order to comply with mandatory reporting statutes (e.g., child abuse), law enforcement or administrative agency investigations, business operations, and other such lawful purposes.
- **Communicate a Threat**—This is the well known Tarasoff exception to confidentiality that involves the clinician's duty to protect others from violence by a patient. The Tarasoff exception exists in a variety of forms in many jurisdictions.[6,7]

It cannot be over-emphasized that the Five C's are a general guideline of exceptions to the ethical duty of confidentiality, which may vary according to the jurisdiction and clinical setting. Keeping in mind the generalities of the Five C's, how does one deal with the analysis of a clinical problem involving confidentiality issues? Here is one way to DEAL with a potential confidentiality issue:

- **D**uty—Does the clinician have a duty to maintain confidentiality in the context of a treatment relationship or for some other reason?
- **E**xception—Does an exception exist? (Use the Five C's as a guide)
- **A**sk—Consider asking for help, such as a consultation from a colleague, risk manager, or attorney.
- **L**aw—Be familiar with the law of the jurisdiction and the confidentiality policy of the facility or organization.

It may surprise some psychiatrists to know that breach of confidentiality allegations are relatively rare as the chief complaint in a lawsuit. Although often threatened by patients and feared by psychiatrists, allegations of breach of confidentiality comprise as little as three percent of malpractice claims against psychiatrists, the overwhelming majority of which are either settled, dismissed, or decided in favor of the psychiatrist.[8]

It is also worth noting that for all the legal and ethical consternation, a confidentiality issue may often be reframed essentially as a clinical dilemma. Physicians are trained to be clinicians, not lawyers, and would do well to keep their clinical hat on while focusing on their ethical compass. In other words, when in doubt about a confidentiality issue it may be advisable to err on the side of the paramount responsibility to care for the patient.[9] One final bit of advice to consider when in doubt on ethical matters comes from the teaching of Peter Blake, MD, who said many times to his students, "When in doubt, do the right thing."[10]

"When in doubt, do the right thing."

—Peter Blake, MD

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1920–2002

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2. Jaffee v. Redmond, 518 U.S. 1 (1996).
3. Gutheil T. *The Psychiatrist As Expert Witness.* Washington, DC: American Psychiatric Press, Inc., 1998. See also the companion volume, *The Psychiatrist in Court: A Survival Guide.*
4. For example, see Mississippi Code Annotated Section 41-21-97.
5. Health Insurance Portability and Accountability Act of 1996, 29 U.S.C.A. 1181, et seq. See also 45 CFR Part 164.
6. Tarasoff v. Regents of the University of California, 551 P.2d 334 (Cal. 1976).
7. Felthous A, Kachigian C. The duty to protect. In: Rosner R (ed). *Principles and Practice of Forensic Psychiatry, Second Edition.* London: Arnold, 2003:147–55.
8. Psychiatric Claims by Cause of Loss for the United States, 1998-2006. Table published by Professional Risk Management Services, Inc., 2007. Available at: www.psychprogram.com/claims/col.htm. Access date: January 22, 2007.
9. Section VIII. *Principles of Medical Ethics of the American Medical Association.* Chicago, IL: American Medical Association, 2001.
10. In memory of Peter Blake, MD. Professor of Medicine, University of Mississippi, School of Medicine, 1920–2002.

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