Digital Commons
@ LMU and LLS

Loyola Marymount University and Loyola Law School
Digital Commons at Loyola Marymount University and Loyola Law School

Loyola of Los Angeles Law Review

Law Reviews

6-1-1996

The Case of the Confidential Confession: Psychiatry

Daniel W. Shuman

Recommended Citation
Daniel W. Shuman, *The Case of the Confidential Confession: Psychiatry*, 29 Loy. L.A. L. Rev. 1717 (1996).
Available at: https://digitalcommons.lmu.edu/llr/vol29/iss4/32

This Symposium is brought to you for free and open access by the Law Reviews at Digital Commons @ Loyola Marymount University and Loyola Law School. It has been accepted for inclusion in Loyola of Los Angeles Law Review by an authorized administrator of Digital Commons@Loyola Marymount University and Loyola Law School. For more information, please contact digitalcommons@lmu.edu.

THE CASE OF THE CONFIDENTIAL CONFESSION: PSYCHIATRY

*Daniel W. Shuman**

The law, medicine, and theology trilogy uniting these Essays, addressing the ethical response to information a professional gains in confidence about a wrongful conviction and an impending execution, raises an overarching question: How does the role of a professional affect our ethical duties as members of society? Likely, few would seriously argue that if the same disclosure about an impending wrongful execution were made to a friend wearing no professional garb that we would find an ethical duty to prevent the friend from disclosing a confidence, rather than an ethical duty compelling the friend to come forward to avoid the wrongful execution. Does the role of a professional displace personal moral standards? Implicit in the problem is the assumption that professionals should act differently.

Attempts to articulate a profession's sense of its unique ethical responsibilities are contained, in part, in its ethical code. Psychiatric ethics draw from the field of medical ethics.[1] Medical codes of ethics, however, have never contemplated an absolute duty of confidentiality. For example, the oath attributed to the fourth-century B.C.E. physician Hippocrates obliges physicians to keep confidential only those things that ought to be kept confidential, without elaborating on what those may be: "Whatsoever in the course of practice I see or hear (or even outside of my practice in social intercourse) *that ought never to be published abroad*, I will not divulge, but consider such things to be holy secrets."[2] The historical context in which this ambiguous pledge of confidentiality arose raises serious questions about the concerns intended to guide this implementation of professional secrecy. Hippocrates was associated with the mainstream

---

* Professor of Law, Southern Methodist University School of Law, Dallas, Texas.
The author gratefully acknowledges a grant from the M.D. Anderson Foundation that supported preparation of this Essay.

1. CHAUNCEY D. LEAKE, PERCIVAL'S MEDICAL ETHICS 287 (1927).
2. *Id.* at 214 (emphasis added).

of the Pythagorean school of thought, which sought to limit public dissemination of its knowledge, apparently for anticompetitive reasons. Moreover, the communal character of life in the fourth century B.C.E. permitting an audience of the sick person's friends and relatives during treatment, belies the notion of confidentiality as a normative concept in medicine.

By the time of the Hippocratic Oath's incorporation into the 1847 *Code of Ethics of the American Medical Association*, the physician's duty of confidentiality and its limitations remained similarly nonabsolute and ambiguous: "Secrecy and delicacy, *when required by peculiar circumstances*, should be strictly observed—and the familiar and confidential intercourse to which physicians are admitted in their professional visits, should be used with discretion, and with the most scrupulous regard to fidelity and honor."[3] The current nonabsolute codification of this duty of confidentiality now reads: "A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law."[4] Although acknowledging that the scope of confidentiality requires balancing a variety of interests, the current code provides no specific ethical guidance for resolving the instant case. The obligation to respect the patient's rights does little to inform the physician about his or her ethical obligation beyond telling a physician to obey the law. The "constraints of the law" escape clause refers to such things as the statutory duty to report child abuse[5] and the judge-made tort law duty, in cases like *Tarasoff v. Regents of the University of California*,[6] to disclose patient confidences when necessary to protect third parties from patients. While there is no existing legal duty to breach confidentiality to report past crimes or to avoid executions of the innocent, we might craft a persuasive argument supporting a legal duty to breach confidentiality in order to protect against executions of the innocent that is as compelling as the legal duties to breach confidentiality to protect against child abuse or patient violence. However, that would be a legal solution, not an ethical one.

---

3. *Id.* at 219-20 (emphasis added).

4. AMERICAN PSYCHIATRIC ASS'N, THE PRINCIPLES OF MEDICAL ETHICS: WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY (1993).

5. Daniel W. Shuman, *The Duty of the State to Rescue the Vulnerable in the United States*, *in* THE JURISPRUDENCE OF AID 131 (Michael A. Menlowe & Alexander McCall Smith eds., 1993).

6. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

Ethics are systems for making moral decisions; laws are systems for setting enforceable, socially acceptable minimal levels of conduct. The pervasiveness of law in our post-modern American culture creates a tendency to view law as setting the outer boundaries for decisionmaking, thereby rendering ethics inconsequential. This perception undermines the importance of moral choice in decisionmaking, a point underscored by the decision to focus these Essays on ethical rather than legal solutions. Thus, to address the appropriate ethical balance in this case requires that we consider why psychiatrists claim they are ethically constrained to keep the confidences of their patients, and whether that consideration should be important enough to avoid nondisclosure of a confidence that would apparently avoid the execution of an innocent man.

Consequentialist and deontological rationales provide support for the confidentiality of psychiatrist-patient communications. The consequentialist rationale posits that because of the sensitivity of the problems for which people seek mental health care, confidentiality is essential to encourage people with mental or emotional problems to seek out therapists; to make candid disclosures which are necessary for effective treatment; and to avoid disruption of the treatment relationship. While superficially compelling, one difficulty with this rationale is that its support in empirical research is equivocal, at best.[7] Natural experiments provide evidence of the problem of proving that an assurance of confidentiality is essential for successful therapeutic outcomes. For example, although patients state, when asked, that confidentiality is important to them, there is no evidence of differences in the number of patients seeking treatment or its outcome following highly publicized revelations of the limitations on confidentiality, such as the decision in *Tarasoff* obligating therapists to breach confidentiality to protect individuals endangered by their patients.[8] While it may be sensible in general for psychotherapists to keep psychotherapist-patient discussions confidential, the risk of disclosure does not demonstrably affect the therapeutic decisions of most patients or prospective patients.

Moreover, the assertion that confidentiality is necessary for effective treatment by psychotherapists relies on an uncritical

---

7. DANIEL W. SHUMAN & MYRON F. WEINER, THE PSYCHOTHERAPIST-PATIENT PRIVILEGE: A CRITICAL EXAMINATION 77-113 (1987).

8. Toni Pryor Wise, Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of* Tarasoff, 31 STAN. L. REV. 165, 165 (1978).

assumption about the efficacy of psychotherapy. Even if confidentiality is necessary, it may not be sufficient for effective psychotherapy. Psychotherapy does not work for all. For example, antisocial personality disorders, characterized by a "pattern of disregard for, and violation of, the rights of others"[9]—not surprisingly, a mental disorder commonly diagnosed in the criminal population,[10] and the only clue we have about the mental disorder that resulted in the patient seeking therapy in this case—are not receptive to psychotherapy.[11] Thus, it is not clear whether in this instance a potential therapeutic benefit can be gained through recognition of a duty of confidentiality for this patient or the class of persons he represents.

The deontological rationale for keeping patient confidences between therapist and patient is that a democratic society should recognize the dignity of the individual by protecting these intimate communications from compelled disclosure. This rationale for confidentiality posits that compelled disclosure of confidential communications is wrong in and of itself without regard to its consequences. While there is a Kantian argument to be made in favor of an absolute duty of confidentiality, few proponents of the importance of confidentiality for its own sake argue for an absolute duty of confidentiality.[12] Most recognize that some things are more important than keeping confidences, although they differ on what these things are.

The rationale for disclosure of this confidence seems, at first blush, almost too obvious to require elaboration. It is important to avoid executing the innocent both to avoid the wrongful loss of life and to achieve just results in the criminal justice system. Our sense of humanity and fairness, as well as Kafkaesque fears of our own wrongful conviction, make this the ultimate measure of the workings of the criminal justice system. Therefore, any information that helps to avoid this wrong should be disclosed, without regard to the professional context in which it was acquired. This argument posits that psychotherapists, like all other members of society, bear an ethical obligation to disclose confidences that would avoid a wrongful

---

9. AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 645 (4th ed. 1994).

10. *See* Al C. Edwards et al., *Prison Inmates with a History of Inpatient Psychiatric Treatment*, 45 HOSP. & COMMUNITY PSYCHIATRY 172 (1994).

11. *See* Foucha v. Louisiana, 504 U.S. 71, 75 (1992).

12. *See, e.g.*, William J. Winslade & Judith Wilson Ross, *Privacy, Confidentiality, and Autonomy in Psychotherapy*, 64 NEB. L. REV. 578, 630-31 (1985).

loss of life. Yet, there is a risk of making too much of this argument in favor of disclosure, both in terms of the historical accuracy of disclosure in therapy and of the willingness of courts to give much weight to this disclosure at this time.

Therapists do not seek historical truth in therapy. The question for most psychotherapeutic techniques is how a patient perceives or feels about the world that is real to that patient—not historical truth.[13] Even for those therapeutic techniques that involve confrontation and challenge of a patient's conceptions of events, therapists rarely conduct factual investigations to verify patient claims in therapy. Indeed, trying to do so by contacting third parties may frustrate therapy. Moreover, courts and clinicians are now struggling with the extent to which certain therapeutic techniques actually taint memories.[14] Thus, it is naive to accept at face value the historical accuracy of the disclosure to the psychiatrist in this case.

Even if the psychiatrist were to disclose the confidential communication, it is not clear that the courts would now receive evidence of this disclosure in a collateral attack on the conviction, even one addressing innocence.[15] Finality, no less so than accuracy, is an essential element of any system for resolving disputes. Ultimately, we must be able to act on judicial decisions with confidence, not only in their correctness, but also in their finality. The conviction may not be overturned, and the execution may proceed, even if the confidential communication is disclosed, because of a prioritization of rules that recognize the importance of finality.

Thus, while the rationale for absolute confidentiality is not compelling, neither is the rationale for disclosure. It is not clear that a breach of confidentiality will lead to the death of effective therapy or avoid the death of an innocent man. Requiring the psychiatrist to choose unilaterally whether to disclose is ultimately unsatisfying.

A unilateral decision by the therapist simultaneously vests the therapist with more power than she wishes and divests the patient of more power than he wishes. Thus, it is the least-desired approach. Because the revelation of this exculpatory evidence was made to the psychiatrist in therapy, and because disclosure is affected by a duty of

---

13. *See* Marianne Wesson, *Historical Truth, Narrative Truth, and Expert Testimony*, 60 WASH. L. REV. 331, 334 (1985).

14. Bruce D. Sales et al., *In a Dim Light: Admissibility of Child Sexual Abuse Memories*, 8 APPLIED COGNITIVE PSYCHOL. 399, 400 (1994).

15. *See* Herrera v. Collins, 506 U.S. 390, 400-04 (1993).

confidentiality thought to be important for therapy, addressing this issue in therapy is a logical starting point. This approach might begin with the therapist inquiring why the disclosure was made. If the admission was made because the patient was troubled by his role in the impending execution of an innocent man and is seeking guidance on what to do about that, an ethically omniscient therapist may address the patient's feelings of guilt and responsibility in therapy. One possible outcome of exploring this issue is both therapeutic and ethical. The patient may come to realize that he would not be able to live with himself if the execution were to proceed and may independently decide to disclose the communication or waive the psychiatrist's ethical duty of confidentiality so that the psychiatrist may disclose this evidence. Alternatively, addressing the issue in therapy may leave the psychiatrist less certain that the patient actually committed the murder and more inclined to think that the confession resulted from guilt about his own criminal past or a desire to impress or challenge the psychiatrist. Or, perhaps not.

This is a tale best left unfinished. While some ethical issues, like the propriety of a therapist's sexual relationship with a patient, have bright-line answers that should not vary from case to case, others, like the disclosure of patient confidences concerning the guilt or innocence of third persons, are case specific. Concrete ethical rules that provide absolute answers to controversies like this one may assuage our desire for certainty but ignore the nature of the therapist-patient relationship. Maximizing congruent therapeutic and ethical outcomes requires carefully balancing competing and conflicting concerns that certainty may frustrate.[16] If mental health professionals acting in their professional capacity have ethical duties that vary from those of other members of the populace, they arise from the unique skills we assume that they possess and the unique conflicts that they are required to address. Imposing one-size-fits-all solutions to these controversies fails to acknowledge these unique skills and conflicts.

---

16. *See* ROBERT A. BURT, TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS vi (1979).