# Confidentiality – Seeking Patient Referrals via Social Media

written by Richard Leslie | January 2, 2019

**Avoiding Liability Bulletin – January 2019**

Suppose that a mental health practitioner is active on a popular social media site or other communication sites/networks involving colleagues (other licensed mental health practitioners) and others who are not licensed health care practitioners. Suppose further that a participating psychotherapist posts a request for a referral recommendation from another practitioner, and in doing so reveals enough information about the person or patient to be referred that the identity of that person or patient may be unintentionally revealed or that suspicions may be raised among family, friends, or others. Or, suppose that a psychotherapist posts on a popular social media site his or her desire to obtain a consultation with another mental health practitioner and in doing so, describes the patient or patient's issues with an abundance of detail? These scenarios assume that the name of the patient is not disclosed.

I create these scenarios because a reader expressed concerns that he/she was seeing an increased number of requests for referrals to psychotherapists on a social media site that gave an abundance of detail about the patient and the patient's issues. I was rather surprised that the examples cited from a well-known and widely used social media site were quite so detailed about the patient to be referred. Moreover, I was surprised to learn that a licensed mental health professional would solicit such referrals from other practitioners on a site that was also accessed by the general public – that is, by those who were not licensed mental health or medical professionals. My first thought was that there must be better ways to obtain one or more referrals to other practitioners for a particular patient and a particular set of issues than to post something on a site such as, but limited to, Facebook.

Practitioners must always be aware of the duty of confidentiality and must be certain that they are not revealing enough information about a particular patient such that the identity of the patient might be accidentally (or negligently) revealed to others, including family or friends. Merely because a name is not mentioned does not assure that a breach of confidentiality will not occur. It is possible that the patient may become aware of the information posted and might be upset or concerned with the detail given. If a therapist was to obtain a carefully crafted signed authorization from a patient that authorized a detailed request for referrals on a publicly accessed site, then the disclosures made would not constitute a breach of

confidentiality. But I would think that patients who are seeking a referral to another practitioner or to a “specialist” of some kind would not react well if asked – “do you mind if I look for a referral for you on the social media site I frequent with many of my colleagues and with members of the general public?”

Suppose a practitioner wants to disregard the above and nevertheless seek a referral to another practitioner by posting something on a social media site. The practitioner should first ponder whether the facts to be revealed are really relevant to obtaining names of other licensees that would make for appropriate referrals. Does it really matter that the client is in his forties, or that the client is a recently divorced dentist whose spouse just left him for the grocery store butcher? Is there another way to seek an appropriate referral without giving unnecessary detail? Of course, if there is appropriate masking that does not change the clinical significance of the information being revealed, masking some or most of the details would be wise. But I nevertheless ask – are the details really necessary? Perhaps it is better to leave the details for the client to explore with the subsequent practitioner.

If the social media group were limited to licensed psychotherapists, for example, and if referrals were sought, it would be less risky to disclose details about the person and the issues involved. Generally (each state’s laws will vary in some degree or in fine nuance), one of the most important exceptions to confidentiality is where a disclosure of confidential information is made to another licensed health care provider for the purpose of diagnosis or treatment of the patient. The disclosures made to other licensed health care professionals would seemingly be for the purpose of obtaining treatment for the patient and would seem to be included within this broad exception to confidentiality (where a signed authorization to disclose is not required). Nevertheless, it is my impression that there are better ways for referring practitioners to make appropriate referrals. There is an expectation in the various mental health professions, either express or implied, that practitioners are knowledgeable about culturally and clinically appropriate referral resources.

I have previously encountered this issue in situations where a practitioner makes a presentation (at a workshop or seminar) to other professionals about the treatment of a particular patient – without using a name, but with an abundance of non-masked detail about the patient. In such situations, another attendee may express some ethical concerns at the degree of detail provided, or may even have a reasonable suspicion of who is being described. I have also encountered this issue when someone writes a paper or a book that similarly gives details about a patient previously treated. What if

the patient discovers that the paper or book was written about him/her without prior authorization or consent? Will the fact that a name was not disclosed protect the writer? Did the therapist/writer exploit the patient's information for his or her own economic gain, and if so, does the patient have reasonable grounds to pursue legal action or to file a complaint?

**REFERRALS**

Are you aware of any law, regulation, or ethical code provision in your state of licensure and in your profession that clearly defines what is expected when one practitioner refers a patient to one or more other practitioners? Why do so many therapists talk about the need to make three referrals? What liability, if any, does a therapist have for negligently making a referral? Is there a duty, or should there be a duty, for the referring therapist to either check with the licensing board or suggest that the patient check with the board in order to see if the practitioner to whom the patient is referred has been the subject of disciplinary action? Is the referring therapist ever under a duty to check with the former patient to see if the referral was acted upon by the patient or that treatment is continuing? Rather than referring to a named practitioner, is it appropriate to refer the patient to a professional association's or other referral service? These are but some of the many questions that may arise when the practitioner is faced with the need or desire to make a referral to one or more other practitioners.

One of the times that mental health practitioners will need to make a referral is when they discover that the patient they are treating requires the expertise or specialized competence of another practitioner. Not all therapists and counselors are competent to treat all patients and all disorders – so practitioners must be sure that they make a referral when their competency is challenged. Some provisions of ethical standards delineate the circumstances when the need for a referral arises (such as, but not limited to, as described immediately above or when a conflict arises), and other provisions may in a broad or general way provide some guidance regarding the ethical obligation(s) when making a referral.

One ethical standard says that when making a referral, the practitioner should take appropriate steps to facilitate an orderly transfer of responsibility. Another ethical standard, when warning against the abandonment of patients, says that if a therapist is unwilling or unable to continue to provide professional services, the therapist will assist the patient in making clinically appropriate arrangements for continuation

of treatment. Another standard says that when practitioners refer clients to other practitioners, they insure that appropriate clinical and administrative processes are completed and that open communication is maintained with both clients and practitioners. These standards seem to this writer to be vague and subject to various interpretations – which could affect enforceability. Of course, not all ethical standards are intended for enforcement – some may be intended as mere suggestions or as guidelines, even aspirations.

None of the standards mentioned above define the particular actions that must be taken in a particular case or situation, nor, I argue, should they. What are the appropriate steps? What constitutes clinically appropriate arrangements? What are appropriate clinical and administrative processes? Unless there is a law or regulation that is applicable, the action(s) that must or should be taken in each situation is left to the sound clinical judgment of the practitioner. Thus, when answering the questions asked above, and many others (as I may do in future articles), the answers necessarily depend upon the particular facts and circumstances involved, including the interpretations of applicable ethical standards, guidelines, laws, or regulations.