

Virtual Mentor

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ETHICS CASE

Special Protections for Mental Health Treatment Notes

Commentary by Anthony P. Weiss, MD, MBA

Dr. Kessler is a psychiatrist at Parks Medical Associates, a large multispecialty medical practice with more than 60 physicians. Dr. Kessler has had an interest in health information technology since he was an undergraduate majoring in computer science. Over the past year, he has been managing his group's transition from paper charts to an electronic medical record (EMR) system. He believes that the system will produce more efficient and coordinated patient care by giving clinicians seamless access to patient medical records, thereby leading to better patient health outcomes and overall cost savings for the practice.

Given the sensitive nature of psychiatry visits, Dr. Kessler proposes the use of a firewall as an additional safeguard to ensure the confidentiality of patients' mental health records. This firewall prevents employees who are not mental health clinicians from accessing psychiatry notes.

When Dr. Kessler presents this proposal at a meeting with senior members of the practice, several physicians raise their concerns. Dr. Liu, an internist, asks, "How will I be able to monitor my patients' depression or alcohol treatment if I can't read the psychiatrist's notes?" Dr. O'Leary, a gynecologist, wonders, "Aren't we perpetuating the stigma surrounding mental illness by creating special protections?"

Commentary

The development of electronic methods for documenting and sharing medical information in the health record has raised a number of new ethical challenges and given new life to some old ones. This case highlights an important issue: how to handle the documentation of mental health care so that patient wishes for confidentiality are balanced with the need for interdisciplinary communication and care coordination.

For the purposes of this discussion I will put aside many of the other complexities associated with the privacy and confidentiality of mental health information, such as situations where clinicians are *obligated* to breach confidentiality to protect the safety of the patient or other members of society (e.g., homicidal threats, evidence of child abuse or neglect, statements of imminent suicidal intent) and other situations in which the notes are barred from view by anyone but the author (i.e., psychotherapy process notes). I will confine the discussion to the sharing of information within a specific practice, inasmuch as state laws differ in their restrictions on the communication of mental health information to an outside entity. This latter point is

becoming increasingly difficult to ignore as the boundaries of information access become blurred with the advent of health information exchanges.

Even with these issues conveniently out of the way, the matter at hand is ethically challenging. On one hand we have the important emphasis on confidentiality, the expectation that information provided by a patient to his or her physician will not be shared without the patient's permission. The ethical basis for confidentiality is said to be the principle of respect for patient autonomy. One could also argue that confidentiality is critical for beneficence, since, without a guarantee of confidentiality, the patient will be reticent about sharing important information, and the physician's capacity to accurately diagnose and treat him or her would be compromised. For example, a patient who lacks trust in the confidentiality of the physician encounter may not disclose that his or her symptoms of anxiety began after a sexual assault, thus impeding the physician's ability to diagnose and effectively treat posttraumatic stress disorder.

As described in the case, societal stigma related to mental illness plays an important role in this discussion. Stigma and shame about mental health diagnoses often inhibits patients from disclosing relevant information to their physicians or seeking help from mental health specialists. And when they do share this type of information, patients desire greater levels of confidentiality. Paradoxically however, the methods used to ensure this confidentiality ("hiding" notes) could perpetuate the stigma associated with these conditions, as it suggests that this "shameful" information, somehow distinct from medical care, should be kept in a corner. Thus, a cycle of stigma is continued.

There may also be important safety risks associated with cordoning off the mental health aspects of the care provided. The principle of respect for autonomy may need to be balanced by the principle of nonmaleficence. A psychiatric consultation that elicits important risk factors for suicide may be of great value to a primary care physician's determination of risk when considering prescribing varenicline or in a neurologist's prescribing an anticonvulsant—medications that may exacerbate risks of self-harm in a vulnerable person. Furthermore, some psychotropic medications, such as the atypical antipsychotics, raise the risk of metabolic syndrome and require close medical monitoring and care coordination. When there is a culture of secrecy around everything pertaining to mental health, and psychiatry notes are not viewable, collaborative activities between physicians become far more difficult.

Two solutions to this situation attempt to take a middle road. One approach leaves the decision to suppress mental health notes to the patient—akin to an informed consent process. Although patient-centered and thoughtful, this resolution can cause problems if the patient wishes to suppress the note but the psychiatrist believes the information should be viewable due to concerns about harm to the patient from poor care coordination.

A second approach allows some information to be viewable to all (e.g., psychotropic medications in the medications list) but the remaining content of the psychiatric note is secured behind a “firewall.” This has the benefit of protecting the information that may be of greatest concern to the patient, but often creates a guessing game for clinicians who, based on the few clues available in the record, attempt to deduce the diagnosis. This approach also requires authorizing a growing number of clinicians (especially those working in emergency settings) to be able to “break the glass” to read the otherwise suppressed notes. In the end there may be a false sense of security, as ultimately several hundred clinicians within the organization may have legitimate access to a note that the patient believes is confidential. Furthermore, it doesn’t address the mental health content and diagnoses contained within the notes of non-mental-health professionals. This is important since the vast majority of psychiatric care is actually provided by primary care physicians, rather than psychiatrists.

There are no easy answers, and the field will need to find its way, as physicians work with patients to develop documentation approaches that are acceptable to all. Evolving technology within electronic medical record systems, which allow greater flexibility in selecting heightened security for discrete portions of a note, are a helpful advance. Open discussion with patients about the process employed, including the various people who may legitimately need to see the notes to provide them with optimal care, is now a critical part of an initial visit. In addition, physicians need to use greater care in drafting notes, realizing they may be writing for a broader audience, including the patient.

With the national push toward electronic data collection and ultimately data sharing, the general concerns about patient privacy and confidentiality of the medical record are likely to remain front and center for the foreseeable future. Whether the need for psychiatric exceptionalism persists is less certain, but technology may be the stimulus to encourage long overdue discussions within the mental health community (patients and clinicians) about how best to retain trust while not perpetuating stigma and inadvertently promoting poor quality care.

Further Reading

Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 4th ed. New York, NY: Oxford University Press; 1994: 406-429.

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