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Legal Concerns in Psychosomatic Medicine

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Legal concerns often arise in the context of medical practice, and the field of psychosomatic medicine is no exception. In the practice of psychosomatic medicine, legal issues may arise for many reasons. For example, the treatment of patients with psychiatric illness may focus particular attention on sensitive issues such as confidentiality and the limits thereof. Second, medical and surgical colleagues often consult psychiatrists for legal and quasi-legal questions such as a patient's decision-making capacity and treatment refusal, perhaps because these issues involve assessment of mental reasoning and abnormal behavior [1]. Finally, medicine is practiced in the context of an increasingly complex society with competing values and interests, and these tensions often emerge at the level of the individual patient. Examples include cases of risk of harm to third parties and malpractice liability.

The law provides a framework that affects certain aspects of how psychosomatic medicine is practiced. That framework is often invisible, yet it exerts its effect at some of the most challenging points in rendering care to patients. As a result, it is important for physicians to be familiar with the applicable laws in the jurisdictions in which they practice and the resources available to them to obtain consultation and support around complex legal issues. This article will address many of the legal issues commonly encountered in psychosomatic medicine, including confidentiality, capacity and competency, informed consent, treatment refusal, substitute decision making, and malpractice. Overall, however, it is most important for physicians to recognize that the best way to avoid entanglements with the law is through the consistent provision of sound clinical care to their patients.

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CONFIDENTIALITY

Confidentiality has been a cornerstone of the doctor–patient relationship since at least 430 BC when it was codified in the Hippocratic Oath, “Whatever I see or hear, professionally or privately, which ought not to be divulged, I will keep secret and tell no one” [2]. Since the time of Hippocrates, doctor–patient confidentiality has remained an important ethical, professional, and legal requirement in the practice of medicine [3–6]. However, the ideal of absolute confidentiality between doctor and patient has come into conflict with other considerations in a complex society. Over time, a number of exceptions to the rule of confidentiality have emerged. Historically, these narrow exceptions to confidentiality occurred either where courts or legislatures determined that confidentiality would cause more harm than good, or where confidentiality would run counter to an important societal safety interest.

Tarasoff and the Duty to Protect

The duty to protect third parties from physical harm by patients is one well-known potential exception to confidentiality [1]. In the California decision of *Tarasoff v Board of Regents*, the court held that psychotherapists have a duty to act to protect third parties when the therapist knows or should know that the patient poses a threat of serious harm to the third party [7]. In reaching this conclusion, the court relied on a balancing analysis of patients’ rights to privacy and the public interest, “The Court recognizes the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy. But this interest must be weighed against the public interest in safety from violent assault” [7].

Not all jurisdictions recognize the duty to protect [8,9]. Many states have passed statutes that address the duty to protect third parties, and others have either limited the scope of or eliminated the duty [10,11]. State statutes generally limit the circumstances in which a duty to protect arises. For example, state law may require a specific threat to an identifiable third party, a known history of violence on the part of the patient, and/or a reasonable reason to anticipate violence. In addition, state laws may also delineate the measures that may be taken to discharge the duty to warn, such as notifying police or other law enforcement agencies, hospitalizing a patient, or warning the potential victim. One state that employs this approach is Massachusetts [12].

In the context of psychiatric consultation to medical and surgical services, psychiatrists and other mental health professionals should also be aware of the scope of duty to protect laws in the jurisdictions in which they practice because these statutes may apply to psychiatrists and mental health professionals but not to physicians in general [12]. In these jurisdictions, the psychiatric consultant may have a legal obligation to warn a third party beyond that of the physician requesting the consultation. In some situations, the psychiatrist’s duty to warn might even run counter to competing legal requirements for the primary treatment team [12–14]. For example, Massachusetts requires physicians, in general, to keep HIV-related information confidential, but also

imposes a duty to protect on psychiatrists. In the case of an HIV-positive individual who is putting an unknowing sexual partner at risk, medical and surgical physicians are bound by the HIV confidentiality statute, whereas psychiatrists have competing obligations under the HIV and *Tarasoff*-inspired statutes.

As highlighted in the above scenario, treating patients with HIV and other infectious diseases may present a tension between confidentiality and the well-being of third parties or society at large. In fact, one of the historic precedents that the *Tarasoff* court used in its reasoning was the existence of mandated reporting of certain communicable diseases, which predated wider duties to protect third parties [7]. States and the federal government, for example, have laws regarding which communicable diseases must be reported to state authorities and/or the Centers for Disease Control. Common examples include varicella, hepatitis, severe acute respiratory syndrome, and HIV, but the list of reportable infectious diseases is generally lengthy so physicians should be aware of the requirements in the jurisdictions in which they practice [15–17]. Especially regarding HIV, jurisdictions vary regarding what information must be reported, whether reporting is anonymous, whether written permission is required to release information, and whether spousal notification is required [14,16,17]. In addition, doctors have been held civilly liable in cases both predating and since *Tarasoff* for failure to disclose a patient's infectious disease status that led to the infection of other individuals [18–21].

The tension between confidentiality and risk to third parties in the context of infectious disease, and HIV in particular, is not a new one. The Council on Ethics and Judicial Affairs of the American Medical Association recognized the need for legal guidance in this area 2 decades ago when it called for states to draft laws that provided liability protection for physicians for failure to warn contacts of their HIV-positive patients, that established clear guidelines for physician reporting to public health agencies, and that would guide public health personnel in the tracing of individuals at risk of exposure to HIV [22]. As it presently stands, the American Medical Association has called for continued efforts to address confidentiality issues that may emerge in the treatment of HIV-positive individuals. However, physicians are still left without concrete, legal guidance in many situations [14,23].

Overall, it is critical for psychiatrists to be aware of the applicable laws in the jurisdictions in which they practice and to be cognizant of available legal and risk-management resources should a complex situation arise in which the applicable laws appear to conflict with each other. As a rule of thumb, however, the starting point for practically approaching situations in which the psychiatrist may have a duty to share patient information is from the original position of doctor–patient confidentiality. Confidentiality is a cornerstone of the doctor–patient relationship and, as such, breaches for any reason should be carefully considered. Clinicians should always limit the amount of information disclosed to the minimum necessary to achieve the purpose of the disclosure and attempt to make clinical interventions, such as hospitalization of the patient or

otherwise engaging the patient in a safe plan, before resorting to releasing information to any third party [24].

Abuse and Neglect

Unlike the duty to warn, there is no ambiguity about the responsibility of physicians in the United States to report child and elder abuse and neglect to state authorities; every state has legislation that mandates physicians to report child and elder abuse and neglect [25–28]. However, although federal law sets a minimum definition for what actions and/or failures to act constitute child abuse and neglect, states have interpreted the federal definition in different ways leading to jurisdictional differences in laws [25,27,28]. In general, states employ a definition of child abuse incorporating “harm or substantial risk of harm” or “serious threat or serious harm” to a person under the age of 18 [27].

Similar to child abuse, the definitions of elder abuse and neglect vary between jurisdictions, but most state laws include five common elements: infliction of pain or injury, infliction of emotional or psychologic harm, sexual assault, material or financial exploitation, and neglect [26]. Elders are also at risk for self-neglect as their mental and physical functional abilities decline [29]. As mandated reporters, physicians should familiarize themselves with both reporting requirements and available screening and investigative resources in the jurisdictions in which they practice, especially because one of the barriers to reporting elder abuse and neglect may be inadequate detection [30].

There is often concern that reporting abuse or neglect to state agencies is a breach of doctor–patient confidentiality that could leave physicians legally liable for damages. It is critical for physicians to be aware that liability attaches for failure to report, and that good-faith reporting in reliance on the law is a valid defense to a civil suit for breach of confidentiality brought by or on behalf of the patient. Finally, most jurisdictions employ a reasonable suspicion standard for reporting suspected child abuse or neglect, which means that the reporting physician or other covered provider must exercise professional judgment and good faith in making a report of suspected abuse or neglect, but need not have definitive proof or evidence that such abuse or neglect has occurred [1,26–28].

Health Insurance Portability and Accountability Act

When Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA) [31], physicians—and psychiatrists in particular—were concerned about the impact of this new federal legislation on the handling of confidential patient information, which was previously regulated mostly by state law. Specific concern focused on how HIPAA might alter the tradition of doctor–patient confidentiality and affect record keeping in psychiatry because the law promulgated new rules governing the management of health information that applied to physicians who perform certain electronic transactions, including billing [32]. Because hospitals perform the electronic functions

covered by HIPAA, most, if not all, consultation liaison psychiatrists are covered by the provisions of HIPAA.

HIPAA governs the management of “protected health information,” which includes information that identifies a patient (such as name or social security number), is about a mental or physical condition, describes services or treatment provided, or relates to payment [33]. The main provisions of HIPAA that are relevant to the practice of psychosomatic medicine relate to disclosure of medical information, patient access to information, and a new category of record established under HIPAA called “psychotherapy notes.” Overall, as the following discussion will elucidate, rather than increasing the privacy of medical records, HIPAA had the opposite effect of increasing the circumstances under which protected health information could be released without specific consent from patients [25,32,34].

When lawmakers passed HIPAA, they aimed to improve the efficiency and effectiveness of the health care system [31]. In categorizing what information is considered protected health information under HIPAA, lawmakers had to recognize that although confidentiality and privacy are important considerations in medical practice, the concept of medical records as “locked files” in an office cabinet is outdated, and the functioning of a complex health care system requires sharing of information between multiple entities on a regular basis [32]. The implementation of HIPAA addressed these concerns by allowing covered entities to release protected health information for the purposes of treatment, payment, and health care operations without specific authorization or consent by the patient [32]. This decision by lawmakers to abolish the consent requirement for the release of patient medical information raised concern among advocates of medical privacy, who worried that the new era of medical information management would progressively eclipse patient confidentiality in the interest of furthering the administrative and operational needs of the modern health care system [34–36].

Of note, HIPAA does place some limits on disclosure by requiring covered entities such as hospitals to inform patients of the institution’s practices under HIPAA in the form of privacy notices. In addition, patients may request records of disclosures of their protected health information. Finally, federal and state laws that grant additional protection to sensitive health information preempt HIPAA so that written informed consent may still be required for its release. Examples of these types of information include records relating to HIV status and treatment, genetic testing, records from alcohol and substance abuse treatment programs, and domestic violence and sexual assault records [25,32].

In the past, psychiatric records and medical records were often treated differently. For example, at our institution, pre-HIPAA, psychiatry notes were redacted from the general medical chart when records were released to patients. HIPAA, however, gives a broad right of access to patients for their medical records with only a narrow exception. Under HIPAA, a patient’s access to records may be denied only if a licensed professional reasonably

determines that releasing the record would harm, endanger the life of, or jeopardize the physical safety of the patient or another person [32]. Except in the narrow circumstance of harm avoidance, all records, medical and psychiatric, in the patient's medical chart are accessible by the patient.

HIPAA does provide a narrow exception for "psychotherapy notes," but this exception is exceedingly narrow and does not cover most documentation of psychotherapy sessions per se. Specifically, psychotherapy notes are defined in HIPAA as clinician's notes that document or analyze the contents of a conversation that occurs during a private counseling session, and are kept separate from the rest of the individual's record. Even if these notes are kept in a separate location, certain information is not subject to the psychotherapy notes provision, including medications, test results, diagnoses and prognosis, progress, and treatment plans [5,37]. Patients do not have the right to access psychotherapy notes, but there is no prohibition on access to these notes, either [37]. For these notes to be released for any purpose, specific authorization is required. Finally, even though psychotherapy notes are kept separately from the medical chart, they are considered to be part of the medical record for legal purposes should the record be subpoenaed for litigation [1].

Two additional considerations regarding HIPAA are that it sets the minimum requirements regarding the protection of health information and does not prevent the release of information in emergency settings or settings in which there are mandated reporting obligations. In other words, states are free to promulgate legislation that provides greater protection for patient information than HIPAA provides, and HIPAA continues to permit disclosure of information in situations that are already part of general practice such as emergencies and mandated reporting, in addition to 11 other circumstances [1,5]. Finally, even though HIPAA permits disclosure without consent in many situations, it is critical to use clinical judgment in determining the minimum necessary information that needs to be disclosed to fulfill the specific purpose for which it is being released [32].

TREATMENT: CONSENT AND REFUSAL

Consultation psychiatrists are often asked to assess the quality of a patient's decision-making process, especially when the patient refuses an intervention that the treating doctors believe has a favorable risk-benefit profile for the patient's condition. This threshold assessment of decision-making ability is a capacity assessment. Capacity is a clinical determination of an individual's ability to perform a task or execute a set of functions. The legal equivalent of capacity is competency, which is a judicial determination. In the eyes of the law, all adults are presumed competent [1,38-40].

Competency, or lack thereof, may be global, as in the case of a patient in a coma. More commonly, however, the assessment of capacity and competency is task specific. In the area of civil law, examples of specific competencies are testamentary capacity (the ability to make a will), decision-making capacity (the ability to consent or refuse treatment), and testimonial capacity (the ability

to testify in court.) Because different tasks require different abilities, information, and levels of understanding, the first step in making a capacity determination is to ask the basic question, "Capacity for what?" An understanding of the type of decision the patient is faced with—for example, accepting or refusing a recommended procedure, refusing all treatment, refusing or accepting placement—allows the consultant to assess the degree to which the patient understands the particular information relevant to the decision.

Capacity Assessment

A patient's capacity to make a medical decision rests on an understanding of the illness, the proposed treatment, and the consequences of the treatment. Appelbaum and Grisso [41] have proposed a practical framework for capacity assessment that relies on a four-prong analysis. All four criteria must be met for the patient to demonstrate capacity. The criteria are: preference, factual understanding, appreciation of the significance of the facts presented (often referred to as a more nuanced or global understanding of risks and benefits), and rational manipulation of information.

In assessing preference, the relevant question is whether the patient is able to state a stable preference. A patient who is either unable or unwilling to express (or commit to) a preference presumptively lacks capacity. The second element, factual understanding, may be assessed by asking if the patient has attained knowledge of the nature of the illness, the treatment options, the prognosis with and without treatment, and the risks and benefits of treatment. In determining whether a patient has a factual understanding or is capable of developing one, it is critical to ascertain what efforts have been made by the treating physicians and other staff to educate the patient about the proposed treatment. A patient who has never been informed about the proposed treatment cannot be expected to know the relevant medical information. The patient must have the ability to retain the information when it is presented and use it in the decision-making process.

Third in the assessment of capacity is the determination of whether the patient appreciates the significance of the information presented. Appreciation goes beyond the facts; it requires the patient to achieve a broad perspective on the risks and benefits of accepting or refusing a proposed intervention and to demonstrate an understanding of the implications the decision will have for his or her future. Last, the patient must demonstrate that his or her decision-making process is a rational one. This element takes into account the patient's past preferences and life decisions, and focuses not on the rationality of the final decision but on the process by which the patient arrived at the final decision. For example, in the case of a Jehovah's Witness who would certainly live with a blood transfusion but certainly die without it, the decision to reject the blood transfusion might, on its face, seem irrational. However, the decision conceptualized in the context of the individual's life of faith and belief that acceptance of such treatment would be contrary to religious doctrine, would be considered a rational one.

Informed Consent

Capacity is a threshold finding for the ability to consent to or refuse medical treatment. In civil law, any unauthorized touching is considered a battery, and medical interventions are no exception. In the context of treatment, a patient must give informed consent before any medical intervention can begin [42]. Even though the term informed consent is used, patients' refusal of treatment must also be informed. The concept of informed consent has been a cornerstone of medical treatment since the 1960s, and grew out of the broader concept of autonomy before it appeared in the medical context [43,44]. Informed consent is the process by which the patient agrees to allow the physician or other treater to do something to or for him or her. Informed consent is not just signing a form; instead, the emphasis should be on the process of communication, information exchange, and acceptance or rejection of the proposed intervention by the patient [40].

The legal standard for informed consent incorporates two elements in addition to the threshold requirement of capacity. Informed consent must be knowing (or intelligent) and voluntary [42,45–48]. The standard for what information is required for consent to be knowing or intelligent varies from jurisdiction to jurisdiction. There are two general approaches to determining how much information a physician must present to a patient for consent given by that patient to meet the knowing criteria [40]. The first, known as the “reasonable professional standard,” is clinician-focused. The second, known as the “reasonable patient standard,” is patient-focused. The reasonable professional standard is followed by a small majority of states. This approach requires clinicians to provide the amount of information to the patient that a reasonable professional would provide under the same or similar circumstances. On the other hand, the reasonable patient standard employed by a substantial minority of states requires clinicians to provide the amount of information that would be used by a reasonable or average patient in making an informed decision. Some states employing the patient-centered approach go further, requiring an inquiry into what information the particular patient would find material or relevant in making this particular decision [49]. Finally, two states use a mixed approach in determining the amount of information required [50].

From the practical perspectives of clinical practice and risk management, the general rule of thumb is that the more information provided the better. Overall, whatever the jurisdiction, clinicians will be in good stead if they provide six broad categories of information:

1. the diagnosis and the nature of the condition being treated;
2. the reasonably expected benefits from the proposed treatment;
3. the nature and likelihood of the risks involved;
4. the inability to precisely predict results of the treatment;
5. the potential irreversibility of the treatment; and,
6. the expected risks, benefits, and results of alternative, or no, treatment [50].

Overall, a process involving frank discussion and exchange of information between the doctor and the patient is seen as the ideal of informed consent [50].

Finally, there are limits to the amount of information physicians are responsible for sharing in the course of informed consent. For example, the Massachusetts Supreme Judicial Court has acknowledged the need for a balance between patients' right to know, fairness to doctors, and a more general societal interest that the law not place "unrealistic and unnecessary burdens" on clinicians [51].

Voluntariness is the second fundamental element of informed consent. Consent must be given without coercion, that is, without external forces that limit the ability of the patient to exercise a choice [42,52,53]. The distinction between a voluntary and a coerced choice is a complex inquiry [54]. For example, in general, individuals pressured by their family members to make a certain decision or to agree to a medical treatment are generally found to have acted voluntarily both from ethical and legal perspectives, although exceptions do exist [55,56]. On the other hand, although there is debate on the issue, individuals who are totally dependent on others for their care, such as residents of long-term care facilities and prisoners, are often categorically deemed unable to give voluntary consent to treatment and research because of the inherent unequal balance of power between the patient and the institutional administration or authorities [57–60].

In certain limited circumstances, informed consent is not required for the initiation of treatment. These settings, however, should be considered the exception and not the rule [61–63]. The most common of these exceptions is for emergency treatment, defined as situations in which failure to treat would result in serious and potentially irreversible deterioration of the patient's condition. Treatment under the emergency exception may only continue until the patient is stabilized, and at that time informed consent must be obtained. In addition, if the physician has knowledge that a patient would have refused the emergency treatment, if competent, the patient's prior expressed wishes cannot be overridden by the emergency.

The other generally acknowledged exceptions to the informed consent requirement are waiver and therapeutic privilege [61–63]. A patient may waive consent and opt to defer to the judgment of the clinician or another individual, but it should be well documented that the patient has the capacity to waive informed consent [42]. In the case of therapeutic privilege, a physician may proceed with a proposed intervention by getting consent from an alternate decision maker if the consent process itself would contribute to a worsening of the patient's condition [48,64]. Therapeutic privilege does not apply, however, in a situation where providing information to the patient might make the patient less likely to accept treatment. Overall, therapeutic privilege and waiver are extremely narrow categories, and represent exceptions to the doctrine of informed consent that should be used in only the most carefully considered, well-defined circumstances.

Advance Directives and Substitute Decision Making

When a patient lacks capacity and is unable to give informed consent or refusal for medical treatment, principles of law and ethics require that someone give

authorization for medical intervention or nonintervention. This other person is referred to as a substitute decision maker who is charged with making decisions for the patient. In most circumstances, the substitute decision maker is required to make decisions according to what the patient would have wanted were the patient able to make his or her own decisions. This standard is known as substituted judgment. In some circumstances, especially involving guardianships and minors, the substitute decision maker may be asked to make decisions according to the patient's best interests [40].

Substitute decision makers may be appointed in several different ways. One method of appointing a substitute decision maker is through an advance directive. An advance directive is a document crafted by an individual to appoint a substitute decision maker or give instructions about how to make future decisions should the person become incapacitated and unable to make his or her own decisions in the future. Two common types of advance directives are the health care proxy and the durable power of attorney. They are both characterized by the presence of a "springing clause." That is, the documents take no effect until a future time when a patient is deemed to lack decision-making ability. When such a time comes, the documents "spring" or become active, and the terms of the advance directive are activated. Advance directives may have an instructional component directing further care in the event of future incapacity, appoint a substitute decision maker, or be a hybrid with an instructional component and appointment of a substitute decision maker.

Notwithstanding the 1990 passage of federal law that required the provision of information about advance directives, the documentation of existing directives, and the education of health care staff and the community about advance directives, most individuals still do not have advance directives [65,66]. In the absence of an advance directive, several options may exist for how to proceed in the treatment process. Some states, such as Illinois, have statutes that govern how to appoint substitute decision makers in the absence of an advance directive [67]. In Illinois, in the event that an incapacitated person has no advance directive, the law gives the highest priority to the patient's guardian, followed by spouse, adult child, and then parent as the order in which another individual should be appointed as a substitute decision maker, and then continues along progressively more distant blood relatives, ending with a close friend or the guardian of the estate [67].

In states where there is no statutory provision, the options vary by jurisdiction, the nature of the treatment, and the severity and expected duration of the incapacity. For example, in situations where the treatment is of low risk, consent is often obtained from family at the bedside. This practice may also be employed for other treatment decisions, depending on the jurisdiction [14,40]. However, as proposed treatments become increasingly intrusive, aggressive, or risky, the need for a formally designated substitute decision maker increases. State statutes and case law may determine whether a formal mechanism such as guardianship or court approval is required for a particular intervention. Depending on the jurisdiction and the proposed intervention, such formal mechanisms may be

required even when the treating physician believes the intervention is routine. One example is the use of antipsychotic medications in Massachusetts [68].

MALPRACTICE

As professionals, psychiatrists owe a duty of care to their patients, both ethically and legally. Malpractice law is the area of tort law that deals with personal injuries caused by the treatment activities of medical professionals [1,69]. To establish a malpractice claim, four elements must be met. First, it must be established that a doctor–patient relationship existed, which imposed a duty of reasonable care on the physician with regard to the patient. Second, it must be shown that the physician breached that duty. Third, it must be shown that the breach, or dereliction, of the duty directly caused the patient’s harm. Fourth, it must be shown that the patient suffered damage as a result of the physician’s actions or inactions [1,39,52,69]. The elements of a malpractice action are often termed the four “D”s: duty, dereliction of duty, direct causation, and damages.

Malpractice is a tort of negligence. It occurs when a physician’s or other professional’s conduct and practice deviate from the accepted standard of care for the profession, and that deviation causes damage to the patient or recipient of care. Negligence is an unintentional tort, meaning that the deviation from the accepted level of care need not be purposeful or intended by the physician. Finally, a national standard of care is generally employed as the benchmark for whether the physician’s duty was breached.

There is often confusion about the responsibility and liability of physicians acting in a consultative capacity. Treating clinicians have the primary duty of care for the patient. On the other hand, consultants do not have the same duty to the patient [62]. The duty of the consultant is to the consultee, or the requesting physician. In other words, the consultant must provide consultation with reasonable care. However, once consultants cross the boundary between advising the consultee and actually providing treatment to the patient, the consultant owes the patient the same standard of care as the treating physician. For example, if the consultant recommends that the consultee prescribe a medication to the patient, the duty is to the consultee. However, if the consultant enters the order and actually prescribes the medication to the patient, the consultant will be held to the level of care of a treating physician. It is thus important for the consultant to be aware of his or her role in the treatment of the patient, and to maintain clear division of tasks with the consultee regarding all psychiatric interventions in the care of the patient. Additionally, if the consultant does assume a treating role, then he or she should be cognizant of the need to monitor and follow-up on the patient as if he or she is the primary treating psychiatrist.

SUMMARY

In the practice of psychosomatic medicine, the psychiatric consultant is likely to be confronted with questions at the interface of psychiatry and law. These

issues generally emerge around questions of confidentiality and exceptions to confidentiality, assessments of a patient's ability to consent to and refuse treatment, and concerns about malpractice liability. Overall, psychiatrists should approach the care of patients clinically, while understanding the applicable laws and regulations of the jurisdictions in which they practice. In addition, clinicians should be aware of the legal and risk management resources available to them should a complex situation arise. Finally, the psychiatric consultant should make use of consultation when complex issues emerge at the interface of psychiatry and law.

References

- [1] Schouten R, Brendel RW. Legal aspects of consultation. In: Stern TA, Fricchione GL, Cassem EH, et al, editors. *The Massachusetts General Hospital Handbook of General Hospital Psychiatry*. 5th edition. Philadelphia: Mosby, Inc.; 2004.
- [2] Hippocrates. The Oath. Translated by J Chadwick and WN Mann. In: Lloyd GER, editor. *Hippocratic Writings*. London: Penguin Books; 1983. p. 67.
- [3] American Psychiatric Association. Position Statement on Confidentiality. Washington, DC: American Psychiatric Association; 1978.
- [4] American Psychiatric Association. The principles of medical ethics with annotations especially applicable to psychiatry. Available at: http://www.psych.org/psych_pract/ethics/medicalethics2001_42001.cfm. Accessed September 26, 2007.
- [5] Appelbaum PS. Privacy in psychiatric treatment. *Am J Psychiatry* 2002;159:1809–11.
- [6] Brendel RW, Brendel DH. Professionalism and the doctor–patient relationship in psychiatry. In: Stern TA, editor. *The Ten-Minute Guide to Psychiatric Diagnosis and Treatment*. New York: Professional Publishing Group; 2005. p. 1–7.
- [7] *Tarasoff v. Board of Regents of the University of California*. [17], 425. 1976. Cal.3d.
- [8] Almason AL. Personal liability implications of the duty to warn are hard pills to swallow: from *Tarasoff* to *Hutchinson v. Patel* and beyond. *J Contemp Health Law Policy* 1997;13: 471–96.
- [9] Ginsberg B. *Tarasoff* at thirty: victim's knowledge shrinks the psychotherapist's duty to warn and protect. *J Contemp Health Law Policy* 2004;21:1–35.
- [10] Appelbaum PS, Zonana H, Bonnie R, et al. Statutory approaches to limiting psychiatrists' liability for their patients' violent acts. *Am J Psychiatry* 1989;146:821–8.
- [11] Kachigian C, Felthous AR. Court responses to *Tarasoff* statutes. *J Am Acad Psychiatry Law* 2004;32:263–73.
- [12] Duty to warn patient's potential victims; cause of action. Ch. 123, § 36B (2005); Mass.Gen.Laws.
- [13] HLTVIII test; confidentiality; informed consent. § 70F (2005); Mass. Gen. Laws Ch. 11.
- [14] Brendel RW, Cohen MA. Ethical issues, advance directives, and surrogate decision-making. In: Cohen MA, Gorman J, editors. *Comprehensive Textbook of AIDS Psychiatry*. New York: Oxford University Press; 2008.
- [15] Averbhoff F, Zimmerman L, Harpaz R, et al. Varicella Surveillance Practices—United States. *MMWR Morb Mortal Wkly Rep* 2004;55:1126–9, 6 A.D.
- [16] New York State Department of Health. HIV reporting and partner notification questions and answers, NYSDOH 2000. 2000. Available at: www.health.state.ny.us. Accessed March 26, 2006.
- [17] New York State Department of Health AIDS Institute. Identification and ambulatory care of HIV-exposed and -infected adolescents, Appendix B—summary, HIV reporting and partner notification. 2003. Available at: www.hivguidelines.org. Accessed April 16, 2006.
- [18] *Bradshaw v. Daniel*. [854], 865. 1993. S.W.2d, Supreme Court of Tennessee.

- [19] Gostin LO, Webber DW. HIV infection and AIDS in the public health and health care systems—The role of law and litigation. *J Am Med Assoc* 1998;279:1108–13.
- [20] Liang BA. Medical information, confidentiality, and privacy. *Hematol Oncol Clin North Am* 2002;16:1433–47.
- [21] Zinn C. Wife wins case against GPs who did not disclose husband's HIV status. *BMJ* 2003;326:1286.
- [22] American Medical Association Council on Ethical and Judicial Affairs. Ethical issues involved in the growing AIDS crisis, Report A-187. Available at: www.ama-assn.org. 1987. Accessed September 4, 2006.
- [23] American Medical Association. Policy H-20–915: HIV/AIDS Reporting, Confidentiality, and Notification. 2003. Available at: www.ama-assn.org. Accessed September 4, 2006.
- [24] Beck JC. Legal and ethical duties of the clinician treating a patient who is liable to be impulsively violent. *Behav Sci Law* 1998;16:375–89.
- [25] Brendel RW. An approach to forensic issues. In: Stern TA, editor. *The Ten-Minute Guide to Psychiatric Diagnosis and Treatment*. New York: Professional Publishing Group; 2005. p. 399–412.
- [26] Kazim A, Brendel RW. Abuse and neglect. In: Stern TA, Herman JB, editors. *Massachusetts General Hospital Psychiatry Update and Board Preparation*. 2nd edition. New York: McGraw-Hill; 2004.
- [27] Milosavljevic N, Brendel RW. Abuse and neglect. In: Stern TA, Rosenbaum JF, Fava M, et al, editors. *Comprehensive Clinical Psychiatry*. Philadelphia: Mosby/Elsevier; 2008.
- [28] Schouten R. Legal responsibilities with child abuse and domestic violence. In: Jacobson JL, Jacobson AM, editors. *Psychiatric Secrets*. Philadelphia: Hanley & Belfus; 2001.
- [29] Abrams LC, Lachs M, McAvay G, et al. Predictors of self-neglect in community-dwelling elders. *Am J Psychiatry* 2002;159:1724–30.
- [30] Kahan FS, Paris BE. Why elder abuse continues to elude the health care system. *Mt Sinai J Med* 2003;70:62–8.
- [31] Health Insurance Portability and Accountability Act of 1996. Public Law 1996;104–91.
- [32] Brendel RW, Bryan E. HIPAA for psychiatrists. *Harv Rev Psychiatry* 2004;12:177–83.
- [33] HIPAA Privacy Rule. 45, 164.512. 2001. C.F.R.
- [34] Feld AD. The Health Insurance Portability and Accountability Act (HIPAA): its broad effect on practice. *Am J Gastroenterol* 2005;100:1440–3.
- [35] Friedrich MJ. Practitioners and organizations prepare for approaching HIPAA deadlines [medical news and perspectives]. *J Am Med Assoc* 2001;286:1563–5.
- [36] Gordon S. Privacy standards for health information: the misnomer of administrative simplification. *Delaware Law Review* 2002;23–56.
- [37] Maio JE. HIPAA and the special status of psychotherapy notes. *Lippincotts Case Manag* 2003;8:24–9.
- [38] Appelbaum PS, Roth LH. Clinical issues in the assessment of competency. *Am J Psychiatry* 1981;138:1462–7.
- [39] Appelbaum PS, Gutheil TG. *Clinical Handbook of Psychiatry and the Law*. Philadelphia: Wolters/Kluwer/Lippincott Williams & Wilkins; 2006.
- [40] Schouten R, Edersheim JG. Informed consent, competency, treatment refusal, and civil commitment. In: Stern TA, Rosenbaum JF, Fava M, et al, editors. *Massachusetts General Hospital Comprehensive Clinical Psychiatry*. Philadelphia: Mosby/Elsevier; 2008.
- [41] Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. *N Engl J Med* 1988;319:1635–8.
- [42] Appelbaum PS, Lidz CW, Meisel A. *Informed Consent: Legal Theory and Clinical Practice*. New York: Oxford University Press; 1987.
- [43] Dalla-Vorgia P, Skiadas P, Garanis-Papadatos T. Is consent in medicine a concept of only modern times? *J Med Ethics* 2001;27:59–61.
- [44] Mohr JC. American medical malpractice litigation in historical perspective. *JAMA* 2000;283:1731–7.

- [45] *Schloendorff v. Society of New York Hospital*. 92[105]. 1914. *Northeast Reporter*.
- [46] *Salgo v. Leland Stanford, Jr. University Board of Trustees*. 170(317), 170–182. 1957. P.2d, California Court of Appeals.
- [47] *Natanson v. Kline*. 1093(350), 1093–1109. 1960. P.2nd, Supreme Court of Kansas.
- [48] *Canterbury v. Spence*. 772[464]. 1972. F.2d, D.C. Cir. *cert. denied*, 409 U.S. 1064.
- [49] Iheukwumere EO. Doctor: are you experienced? The relevance of disclosure of physician experience to a valid informed consent. *J Contemp Health Law Policy* 2002;18:373–419.
- [50] King JS, Moulton BW. Rethinking informed consent: the case for shared medical decision-making. *Am J Law Med* 2006;32:429–93.
- [51] *Precourt v. Frederick*. [481], 1144. 1985. *Northeast Reporter 2d*, Massachusetts Supreme Judicial Court.
- [52] Keeton WP, Dobbs DB, Keeton RE, et al. *Prosser and Keeton on the Law of Torts*. 5th edition. St. Paul: West Publishing Co.; 1984.
- [53] Faden RR, Beauchamp TL. *A History and Theory of Informed Consent*. New York: Oxford University Press; 1986.
- [54] Roberts LW. Informed consent and the capacity for voluntarism. *Am J Psychiatry* 2002;159:705–12.
- [55] Grisso T, Appelbaum PS. *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals*. New York: Oxford University Press; 1998.
- [56] Mallary SD, Gert B, Culver CM. Family coercion and valid consent. *Theor Med* 1986;7:123–6.
- [57] Gold JA. *Kaimowitz v. Department of Mental Health: involuntary mental patient cannot give informed consent to experimental psychosurgery*. *Rev Law Soc Change* 1974;4:207–27.
- [58] National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. *Report and Recommendations: Research Involving Prisoners*. 1976. Washington, D.C.: U.S. Government Printing Office.
- [59] National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. *Research Involving Those Institutionalized as Mentally Infirm: Report and Recommendations*. 1978. Washington, D.C.: U.S. Government Printing Office; Ref Type: Pamphlet.
- [60] Moser DJ, Arndt S, Kanz JE, et al. Coercion and informed consent in research involving prisoners. *Compr Psychiatry* 2004;45:1–9.
- [61] Meisel A. The “exceptions” to the informed consent doctrine: striking a balance between competing values in medical decision making. *Wis L Rev* 1979;1979:413–88.
- [62] Schouten R, Brendel R. Legal Aspects of Consultation. In: Stern T, Fricchione G, Cassem N, et al, editors. *Massachusetts General Hospital Handbook of General Hospital Psychiatry*. 5th edition. Philadelphia: Mosby; 2004. p. 349–64.
- [63] Sprung CL, Winick BJ. Informed consent in theory and practice: legal and medical perspectives on the informed consent doctrine and a proposed reconceptualization 43. *Crit Care Med* 1989;17:1346–54.
- [64] Dickerson DA. A doctor’s duty to disclose life expectancy information to terminally ill patients. *Cleveland State Law Rev* 1995;43:319–50.
- [65] Patient Self-Determination Act of 1990. 42, 1395 cc(a). 1990. U.S.C.
- [66] Patient Self-Determination Act. 60, 123 at 33294. 1995. C.F.R.
- [67] Health Care Surrogate Act. 755, 40. 2005. Ill. Comp. Stat.
- [68] *Rogers v. Commissioner of Department of Mental Health*. Mass Rep. Mass Supreme.Judic. Court. [390], 489-513. 11-29-1983. N.E.2d.
- [69] Schouten R, Brendel RW, Edersheim JG. Malpractice and boundary violations. In: Stern TA, Rosenbaum JF, Fava M, et al, editors. *Comprehensive clinical psychiatry*. Philadelphia: Mosby/Elsevier; 2008.