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Protect Doctor-Patient Confidentiality

Sandeep Jauhar NOV. 19, 2015

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WHEN should a doctor betray a patient's confidence? This week the Supreme Court of the State of Washington heard arguments on this question in a case that has profound implications for the doctor-patient relationship.

In the case, Volk v. DeMeerleer, a psychiatrist, Howard Ashby, was sued after a patient of his, Jan DeMeerleer, shot and killed an ex-girlfriend and her 9-year-old son before killing himself. (Mr. DeMeerleer also stabbed another son, who survived.) The estate of the victims, Rebecca and Phillip Schiering, took legal action, arguing that Dr. Ashby was liable because he had not warned the Schierings. A lower court ruled in Dr. Ashby's favor on the grounds that Mr. DeMeerleer, who had occasionally voiced homicidal fantasies, had made no specific threats toward the Schierings during his treatment.

But last November an appeals court reversed that judgment, asserting that doctors could be required to warn "all foreseeable victims" of potentially dangerous

patients in their care. Whether the attack on the Schierings was foreseeable, the court said, should be decided by a jury.

Though the murder of innocents is obviously a tragedy, the Washington State Supreme Court should overturn the appeals court's decision. Not only does that judgment greatly expand the circumstances in which psychiatrists would be required to violate patients' confidentiality; those violations in the end would also not serve the purpose for which they were intended.

Throughout history, doctor-patient confidentiality has been a cornerstone of Western medical practice. The duty to keep patients' information private is written into the codes of ethics of medical organizations, and is even in the Hippocratic oath: "What I may see or hear in the course of treatment," it says, "I will keep to myself."

Patients allow physicians into their private lives on the condition that the information we learn will not be used against them. I once took care of a business executive in the emergency room who had hired call girls during a weekend drug binge. When he saw a police officer outside his room, he quietly handed me an envelope containing a large amount of white powder. I wasn't sure what to do with it, so I discarded it. For the next several hours the patient eyed me suspiciously, probably wondering whether I had ratted him out. But it never occurred to me to do so.

Of course, like all ethical imperatives, doctor-patient confidentiality is not absolute. Doctors have to disclose private information when it is clearly in the patient's interest (documenting a drug allergy in the medical record, for example) or when it comes to complying with a court order (as in cases of child abuse). We must also betray confidentiality when it is in the "public interest" (reporting infectious diseases, for example).

The duty to warn third parties in danger is also an important exception to confidentiality. We publicly disclose the identities of sex offenders. We alert family members when hereditary diseases in our patients come to light. A colleague of mine once took care of a patient, a school bus driver, who received an implantable defibrillator after suffering cardiac arrhythmias. When my colleague advised the man to quit his job because of the potential risk to young children, the man refused,

so my colleague reported him to the Department of Motor Vehicles. It was an action that my colleague felt very comfortable taking, even though it created an irreparable rift in that relationship.

In the same vein, doctors have a duty to warn individuals who are threatened by their patients with bodily harm. This obligation was largely shaped by the seminal 1976 case of Tarasoff v. Regents of the University of California, in which the Supreme Court of California ruled that mental health professionals had a responsibility to protect the intended victims of their violent patients through direct warning or by notifying the police. As Justice Matthew Tobriner famously wrote in the majority opinion, “The protective privilege ends where the public peril begins.” The case has served as a basis for law in 33 states obligating physicians to warn or protect third parties.

However, the Tarasoff case has generally been interpreted to confer an obligation to warn individuals who are *specifically* targeted by psychiatric patients. The lower court in Washington observed that Jan DeMeerleer communicated no threats toward the Schierings during his treatment. Predicting when violence will occur or where it will be directed is difficult under the most straightforward of circumstances. When the threat is not articulated, it is next to impossible.

The World Medical Association states that confidentiality may be breached when the expected harm of maintaining privacy is believed to be “imminent, serious” and “unavoidable.” This standard does not appear to have been met in the case before the Washington Supreme Court.

Breaching doctor-patient confidentiality in such situations will likely be self-defeating. Mentally ill patients may not seek treatment, and psychiatrists, saddled with new legal liabilities, may decline to treat them. We are more likely to minimize harm if the confidence of patients at the greatest risk for violence is maintained.

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