CONFIDENTIALITY – Death of Patient

written by Richard Leslie | September 30, 2021

Avoiding Liability Bulletin – October 2021

NOTE: This article was first published on the CPH Insurance's website in April 2016, prior to the Covid-19 pandemic. It appears below with minor changes. I thought it might be appropriate to republish at this time.

CONFIDENTIALITY – Death of Patient

While thankfully not an everyday occurrence, it is not a rarity that a patient unexpectedly dies during the course of treatment or shortly after termination. Death may result from natural causes, from a long standing illness, from an auto or other accident, from a criminal act, from Covid-19 or one of its variants, or from an unexpected suicide. The sadness of such situations is obvious, and the loss will likely affect the therapist's psyche and provoke a variety of thoughts. Very quickly, however, the therapist's thoughts may (or should) turn to the issue of confidentiality.

One or more family members, or a spouse or partner may be aware of the fact that the deceased was in treatment with the practitioner and may make inquiry. If the death is of a suspicious nature, the police or other investigators will likely inquire. The county coroner or medical examiner may contact the mental health practitioner in an effort to determine the cause of death. Or, the practitioner may fear that someone close to the patient will assert that the practitioner failed to recognize the danger that the patient was in immediately prior to the time of a suicide. While no one rule will govern every situation that may occur, there is one legal principle that will help in most situations – that is, the principle, recognized in most state laws, that the duty of confidentiality survives the death of the patient.

The first instinct that mental health practitioners should have when someone is seeking information or records concerning a patient, former patient, or deceased patient, is to respectfully resist. The instinct to resist will help to prevent a technical, inadvertent, or negligent release of confidential information – as when a therapist may be trying to console a grieving spouse or family member, or to convince someone that competent and appropriate treatment was rendered. Resistance can change to compliance when there is a proper authorization presented, *signed by someone with authority to sign*, or when the practitioner knows or learns that compliance is required or permitted (without a signed authorization) under applicable law.

NOTE: The following article was first published on the CPH Insurance's website in April 2014. It appears below with minor changes. Its re-publication was prompted by questions raised by practitioners who were shifting their practices between sessions held via telehealth and

in-person sessions as a result of the ever evolving Covid 19 (and its variants) pandemic.

FEES

Under what circumstances is it appropriate to raise a patient's fee during the course of therapy? Does raising one's fee during the course of therapy raise the issue of exploitation? Is there a limit to the size of the increase? Is a twenty-five percent increase ethically permissible?

While there may be a law or regulation somewhere that addresses this issue, I am not aware of any that directly addresses the raising of a patient's fee during the course of therapy. In short, I would argue that raising one's fee during the course of therapy does *raise the issue* of exploitation. A therapist or counselor might seek to raise his or her fee for a variety of reasons. Some argue that raising the fee of an existing patient should be viewed as exploitation because the patient or client came in with an understanding of the fee, and then, just when the patient became reliant upon the practitioner, the practitioner raised the fee. Patients may justifiably feel exploited – especially if not informed of the possibility of raises, or the limitations to raises (e.g., as to frequency or percentage), in the disclosures made to patients prior to the commencement of treatment.

Ethical standards of professional associations may not address the issue directly, or at all, because of their sensitivities to antitrust concerns. Those that address the issue are likely to require disclosure to the patient concerning the possibility of future increases and/or prior reasonable notice of an increase. Generally, laws, regulations, or codes of ethics will require that the practitioner disclose, prior to the commencement of treatment, the fee to be charged for the services to be rendered or the basis upon which the fee will be computed or determined. If a practitioner wants to reserve the right to raise fees during the course of therapy, assuming there is no statutory or ethical prohibition against such action, that fact should be disclosed to the patient, in writing, prior to the commencement of treatment. Other information might also be considered for inclusion, such as the frequency or number of raises possible, the percentage of any possible increase, and the amount of prior notice to be given of a proposed increase.

Because of the potential for allegations of exploitation, and in order to avoid the drafting of a complex disclosure statement regarding this issue, it might be easiest and safest to raise fees for new patients and to continue to see existing patients at the fee that is established at the outset of their treatment. Of course, the practitioner is free to implement policies around fees as he or she deems appropriate – provided that no law, regulation, or ethical code provision is violated. With respect to the twenty-five percent increase question posed above, practitioners should carefully consider whether such an increase could be considered to constitute exploitation under the circumstances, or whether it would be considered as reasonable and fair by the patient, by an ethics committee, or by the state licensing board.

PSYCHOTHERAPY: STIGMA and REGULATION (Some Thoughts to Ponder)

What is “psychotherapy”? According to one author, who wrote a scholarly four volume work which advocated for no governmental regulation of psychotherapy, his definition was that psychotherapy was “an unidentified technique applied to unspecified circumstances with unpredictable outcomes, requiring rigorous training.” He advocated that government should not regulate an activity that cannot be adequately defined. In another scholarly article, it was said that “psychotherapy is a complex, multi-layered process with the potential to bring about changes at multiple levels of functioning, from the neurobiology of the brain to the individual’s role in the social world.”

The licensing law for psychologists (in California), defines psychotherapy as “the use of psychological methods in a professional relationship to assist a person or persons to acquire greater human effectiveness, or to modify feelings, conditions, attitudes, and behaviors that are emotionally, intellectually, or socially ineffectual or maladaptive.” There are more definitions of “psychotherapy” that can be and have been offered – both in articles and in state laws. Consistent with these broad definitions of “psychotherapy,” the matters and problems addressed by psychotherapists with their patients or clients is seemingly limitless. The delivery of psychotherapy services via telehealth has significantly increased, perhaps multiplied, as a result of the Covid-19 pandemic, and it is likely to continue to expand in the coming years, attracting first time consumers of psychotherapy services.

It is widely acknowledged that many people across the social spectrum do not seek help because of the stigma attached to psychotherapy and mental health treatment. Governments and non-governmental organizations continue to strive for the elimination or reduction of the stigma that attaches to psychotherapy/mental health services. With this in mind, it is important to pay attention to *the manner and degree of government regulation* now imposed (or that may be imposed) by state regulators related to psychotherapy services rendered via telehealth. When reading some of the regulatory provisions in existence or those being proposed (in several states, including Ohio!), it seems that a telehealth session between every consumer/client and every psychotherapist (under limitless facts and circumstances) is portrayed to be of such magnitude, danger or intensity as to be something to be feared – rather than to be seen as simply another routine session.

These kinds of regulations may well contribute to the stigma that attaches to psychotherapy services, especially those rendered via telehealth. Telehealth services are increasingly being rendered and received by more technologically aware consumers and practitioners. Licensed practitioners in all states are already required, by law or regulation, to provide services within the scope of their competence – whether the services are provided in person, via telehealth, or via equestrian experiences. States should not, and need not, regulate exactly how each telehealth encounter with each client is to be performed. What about the telehealth laws and regulations, if any, in your state of practice?