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Confidentiality, Ethics, and Informed Consent

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In Fisher’s (January 2008) excellent and much-needed article, she rightly implied that when discussing ethical dilemmas, psychologists may find themselves saying “consult an attorney” almost as often as they find themselves saying, “consult a fellow psychologist.” Fisher’s article was meant to turn the ship so to speak, by providing psychologists with a foundation for thinking clearly about confidentiality issues—a foundation that does not use legal arguments as primary building blocks.

The above being said, we offer comments about four issues that we hope will add to the fine ideas expressed by Fisher (2008). First, we believe that Fisher’s careful analysis of this area has opened a somewhat clearer view of a problem that many psychologists have when they write about client consent. Client consent really means two very different things (as Fisher implied but which we wish to emphasize). Psychologists can obtain client “consent” to disclose information, such as having the client consent to the release of records to another psychologist. Presumably under such circumstances, the client really does consent. In contrast, psychologists can also obtain “consent” when they ask clients to sign a statement acknowledging that confidentiality may be broken under certain circumstances. We believe that using the same word to describe both situations is confusing because in everyday language “consent” denotes voluntary or even proactive agreement. Obviously, Fisher did not create this problem, but her article throws it into relief, especially in Sections II, III, and IV of the model. Thus, when one reads the word “consent” in Fisher’s model (Table 2, p. 7), it is not always clear whether the usage refers to true consent or to acknowledgement of the limits of confidentiality. Perhaps the term “client consent” should be used only to refer to situations in which clients really do endorse a psychologist’s action, and a somewhat different phrase should be chosen to describe the process whereby psychologists are to provide complete information about the limits of confidentiality (e.g., “acknowledgement of guidelines that will be followed in psychotherapy” or “client acknowledgement of exceptions to confidentiality”).

A second point is related somewhat to our discussion above. In her narrative, Fisher apparently endorsed Behnke’s (2004) “doors” model, including the door that allows disclosure when legally permitted for a valid purpose. Yet, Fisher’s (2008) choice of wording in Section III (“Obtain Truly Informed Consent to Disclose Voluntarily,” p. 7) of her model seems slightly confusing for two reasons. First, Rule A under Section III says: “Respect the rule: Disclose without client consent only if legally unavoidable” (p. 7). This seems somewhat different from the American Psychological Association (APA) Ethical Standard 4.05(b), which says that one can disclose confidential information without client consent “where permitted by law for a valid purpose” (APA, 2002, p. 1066). It also seems different from Behnke’s and even Fisher’s narrative to some extent. Thus, the question arises as to whether Fisher believes that confidential information can be disclosed for a valid purpose or that it can be disclosed only if legally unavoidable. Second, it seems a little inconsistent for Fisher to criticize using legal arguments as the foundation for thinking about confidentiality yet then to suggest (Section III, Rule A, p. 7) that the only way one should break confidentiality without consent is if the legal system demands it. If psychologists wish to redeem confidentiality from the clutches of the legal system, as we think about a legitimate basis for breaking confidentiality and highlight relevant legal issues, shouldn’t we at least give equal weight to principled arguments about potentially higher ethical commitments (perhaps, for example, saving the lives of many people)?

Third, although Fisher (2008) analyzed to some extent the words of the current Ethics Code, reviewed the wording of several older versions of the Ethics Code, and implicitly criticized some of these versions, it is still not completely clear where Fisher stands regarding the current relationship between the Ethics Code and confidentiality. Another way of saying this is that there is little in the article to tell us whether Fisher believes that the current APA Ethics Code is just fine the way it is or should be changed in order to shore up the (presumably) eroding foundation of confidentiality. We do understand that Fisher’s central point here is not to critique the current code but rather primarily to use it as a part of discussing confidentiality. Still, we would have liked to hear her ideas on this matter. Thus, when she says on p. 6, “Underneath all the legally imposed exceptions, the familiar old ethical rule is still there. The rule is simple enough,” one wonders how “simple” it can be given the earlier careful distinctions Fisher drew between various versions of the Ethics Code.

Fourth, we believe that Fisher’s (2008) article would have been strengthened by some consideration of multicultural and cross-cultural issues. Although there are many practice settings in which psychologists’ commitment to confidentiality may not be significantly and often altered by cultural influences, it is obvious that there are cultural issues bound up in confidentiality (e.g., Meer & VandeCreek, 2002; Pettifor & Sawchuk, 2006). Thus, Fisher’s model would be strengthened if one or more sections of it were to explicitly remind psychologists that culture plays a role in how we understand the construct of confidentiality and how we carry out our commitments.

We appreciate the contribution of this article to the literature on confidentiality;
we believe that it will be required reading in many psychology training programs, and rightly so.

REFERENCES


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**Clarifying Confidentiality With the Ethical Practice Model**

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The important issues raised by Pipes, Blevens, and Kluck (2008, this issue) illustrate the complications that can arise in discussing confidentiality and making decisions about it.

First, they noted that the term client consent is used by psychologists to mean two quite different things about confidentiality: (a) acknowledgment of its limits and (b) consent to disclose specific information. They suggested that only the latter should be called consent.

I agree that it would be misleading to call an acknowledgement of limits a consent. At intake, what psychologists need from a prospective client is not only an acknowledgement but an acceptance of the exceptions they may make to confidentiality. Obtaining informed consent requires making sure that the client both understands (i.e., is informed about) confidentiality’s limits and consents to accept them. Thus, in Step II of the ethical practice model (Fisher, 2008), as part of obtaining the prospective client’s consent to receive our services (or participate in our research) we obtain an initial general consent—consent in advance for disclosures we might make later.

The second stage of consent about confidentiality (at Step III of the model) involves client-specific consent for disclosures not listed among the general limits of confidentiality that apply to all clients. During treatment, for example, psychologists obtain clients’ written consent for disclosures needed in their own case (e.g., for conversation with a family member or for release of a report).

In the ethical practice model (Fisher, 2008), the term consent therefore means exactly what it says in both Step II and Step III. The American Psychological Association (APA) Ethics Code (APA, 2002) also uses that term in both contexts: Psychologists must begin with an “informed consent” conversation about the limits of confidentiality (e.g., see Ethical Standards 8.02, Informed Consent to Research, p. 1069; 9.03, Informed Consent in Assessments, p. 1071; and 10.01, Informed Consent to Therapy, p. 1072); and they may disclose information at any time by obtaining the client’s “appropriate consent” (see Ethical Standard 4.05, Disclosures, p. 1066).

Pipes et al. (2008) objected that Step II (at intake) does not involve “true consent” (p. 623) because it represents only “acknowledgement of the limits of confidentiality” (p. 623), not “voluntary or even proactive agreement” (p. 623). This description does fit psychologists’ legal obligation under the Health Insurance Portability and Accountability Act (HIPAA), which requires only that the prospective client sign the Notice of Privacy Practices to document that it was received. This involves only the providing of information, not the obtaining of consent. In contrast, the APA Ethics Code (APA, 2002) and the ethical practice model (Fisher, 2008) require “true” informed consent, and that explicitly protects voluntariness. Once informed about the confidentiality risks, clients willing to receive our services give us consent to proceed; and voluntariness is protected because they are free to give “informed refusal” of services instead. Voluntariness is lost only if we obtain “uninformed consent”—consent from clients not adequately informed about the risks.

Second, Pipes et al. (2008) made several comments about laws, one of which referred to Behnke’s (2004) “doors” model. I endorse his metaphor as a useful reminder that APA Ethical Standard 4.05 (Disclosures) allows information to leave the room in only three circumstances: (first door) when mandated by law; (second door) when allowed by law for a valid purpose. However, my personal position is more client protective: I believe the third door should remain closed; I do not believe a disclosure suddenly becomes ethical the moment our legislators deem it legal. Therefore, Step III (Rule A) of the ethical practice model suggests that, unless legally unavoidable, we should do our best not to disclose without consent.

Note that psychologists have two opportunities to obtain the client consent that I advocate: at intake (Step II) or at the time of disclosure (Step III). If, in advance, we weigh the competing interests (e.g., client confidentiality vs. societal interests) and decide which circumstances we personally believe create a valid purpose for disclosure (Step I, Preparation), we can include those among the “limits of confidentiality” to be discussed in the initial informed consent conversation (Step II). If such a circumstance arises later, we are free to disclose, not because that disclosure is allowed by law, but because we had already obtained the informed client’s consent. Note also that the APA Ethics Code (APA, 2002, p. 1066) permits disclosure without client consent when “permitted by law for a valid purpose,” but it does not require it. (For this I am especially grateful, since my own state’s privacy law allows approximately 40 exceptions to confidentiality, not to mention the unreasonably broad exceptions legally allowed by the federal HIPAA regulations.)

Pipes et al. (2008) found it “a little inconsistent” (p. 623) that I criticized the use of legal arguments as the foundation for thinking about confidentiality yet suggested that one may breach confidentiality if the legal system demands it. The ethical practice model (Fisher, 2008) is ethics based in the sense that it is constructed from our profession’s ethical standards, not structured around laws. But no such model would be complete or useful if it ignored the fact that laws can limit our ability to protect confidences. Like the Ethics Code, the model allows disclosure when “mandated by law”; otherwise, all psychologists would be ethically required to engage in civil disobedience whenever faced with a legal demand for disclosure. But the model advocates that we respond ethically to the existence of such laws. Instead of lightly breaching confidentiality, we can learn to use the laws that protect it (Step I), advise clients about laws that limit it (Step II), and then limit disclosure to the extent legally possible (Steps III and IV).