

Patient Privacy or Public Protection? Government Attempts to Address Mental Health Issues While Protecting Patient Communications

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Since the mass shootings at Virginia Tech, an Aurora, CO movie theater, and Sandy Hook Elementary, the federal government has taken another look at the legal regulations regarding privacy when dealing with violent individuals suffering from mental illness. Specifically, policymakers have asked the difficult question of whether current patient privacy protections impede the ability to prevent acts of violence by those with mental illness. In January 2013, in specific response to the Sandy Hook shootings, President Obama issued a 15-page plan aimed at reducing gun violence in America. The first tab within this plan describes the growing concern among states that the Health Insurance Portability and Accountability Act (HIPAA) has served as a basis “for not sharing relevant information on people prohibited from gun ownership for mental health reasons.” The plan indicates the administration will make it a priority to remove any perceived barriers to disclosure. On the same day the President released the plan, Department of Health and Human Services Secretary Kathleen Sebelius issued a statement calling for an end to senseless gun violence by reducing negative attitudes toward people with mental illness, recognizing mental illness and warning signs, and enhancing access to treatment. A full understanding of the intersection of violence, mental illness, patient privacy, and public safety, begins with the seminal case of *Tarasoff v. Regents of University of California*. This California Supreme Court case involved a University-employed psychologist that received threats from a mentally ill patient regarding violence to a specific named individual. The patient ultimately murdered the identified individual and the family of the murder victim brought suit claiming that the psychologist’s failure to disclose the threats to appropriate authorities rose to the level of negligence. While the psychologist did suggest hospitalization and informed campus police of the issue, he did not believe that the patient was dangerous enough to be involuntarily detained. The court ultimately ruled in favor of the victim’s family and held that a mental health professional

has a duty not only to a patient but also to individuals who are specifically being threatened by a patient. Justice Mathew O. Tobriner wrote the famous holding in the majority opinion: "The public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins." The decision sparked laws in virtually every state to change and include statutory requirements for notification and duty to warn those against whom threats have been made and the debate between rules of confidentiality and privilege and duty to warn has existed ever since. It will be interesting to monitor whether similar lawsuits will arise as a result of recent tragedies involving alleged perpetrators with histories of mental illness and to what extent the *Tarasoff* decision will influence the courts in those jurisdictions. While the *Tarasoff* case essentially confirms the likelihood of civil tort liability for providers who fail to disclose relevant information in appropriate circumstances, there is an ongoing debate regarding the applicability and level of importance of HIPAA compliance in these same situations. The HIPAA Privacy Rule sets forth the criteria for voluntary disclosures that do not require a patient's authorization or consent. These exceptions allow providers to use protected health information (PHI) for important public policy reasons and permit disclosures: (1) required by law; (2) for public health activities; (3) about victims of abuse, neglect, or domestic violence; (4) for health oversight activities; (5) for judicial and administrative proceedings; (6) for law enforcement; (7) about decedents to coroners, medical examiners, and funeral directors; (8) for cadaveric organ, eye, or tissue donation; (9) for research purposes pursuant to a waiver of authorization, for reviews preparatory to research, and for research on a decedent's information; (10) to avert a serious threat to health or safety; (11) for military and veterans' affairs, national security, and intelligence; and (12) for workers' compensation. It is undisputed that HIPAA permits disclosures in situations outside of the health care context, including for law enforcement purposes and to avert a threat to health or safety. To further clarify, a health care provider may use or disclose PHI if the provider in good faith believes it is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, and where the disclosure is to a person reasonably able to prevent or lessen the threat (e.g., law enforcement official, family member, school administrator). On January 15, 2013, the Director of the Office for Civil Rights, Leon Rodriguez, issued a letter to all health care providers with the goal of clarifying circumstances by which providers should disclose health information. A few months later, the U.S. House Energy and Commerce Subcommittee on Oversight and Investigations put the topic on the docket in an attempt to better understand the scope of HIPAA's privacy protections and the ways in which they could potentially interfere with a physician's ability to report information among other health care providers, patients, and families. Despite the government's interest in encouraging permitted disclosures, all providers are faced with a genuine dilemma: voluntarily disclose in the name of public safety and risk a HIPAA violation or withhold information to protect patient privacy. This dilemma is further complicated by evidence that many health care providers apply the HIPAA regulations overzealously leaving family members, caregivers, public health officials, and law enforcement hindered in their efforts to obtain information. To illustrate the pervasiveness of the aggressive (and often misused) application of HIPAA, the *New York Times* reported in 2007 that

birthday parties in nursing homes in New York were being canceled for fear that revealing a resident's date of birth would violate HIPAA. While some guidance has been issued by the OCR to describe scenarios under which disclosure under HIPAA is permitted, the applicable provisions do not impose an absolute requirement to disclose. Rather, disclosure is left to the provider's discretion, and the ability to modify the ever-pervasive "don't tell anyone anything" mentality has proven difficult at best. Rodriguez acknowledged the permissive disclosure issue during his testimony stating that "providers are not subject to penalties for declining to make disclosures that HIPAA merely permits." However, he simultaneously stressed the government's interest in encouraging providers to use permissive disclosure when appropriate. The major factor likely to force a shift in the current paradigm is continued government involvement in the discussion and provider education and outreach focused on understanding HIPAA as a whole. Physicians must be comfortable that a disclosure made in the interest of public safety will not land them on the OCR's "most wanted" list or in front of a judge. The testimony of Rodriguez was aimed at quelling exactly these concerns, emphasizing that enforcement of HIPAA violations is largely concentrated on large, systemic failures to comply with the HIPAA rules and not providers who have made good faith determinations to comply with the permitted disclosure provisions under the Privacy Rule. However, fundamental attitude changes within larger health care organizations also are necessary to assist providers in navigating the muddy waters of permitted disclosures under HIPAA. All too often, HIPAA compliance training materials focus on the consequences of improper disclosures highlighting primarily the severe financial and reputational harm that follows a breach. However, one component of HIPAA education should include case studies and scenarios where disclosures under HIPAA are permitted (or required under state law and *Tarasoff*) thus encouraging providers to make determinations based on appropriate, individualized clinical sensitivity and not the potential for scrutiny by federal regulators. In making these determinations, providers must appropriately balance the ethical and clinical requirements of their professions with the privacy regulations that were instituted to similarly promote public health and safety. As a result, the "don't tell anyone anything" approach is no longer a viable alternative to a detailed understanding and appreciation of the goal and intent of the HIPAA protections. The answer to the question of whether HIPAA helps or hinders patient care and public safety is that HIPAA promotes both patient care and public safety provided that health care entities and providers are educated on the nuances of the regulation and the appropriate ways to apply its protections. Educational materials that focus on real world examples and practical application of the privacy regulations would go a long way in dispelling the fear of liability, which permeates virtually all decisions regarding disclosure. In any case, rest assured that both state and federal governments, along with providers, professional societies, trade organizations, and other health care policymakers will continue debating the effectiveness and applicability of HIPAA regulations especially in the face of random acts of gun violence by those with histories of known mental illness. *Originally published in Health Lawyers Weekly, AHLA, Vol. XI, Issue 47 (December 2013).*

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