



The ethical and legal implications of *Jaffee v Redmond* and the HIPAA medical privacy rule for psychotherapy and general psychiatry

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In *Jaffee v Redmond* [1], the US Supreme Court ruled in 1996 that communications between a psychotherapist and a patient are privileged in the federal courts [2–7]. In the new Health Insurance Portability and Accountability Act (HIPAA) medical privacy rule [8], the United States Department of Health and Human Services established confidentiality protections for medical records, in general, and for psychotherapy notes, in particular. This article examines the legal and ethical implications of these two developments. Together, they represent the culmination of a 50-year effort to assure that the law recognizes that especially strong confidentiality rules are needed for psychotherapeutic communications.

History

For confidentiality purposes, the distinction between general medical data and psychotherapeutic communications was articulated in the early 1950s and reinforced by events in the Cold War era. At that time, when the dominant form of psychotherapy was psychoanalytic in nature, courts and legislatures began to take notice of the fact that such treatment required a level of disclosure by the patient to the psychotherapist that went far beyond the disclosures most usually needed in typical medical encounters [9]. Long before psychoanalysis began the scientific study of the darker side of human nature, however, it was recognized that the inner life of the ordinary man

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could, if exposed, bring him into conflict with society. As Montaigne wrote in the sixteenth century:

There is no man so good, who, were he to submit all his thoughts and actions to the laws, would not deserve hanging ten times in his life; and he may well be a man whom it would be a great injustice and great harm to punish and ruin. (Essays: Of Vanity)

Because most psychotherapy in the 1950s was conducted by psychiatrists, the early writing on the subject refers to psychiatrist–patient communications. The first legal decision creating a privileged status for psychiatrist–patient communications was *Binder v Ruwell* [10]. This 1952 case was considered so important that the entire text of the opinion was published in the *Journal of the American Medical Association*, a most unusual occurrence. In *Binder v Ruwell*, the court spelled out the rationale for special protection of psychotherapeutic communications, contrasting the necessity for such protection with the lack of a similar rationale for medical treatments in general:

The ordinary physician seeks from his patient disclosure of facts relating to a particular malady, insofar as the information might aid him in ascertaining the subjective symptoms; the psychiatrist seeks to ascertain the cause of mental or emotional disturbances of a maladjusted patient. His sphere of inquiry necessarily covers every experience of the patient. He may be interested in knowing the experiences of childhood. That may weigh very heavily with him in determining the cause of the disturbance. He may be interested in the experience of the patient during puberty, during adolescence. In fact, what he seeks to do is to bring back to the conscious memory of the patient things forgotten but which lied dormant in the subconscious mind. He probes deeply, and it is necessary for him to get that information out of the mouth of his patient.

From the 1950s to the 1990s, based on the reasoning first set forth in *Binder v Ruwell*, an extensive literature of legal case law and commentary developed both in support of stringent protection for psychotherapeutic communications and in support of the differentiation of such communications from those that typically occur in other medical treatments. The immorality of disclosing the former type of information obtained in a context that supposedly guarantees complete confidentiality was well expressed by a California jurist: "...there is obviously something revolting about the spectacle of a psychotherapist testifying to a patient's confidences in a criminal action in which the patient is a defendant" [11].

In the early 1970s, following a decade of study, a committee of the US Supreme Court first proposed a specific privilege rule providing a privilege for psychotherapist–patient communications [12].

By the 1990s, legislatures in all 50 states had established some form of privilege for psychotherapeutic communications, but the federal courts were divided on the issue. *Jaffee v Redmond* settled the question of a federal privilege and did so decisively. The privilege announced by the US Supreme

Court in *Jaffee v Redmond* in 1996, like the attorney–client privilege, is an *absolute privilege*, meaning that it is not subject to case-by-case balancing by trial judges who might otherwise weigh the need for the evidence that the privilege excludes against the need of the justice system. By contrast, the executive privilege that protects confidential communications of the President of the United States is an example of a *qualified privilege*; that is, it is a privilege subject to case-by-case balancing by a judge. Thus, in *Jaffee v Redmond*, the US Supreme Court clearly signaled its intention that the psychotherapist–patient privilege must be as reliable and unequivocal as possible so as to promote an atmosphere of “confidence and trust” within the psychotherapeutic relationship.

Jaffee v Redmond also has symbolic significance that ultimately may overshadow its substantive implications. In an era when almost all observers agree that we have been facing a discouraging decline in our ability to maintain confidential treatment relationships, *Jaffee v Redmond* stands as a possible turning point in society’s willingness to support confidential psychotherapy. This is so because in the federal courts where the pursuit of truth through the examination of all available evidence is ordinarily a decisive value, privileges are generally looked upon with extreme disfavor. The fact that the US Supreme Court so strongly established the *Jaffee v Redmond* privilege therefore can be seen as an expression of a societal understanding that confidential psychotherapy is so important that other compelling considerations favoring disclosure should give way. Therefore, *Jaffee v Redmond* has ramifications beyond the Federal Rules of Evidence and the judicial proceedings in which *Jaffee v Redmond* now plays a concrete role.

To understand the significance of *Jaffee v Redmond*, it is important also to understand what it does not do [13]. For instance, *Jaffee v Redmond* does not have any direct legal effect on disclosures made under private arrangements, such as insurance contracts between insurers and patients, and *Jaffee v Redmond* does not directly affect disclosures that a psychotherapist makes pursuant to a patient’s consent. This is not to say, however, that the symbolic meaning of *Jaffee v Redmond* is without effect in such situations; it has been recognized by legal scholars for decades that privilege rules in fact do affect the arrangements that citizens make for their interactions outside the judicial system, and so *Jaffee v Redmond* affects the way we view nongovernmental and contractual disclosures [14].

The ethics codes of the psychiatric and medical professions strongly support an obligation of practitioners to abide by the law; however, difficult situations arise where legal and ethical obligations can be in tension or even in direct conflict. Sometimes, the legal system requires disclosures that may be considered unethical. Sometimes, the legal system expects disclosures when ethical obligations point toward confidentiality [15]. *Jaffee v Redmond* and the HIPAA rule, to some extent, reduce the conflicts between law and ethics. They are based, in part, on the law’s recognition of the ethical codes of professional groups. In turn, they now lend significant support to

a psychotherapist who would resolve ethical conflicts in the direction of protecting a patient's confidentiality.

Difficult conflicts

In the real world at present, certain conflicts between the technical requirements for the conduct of psychotherapy and the ethical and legal obligations of practitioners have no clear path to a resolution [15,16]. For example, some ethics codes urge the practitioner to disclose limits of confidentiality to the patient at the beginning of the treatment relationship, including, as an example, a legal obligation of the psychotherapist under state law to report credible evidence of child abuse. Ordinarily, a person given such a warning would then take the likelihood of a disclosure into consideration when deciding whether to disclose such incriminating information within the psychotherapeutic relationship. Taken literally, however, such a reporting requirement and the ethical obligation to abide by it could bring about a situation in which a patient who actually has been abused or has been an abuser cannot undertake psychotherapy for that problem without bringing into play the full force of the legal system intended to prevent or punish child abuse. Even more difficult to resolve is the situation of a patient in psychoanalysis—a treatment in which the basic technical rule states that the patient must not withhold any information from the analyst. How can such a treatment logically go forward after a patient has been handed a laundry list of matters, which if described to the analyst, will be reported to the authorities?

When a practitioner faces a situation in which a disclosure of confidential information is being requested or considered, a complicated set of legal, ethical, and practical considerations comes into play. To simplify the discussion here, we will consider separately those situations in which the patient agrees to a disclosure, and those situations in which a disclosure is sought or intended without the patient's consent. It is, of course, the latter situations in which *Jaffee v Redmond* and other privilege rules such as state statutes might come into play. The actual decision that a psychotherapist arrives at in any situation, however, is subject first and foremost to the ethical precepts of the professions.

When the patient consents

Patients frequently consent to disclosures of confidential information related to communications they have made to psychotherapists. Most notably, this situation arises in relation to third-party payment for the therapy itself. It may arise in other situations as well, such as in connection with applications for disability or life insurance, or for security clearances. Patients may also request (and hence consent to) the disclosure of information

by a psychotherapist in a court proceeding in which they believe the therapist's testimony might assist their case. Because each of these instances of possible disclosure would not be taking place against the patient's wishes, none of them are affected directly by *Jaffee v Redmond* or other privilege rules. The HIPAA rule also generally allows a patient to authorize release to third parties.

Usually, in the context of third-party payment, the permission to disclose is referred to as a "consent" or "authorization," whereas in the context of privilege rules, the permission to disclose is called a *waiver* of the privilege. When the patient voluntarily waives the privilege, the therapist has no legal basis to assert a privilege on the patient's behalf. By analogy, when the patient has consented to the disclosure of confidential communications to third-party payers, the psychotherapist usually has no legal or ethical basis on which to decline to make such a disclosure. In some jurisdictions, such a disclosure may actually be required (to support the patient's insurance claim), but in the District of Columbia, such a disclosure might be illegal, even with the patient's consent. Where a consented-to disclosure is contemplated, a psychotherapist has an ethical obligation to disclose only the minimum amount of information needed to satisfy the purpose of the request. The HIPAA rule also generally expects only the "minimum necessary" disclosure that achieves the purpose of the disclosure.

An important principle of privilege law is that a waiver of the privilege must not be *coerced*; that is, for a waiver to be valid it must be freely given. Thus, the mere fact that the patient's waiver or consent exists is not sufficient in and of itself to justify a disclosure. Where doubt exists in the psychiatrist's mind as to the "voluntary" nature of the waiver, an ethical duty exists to resist disclosure until such a doubt can be resolved. A recent example of this issue was the waiver of the psychotherapist–patient privilege by Monica Lewinsky in the course of her interrogation by the Independent Counsel investigating President Clinton. At least one senior federal court judge has raised the question of whether her therapist should have, without an examination of the subpoena by a federal court, provided testimony regarding her treatment when the waiver on which a subpoena was based might have been extracted from Ms. Lewinsky as part of a deal to keep her out of prison [17]. By analogy, the fact that a patient has signed an authorization for disclosure of information to a third party such as a third-party payer is not in itself sufficient to remove all questions of ethics when a psychiatrist makes such a disclosure. In many instances, it is clear that the patient would have no choice but to sign a blanket consent in order to receive treatment when, in fact, the disclosure of only a very limited subset of information may be necessary and ethical.

Finally, even when a patient has given a voluntary consent to a disclosure or a voluntary waiver of a privilege, situations can exist where a psychiatrist is of the opinion that the disclosure is not in the patient's best interest. This might occur, for example, where a patient may have an incomplete

understanding of the extent of the disclosures that might take place or of the possible consequences of such a disclosure. In such situations, an ethical psychiatrist should seek to avoid the disclosure and, in cases of doubt, should consult with professional colleagues and legal advisors prior to any release of confidential information.

In the context of psychotherapy, the issue of the validity of a general consent to disclosure signed in advance of the actual therapy is particularly troubling. Not only may a patient not understand what information would be disclosed as a result of the consent but it also may be that, at the time of the signing, the patient is not even aware of the nature of the information that could emerge during the psychotherapy. In ruling that such consents do not justify disclosure of all records of Medicaid patients to a state auditor, one well-known court ruling [18] put it this way:

It would be unreasonable to hold that an indigent patient who signs a form stating that a provider may release certain medical records to the State exercises a knowing waiver of his interest in not having his most personal confidences to the psychiatrist disclosed. It is far more likely that, if he reads the form at all, a patient would assume that the records would include only billing information and similar non-confidential matters.

When the patient does not consent

A disclosure of confidential information without the consent of a patient should be viewed as a most serious matter. In some instances, such a disclosure may be required by law, whereas in other situations, it may be motivated by an ethical duty or an attempt to avoid liability.

In the courts, information created as the result of a psychotherapeutic encounter is generally protected from compelled disclosure by state privilege statutes and, in the federal courts, by *Jaffee v Redmond*. In state courts, information that falls outside the specific protection of psychotherapist–patient privilege may be protected by physician–patient privilege statutes. HIPAA provides additional protections (discussed further below) against release in litigation of medical records. These safeguards, taken together, mean that subpoenas and other requests for information should not result in disclosure of confidential information unless the patient has affirmatively declined to exercise the *Jaffee v Redmond* or other applicable privilege. Furthermore, it is an ethical responsibility and, in some jurisdictions, a legal requirement that the psychiatrist assert the privilege on the patient's behalf in case of the patient's absence or incapacity.

Some disclosures are required by law without regard to the patient's wishes. For instance, physicians are required to report to authorities certain communicable diseases and gunshot wounds. In addition, every state now requires physicians and certain other professionals to report child abuse and, in some states, to report elder abuse. Failure to obey such laws can lead to legal action against the physician, including professional disciplinary

proceedings. To the extent that such laws legitimately protect society, they are in consonance with ethical principles. On the other hand, there are situations in which a psychotherapist believes that the making of such a report, with the predictable consequences of intervention by the authorities, would do more harm than good. In such a situation, the law might be viewed as “unjust” if, in fact, it fails to take account of the particular circumstances. Although failure to make a report in such a case could involve a violation of the law, the psychotherapist might decide that withholding a report is the most ethical choice. Some professional groups have advised their members that professional judgment is the best guide in such circumstances even when the decision to violate the law might expose the professional to legal consequences. In the words of the code of ethics of the American Medical Association, “ethical values and legal principles are usually closely related, but ethical obligations typically exceed legal duties.... In exceptional circumstances of unjust laws, ethical responsibilities should supercede legal obligations” [19].

Similarly, the code of ethics of the American Psychiatric Association reads, “when the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, to unimpaired treatment, should be given priority” [20].

Finally, the ethical obligation to protect third parties from a patient’s intent to harm them may arise in situations where the patient’s threat is credible, specific, and imminent. Issuing such a warning without the patient’s consent would constitute a violation of the confidential relationship but, at the same time, could be the most ethical course of action. In addition, although in many states the psychiatrist is not required by law to issue a warning, he may nevertheless be liable to an injured third party as the result of a failure to do so. In the best-known legal decision on this subject, the California Supreme Court held in the Tarasoff case that a duty to protect an endangered third party might exist under some circumstances, and the failure to carry out that duty could create a liability (ie, exposure to being sued) [6].

Before such a warning is issued, professional ethics dictates that the therapist first seek to involve the patient in the process of protecting an intended victim rather than acting against the patient’s wishes. If the patient’s consent or cooperation cannot be obtained, then the psychiatrist who chooses to take protective steps should disclose only the minimum and specific information necessary to comply with the law. The patient’s entire record should not be released.

Even following such a disclosure, in some states the patient’s confidential communications to the psychiatrist may continue to be privileged; that is, information in the possession of the psychotherapist cannot be forced to be disclosed or used against the patient in a subsequent legal proceeding simply because some or all of the information was disclosed earlier for a different purpose. Because the *Jaffee v Redmond* privilege is so recent, the question of the status of the privilege in a case after a “Tarasoff-type” warning is unsettled for the federal courts [21–23]. The new HIPAA rule suggests that

disclosure, if it occurs, may be subject to a protective order. This order would prohibit the parties in state or federal court from using or disclosing the records for any purpose other than the litigation. It also requires the return or destruction of the records at the end of the litigation [Section 512(e)]. More generally, although the disclosure of confidential information may constitute a waiver of the privilege, the rules governing such situations (so called “waiver doctrine”) vary within and among jurisdictions.

The HIPAA privacy rule

The HIPAA of 1996 recognized that stronger confidentiality protections are an essential part of the transition to electronic management of medical information. The medical privacy rule was announced by President Clinton in December 2000 [8]. President Bush reaffirmed in April 2001 that the rule would take effect, and compliance is now scheduled for April 2003, although some changes may occur before that time. The rule is notable for providing national standards for medical confidentiality for personal health information, with stricter protections for psychotherapy notes.

Explaining the details of the HIPAA privacy rule is beyond the scope of this article. For therapists, the general provisions apply to all electronic, written, and oral communications identified by patient. The ethical and legal restraints on disclosure of confidential information that existed before HIPAA remain in effect. The HIPAA rule adds a layer of protection by making certain disclosures illegal for the first time. In doing so, the rule provides a more complete legal basis for adherence to ethical principles by psychotherapists.

One notable feature of the rule is that it singles out “psychotherapy notes” for special stringent protection. As explained in the rule’s preamble [8],

Generally, we have not treated sensitive information differently from other protected health information; however, we have provided additional protections for psychotherapy notes because of *Jaffee v Redmond* and the unique role of this type of information.

The definition of psychotherapy notes [8] provides,

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record.

Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

For information covered by this definition, especially strict rules apply. For instance, psychotherapy notes cannot legally be disclosed based on a

general consent signed in advance of the psychotherapy. Instead, disclosure would require a more specific and limited authorization spelling out the information to be released, to whom, and for what purpose. Importantly, no third-party payer can condition enrollment in a health plan or payment of a claim on a patient's agreement to sign such an authorization. This limit for psychotherapy notes on release for payment is thus stricter than the general HIPAA rule, which permits disclosure without authorization for purposes of treatment, payment, or health care operations.

As HIPAA is implemented, therapists will need advice from their professional organization on how best to manage confidential information in this unfamiliar new world. Some topics will involve management and ethical issues. For instance, how will therapists assure that the correct records are separated from the rest of the medical record in order to qualify for the stricter psychotherapy-notes protections? How will demands from insurance companies to prevent these records from being kept separate be reconciled with the ethical requirement of confidentiality? Other topics may require legal clarification, perhaps from the Department of Health and Human Services or from legal counsel. For instance, when and how can therapists share information with others on a treatment team? What is the scope of the various terms that are excluded from the definition, so that the stricter protections do not apply?

It is not surprising to have uncertainty as a major new rule goes into effect. Despite uncertainty as to the details, however, the HIPAA privacy rule combined with the effect of *Jaffee v Redmond* provides an unprecedented set of legal protections to reinforce the ethical precepts underlying the protection of the confidentiality of psychotherapy communications.

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