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Protection for Psychotherapy Notes under the HIPAA Privacy Rule: As Private as a Hospital Gown

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PROTECTION FOR PSYCHOTHERAPY
NOTES UNDER THE HIPAA
PRIVACY RULE:
AS PRIVATE AS A HOSPITAL GOWN¹

Stephanie O. Corley[†]

“The mental health of our citizenry, no less than its physical health, is a public good of transcendent importance.”

*Jaffee v. Redmond*²

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¹ *All the Privacy of a Hospital Gown*, SEATTLE TIMES (June 7, 2007, 12:00 AM), http://seattletimes.nwsourc.com/html/editorialsopinion/2003737167_prived07.html.

² *Jaffee v. Redmond*, 518 U.S. 1, 11 (1996).

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INTRODUCTION

In 2002 when the Department of Health and Human Services (HHS) established the “Privacy Rule” pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA),³ HHS

³ 42 U.S.C. §§1320d-2 to -6 (1996); Standards for Privacy of Individually Identifiable Health Information, 67 Fed. Reg. 53,182, 53,182, 53,268 (Aug. 14, 2002). The first compliance date for most covered entities was April 14, 2003. *Id.* at 53, 183.

carved out special protection for psychotherapist's notes.⁴ This provision requires patient authorization for use or disclosure of psychotherapy notes.⁵ To rationalize this provision, HHS relied upon the Supreme Court's rationale from its landmark decision, *Jaffee v. Redmond*,⁶ in which the Court created a federal psychotherapist privilege.⁷ The Court recognized the need to protect psychotherapist's notes from public disclosure because "[e]ffective psychotherapy . . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears . . . [And] the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment."⁸

Although HHS relied upon the Court's reasoning in *Jaffee*, the Privacy Rule does not protect psychotherapist's notes to the same extent that the federal psychotherapist privilege does in the context of litigation. The Privacy Rule's protection of psychotherapy notes is far more limited.⁹ In fact, the Privacy Rule's protection for notes related to psychotherapy can be likened to an ill-fitting hospital gown—too small and loosely tied, so that the patient is exposed for others to see.¹⁰

The psychotherapy notes provision seems relatively straightforward. However, it is not. To qualify as psychotherapy notes, the notes must be (1) produced by a mental health professional in a private, group, joint, or family counseling session; and (2) kept separate from the rest of the medical record.¹¹ The Privacy Rule does not require psychotherapists to keep psychotherapy notes, but instead gives

⁴ Uses and Disclosures for Which an Authorization is Required, 45 C.F.R. § 164.508 (2002).

⁵ *Id.* In general, psychotherapy notes can be considered as a separate, non-public medical record. Also, for the purposes of this note "psychotherapist," "therapist," "psychologist," "mental health practitioner," or "mental health professional" means "a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session." Definitions, 45 C.F.R. § 164.501 (2011).

⁶ 518 U.S. at 1. Redmond, a police officer, shot Allen. A representative of Allen's estate, Jaffee, filed an excessive force claim. Jaffee requested Redmond's records from her sessions with a licensed social worker. Redmond opposed the request, but the trial court rejected the opposition. Redmond appealed, which led to the Supreme Court's decision. *Id.* at 4–6.

⁷ See Standards for Privacy of Individually Identifiable Information, 64 Fed. Reg. 59918, 59941–42 (proposed Nov. 3, 1999) (to be codified at 45 CFR pts. 160–64).

⁸ *Jaffee*, 518 U.S. at 10.

⁹ See *infra* Parts V, VI.

¹⁰ See *All the Privacy of a Hospital Gown*, *supra* note 1.

¹¹ Definitions, 45 C.F.R. § 164.501 (2011).

mental health practitioners unilateral discretion to record notes taken during psychotherapy sessions in either the patient's general medical chart or a separate, confidential chart.¹² Additionally, there are eight general exceptions to the requirement of patient authorization for disclosure of psychotherapy notes and five exclusions to the definition of psychotherapy notes.¹³

Thus, even if a psychotherapist keeps separate, nonpublic notes (e.g., psychotherapy notes), highly sensitive information may still be included in a patient's general medical chart. This is possible because the definition of psychotherapy notes does not include a summary of diagnosis, symptoms, functional status, treatment plan, prognosis and progress, as well as type of treatment, frequency of treatment, counseling session start and stop times, clinical tests, and medication.¹⁴ HHS created so many exclusions and exceptions to the psychotherapy notes provision that a patient's sensitive mental health information may be accessed by hundreds of health-care personnel with limited or no recourse for the patient.¹⁵

This Note recommends changes to the Privacy Rule to strengthen protection for medical records related to psychotherapy. Although the Privacy Rule allows unauthorized disclosure for multiple reasons, the focus of this Note is on disclosure for treatment purposes. Thus, these recommendations take into account the fact that, like a hospital gown, privacy protections ought to be adjusted based upon treatment. If a person is in cardiac arrest, the first priority is not ensuring that the hospital gown is tied tightly, but rather that the patient does not die. The same is true for psychotherapy; if a patient is suicidal, unauthorized disclosure may be required. The key question is how tightly privacy strings should be tied when there is no imminent harm compelling unauthorized disclosure. This Note attempts to answer this ques-

¹² See Uses and Disclosures for Which an Authorization is Required, 45 C.F.R. § 164.508(a)(2)(i) (2011).

¹³ See 45 C.F.R. § 164.508(a)(2).

¹⁴ See *id.* § 164.501.

¹⁵ See *infra* Part III.C. Under the Privacy Rule there is no private right of action or individual remedy. See, e.g., *Baum v. Keystone Mercy Health Plan*, No. 11–1261, 2011 WL 4632569, at *3 (Oct. 5, 2011). A private party can file a complaint with the Office for Civil Rights, but only the government can bring an enforcement action for violations of the Privacy Rule. See *Health Information Privacy: If I Believe that My Privacy Rights Have Been Violated, When Can I Submit a Complaint?*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.hhs.gov/ocr/privacy/hipaa/faq/right_to_file_a_complaint/352.html (last updated Feb. 14, 2008); see *Health Information Privacy: HIPAA Enforcement*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/ocr/privacy/hipaa/enforcement/index.html> (last visited Apr. 16, 2012).

tion and to offer solutions that balance psychotherapist-patient confidentiality and the need for limited disclosure.

Part I explores a clinical dilemma in order to make clear the current limitations of the Privacy Rule. Part II explores three ethical principles: psychotherapist-patient confidentiality, ethical record keeping, and the ethical goal of sharing information in order to effectively treat patients. Part III explores barriers to effective psychotherapy. Parts IV–VI discuss the Privacy Rule’s psychotherapy notes provision.

Part VII recommends changes to the Privacy Rule to enhance protection of psychotherapy notes. These changes include redefining and clarifying the psychotherapy notes provision, limiting disclosure to the “minimum necessary” information in a patient’s general medical chart, limiting access to medical records related to psychotherapy, expanding notice requirements, and funding continuing education for mental health professionals. Lastly, Part VIII explains why adding greater privacy protection to the HIPAA Privacy Rule is the best method for improvement.

I. A CLINICAL DILEMMA

Grace is a patient at a large medical center, Healing Clinic. Grace’s initial reason for seeking psychotherapy was a recommendation by her treating oncologist, Dr. O, who believes Grace is likely depressed. Because depression and other mental illnesses can negatively affect cancer treatment, Dr. O believes it is imperative that her patients receive proper treatment for mental illness in conjunction with oncology treatment. Grace’s mental health treatment includes both medication and talk therapy. As part of Grace’s talk therapy she reveals what she considers to be highly sensitive information about her spiritual beliefs. Grace was formerly unwavering in her faith in God, but her cancer diagnosis left her with serious questions. Grace feels ashamed by her spiritual doubts, especially since involvement in her faith and church has been a life-long source of identity for her and her family.

Unbeknownst to Grace, Healing Clinic has a policy that requires its health-care practitioners to chart all records in its electronic record keeping system. Because Grace’s psychotherapist charted her notes in Grace’s general medical record, anyone directly involved in Grace’s care has access to the notes. Upon reviewing her record, Grace realizes her doubts about God are spelled out in black and white. Grace fears that her friends or acquaintances will read what she told her therapist because many of them work at Healing Clinic. Feeling betrayed, Grace chooses not to continue psychotherapy.

The above dilemma is based in fact and highlights a problem for patients, physicians, psychotherapists, and health-care operations in the United States. How should the Healing Clinic deal with records taken during psychotherapy? This question is complicated per se, but is even more complicated for patients undergoing treatment within health-care institutions where sharing information is encouraged or required, such as large institutions that practice multidisciplinary medicine or use electronic record keeping systems. In institutions such as these, providing affordable, effective medical care and preserving patient confidentiality are equally important goals that are often at odds. As evidenced by the Privacy Rule's psychotherapy notes provision, the trend in such health-care delivery systems has been to share information with those directly involved in a patient's care in order to deliver better care. The reason for this trend is that sharing information often makes sense in terms of providing a patient with safe, effective health care. However, the risk is that a situation like Grace's will occur.

In order to avoid an outcome like Grace's, privacy protection for psychotherapy records should be strengthened. However, is there a way to provide more privacy protection that does not preclude other treatment objectives such as treating co-occurring diseases by multidisciplinary teams? The Privacy Rule leaves these key questions unresolved, and the answers often depend upon one's point of view.

From the patient's perspective, confidentiality is critical. A patient should have the right to control personal information divulged in a confidential psychotherapy session. At a minimum, patients should be consulted when highly sensitive information is going to be shared. Grace's trust was violated because the psychotherapist did not properly explain to Grace that she would be sharing information with other members of Grace's cancer treatment team.

From the doctor's perspective, effective treatment is critical. If a hospital restricts access to certain kinds of information, and the patient does not disclose that information, there may be irreparable harm. A hospital administrator must consider the consequence of seeking consent each time a clinician needs to disclose patient information during treatment. At a hospital that treats millions of patients annually, the cost may be prohibitive. If practitioners have to spend more time with each patient asking for permission, they will see fewer patients, and the hospital will have to hire more personnel. Hiring personnel increases costs. Increased costs ultimately affect the patient in the form of higher health-care prices or insurance premiums. This limits patients' access to health care.

This Note recommends changes to the Privacy Rule that strengthen the protection of psychotherapy notes. The solutions recommend-

ed also attempt to satisfy the competing interests and goals of all parties involved. For this reason, physicians' ethical obligations, barriers to effective psychotherapy, and the realities of modern day medical treatment are discussed in detail below.

II. ETHICAL CONSIDERATIONS: PSYCHOTHERAPIST-PATIENT CONFIDENTIALITY, ETHICAL RECORD KEEPING, AND THE DUTY TO DO NO HARM

A. Not as Simple as "Keeping a Secret"

Physician-patient confidentiality has long been deemed essential under medical ethical standards.¹⁶ The tradition of confidentiality is based upon the belief that by preserving patient confidences, the patient will speak "without any hesitation so as to receive the best medical care."¹⁷ The concept of physician-patient confidentiality is said to date back to the fifth century BCE when the Greek physician Hippocrates wrote, "[w]hatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private."¹⁸

In 1847, members of the newly formed American Medical Association (AMA) adopted the first national code of professional ethics in medicine.¹⁹ It set forth "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

¹⁶ AM. MED. ASS'N, ORIGINAL CODE OF MEDICAL ETHICS 93 (1847) [hereinafter ORIGINAL CODE OF MEDICAL ETHICS], available at <http://www.ama-assn.org/resources/doc/ethics/1847code.pdf>. Physician-patient confidentiality is also a duty under common law. See ROGER B. DWORKIN, LIMITS: THE ROLE OF THE LAW IN BIOETHICAL DECISION MAKING 95 (1996) (citing, e.g., *Hammonds v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793 (N.D. Ohio 1965); *Horne v. Patton*, 287 So. 2d 824 (Ala. 1974); *Hague v. Williams*, 181 A.2d 345, 349 (N.J. 1962)).

¹⁷ Hindi T. Mermelstein & Joel J. Wallack, *Confidentiality in the Age of HIPAA: A Challenge for Psychosomatic Medicine*, 49 PSYCHOSOMATICS 97, 97 (2008).

¹⁸ *Greek Medicine: The Hippocratic Oath*, U.S. NATIONAL LIBRARY OF MEDICINE, NIH.GOV, http://www.nlm.nih.gov/hmd/greek/greek_oath.html (last visited Jan. 25, 2012); Peter Tyson, *The Hippocratic Oath: Modern Version*, NOVA (Mar. 27, 2001), http://www.pbs.org/wgbh/nova/doctors/oath_modern.html.

¹⁹ ORIGINAL CODE OF MEDICAL ETHICS, *supra* note 16.

and honor.”²⁰ Today, the AMA’s Code of Medical Ethics still deems confidentiality an inherent part of the physician-patient relationship.²¹

Psychiatrists are also bound by the AMA’s Code of Medical Ethics.²² However, in 1973, the American Psychiatric Association published *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*.²³ The American Psychiatric Association recognized that although the AMA’s standards of conduct are the same for psychiatrists, “there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice.”²⁴ One of those special ethical problems involves confidentiality.²⁵ The American Psychiatric Association explains that the importance of confidentiality “is based in part on the special nature of psychiatric therapy [and] on the traditional ethical relationship between physician and patient.”²⁶

The American Psychiatric Association’s *Principles* and the American Psychological Association’s *Ethical Principles of Psychologists and Code of Conduct* (Code of Conduct) both deem confidentiality as essential to treatment, and yet both ethical codes recognize that confidentiality is not absolute.²⁷ The American Psychological Association’s Code of Conduct section 4.01 states, “psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recog-

²⁰ *Id.* at 93.

²¹ *Patient Confidentiality*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/patient-confidentiality.shtml> (last visited Feb. 23, 2012) (“In general, AMA’s *Code of Medical Ethics* states that the information disclosed to a physician during the course of the patient-physician relationship is confidential to the utmost degree.”).

²² *Ethics*, AM. PSYCHIATRIC ASS’N, <http://www.psych.org/MainMenu/PsychiatricPractice/Ethics.aspx> (last visited Feb. 12, 2012).

²³ *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, AM. PSYCHIATRIC ASS’N, 1 (2009 ed. rev.), <http://www.psych.org/mainmenu/psychiatricpractice/ethics/resourcesstandards/principlesofmedicalethics.aspx> (indicating the AMA approved a new version of *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* in 1980 and as the *Principles* have been amended, the AMA continues to approve the updated versions).

²⁴ *Id.* at 1.

²⁵ *Id.* at 6.

²⁶ *Id.*

²⁷ *Id.* at 6–7; *Ethical Principles of Psychologists and Code of Conduct, Standard 4: Privacy and Confidentiality*, AM. PSYCHOLOGICAL ASS’N, <http://www.apa.org/ethics/code/index.aspx?item=4> (last visited Feb. 12, 2012) [hereinafter *Code of Conduct*].

nizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.”²⁸ Although confidentiality is at the heart of psychiatric and psychological ethical codes, confidentiality in the clinical setting is not as straightforward as Hippocrates’s notion of “keeping a secret.”

B. Ethical Record Keeping

In addition to confidentiality, professional record keeping is also an ethical practice.²⁹ For example, under Standard 6.01 of the APA’s Code of Conduct, record keeping related to a psychologist’s professional work meets ethical standards if created “in order to facilitate provision of services later by them or by other professionals . . . meet institutional requirements, ensure accuracy of billing and payments, and ensure compliance with law.”³⁰

Clinical record keeping serves multiple purposes, benefiting both the therapist and the patient. Generally, records provide a patient with an oversight mechanism so that the therapist may be held accountable for using effective therapy techniques and methods.³¹ Records give the patient an opportunity to be more involved in care.³² Patients have found that using online record management tools allows them to “manage their conditions and make treatment choices.”³³ Records provide a patient with continuity of care in circumstances such as a psychotherapist’s retirement or death.³⁴ Records also provide continuity of care when the psychotherapist must collaborate with another

²⁸ *Code of Conduct*, *supra* note 27, at § 4.01.

²⁹ See, e.g., AM. PSYCHIATRIC ASS’N, DOCUMENTATION OF PSYCHOTHERAPY BY PSYCHIATRISTS 1 (2002), available at <http://www.americanmentalhealth.com/media/pdf/200202apaonnotes.pdf> (“[M]edical-legal principles indicate that the medical record should be complete, factual, and accurate.”); see generally *Record Keeping Guidelines: American Psychological Association*, 62 AM. PSYCHOLOGIST 993 (2007), <http://www.apa.org/practice/guidelines/record-keeping.pdf>.

³⁰ *Code of Conduct*, *supra* note 27, at § 6.01.

³¹ See RICHARD M. ZWOLINSKI & C.R. ZWOLINSKI, THERAPY REVOLUTION: FIND HELP, GET BETTER, AND MOVE ON WITHOUT WASTING TIME OR MONEY 96, 103 (2009).

³² Laura Landro, *Online Records Get Patients Involved in Care*, WALL ST. J., Mar. 18, 2009, at D1.

³³ *Id.*

³⁴ ELLEN T. LUEPKER ET AL., RECORD KEEPING IN PSYCHOTHERAPY & COUNSELING: PROTECTING CONFIDENTIALITY AND THE PROFESSIONAL RELATIONSHIP 169 (2003).

clinician.³⁵ Records protect the patient or psychologist in the event of legal or ethical proceedings.³⁶ Records facilitate third-party reimbursement.³⁷ However, the converse to the numerous benefits mentioned above is that records compete with confidentiality.³⁸ Upon maintenance or dissemination of psychotherapy notes, confidentiality must be maintained to the greatest degree possible.

C. “To Do No Harm”

The Hippocratic Oath also includes the ethical goal “to do no harm.”³⁹ Hippocrates explained as follows:

The concoctions indicate a speedy crisis and recovery of health; crude and undigested evacuations, and those which are converted into bad abscesses, indicate either want of crisis, or pains, or prolongation of the disease, or death, or relapses; which of these it is to be must be determined from other circumstances. The physician must be able to tell the antecedents, know the present, and foretell the future — must mediate these things, and have two special objects in view with regard to disease, namely, *to do good or to do no harm*.⁴⁰

According to Hippocrates, physicians are ethically required to gather as much knowledge as possible about the patient in order to do no harm. Modern parallels of the Hippocratic Oath, such as the Lasagna Oath, include a related ethical guideline such as: “I will not be ashamed to say ‘I know not,’ nor will I fail to call in my colleagues when the skills of another are needed for a patient’s recovery.”⁴¹ Thus, gathering information and collaboration are ethical obligations

³⁵ *See id.*

³⁶ *Record Keeping Guidelines: American Psychological Association, supra* note 29, at 993.

³⁷ *Id.*

³⁸ *Id.* at 997.

³⁹ HIPPOCRATES, OF THE EPIDEMICS, Book I, Sec. II, para. 5 (Francis Adams trans., 2007), available at <http://ebooks.adelaide.edu.au/h/hippocrates/epidemics/index.html>.

⁴⁰ *Id.* (emphasis added).

⁴¹ Tyson, *supra* note 18 (noting that the modern Hippocratic Oath was “written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today”). *see* Melissa Hantman, *From Antiquity to Eternity: Revised Hippocratic Oath Resonates with Graduates*, CORNELL UNIV. NEWS SERV. (June 22, 2005), http://www.news.cornell.edu/stories/June05/Hippocratic_Oath.mh.html.

to the patient as well. However, information gathering and collaboration, like ethical record keeping, compete with confidentiality.⁴²

III. BARRIERS TO EFFECTIVE PSYCHOTHERAPY: WHY PSYCHOTHERAPY “DEPENDS UPON AN ATMOSPHERE OF CONFIDENCE AND TRUST”

In any given year, approximately 26 percent of American adults suffer from a diagnosable mental disorder.⁴³ Yet, only a fraction of those who need mental health treatment seek it.⁴⁴ This number is alarming because for American adults, suicide—which is strongly correlated with mental illness—is the fourth largest cause of death in the United States.⁴⁵ It ranks above diabetes mellitus, cerebrovascular disease, chronic lower respiratory disease, liver disease, homicide, and HIV.⁴⁶

Concerns about confidentiality and data security combined with the consequences of stigma interfere with patients seeking treatment.⁴⁷ Not surprisingly, an individual is less likely to seek treatment or disclose sensitive information if she believes that the information may be disseminated outside the treatment relationship.⁴⁸ To fully understand these barriers, it is important to look at (1) why the psychotherapy-patient relationship is unique, (2) the historical perspective on mental illness and the stigma that remains from this history, and (3) how modern day health-care delivery creates new barriers to treatment as a

⁴² *Record Keeping Guidelines: American Psychological Association*, *supra* note 29, at 995–97.

⁴³ *Any Disorder*, NAT'L INST. OF MENTAL HEALTH, http://www.nimh.nih.gov/statistics/pdf/NCS-R-Any_Disorder.pdf (last visited Jan. 25, 2012). This statistic is taken from a survey conducted in the United States in which the objective was to “estimate 12-month prevalence, severity, and comorbidity of DSM-IV anxiety, mood, impulse-control, and substance disorders in the recently completed U.S. National Comorbidity Survey Replication.” Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of Twelve-Month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 *ARCHIVES GEN. PSYCHIATRY* 617 (2005).

⁴⁴ *See Statistics*, NAT'L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/statistics/index.shtml> (last visited Jan. 25, 2011).

⁴⁵ *Top 10 Causes of Death in the U.S. (2007)*, NAT'L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/statistics/pdf/CDC-10LeadingCausesofDeath.pdf> (last visited Jan. 25, 2012).

⁴⁶ *Id.*

⁴⁷ *See infra* Part III.B.

⁴⁸ *See* U.S. DEP'T HEALTH & HUMAN SERVS., *MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL* 1, 438–41 (1999) [hereinafter *SURGEON GENERAL REPORT*], available at <http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf>.

result of expanded access to patient records with the advent of electronic health records (EHR) and multidisciplinary teams.

A. The Impact of Diminished Confidentiality on the Psychotherapy-Patient Relationship

As evidenced by the Grace example in Part I, confidentiality and trust are critical to effective treatment of mental illness. In *Jaffee*, the Supreme Court highlighted why confidentiality and trust are key components of psychotherapy:

Treatment by a physician for physical ailments can often proceed successfully on the basis of a physical examination, objective information supplied by the patient, and the results of diagnostic tests, [whereas] effective psychotherapy, by contrast, depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure⁴⁹

Psychotherapy patients are asked to share their “innermost thoughts and feelings.”⁵⁰ Thus, inherent in psychotherapeutic treatment is trust between the psychotherapist and patient.⁵¹ In order to establish trust, the patient and psychotherapist rely in part upon the confidential nature of the relationship.⁵²

Moreover, psychotherapist-patient confidentiality is unique “[b]ecause of the sensitive nature of the problems for which individuals consult psychotherapists, [and because] disclosures . . . made during counseling sessions may cause embarrassment or disgrace.”⁵³ A patient might disclose information that is not socially acceptable or even legal, such as suicidal thoughts or drug use. Confidentiality is critical when “the ability of patients to convey potentially embarrass-

⁴⁹ *Jaffee v. Redmond*, 518 U.S. 1, 10 (1996).

⁵⁰ Mermelstein & Wallack, *supra* note 17, at 98.

⁵¹ SURGEON GENERAL REPORT, *supra* note 48, at 439–40; see Leslie Pickering Francis, *The Physician-Patient Relationship and A National Health Information Network*, 38 J.L. MED. & ETHICS 36, 36–38 (2010).

⁵² See SURGEON GENERAL REPORT, *supra* note 48, at 439–40; see Francis, *supra* note 51, at 36–38.

⁵³ *Jaffee*, 518 U.S. at 10; Mermelstein & Wallack, *supra* note 17, at 98 (“Nowhere in medicine is the need for confidentiality more evident than in psychiatry. We ask our patients not only to tell us about their symptoms but also to share with us their innermost thoughts and feelings. Also, the problems that drive individuals to seek mental health treatment may include drug abuse and overdose, psychosis, sexual abuse, violence, suicide attempts, family disputes, disorders of thinking, and other conditions most people find embarrassing and stigmatizing. These individuals are highly vulnerable and dependent on physicians to protect the very same ‘shameful secrets’ that needed to be divulged in order for care to take place.”).

ing information is essential for accurate diagnosis and effective treatment.”⁵⁴

As evidenced by Grace, because of the unique nature of the psychotherapist-patient relationship, unauthorized disclosure could seriously harm the psychotherapy relationship.⁵⁵ In many instances, the damage is irreparable because “the mere possibility that confidential information might be disclosed prevents successful treatment from occurring by interfering with the development of the necessary trusting psychotherapy relationship and open communication with the therapist.”⁵⁶ In considering how to strengthen privacy protection for psychotherapy records under the Privacy Rule, it is critical to consider the uniqueness of the psychotherapist-patient relationship.

B. The Stigma of Mental Illness and Its Impact Outside of Treatment

Stigma and negative connotations associated with mental illness discourage some patients from seeking treatment. A recent study led by Constance Guille, Clinical Instructor of Psychiatry at Medical University of South Carolina, found that more than half of the medical interns who screened positive for depression expressed concern about what others would think if they received mental health treatment, and 43 percent believed that their colleagues would have less confidence in them if they sought mental health treatment.⁵⁷ The study attributed these results to the “long-standing belief . . . in residency education that perpetuates the idea that psychiatric disorders and psychological

⁵⁴ Paul S. Appelbaum, *Privacy in Psychiatric Treatment: Threats and Responses*, 159 AM. J. PSYCHIATRY 1809, 1809 (2002).

⁵⁵ *APA Raises Privacy Concerns on Mental Health Records: Proposed Nationwide System of Electronic Records Requires Managing Many Patient Confidentiality Issues*, AM. PSYCHOLOGICAL ASS'N (Mar. 31, 2005), <http://www.apa.org/news/press/releases/2005/03/patient-privacy.aspx>.

⁵⁶ *Id.*; Jaffee, 518 U.S. at 10; see Jennifer Evans Marsh, *Empirical Support for the United States Supreme Court's Protection of Psychotherapist-Patient Privilege*, 13 ETHICS & BEHAV. 385, 385 (2003) (reporting that the study participants who had a privilege condition had a significantly higher willingness to disclose information than those who did not have a privilege condition).

⁵⁷ Constance Guille et al., *Utilization and Barriers to Mental Health Services Among Depressed Medical Interns: A Prospective Multisite Study*, J. GRAD. MED. ED. 210, 210, 212 (2010); cf. Srijan Sen et al., *A Prospective Cohort Study Investigating Factors Associated with Depression During Medical Internship*, 67 ARCHIVES GEN. PSYCHIATRY 557, 557–58 (2010) (detailing a study of 740 interns entering residency programs in 13 U.S. hospitals in 2007–2009 that found depression increases during medical internships); see *Symptoms of Depression Increase During Medical Internship*, SCIENCE DAILY (Apr. 6, 2010), <http://www.sciencedaily.com/releases/2010/04/100406205354.htm>.

problems are shameful.”⁵⁸ The results of the Guille study reflect the long history of stigma associated with mental illness. Arguably, medical interns should understand the importance of mental health treatment and risks of foregoing treatment better than the average person.

Historically, laws in the United States reinforced this stigma. For years, legal rights for the mentally ill were essentially nonexistent. Involuntary civil commitment hearings were merely a formality.⁵⁹ Not until the 1960s and 1970s were due process safeguards fully extended to the mentally ill.⁶⁰ Prior to the 1960s, an involuntarily committed patient’s right to refuse treatment was not recognized.⁶¹ Over patient objections, doctors frequently treated patients using torturous methods.⁶² Electro-convulsive therapy (ECT), commonly referred to as shock therapy, is one such example.

ECT began in the 1930s and during the 1940s and 1950s it was one of the only treatments for mental illness.⁶³ When ECT was first used patients were shocked while wide awake, “feeling their bodies’ convulsions, which were sometimes severe enough to break bones.”⁶⁴ Today, advancement in scientific understanding and treatment of mental illness has changed.⁶⁵ In fact, ECT is now considered safe and extremely successful in treating patients with treatment-resistant depression.⁶⁶ But due to ECT’s former misuse, misconceptions about ECT are prevalent. For many, the only understanding they have of ECT is Jack Nicholson being electrocuted—convulsing, and grimacing—in the movie *One Flew over the Cuckoo’s Nest*.⁶⁷ In many ways, society has not caught up to science.⁶⁸ Misconceptions about mental

⁵⁸ Guille et al., *supra* note 57, at 214.

⁵⁹ See Jennifer Rebecca Levinson, *Elizabeth Parsons Ware Packard: An Advocate for Cultural, Religious, and Legal Change*, 54 ALA. L. REV. 985, 1005 (2003) (noting that in 1864, an Illinois statute provided for civil commitment of married women by their husbands “without the evidence of insanity [or distraction] required in other cases.”).

⁶⁰ See *In re Gault*, 387 U.S. 1 (1967); see *O’Connor v. Donaldson*, 422 U.S. 563, 580 (1975); see *Addington v. Texas*, 441 U.S. 418, 425–26 (1979).

⁶¹ See *Rennie v. Klein*, 462 F. Supp. 1131, 1144–45 (D.N.J. 1978); see *Rogers v. Comm’r of Dep’t of Mental Health*, 458 N.E.2d 308, 308 (Mass. 1983).

⁶² Jeff Stryker, *Psychiatry’s Electric Revolution: A New Shock Therapy or the Same Old Charges?*, S.F. CHRON., Dec. 24, 2006, at B1.

⁶³ Melissa Dahl, *Shock Therapy Makes a Quiet Comeback*, MSNBC.COM (Aug. 6, 2008, 8:22:38 AM), http://www.msnbc.msn.com/id/26044935/ns/health-mental_health/.

⁶⁴ *Id.*

⁶⁵ See *id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ See SURGEON GENERAL REPORT, *supra* note 48, at 87–88, 439–40; see Guille et al., *supra* note 57, at 210–14; see Dahl, *supra* note 63.

disorders and a lack of sensitivity toward those with mental illness are commonplace.⁶⁹ For example, use of words like “loony,” “crazy,” “wacko,” or “psycho” are often said without a second thought.⁷⁰

In addition to societal misconceptions, the stigma of mental illness has harmful consequences. In support of the Privacy Rule, HHS noted that “a breach of a person’s health privacy can have significant implications well beyond the physical health of that person.”⁷¹ Implications include “loss of a job, alienation of family and friends, the loss of health insurance, and public humiliation.”⁷² Out of the four examples that HHS included in the Privacy Rule’s preamble, two relate to psychotherapy treatment.⁷³ The first example was of a Congressional candidate who “nearly saw her campaign derailed when newspapers published the fact that she had sought psychiatric treatment after a suicide attempt.”⁷⁴ The second example was about a thirty-year FBI veteran who “was put on administrative leave when, without his permission, his pharmacy released information about his treatment for depression.”⁷⁵

Moreover, a 2004 research study conducted on behalf of the University of Michigan Depression Center found that many employees believe they will be fired if their employer finds out about their mental health issues.⁷⁶ Some employees “pay for the mental health treatment out of pocket because they are afraid that the HR or benefits department would find out about their treatment.”⁷⁷ In addition, a 2010 survey by the APA found that employee’s fears about losing work status and concerns about confidentiality are “more often . . .

⁶⁹ See *StigmaBusters Alert*, NAT’L ALLIANCE ON MENTAL HEALTH (Oct. 2003), http://www.nami.org/Content/ContentGroups/StigmaBusters/20032/October1/Stigma_Alert_-_October_2003.htm; see PATRICK W. CORRIGAN & ROBERT K. LUNDIN, DON’T CALL ME NUTS 1 (2001).

⁷⁰ See *StigmaBusters – Fight Stigma*, NAT’L ALLIANCE ON MENTAL HEALTH, http://www.nami.org/template.cfm?section=about_stigmabusters (last visited Jan. 25, 2012).

⁷¹ See Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. at 82,462, 82,468 (Dec. 28, 2000).

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ Karyn-Siobhan Robinson, *Stigma Prevents Depressed Workers from Seeking Treatment, Study Shows*, HR MAGAZINE (June 2004), available at http://findarticles.com/p/articles/mi_m3495/is_6_49/ai_n6076892/.

⁷⁷ *Id.*

barriers to seeking treatment for mental health issues than for other illnesses.⁷⁸

Unfortunately, patients have good reason to fear that sensitive personal information about their mental health will have a negative impact. For instance, Patricia Galvin was denied disability benefits after her health insurer, UnumProvident, accessed information that was recorded during psychotherapy sessions at Stanford Hospital & Clinics.⁷⁹ When Galvin released her records to UnumProvident, her general medical chart contained notes from psychotherapy sessions.⁸⁰ Under the Privacy Rule, charting notes from psychotherapy sessions in Galvin's general medical chart is HIPAA compliant.⁸¹

While the scientific understanding of mental illness has dramatically changed, the stigma surrounding persons with mental illness has not.⁸² Unfortunately, persons with mental illness continue to be treated differently and, for this reason, many people avoid diagnosis and fear seeking treatment.⁸³ Until society's view of mental illness catches up to science, confidentiality regulations for psychotherapy records should be strong enough to help counterbalance stigma. The Privacy Rule's psychotherapy notes provision does not meet this goal.

C. Modern Health-Care Delivery and Its Effects on Confidentiality and Data Security

1. EHR and Multidisciplinary Teams

With changes to the delivery of health care, ethical standards and laws have interpreted "confidentiality" in terms of the "widening circle of individuals involved with the patient's care."⁸⁴ Typically, con-

⁷⁸ Press Release, Am. Psychiatric Ass'n, Employees Report Mixed Feelings about Seeking Health Care Treatment (Jan. 25, 2010), available at <http://www.psych.org/MainMenu/Newsroom/NewsReleases/2010-News-Releases/Employees-Report-.aspx?FT=.pdf>; nevertheless, "research supports the fact that when people receive needed care, they are healthier and more productive" *Id.*

⁷⁹ Theo Francis, *Spread of Record Stirs Patient Fears of Privacy Erosion*, WALL ST. J., Dec. 26, 2006, at A1.

⁸⁰ *Id.*

⁸¹ See Uses and Disclosures for Which an Authorization is Required, 45 C.F.R. § 164.508(a)(2)(i)(A) (2011).

⁸² See SURGEON GENERAL REPORT, *supra* note 48, at 87–88, 439–40; see Guille et al., *supra* note 57, at 210–14; see Dahl, *supra* note 63.

⁸³ See SURGEON GENERAL REPORT, *supra* note 48, at 439.

⁸⁴ Paul W. Mosher, *We Have Met the Enemy and He (Is) Was Us*, in CONFIDENTIALITY, ETHICAL PERSPECTIVES AND CLINICAL DILEMMAS 230, 231 (Charles Levin et. al. eds., 2003).

sent to disclosure of confidential medical information is implied if the disclosure is made to medical personnel directly involved in patient care.⁸⁵ Although implied disclosure is commonly accepted and often enhances treatment, in some circumstances, psychotherapy is impaired by this expanded understanding of consent to disclosure.⁸⁶

For most people living in the United States, the days of receiving medical treatment from only a few doctors over the course of a lifetime have all but disappeared.⁸⁷ Health care is now typically delivered by large-scale institutions.⁸⁸ Hundreds of employees may have access to patient records on any given day.⁸⁹ In fact, it is estimated that 150 people have access to a patient's medical record during a typical hospital stay.⁹⁰ As institutions grow and adopt EHR systems, more and more demands are placed on health professionals to share information with others.⁹¹ As a result, more and more people have knowledge of patients' sensitive health information.⁹²

Furthermore, this exposure will no doubt increase. Both President George W. Bush⁹³ and President Barack Obama have called for a nationwide interconnected network of EHR by 2014.⁹⁴ In fact, the government is incentivizing the use of electronic systems⁹⁵ and, in the

⁸⁵ See *Patient Confidentiality*, *supra* note 21.

⁸⁶ See Mosher, *supra* note 84, at 231.

⁸⁷ See Jane Porter, *Team Based Approach*, WALL. ST. J., Dec. 17, 2009, at B8.

⁸⁸ Laurence B. McCullough, *Ethics in the Management of Health Care Organizations*, PHYSICIAN EXEC., Nov.-Dec. 1993, available at http://findarticles.com/p/articles/mi_m0843/is_n6_v19/ai_14686674/.

⁸⁹ See *Confidentiality of Medical Records: A Situation Analysis and AHIMA's Position*, AHIMA, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok2_000623.hcsp?dDocName=bok2_000623 (last visited Feb. 23, 2012).

⁹⁰ *Id.* (quoting Christine Gorman, *Who's Looking at Your Files*, TIME, May 6, 1996, at 60, 61); see also Melissa Steward, *Electronic Medical Records: Privacy, Confidentiality, Liability*, 26 J. LEGAL MED. 491, 498 (2005).

⁹¹ See Mermelstein & Wallack, *supra* note 17, at 98.

⁹² See *id.*

⁹³ See Mark A. Rothstein, *Health Privacy in the Electronic Age*, 28 J. LEGAL MED. 487, 488 (2007).

⁹⁴ See Deborah C. Peel, Opinion, *Your Medical Records Aren't Secure: The President Says Electronic Systems Will Reduce Costs and Improve Quality, But They Could Undermine Good Care if People Are Afraid to Confide in Their Doctors*, WALL. ST. J., Mar. 23, 2010 at A17.

⁹⁵ Timothy W. Martin, *More Doctors Are Prescribing Medicines Online*, WALL ST. J. (Apr. 20, 2010), <http://online.wsj.com/article/SB10001424052702304159304575184624170912494.html>. The Center for Medicare and Medicaid Services (CMS), the federal agency that oversees the big federal insurance programs, began paying doctors a bonus for e-prescribing in 2009. *Id.* See Phil Galewitz & Christopher Weaver, *Health IT Chief to*

near future, may actually start penalizing those who do not use them.⁹⁶ The former National Coordinator for Health Information Technology, David Blumenthal, reported in February 2011 that his office made \$27 billion in incentive payments to health providers to automate their records.⁹⁷ Indeed, many large institutions are already using EHR systems to “improve the efficiency and effectiveness of medical care.”⁹⁸ The problem is that once patient data is entered into databases or electronic systems, both the psychotherapist and patient lose a measure of control over who accesses those records.⁹⁹ As a result, using electronic medical records is complicated for psychotherapists, particularly when part of a multidisciplinary team.¹⁰⁰

Multidisciplinary medical teams are commonplace in modern medicine in part due to co-morbidity—the presence of more than one disorder or illness.¹⁰¹ The positive outcome of one disease may be dependent upon treatment of the other disease, which means that disclosure of mental health illness is sometimes essential to effective

Step Down, WASH. POST (Feb. 3, 2011, 10:15 PM), <http://www.washingtonpost.com/wp-dyn/content/article/2011/02/03/AR2011020307250.html>.

⁹⁶ Martin, *supra* note 95 (noting that beginning in 2012, CMS will penalize doctors who do not issue e-prescriptions).

⁹⁷ Galewitz & Weaver, *supra* note 95.

⁹⁸ Mermelstein & Wallack, *supra* note 17, at 98; see *HHS Secretary Kathleen Sebelius Announces Major Progress in Doctors, Hospital Use of Health Information Technology*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Feb. 17, 2012), <http://www.hhs.gov/news/press/2012pres/02/20120217a.html> (“Today’s announcement details information from a new survey conducted by the American Hospital Association and reported by the HHS Office of the National Coordinator for Health IT which found that the percentage of U.S. hospitals that had adopted EHRs has more than doubled from 16 to 35 percent between 2009 and 2011. And, 85 percent of hospitals now report that by 2015 they intend to take advantage of the incentive payments made available through the Medicare and Medicaid EHR Incentive Programs.”).

⁹⁹ Mosher, *supra* note 84, at 234–35.

¹⁰⁰ See Margaret M. Richards, *Electronic Medical Records: Confidentiality Issues in the Time of HIPAA*, 40 PROF. PSYCHOL. 550, 550 (2009).

¹⁰¹ See *The Multidisciplinary Team Approach to Healthcare*, YAHOO! VOICES (Jun. 29, 2007), http://www.associatedcontent.com/article/291553/the_multidisciplinary_team_approach.html?cat=5; *Mental Illness Exact Heavy Toll, Beginning in Youth*, NAT'L INST. OF HEALTH & MED. (June 6, 2005), <http://www.nimh.nih.gov/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml> (“Multidisciplinary teams, as the name implies, are teams of people from different disciplines that come together for a common purposes. . . . With a diverse group of healthcare professionals, such as physicians, nurses, pharmacists, dieticians, and health educators, social service and mental health providers there is more certainty that all the needs of the patient will be met.”).

treatment.¹⁰² In addition, multidisciplinary teams benefit patients because they are also more likely to meet a patient's needs by approaching the patient's care from different angles.¹⁰³ In the case of breast cancer, for example, specialized health-care professionals, including oncologists and psychotherapists, provide a "continuum of care through diagnosis, treatment, recovery, and survivorship."¹⁰⁴

Despite the advantages, multidisciplinary teams create unique ethical conflicts.¹⁰⁵ Naturally, a key component to a multidisciplinary team approach is sharing information.¹⁰⁶ This makes it difficult for psychotherapists to protect a patient's confidentiality.¹⁰⁷ It is even more complicated when all members of a team have access to a patient's medical record.¹⁰⁸ Conversely, the psychotherapist is allowed see a client's entire medical history in order to reach a more accurate diagnosis.¹⁰⁹ Yet, some patients do not want to share information with others for fear of the negative effects of stigma, potential loss of employment or benefits, or embarrassment.¹¹⁰

2. Data Security

In addition to expanding access to patient records due to EHR, another key concern is data security. With the increased use of EHR, some patients do not believe that their medical records will remain confidential if stored electronically.¹¹¹ In a 2009 opinion poll con-

¹⁰² See *The Multidisciplinary Team Approach to Healthcare*, *supra* note 101. Among patients diagnosed with mental disorders, at least 24 percent have known physical disorders and many more have unrecognized or untreated physical comorbidity. Bonnie Davis, *Assessing Adults with Mental Disorders in Primary Care*, 29 THE NURSE PRACTITIONER 19, 19 (2004). "[T]he most common general medical conditions that cause psychiatric symptoms are from the cardiovascular, endocrine, immune, and neurological systems . . ." *Id.* at 26.

¹⁰³ *The Multidisciplinary Team Approach to Healthcare*, *supra* note 101.

¹⁰⁴ *Id.*

¹⁰⁵ Richards, *supra* note 100, at 553.

¹⁰⁶ *The Multidisciplinary Team Approach to Healthcare*, *supra* note 101.

¹⁰⁷ Richards, *supra* note 100, at 550.

¹⁰⁸ *Id.* at 550.

¹⁰⁹ *See id.*

¹¹⁰ *See id.*

¹¹¹ *The Public and the Health Care Delivery System*, KFF.ORG 1, 4 (Apr. 2009), available at <http://www.kff.org/kaiserpolls/upload/7888.pdf>. When asked, "If your medical records and personal health information were to be stored electronically and could be shared online, how confident are you that those records and information would remain confidential? Are you very confident, somewhat confident, not too confident, or not at all confident?" Twenty-five participants responded "not too confident" and thirty-four responded "not confident at all," whereas eleven responded "very confident," and thirty responded "somewhat confident." *Id.* Even with a +/-

ducted by the Harvard School of Public Health, among participants who were asked whether they were confident that their medical records and personal health information would remain confidential if stored electronically, only 11 percent responded “very confident.”¹¹² Thirty-four percent responded that they were “not at all confident.”¹¹³

Moreover, data security lapses or breaches occur with alarming frequency. In its 2010 Benchmark Study on Patient Privacy and Data Security, the Ponemon Institute reported that “[s]ixty percent of organizations in [its] study had more than two data breaches in the past two years;” in 2011, the Ponemon Institute’s second annual study reported that “the number of data breaches among healthcare organizations participating in the 2010 and 2011 studies is still growing—eroding patient privacy. . . .”¹¹⁴ News stories reinforce Ponemon’s report. Data security lapses or breaches occur with alarming frequency. For example, in 2008, a New York Presbyterian Hospital employee stole information from 40,000 patient records.¹¹⁵ In 2010, another employee inadvertently placed data on a server, and, as a result, over 6,800 patient records were accessible online.¹¹⁶

As a result of the effects that modern health-care delivery have on confidentiality and data security, HHS needs to strengthen its privacy protection for psychotherapy records. Fears related to access of high-

3.5 percentage points margin of sampling error, a majority is not confident that their personal health information will remain confidential if stored electronically. *Id.* at 2, 4. See Peel, *supra* note 94.

¹¹² *The Public and the Health Care Delivery System*, *supra* note 111, at 4.

¹¹³ *Id.*

¹¹⁴ Sixty-five health-care organizations participated in the study. PONEMON INST., BENCHMARK STUDY ON PATIENT PRIVACY AND DATA SECURITY 1–2, 16 (Nov. 9, 2010), *available at* [http://www.dgshealthlaw.com/uploads/file/Ponemon_Benchmark_Study_on_Patient_Privacy_and_Data_Security%5B1%5D\(1\).pdf](http://www.dgshealthlaw.com/uploads/file/Ponemon_Benchmark_Study_on_Patient_Privacy_and_Data_Security%5B1%5D(1).pdf) (“The top three causes of breach are: unintentional employee action, lost or stolen computing devices and third-party snafu.”); see also PONEMON INST., SECOND ANNUAL BENCHMARK STUDY ON PATIENT PRIVACY & DATA SECURITY 1 (Dec. 2011), *available at* http://www2.idexpertscorp.com/assets/uploads/PDFs/2011_Ponemon_ID_Experts_Study.pdf (“The frequency of data breaches among organizations in this study has increased 32 percent from the previous year. In fact, 96 percent of all healthcare providers say they have had at least one data breach in the last two years. Most of these were due to employee mistakes and sloppiness—49 percent of respondents in this study cite lost or stolen computing devices and 41 percent note unintentional employee action. Another disturbing cause is third-party error, including business associates, according to 46 percent of participants.”).

¹¹⁵ *Patients’ Data Stolen, Hospital Says*, N.Y. TIMES (Apr. 12, 2008), <http://www.nytimes.com/2008/04/12/nyregion/12records.html>.

¹¹⁶ *City Hospital Apologizes for Information Leak*, CBS N.Y.COM (Sept. 27, 2010, 7:59 PM), <http://newyork.cbslocal.com/2010/09/27/city-hospital-apologizes-for-patients-info-leak/>.

ly sensitive personal information combined with legitimate concerns about stigma will continue to act as barriers to patients who need to seek treatment for mental illness. Mental health patients need more assurance that their most sensitive information will be protected.

By setting a standard that allows psychotherapists to place highly sensitive patient information in databases or systems that are subject to security breaches and accessible to hundreds of people, psychotherapist-patient confidentiality is eroding. Although patients can still be treated for mental illness using other treatments such as medication, an effective treatment method—psychotherapy—may become ineffective. Psychotherapy might be limited to those who can afford to pay out-of-pocket in order to keep their personal information “offline.” However, it is unclear whether the government will continue to *allow* offline psychotherapy, as evidenced by aggressive incentivizing and penalizing tools. The ultimate result may be stagnation or regression in understanding and treating mental illness.

IV. THE HIPAA PRIVACY RULE: PREEMPTION AND APPLICABILITY

A. The Privacy Rule Does Not Preempt More Stringent State Laws

The Privacy Rule created for the first time a set of national standards for the protection of medical records.¹¹⁷ The Privacy Rule set the “floor of ground rules.”¹¹⁸ Thus, if a state’s laws provide more privacy protection for psychotherapist-patient communications and psychotherapy records, the state’s laws supersede the Privacy Rule.¹¹⁹ Although many states’ laws provide more protection than the Privacy Rule,¹²⁰ HHS set the floor too low, and the minimum requirements need to be raised, as illustrated by the example about Grace in Part I.

¹¹⁷ See Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462, 82,464 (Dec. 28, 2000).

¹¹⁸ *Id.*

¹¹⁹ See *id.*

¹²⁰ See Jonathan White et al., *Privacy and Security Solutions for Interoperable Health Information Exchange: Report on State Law Requirements for Patient Permission to Disclose Health Information*, U.S. DEP’T OF HEALTH & HUMAN SERVS. § 3.1 (Aug. 2009), http://www.healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10741_910326_0_0_18/DisclosureReport.pdf.

Furthermore, although HHS intended for the Privacy Rule to provide only a minimum threshold,¹²¹ at least one state changed its more stringent law to reflect the Privacy Rule. In 2009, Ohio changed its community mental health statute from requiring authorization for disclosure in most instances to allowing unauthorized disclosure to facilitate continuity of care¹²² because the “[Ohio Department of Mental Health] felt it was critical that Ohio law be brought in line with HIPAA.”¹²³ More states may place “continuity of care” and consistency with the HIPAA Privacy Rule ahead of privacy and change more stringent laws to the minimum required. Thus, the HHS threshold should be raised.

B. Applicability of the HIPAA Privacy Rule

The Privacy Rule applies to covered entities—a health plan, a health plan clearinghouse, or a health care provider that transmits any health information in electronic¹²⁴ form in connection with a transaction covered under the Privacy Rule.¹²⁵ Transactions covered under the Privacy Rule include, but are not limited to, treatment, payment,

¹²¹ See Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. at 82,464.

¹²² OHIO REV. CODE ANN. § 5122.31 (A)(7) (LexisNexis 2011) (“That hospitals within the department, other institutions and facilities within the department, hospitals licensed by the department . . . and community mental health agencies may exchange psychiatric records and other pertinent information with payers and other providers of treatment and health services if the purpose of the exchange is to facilitate continuity of care for a patient.”); see also Letter from Sandra Stephenson, MSW, MA, Director of the Ohio Dep’t of Mental Health, to Stakeholders, Ohio Community Mental Health System (Oct. 13, 2009), available at <http://www.mh.state.oh.us/assets/client-rights/community-rights-training-2010-confidentiality-memo.pdf>.

¹²³ Stephenson, *supra* note 122.

¹²⁴ Under the Privacy Rule, electronic is defined as “electronic storage media, including . . . hard drives and any removable [or] transportable digital memory medium.” Definitions, 45 C.F.R. § 160.103 (2011); Relationship to Other Parts, 45 C.F.R. § 164.106 (2011) (“In complying with the requirements of this part, covered entities are required to comply with the applicable provisions of parts 160 and 162 of this subchapter.”). Electronic media also means, “[t]ransmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet . . . [and] extranet . . . , leased lines, dial-up lines, private networks, and the physical movement of removable [or] transportable electronic storage media.” *Id.* § 160.103 (2011). However, electronic excludes transmissions made by “paper, via facsimile, and of voice, via telephone.” *Id.* These methods of delivery “are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.” *Id.*

¹²⁵ Statutory Basis, 45 C.F.R. § 164.102 (2011).

and health-care operations.¹²⁶ Although “covered entity” and “transaction” are more broadly defined under the Privacy Rule, the scope of this Note is limited to health-care providers¹²⁷ and treatment¹²⁸ as defined by the Privacy Rule. In summary, the Privacy Rule’s applicability provision is very broad and, in the near future, it will be nearly impossible for a health-care provider to avoid the Privacy Rule’s penumbra.

V. “PSYCHOTHERAPY NOTES” UNDER THE HIPAA PRIVACY RULE

A. Process Notes Become Psychotherapy Notes

Prior to the implementation of the Privacy Rule, psychotherapists often kept “progress notes,” which recorded “[s]ummary information, such as current state of the patient, symptoms, summary of the theme of the psychotherapy session, diagnoses, medication prescribed, side effects, and any other information necessary for treatment or payment.”¹²⁹ This information was kept in the patient’s general medical

¹²⁶ See Uses and Disclosures for Which an Authorization is Required, 45 C.F.R. § 164.508(a)(2)(i) (2011). For definitions of treatment, payment, and health-care operations see *id.* § 164.501.

¹²⁷ A health-care provider under HIPAA means “[e]very health care provider, regardless of size, who electronically transmits health information in connection with certain transactions” *Summary of the HIPAA Privacy Rule*, HHS.GOV 2 (Apr. 2003),

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>. “These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which HHS has established standards under the HIPAA [Privacy Rule].” *Id.* “Using electronic technology, such as email, does not mean a health care provider is a covered entity; the transmission must be in connection with a standard transaction.” *Id.* “The Privacy Rule covers a health care provider whether it electronically transmits these transactions directly or uses a billing service or other third party to do so on its behalf.” *Id.* “Health care providers include all ‘providers of services’ (e.g., institutional providers such as hospitals) and ‘providers of medical or health services’ (e.g., non-institutional providers such as physicians, dentists and other practitioners) as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care.” *Id.*

¹²⁸ “Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.” Definitions, 45 C.F.R. § 164.501 (2011).

¹²⁹ See 65 Fed. Reg. at 82,462, 82,622–23 (Dec. 28, 2000) (to be codified at 45 C.F.R. pt. 164).

file.¹³⁰ Some psychotherapists also kept “process notes,” which contained the psychotherapist’s “impressions about the patient . . . details of the psychotherapy conversation considered to be inappropriate for the medical record, and . . . used by the provider for future sessions.”¹³¹ Process notes were “often kept separate to limit access, even in an electronic record system, because they contain sensitive information relevant to no one other than the treating provider.”¹³²

HHS recognized this practice and commented that “these separate ‘process notes’ are what we are calling ‘psychotherapy notes.’”¹³³ HHS further commented that psychotherapy notes are the “personal notes of the treating provider and are of little or no use to others who were not present at the session to which the notes refer.”¹³⁴ HHS made clear that psychotherapy notes are “not intended to communicate to, or even be seen by, persons other than the therapist.”¹³⁵ HHS limited the definition of psychotherapy notes by stating that they “do not refer to the medical record and other sources of information that would normally be disclosed for treatment, payment, and health care operations.”¹³⁶

Nevertheless, HHS acknowledged that not everyone agreed that only personal notes of the treating provider should be contained in psychotherapy notes. In the December 28, 2000 version of the Privacy Rule, HHS stated that many commentators who responded to the proposed rule believed that “psychotherapy notes should include frequencies of treatment, results of clinical tests, and summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.”¹³⁷ The commentators claimed that “this information is highly sensitive and should not be released without the individual’s written consent, except in cases of emergency.”¹³⁸ HHS responded by stating that it did not want psychotherapy notes to be the “only source of information that [is] critical for the treatment of the patient or for

¹³⁰ *Id.* at 82,623.

¹³¹ *Id.* at 82,622–23.

¹³² *Id.* at 82,623.

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.* The final Privacy Rule published in December 2000 was later modified by the final Privacy Rule published on August 14, 2002, *See* 67 Fed. Reg. at 14775, 14776–77 (Mar. 27, 2002) (Proposed Rule); *see* 67 Fed. Reg. at 67 Fed. Reg. at 53181, 53182 (Aug. 14, 2002) (Final Rule); *see also* *Health Information Privacy: HIPAA Administrative Simplification Statute and Rules*, U.S. DEP’T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/ocr/privacy/hipaa/administrative/index.html> (last visited Apr. 16, 2012).

¹³⁸ *Id.*

getting payment for the treatment,” which is in part why HHS created eight exceptions and restricted its definition of psychotherapy notes.¹³⁹

Ironically, the expanding use of technology and the growing need to share patient information prompted Congress to pass HIPAA in 1996 and require HHS to promulgate the Privacy Rule.¹⁴⁰ Yet, the psychotherapy notes provision reinforced old practices and failed to properly consider the changes to the health-care system caused by expanded use of EHR, including the growing number of person who have access to a patient’s medical records. HHS should have used the Privacy Rule to strengthen protection for psychotherapy records and not just maintained the status quo.

B. Psychotherapy Notes Defined under the HIPAA Privacy Rule

The Privacy Rule defines psychotherapy notes, first, as notes taken by a mental health professional “documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session.”¹⁴¹ Thus, if notes are recorded from a psychological assessment conducted outside of a counseling session, these notes do not qualify as “psychotherapy notes.” Additionally, if a patient discusses her mental health with a provider other than a mental health professional, the notes taken about this conversation are not “psychotherapy notes.” Although this definition limits psychotherapy notes, it is reasonable because the purpose of the protection is full and frank disclosure in the context of psychotherapy. However, because “psychotherapy notes” may lead some to believe this term of art encompasses all medical records related to mental health, health-care providers should provide more explicit notice to patients explaining the distinction and its mental health record keeping policies.

Second, to qualify as psychotherapy notes, these notes *must* also be separated from the rest of the individual’s medical record.¹⁴² Sepa-

¹³⁹ *Id.*

¹⁴⁰ *Id.* at 82,462–63 (“In enacting HIPAA, Congress recognized the fact that administrative simplification cannot succeed if we do not also protect the privacy and confidentiality of personal health information. The provision of high-quality health care requires the exchange of personal, often-sensitive information between an individual and a skilled practitioner. Vital to that interaction is the patient’s ability to trust that the information shared will be protected and kept confidential.”); Congress found that although both federal and state laws existed to protect privacy, there were gaps in privacy protections related to health care. *Id.* at 82,463–64.

¹⁴¹ Definitions, 45 C.F.R. § 164.501 (2011).

¹⁴² *Id.*

rate is not defined under the Privacy Rule, but it is logical to conclude that separate means in a physically distinct filing space—whether virtual or physical. If psychotherapy notes are not kept separate and are charted or stored with the patient’s general medical chart, the notes cease to be “psychotherapy notes.”

C. General Exceptions to Requiring Authorized Disclosure for Psychotherapy Notes

Under the Privacy Rule, if a psychotherapist creates “psychotherapy notes,” patient authorization is required for use or disclosure in most circumstances.¹⁴³ However, even if a psychotherapist separates notes from a patient’s general medical chart, she may use or disclose the notes without authorization for multiple reasons, including:

- 1) when necessary to lessen the threat of imminent death or other severe consequences to a person or the public;¹⁴⁴
- 2) use by the originator of the psychotherapy notes for treatment;¹⁴⁵
- 3) use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling;¹⁴⁶
- 4) use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual;¹⁴⁷
- 5) use or disclosure to a health oversight agency that is required or permitted with respect to oversight of the originator of the

¹⁴³ See Uses and Disclosures for Which an Authorization Is Required, 45 C.F.R. § 164.508(a)(2) (2011).

¹⁴⁴ Uses and Disclosures for Which an Authorization or Opportunity to Agree or Object Is Not Required, 45 C.F.R. § 164.512(j)(1)(i) (2011). Section 164.512(j)(1)(i) permits a covered entity, “consistent with applicable law and standards of ethical conduct, [to] use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure” is both “necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public” and “is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.” *Id.*

¹⁴⁵ 45 C.F.R. § 164.508(a)(2)(i)(A) (2011).

¹⁴⁶ *Id.* § 164.508(a)(2)(i)(B) (2011).

¹⁴⁷ *Id.* § 164.508(a)(2)(i)(C) (2011).

psychotherapy notes;¹⁴⁸

6) when required to investigate or determine the covered entity's compliance with e-privacy of individually identifiable health information;¹⁴⁹

7) disclosure of personal health information to a coroner or medical examiner in order to assist the coroner to identify the decedent, determine cause of death or as required by law;¹⁵⁰

8) in circumstances required by law.¹⁵¹

Most of the above-mentioned exceptions provide a reasonable risk-benefit ratio for allowing unauthorized disclosure of psychotherapy notes.¹⁵² In order to protect others from harm, the law requires a health provider to breach psychotherapist-patient confidentiality if there is a risk of danger to a third party and in circumstances required by law such as reporting neglect or domestic violence.¹⁵³ Additionally, a covered entity is permitted to disclose psychotherapy notes without authorization when necessary to lessen the threat of imminent death or other severe consequences to the patient.¹⁵⁴ When there is the possibility of harm to a patient or a third party, there are easily identifiable ethical reasons for creating an exception to the Privacy Rule. Furthermore, assisting a coroner or medical examiner in identifying a decedent or determining the cause of death¹⁵⁵ is a reasonable exception. If a person is deceased, not much more harm could come to the patient. Certainly, wealthy or famous persons might argue that it harms the decedent's reputation or estate, but the Privacy Rule's

¹⁴⁸ Uses and Disclosures for Which an Authorization or Opportunity to Agree or Object Is not Required, 45 C.F.R. § 164.512(d) (2011); 45 C.F.R. § 164.508(a)(2)(ii) (2011).

¹⁴⁹ Uses and Disclosures of Protected Health Information, 45 C.F.R. § 164.502(a)(2)(ii).

¹⁵⁰ 45 C.F.R. § 164.512(g)(1) (2011).

¹⁵¹ *Id.* § 164.512 (including, but not limited to, disclosures for law enforcement purposes; disclosures about victims of abuse, neglect or domestic violence; and disclosures of personal health information in judicial and administrative proceedings).

¹⁵² Mermelstein & Wallack, *supra* note 17, at 99.

¹⁵³ 45 C.F.R. § 164.512(c) (2011); Mermelstein & Wallack, *supra* note 17, at 99; 45 C.F.R. § 164.512 (including, but not limited to disclosures for law enforcement purposes; disclosures about victims of abuse, neglect or domestic violence; and disclosures of personal health information in judicial and administrative proceedings).

¹⁵⁴ 45 C.F.R. § 164.512(j)(1)(i) (2011); Mermelstein & Wallack, *supra* note 17, at 99 ("HIPAA standards permit disclosure of medical information in the interest of caring for patients and protecting patients or the community . . .").

¹⁵⁵ 45 C.F.R. § 164.512(g)(1) (2011).

psychotherapy notes provision is limited to treatment of mental illness.¹⁵⁶

Other reasonable exceptions include use by the covered entity to defend against a legal action,¹⁵⁷ or satisfy the requirements of oversight¹⁵⁸ or compliance.¹⁵⁹ Use or disclosure by the covered entity to defend against a legal action is commonplace. Self-regulating professional bodies often grant its members this exception.¹⁶⁰ Moreover, there are privacy protections that a patient could request from the court, such as a placing protective order on the documents.¹⁶¹

Oversight and compliance exceptions are commonplace as well.¹⁶² Legislatures or administrative agencies will often include exceptions in order to facilitate compliance with statutes or regulations.¹⁶³ Although these exceptions do lessen privacy protection and diminish psychotherapist-patient confidentiality, they are often necessary for enforcement purposes. Furthermore, these provisions protect the patient because they ensure that the originator of the psychotherapy notes is complying with the law, including provisions of the Privacy Rule.

¹⁵⁶ See Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462, 82,464 (Dec. 28, 2000).

¹⁵⁷ Uses and Disclosures for Which an Authorization is Required, 45 C.F.R. § 164.508(a)(2)(i)(C) (2011).

¹⁵⁸ *Id.* § 164.502(a)(2)(ii); see *id.* § 164.506.

¹⁵⁹ *Id.* § 164.512(d).

¹⁶⁰ See, e.g., MODEL RULES OF PROF'L CONDUCT R. 1.6(b)(5) (2011), available at http://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/rule_1_6_confidentiality_of_information.html ("A lawyer may reveal information relating to the representation of a client to the extent the lawyer reasonably believes necessary: to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer's representation of the client.").

¹⁶¹ *Lahrichi v. Lumera Corp.*, No. C04-2124C, 2005 WL 2898145, at * 3-4 (W.D. Wash. Nov. 1, 2005) (placing a "HIGHLY CONFIDENTIAL-SEALED" protective order on the plaintiff's mental health records); *Gaines-Hanna v. Farmington Public Schools*, No. 04-CV-74910-DT, 2006 WL 932074, at *10-12 (E.D.Mich. Apr. 7, 2006) (ordering plaintiff to permit the inspection and release of her psychiatric records, but made subject to a protective order limiting their use).

¹⁶² See, e.g., MASS. GEN. LAWS ch. 112, § 5 (2011), available at <http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section5>.

¹⁶³ See, e.g., Massachusetts Board of Registration in Medicine, *Physician Obligations with Respect to Patient Medical Records*, MASS.GOV, <http://www.mass.gov/eohhs/docs/borim/physicians/medical-record-obligations.pdf> (last visited Feb. 22, 2012).

Using psychotherapy notes for training purposes is reasonable as well.¹⁶⁴ Certainly, when using psychotherapy notes for training purposes, mental health practitioners should de-identify the record whenever possible. But the Lasagna Oath states, “I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.”¹⁶⁵ Thus, this too is a justifiable exception.

However, there is one exception that is problematic. The originator of the psychotherapy notes may use them for treatment without patient authorization.¹⁶⁶ This provision gives psychotherapists unilateral discretion to decide whether or not to use or disclose psychotherapy notes. As shown by the Grace example in Part I, this exception may cause harmful consequences, such as a patient’s decision to forego psychotherapy altogether. Nevertheless, discretion is not necessarily the issue. If the Privacy Rule psychotherapy notes provision contained additional requirements and restrictions, this exception would be more reasonable. For example, when treating a patient with chronic co-occurring conditions, specialists may need to share information in order to provide the patient with the best treatment possible.¹⁶⁷ However, because the Privacy Rule’s notice requirements are weak, patients lose confidence and trust in the psychotherapy-patient relationship when surprised by seemingly unnecessary and potentially harmful disclosures.

Another difficulty with unilateral disclosure is that some psychotherapists do not see an advantage to keeping psychotherapy notes so they record all notes in the patient’s general medical chart. Moreover, some do not even know that the provision exists. In a 2008 study conducted at Nova Southwestern University, which questioned doctoral level psychologists who were members of the APA and self-identified as clinical practitioners, researchers found that one-fifth of respondents were unaware of the “HIPAA provision allowing practitioners to keep a separate set of psychotherapy notes.”¹⁶⁸ Seventy-nine percent of those surveyed said they were aware of the Privacy Rule allowing for separate notes.¹⁶⁹ Yet, only 46 percent of those who were aware actually kept a separate set of psychotherapy notes, although “half

¹⁶⁴ Uses and Disclosures for Which an Authorization is Required, 45 C.F.R. § 164.508(a)(2)(i)(B) (2011).

¹⁶⁵ Tyson, *supra* note 18.

¹⁶⁶ 45 C.F.R. § 164.508(a)(2)(i) (2011).

¹⁶⁷ Richards, *supra* note 100, at 554.

¹⁶⁸ Julie L. DeLettre & Linda Carter Sobell, *Keeping Psychotherapy Notes Separate from the Patient Record*, 17 CLINICAL PSYCHOL. & PSYCHOTHERAPY 160, 162–63 (2010).

¹⁶⁹ *Id.* at 162.

(49%) [of the respondents] felt that patients benefit most from the use of a separate set of psychotherapy notes.”¹⁷⁰ Finally, on a scale of one to ten, respondents mean rating of how helpful the psychotherapy notes provision was to their practice was a five.¹⁷¹

Patients cannot benefit from the psychotherapy notes provision if mental health practitioners do not perceive an advantage to keeping psychotherapy notes or if therapists are altogether unaware of the provision. HHS should expand the scope of “psychotherapy notes” so that mental health practitioners perceive a benefit to the patient, as well as promote continuing education to ensure that practitioners are aware of the provision.

VI. OUTSIDE THE SCOPE OF “PSYCHOTHERAPY NOTES”

Even if a mental health practitioner keeps psychotherapy notes separate from the patient’s general medical chart, there are five exclusions to the definition of psychotherapy notes. The following are excluded from the definition of psychotherapy notes:

- any summary of diagnosis, symptoms, functional status, treatment plan, prognosis, and progress to date;
- modalities and frequencies of treatment furnished;
- counseling session start and stop times;
- results of clinical tests; and
- medication, prescription, and monitoring.¹⁷²

If a mental health practitioner includes in the patient’s general medical file medication information, counseling session start and stop times, treatment furnished, results of clinical tests, and a summary of diagnosis, functional status, symptoms, prognosis, and progress to date—what remains confidential?

Under the Privacy Rule, this excluded information is categorized as protected health information (PHI).¹⁷³ A covered entity has almost complete discretion regarding disclosure or use of PHI in treatment, payment, and health-care operations.¹⁷⁴ No authorization is required

¹⁷⁰ *Id.*

¹⁷¹ *See id.*

¹⁷² *See* Definitions, 45 C.F.R. § 164.501 (2011).

¹⁷³ Applicability, 45 C.F.R. § 164.500 (2011). PHI is defined as “individually identifiable health information,” which is “transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium.” Definitions, 45 C.F.R. § 160.103 (2011).

¹⁷⁴ *See* Uses and Disclosures to Carry out Treatment, Payment, or Health Care Operations, 45 C.F.R. § 164.506(a) (2011).

for use of PHI in treatment.¹⁷⁵ Thus, unless a covered entity has a policy of separating or restricting access to information related to mental health, any person involved in a patient's care can see what medication a patient is taking to treat a mental illness, how often a patient attends counseling, what type and the frequency of treatment, and results of clinical tests. Additionally, any person involved in a patient's medical care also has access to a summary of the patient's mental health diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

For the sake of brevity, this Note will not analyze each exclusion separately. The following is a summary of common arguments for and against disclosure of excluded information.

A. Arguments against Disclosure of Excluded Information

Disclosure of any one of the exclusions alone may reveal a significant amount of sensitive, and possibly stigmatizing or embarrassing information about the patient. Take diagnosis as an example. Mental disorders are commonly diagnosed by using the criteria set forth in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), which is published by the American Psychiatric Association.¹⁷⁶ For each diagnosable disorder the patient must meet the requirements specified.¹⁷⁷

For example, under the DSM-IV-TR a "major depressive episode" may include feelings of worthlessness, guilt, recurrent thoughts of death, or suicidal ideation.¹⁷⁸ As evidenced by the diagnostic criteria of major depressive episode, mental disorder diagnosis reveals a significant amount of information about the patient. Even if a psychotherapist does not include a patient's subjective disclosures in the general medical chart, a patient's sensitive communications are impliedly

¹⁷⁵ *Id.* § 164.506; see *Uses and Disclosures for Treatment, Payment, and Health Care Operations*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Apr. 3, 2003), available at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/sharingfortpo.pdf>.

¹⁷⁶ See generally AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text revised 2000) [hereinafter DSM-IV-TR].

¹⁷⁷ See generally *id.* at 27-35. The DSM-IV-TR includes five axes and each is used to diagnose patients. *Id.* But a lengthy explanation of the proper use of the DSM-IV-TR is beyond the scope of this Note. For purposes of this Note, the use of the DSM-IV-TR is only to show how including information contained in the DSM-IV-TR affects confidentiality.

¹⁷⁸ DSM-IV-TR, *supra* note 176, at 349.

revealed through diagnosis alone. A major depressive episode is just one example. There are more than 250 disorders in the DSM-IV-TR¹⁷⁹ Any one of these diagnoses reveals a significant amount of information about a patient.

The summary of symptoms exclusion is another example of how the exclusions reveal a significant amount of sensitive information about a patient. In fact, symptoms probably reveal the most sensitive information about a patient. Unlike a symptom such as joint ache caused by arthritis, symptoms for mental illness may include extremely embarrassing and stigmatizing information. For example, following is “classic example” of symptoms of an adolescent with Borderline Personality Disorder (BPD):¹⁸⁰

“Tammy” has been hospitalized for depression, thoughts of suicide, and self-injury at least a dozen times. The few friends she has get burned out by her mood swings and neediness. She can go from loving her friends to hating them in seconds. She uses drugs and self-injury to stem her self-loathing. Tammy trades sex for drugs and alcohol, and thinks that sex is the only way to get males to like her. Many of her sexual encounters have been brief and unrewarding; some have been abusive. But she feels she deserves abusive relationships because she is a terrible person and deserves to be punished. . . . Tammy is only 16 . . .¹⁸¹

Although adolescents or adults with BPD do not all behave exactly alike, many present similarly with co-occurring mental illness, drug or alcohol use, self-injurious behavior, or suicidal thoughts.¹⁸² Again, a great deal of sensitive information may be disclosed if symptoms of a mental disorder are included in a patient’s general medical chart.

Unlike a disease that can be diagnosed by a blood test, mental disorders are often diagnosed by relying in large part upon a patient’s disclosures.¹⁸³ Other objective tests may help to rule out other possible causes, such as hypothyroidism that causes similar symptoms to depression, but for diagnosis of mental disorders, patient disclosure is critical.¹⁸⁴ Because a psychotherapist must rely heavily on a patient’s

¹⁷⁹ See generally *id.*

¹⁸⁰ *Id.* at 706–10.

¹⁸¹ Blaise Aguirre, *Borderline Personality Disorder in Adolescents*, PSYCHOLOGY TODAY (June 1, 2010), <http://www.psychologytoday.com/blog/stop-walking-eggshells/201006/borderline-personality-disorder-in-adolescents>.

¹⁸² John Gunderson, *The McLean Center for the Treatment of Borderline Personality Disorder*, MCLEAN HOSP. (Aug. 2012), <http://www.mclean.harvard.edu/patient/adult/bpd.php>.

¹⁸³ See *supra* Part III.A.

¹⁸⁴ Davis, *supra* note 102, at 26.

disclosures to diagnose, an environment of trust between patient and therapist is critical.¹⁸⁵ As already mentioned, psychotherapy-patient confidentiality is critical to trust and disclosure.¹⁸⁶ Moreover, if patients know that stigmatizing and embarrassing information is going to be revealed to hundreds of strangers, some will forego treatment altogether.¹⁸⁷ Thus, any policies that diminish psychotherapist-patient confidentiality should be looked at critically to make sure that the advantages of disclosure outweigh the disadvantages.

B. Arguments for Disclosure of Excluded Information

In certain circumstances, there are important or even vital reasons to include mental health information in a patient's medical chart.¹⁸⁸ Sharing information is needed to treat comorbid diseases.¹⁸⁹ Recent studies indicate that mental illness has a high degree of comorbidity.¹⁹⁰ Among patients diagnosed with mental disorders, at least 24 percent have known physical disorders and many more have unrecognized or untreated physical comorbidity.¹⁹¹ General medical conditions that commonly "cause psychiatric symptoms stem from the cardiovascular, endocrine, immune, and neurological systems."¹⁹² For example, depression is common in patients with diabetes and heart disease, and the combination has been linked to poor self-management, complications, and even death.¹⁹³ Women with both diabetes and depression have a greater chance of death from heart disease.¹⁹⁴ In fact, after a six-year study conducted by Harvard School of Public Health in Boston, An Pan and his colleagues found that

¹⁸⁵ See *supra* Part III.A.

¹⁸⁶ *Id.*

¹⁸⁷ See *supra* Part III.B–C.

¹⁸⁸ See Rick Nauert, *Anxiety Sensitivity Influences Cardiac Treatment Approach*, PSYCHCENTRAL (Oct. 27, 2010), <http://psychcentral.com/news/2010/10/27/anxiety-sensitivity-influences-cardiac-treatment-approach/20199.html>.

¹⁸⁹ See *supra* Part III.

¹⁹⁰ *Mental Illness Exact Heavy Toll, Beginning in Youth*, *supra* note 101.

¹⁹¹ Davis, *supra* note 102, at 19.

¹⁹² *Id.* at 26.

¹⁹³ *Team Approach Works Best Fighting Depression with Diabetes, Heart Disease*, PSYCHCENTRAL (Jan. 1, 2011), <http://psychcentral.com/news/2010/12/31/team-approach-works-best-fighting-depression-with-diabetes-heart-disease/22204.html>.

¹⁹⁴ *Depression, Diabetes, Heart Disease Linked*, UPI.COM (Jan. 5, 2011, 12:00 AM), http://www.upi.com/Health_News/2011/01/05/Depression-diabetes-heart-disease-linked/UPI-55161294203633/.

“when considering only deaths from cardiovascular disease, women with diabetes had a 67 percent increased risk, women with depression had a 37 percent increased risk and women with both had a 2.7-fold increased risk.”¹⁹⁵ Additionally, physical symptoms may make psychiatric symptoms worse.¹⁹⁶ As a result, more and more psychologists are teaming up with other health-care providers to treat co-occurring disorders.¹⁹⁷ And teaming up is often proving effective.¹⁹⁸

In a study conducted by the University of Washington (UW) and the Group Health Research Institute found that in a randomized controlled trial that tested team care, when nurses worked with patients and health teams to manage care for depression and physical disease together, results showed less depression and better control of blood sugar, blood pressure, and cholesterol.¹⁹⁹ However, it should be noted that this study did not include collaboration with a psychotherapist. The UW study treated depression using medication.²⁰⁰

Sharing information helps clinicians effectively diagnosis and treat disorders. When clinicians isolate information, a patient may not receive the best care possible. Nevertheless, there may be significant costs to psychotherapy if collaborative policies diminish or altogether eliminate confidentiality.

C. Medication Prescription and Monitoring

Medication prescription and monitoring is an exclusion to the psychotherapy notes provision that should not be altered. Because of the possibility of severe adverse interactions between drugs²⁰¹ and other negative effects caused by medication use,²⁰² this exclusion is

¹⁹⁵ *Id.*

¹⁹⁶ *See id.*

¹⁹⁷ *Team Approach Works Best Fighting Depression with Diabetes, Heart Disease*, *supra* note 193.

¹⁹⁸ *See id.*; *see Coordinated Treatment Approach Improves Anxiety Symptoms*, NAT'L INST. OF MENTAL HEALTH (May 18, 2010), <http://www.nimh.nih.gov/science-news/2010/coordinated-treatment-approach-improves-anxiety-symptoms.shtml>.

¹⁹⁹ *Team Approach Works Best Fighting Depression with Diabetes, Heart Disease*, *supra* note 193.

²⁰⁰ *See id.*

²⁰¹ *See Jones v. Bick*, 896 So. 2d 737, 737–48 (Fla. 2004) (finding that a doctor failed to meet the standard of care when he did not consider warnings contained in the Physicians' Desk Reference (PDR) concerning the anti-psychotic drug prescribed to a patient who subsequently died of cardiac arrest), *cert. denied*, 896 So. 2d 1043 (2005).

²⁰² *See Information for Healthcare Professionals: Fluoxetine (Marketed as Prozac)*, FDA (July 2006),

necessary. At first glance, this exclusion may seem oddly placed because most psychotherapists are not permitted to prescribe medication.²⁰³ Likely, the reason for this exclusion is that some psychiatrists, in addition to prescribing medication, treat patients using psychotherapy.²⁰⁴

Like diagnosis and symptoms, medication use may reveal a great deal about a patient's mental health. Prozac²⁰⁵ and lithium²⁰⁶ are tell-tale signs of treatment for mental illness. Prozac is commonly used to treat depression and lithium carbonate is used for the treatment of manic depressive disorder.²⁰⁷ Having this information by itself reveals a great deal. If a person takes lithium carbonate and one presumes the person has manic depressive disorder then one can deduce a person's possible symptoms through the DSM-IV. Again, the DSM-IV symptoms may reveal potentially embarrassing or stigmatizing information. For example, the DSM-IV includes the following symptoms as evidence that a person may be suffering from a manic episode caused by manic depressive disorder: talking very fast, jumping from one idea to another, having racing thoughts, being easily distracted, being restless, losing sleep, having an unrealistic belief in one's abilities, and behaving impulsively and frequently taking part in high-risk behaviors, such as spending sprees, impulsive sex, and impulsive business investments.²⁰⁸

<http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/DrugSafetyInformationforHealthcareProfessionals/ucm084319.htm>.

²⁰³ The reason for this exclusion may also be that some states permit psychologists to prescribe medication. Martin F. Downs, *Psychology vs. Psychiatry: Which Is Better?*, WEBMD, <http://www.webmd.com/mental-health/features/psychology-vs-psychiatry-which-is-better?page=2> (last visited Apr. 16, 2012) (noting that Louisiana and New Mexico permit psychologists to prescribe medication).

²⁰⁴ *See id.*

²⁰⁵ Wilfred W. Acholonu, Jr., *Prozac (Fluoxetine)*, NAT'L ALLIANCE ON MENTAL HEALTH (July 2006), [http://www.nami.org/Content/ContentGroups/Helpline1/Prozac_\(fluoxetine\).htm](http://www.nami.org/Content/ContentGroups/Helpline1/Prozac_(fluoxetine).htm).

The DSM-IV-TR includes the following symptoms as evidence that a person may be suffering from a major depressive disorder: depressed mood; diminished pleasure in all or almost all activities; loss of appetite; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue and loss of energy; feelings of worthlessness; diminished ability to think or concentrate; indecisiveness; and recurrent thoughts of death. Thus, a great deal can be deduced from the word, "Prozac." DSM-IV-TR, *supra* note 176, at 349–51.

²⁰⁶ Leena B. Menon, *Lithium*, NAT'L ALLIANCE ON MENTAL HEALTH, <http://www.nami.org/Content/ContentGroups/Helpline1/Lithium.htm> (last updated Nov. 2010).

²⁰⁷ Acholonu, *supra* note 205; Menon, *supra* note 206.

²⁰⁸ DSM-IV-TR, *supra* note 176, at 357–58.

Although psychotherapist-patient confidentiality may be weakened by disclosing a patient's medications, there are strong policy reasons for excluding medication from psychotherapy notes and permitting disclosure in a patient's PHI. According to a 2006 study conducted by the Institute of Medicine (IOM), "1.5 million Americans are injured every year by medication errors."²⁰⁹ And as many as 7,000 patients die annually from medication errors.²¹⁰ The IOM study's findings make clear that medication errors are far-reaching.²¹¹

Medication errors commonly occur in treatment because a patient is prescribed a medication that adversely interacts with another prescribed medication.²¹² For example, combining Prozac and Imitrex, which is commonly used to treat migraine headaches, is potentially life-threatening.²¹³ If a patient's medication is not included in the general medical chart, there is a greater possibility of prescribing a contraindicated medication and an adverse interaction occurring.

Another reason for excluding medication information from psychotherapy notes and permitting disclosure in a patient's PHI is the consequences of side effects and other negative effects caused by the use of a medication. For example, if a mother takes Prozac after the twentieth week of her pregnancy, her newborn will be six times more likely to develop persistent pulmonary hypertension (PPHN).²¹⁴ An obstetrician treating an expectant mother will be better able to care for her knowing about her Prozac use. The obstetrician likely will sug-

²⁰⁹ *Q&A: Medication Errors in the United States*, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH (Aug. 3, 2006), http://www.jhsph.edu/publichealthnews/articles/2006/wu_medication_errors.html.

²¹⁰ *Id.*

²¹¹ *Id.*; see Kevin B. O'Reilly, *E-prescribing Urged as One Strategy to Prevent Medication Errors*, AM. MED. NEWS (Aug. 21, 2006), <http://www.ama-assn.org/amednews/2006/08/21/prsa0821.htm>. Beyond possible harm to patients' health, another consequence of medication errors is that it costs over \$3 billion annually. *Id.*

²¹² See *Information for Healthcare Professionals: Fluoxetine (Marketed as Prozac)*, *supra* note 202; see Acholonu, *supra* note 205.

²¹³ *Information for Healthcare Professionals: Fluoxetine (Marketed as Prozac)*, *supra* note 202; see Acholonu, *supra* note 205.

²¹⁴ *Information for Healthcare Professionals: Fluoxetine (Marketed as Prozac)*, *supra* note 202; Acholonu, *supra* note 205; PPHN is a "potentially serious but rare respiratory illness." Mallay Occhiograsso, et al, *Persistent Pulmonary Hypertension of the Newborn and Selective Serotonin Reuptake Inhibitors: Lessons from Clinical and Translational Studies*, 169 AM. J. PSYCHIATRY 134, 134, 138 (2012) (noting that "the data supporting a link between SSRI exposure and pulmonary hypertension is weak"). Although the link between selective serotonin reuptake inhibitors and PPHN is debated, disclosing medication information in a patient's general medical chart is critical to safe and effective care due to contraindications, side effects, and other adverse effects caused by use of medication.

gest alternative treatment for the expectant mother in order to avoid the increased chances of PPHN.²¹⁵ Without seeing Prozac in an expectant mother's general medical chart, the obstetrician may miss an opportunity to prevent PPHN.

Thus, medication prescription and monitoring is a reasonable and necessary exclusion to psychotherapy notes because of the possibility of severe adverse interactions between drugs²¹⁶ and the other possible negative effects caused by medication use.²¹⁷ Nevertheless, this exclusion should be considered in light of the other psychotherapy notes exclusions. The cumulative effect of revealing these exclusions significantly diminish psychotherapist-patient confidentiality.

D. The Whole is Greater than the Sum of the Parts

In summary, there are benefits, sometimes vital benefits, to each exclusion to the psychotherapy notes provision under the Privacy Rule. Nevertheless, the cumulative effect of disclosing this information may diminish or harm psychotherapist-patient confidentiality. The impact of this may be a matter of life and death. As mentioned, suicide is the fourth leading cause of death for adults in United States, and mental illness is strongly correlated to suicide.²¹⁸ If patients do not seek help for mental illness, the chances of suicide increase significantly.²¹⁹ Conversely, cognitive behavioral therapy has been shown to "reduce the rate of repeated suicide attempts 50 percent the following year."²²⁰ Thus, because confidentiality and trust impact whether a patient seeks help, fostering effective psychotherapy relationships through confidentiality is critical.

²¹⁵ *Information for Healthcare Professionals: Fluoxetine (Marketed as Prozac)*, *supra* note 202; Acholonu, *supra* note 205.

²¹⁶ *See Jones v. Bick*, 896 So. 2d 737, 737–48 (Fla. 2004) (finding that a doctor failed to meet the standard of care when he did not consider warnings contained in the Physicians' Desk Reference (PDR) concerning the anti-psychotic drug prescribed to a patient who subsequently died of cardiac arrest), *cert. denied*, 896 So. 2d 1043 (2005).

²¹⁷ *See Information for Healthcare Professionals: Fluoxetine (marketed as Prozac)*, *supra* note 202; *see Acholonu*, *supra* note 205.

²¹⁸ *Top 10 Causes of Death in the U.S. (2007)*, *supra* note 45; *see Suicide in the U.S.: Statistics and Prevention*, NAT'L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml> (last visited Jan. 25, 2012).

²¹⁹ *See Suicide in the U.S.: Statistics and Prevention*, *supra* note 218.

²²⁰ *Id.*

VII. AN UPGRADE TO 21ST CENTURY DESIGNER HOSPITAL GOWNS: RECOMMENDATIONS FOR STRONGER PRIVACY PROTECTIONS

The primary goal of additional privacy protection for psychotherapy records should be to enhance psychotherapy by creating an environment in which patients feel more comfortable disclosing highly sensitive information. As mentioned, however, many of the exceptions and exclusions to psychotherapy notes are reasonable. Nevertheless, there are additional requirements that can be added to the Privacy Rule to protect psychotherapy patient confidentiality. Hopefully, stronger privacy protection for psychotherapy notes will in turn increase the number of mentally ill persons who seek treatment, decrease the number of mentally ill persons who are undertreated as a result of ending therapy prematurely, and reduce the incidence of suicide.

A. Redefining and Clarifying “Psychotherapy Notes”

HHS should redefine and clarify the definition of psychotherapy notes. Psychotherapists should be given discretion to record highly sensitive patient information, as well as their personal notes separate from the general medical record. Following is a proposed revised rule:

The purpose of the psychotherapy notes provision is to reinforce the ethical goals of psychotherapist-patient confidentiality and ethical record keeping policies (refer generally to the APA’s *Ethical Principles of Psychologists and Code of Conduct* and the APA’s 2007 Record Keeping Guidelines) and to create a separate medical chart with restricted access where therapists may record his or her patient’s highly sensitive personal information, as well as psychotherapist’s personal notes. Psychotherapy notes may contain (1) highly sensitive personal information (see “minimum necessary” factors to consider); and (2) personal notes of the therapist that have little or no use to others not involved in treatment. This section does not supersede the other provisions under 45 C.F.R. Section 504.

Rather than superseding the other exceptions and exclusions, the focus is on the scope of the information disclosed. Adding the above-recommended provision to the Privacy Rule would give psychotherapists a better understanding of psychotherapy notes and reinforce the ethical principles of psychotherapist-patient confidentiality, ethical

record keeping, and the duty “to do no harm.” For example, if a patient is suicidal and there is a risk of imminent harm, a psychotherapist would still be able to intervene and get the patient the help he or she needs.

Moreover, the language recommended above takes into account the competing needs of patients, psychotherapists, physicians, and health-care administrators. By reinforcing confidentiality in record keeping, the proposed rule would encourage psychotherapists to carefully consider whether the disclosure will harm the patient. Nevertheless, psychotherapists are not forbidden from sharing information when necessary for treatment. Physicians may still collaborate with psychotherapists, when necessary.

B. Limiting Disclosure to Only the “Minimum Necessary” Information to Accomplish the Intended Purpose

HHS should change the Privacy Rule to include an additional standard for record keeping related to psychotherapy. A new standard should apply to psychotherapy notes. Under the Privacy Rule, a “minimum necessary” standard already exists, but it only applies to payments.²²¹ HHS should apply the existing “minimum necessary” standard to treatment as well.

The minimum necessary standard would still give psychotherapists a great deal of discretion because the Privacy Rule states that “a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.”²²² If a psychologist is part of a multidisciplinary team, the psychotherapist will need to share more details in order to accomplish the team’s intended purpose of use. However, if a psychotherapist is not working as part of a team, then the psychotherapist may be more conservative about the details disclosed in a patient’s general medical chart.

Consider, for example, a patient who discloses that he was physically abused at ten years of age and is having difficulty falling asleep.

²²¹ 45 C.F.R. §164.502(b)(1) (2011) (“*Standard: Minimum necessary . . . Minimum necessary applies.* When using or disclosing protected health information or when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.”). Currently the minimum necessary standard does not apply to treatment. *Id.* § 164.502(b)(2)(i).

²²² *Id.* § 164.502(b)(1) (2011).

Instead of recording in a patient's general medical chart that the patient was abused, the psychotherapist could write that the patient "had undergone significant trauma in childhood, which may have exacerbated feelings of anxiety in unfamiliar settings."²²³ The psychotherapist may also record that additional information regarding emotional functioning is contained in a confidential file in the psychotherapist's office or in a restricted access EHR file.²²⁴ This will alert practitioners to a childhood trauma and give enough information to treat the patient for other disorders. Furthermore, if another practitioner believes that knowing more about the childhood trauma would benefit the patient's treatment, the clinician may either ask the patient directly to share the information or may contact the originator of the notes and ask that the information be shared. Although this may add administrative costs and burdens, the benefit to the patient justifies those costs.

Moreover, the "minimum necessary" concept has already been adopted as an ethical goal by some psychologists. In 2007, the American Psychologist Association published its "Record Keeping Guidelines." Under Guideline 10, which relates to organizational settings such as hospitals, the American Psychologist Association states the following:

It is important to note that multidisciplinary records may not enjoy the same level of confidentiality generally afforded psychological records. The psychologist working in these settings is encouraged to be sensitive to this wider access to the information and to record only information congruent with organizational requirements and necessary to accurately portray the services provided. In this situation, if permitted by institutional rules and legal and regulatory requirements, the psychologist may keep more sensitive information, such as therapy notes, in a separate and confidential file.²²⁵

When incorporating "minimum necessary" language into the Privacy Rule, HHS should make clear that a critical factor in deciding the scope of information to record in a patient's general medical chart is whether the information will be widely accessible to other professionals. If so, the psychotherapist ought to record highly sensitive information in separate and confidential psychotherapy notes. In addition, HHS should incorporate other factors that a psychotherapist should consider, such as the role of those with access, the patient's

²²³ Mermelstein & Wallack, *supra* note 17, at 100.

²²⁴ Richards, *supra* note 100, at 553.

²²⁵ *Record Keeping Guidelines: American Psychological Association*, *supra* note 29, at 1000.

wishes, current risk factors, treatment of co-occurring conditions, and collaborative care.

Ultimately, the psychotherapist will have to use her discretion. If the psychotherapist is unsure whether disclosure will harm the psychotherapist-patient relationship, she should speak with the patient about the disclosure and, whenever possible, ask for permission. If the patient or patient's legal guardian is not capable of consent, the psychotherapist will have to use her best professional judgment in light of the risk-benefit factors discussed herein.

C. Limiting Access to Electronic Health Records

In light of data security concerns, HHS should create a rule that requires providers to limit access to psychotherapy notes in EHR systems. Because of the possible negative effects on a patient from inadvertent disclosure outside of treatment, greater data security measures should be put in place for psychotherapy notes. Access should only be permitted when essential for the treatment of a patient. For example, for an outpatient, access may include all persons who prescribe or dispense medication and exclude all certified nursing assistants. This may change if a patient becomes hospitalized.

The Cleveland Clinic Foundation (CCF) provides a good model for determining when access may be essential for the treatment of a patient. CCF has "strict guidelines about who can access patient charts."²²⁶ CCF uses an EHR system that identifies who accessed the chart and for how long, which enables the administration to ensure that employees do not access charts for patients they are not actively treating.²²⁷ In addition, CCF restricts access to some patient's mental health records, but not all. For example, CCF's Psychiatry and Psychology Department and psychologists at Regional Practice Centers instituted a policy of blocking treatment notes so that the rest of the medical team cannot view the details of a patient's treatment.²²⁸ The blocked information can only be unblocked after express permission from the psychiatrist or psychologist.²²⁹ If a multidisciplinary team requests information, the practitioner decides whether to send copies of the treatment notes.²³⁰

²²⁶ Richards, *supra* note 100, at 554.

²²⁷ *See id.* at 553.

²²⁸ *Id.*

²²⁹ *Id.*

²³⁰ *Id.*

However, another department, CCF's Pediatric Behavioral Health Department, does not limit access.²³¹ The reason for this policy is that the majority of patients at the Pediatric Behavioral Health are being treated for chronic medical conditions, and "the collaboration between the psychologists and physicians is paramount to a thorough evaluation and comprehensive treatment."²³² When treating a chronic medical condition, "[p]sychologists benefit from being able to review the medical tests being completed to rule out underlying disease in functional cases, and physicians benefit from access to the behavioral plans or cognitive strategies being implemented by patients to assist with their medical procedures, symptoms, or general development."²³³

The Pediatric Behavioral Department assists patients with functional disorders such as recurrent abdominal pain, daily headaches, toileting issues, or assistance to patients with significant medical or developmental conditions like diabetes, pediatric cancer, transplant evaluations, and other medically-based disorders.²³⁴ In contrast, those patients undergoing treatment at the Department of Psychiatry and Psychology "are referred for more general mental health concerns, such as depression, anxiety, and more severe psychopathology."²³⁵ Many of these patients are outpatients who may or may not be followed by a physician with the Cleveland Clinic system.²³⁶ CCF's restricted EHR policy provides a good model because psychotherapists are reminded to carefully consider whether an unauthorized disclosure will harm the patient. Yet, psychotherapists are not forbidden from sharing information when necessary for treating the patient.

Again, using EHR systems that limit access may place some additional costs or burdens on health-care practitioners and health-care administrators, but the benefit to psychotherapy patients is worth the additional costs. Lastly, it is best to implement protective measures now before an interoperable network of electronic health records is fully realized and thousands of health-care personnel are given access to patient's general medical charts.²³⁷ Likely, it will become more costly and difficult to implement restricted access software programs after providers and health-care institutions adopt interoperable EHR systems.

²³¹ *Id.*

²³² *Id.*

²³³ *Id.* at 553–54.

²³⁴ *Id.* at 553.

²³⁵ *Id.* at 554.

²³⁶ *Id.*

²³⁷ See HHS Secretary Kathleen Sebelius Announces Major Progress in Doctors, Hospital Use of Health Information Technology, *supra* note 98.

D. Expanding Notice Requirements

The Privacy Rule requires Notice of Privacy Practices (NPP) to be distributed to patients, which includes information about how PHI is handled, the disclosure process, and the privacy violation complaint process.²³⁸ However, the NPP is typically lengthy and perhaps too complicated for the average patient to read and comprehend.²³⁹ There is no requirement to discuss the NPP, and once the patient receives it, sharing PHI for treatment, payment, and health-care operations require no further consent.²⁴⁰ Consequently, HHS should add special notice requirements for psychotherapy.

Covered entities should be required to notify patients of policies regarding storage, disclosure, and use of psychotherapy notes. The notice should delineate mental health information that would be put into psychotherapy notes and information that would go into a patient's general medical chart. Notification should be in writing and in a document that pertains only to the covered entity's privacy policy for notes related to mental health. The entity should also provide the name and telephone number of a representative who can answer questions and further explain the policy. This will help patients decide whether or not to work with a psychotherapist. A patient may try to seek out a non-HIPAA psychotherapist. Interestingly, there are psychotherapists who are not governed by HIPAA and who intend to stay that way because of the confidentiality issues discussed herein. This solution may not be ideal because it does not promote collaborative care or treatment of co-occurring disorders, but at least patients will not end up like Grace and decide never to see another psychotherapist.

In addition, HHS recently proposed a change to the Privacy Rule that would expand a patient's right to restrict disclosure of records.²⁴¹ If implemented, the rule will permit patients who pay 100 percent of costs out of pocket the right to restrict the provider from disclosing PHI to a health plan if the disclosure is for the purpose of carrying out payment or health-care operations.²⁴² If the patient has the money to pay out-of-pocket, he can take preventative steps to ensure his records

²³⁸ Mermelstein & Wallack, *supra* note 17, at 99.

²³⁹ *Id.* (citing Michael K. Paasche-Orlow et al., *Notices of Privacy Practices: A Survey of the Health Insurance Portability and Accountability Act of 1996 Documents Presented to Patients at US Hospitals*, 43 MED. CARE 558, 562 (2005)).

²⁴⁰ *Id.* at 99–100.

²⁴¹ Modifications to the HIPAA Privacy, Security, and Enforcement Rules Under the Health Information Technology for Economic and Clinical Health Act, 75 Fed. Reg. 40,923 (proposed July 14, 2010) (to be codified at 45 CFR pt. 164.522).

²⁴² *Id.*

are not disclosed without his consent to health plans. This may have helped Patricia Galvin.²⁴³

Most importantly, if a patient is notified in advance of a psychotherapist's privacy policy, it builds a better foundation of trust, which in turn promotes full and frank disclosure.

E. Funding Continuing Education

Another serious problem with the current psychotherapy notes provision is that many health-care providers are ill-informed.²⁴⁴ Continuing education funding ought to be provided by HHS. Training should be used to help providers understand the Privacy Rule's psychotherapy notes provision. In addition, psychotherapists should undergo training to understand conditions and diseases that commonly co-occur with mental illness, such as heart disease, diabetes, and stroke. It would be useful to educate psychotherapists about what information is critical for other clinicians, which would help them to understand the "minimum necessary" requirement. HHS set aside \$27 billion to incentivize the use of electronic systems, they should also be willing to spend money to create and incentivize more effective privacy training.

VIII. ADDING PRIVACY PROTECTIONS TO THE HIPAA PRIVACY RULE IS THE BEST METHOD FOR IMPROVEMENT

Because of the rapidity of changes being made daily in both science and technology, it is important to effect change in the law through a medium that allows for adaptability. However, it is also important to use a medium that creates uniformity. Thus, using the Privacy Rule as a vehicle for change is the best method for improvement. If implemented through the Privacy Rule, the added privacy protections suggested above will uniformly raise the minimum level of privacy protection afforded to psychotherapy patients. In addition, HHS will be able to continue to adapt the Privacy Rule to changed circumstances.

²⁴³ See *supra* Part III.B.

²⁴⁴ See *supra* text accompanying notes 168–70.

CONCLUSION

The Internet has made sharing personal information with large interconnected networks of people more commonplace. However, the information typically shared through social media is far different from the sensitive and personal information that is communicated in the context of psychotherapy.²⁴⁵ And although many Americans are trading privacy for access to social media tools, when some people find out about the limited privacy protections for social media, they choose not to use Facebook or to limit what they post on Facebook. Unfortunately, many mentally ill individuals take the same approach to psychotherapy treatment.²⁴⁶ Some do not attend therapy at all for fear of public disclosure, and others limit what they disclose as a way to control what information may be made public.²⁴⁷

Research shows that one particularly important reason for the disparity between those suffering from mental illnesses and those seeking treatment is patient concerns about confidentiality and data security.²⁴⁸ An individual is less likely to seek treatment or disclose sensitive information if she believes that the information may be disseminated outside the treatment relationship.²⁴⁹ Fears of unauthorized disclosures, stigma, loss of professional opportunities, growing access to medical records, and data security breaches all interfere with patients seeking treatment.²⁵⁰ Although HHS attempted to preserve a scintilla of psychotherapist-patient confidentiality through the psychotherapy notes provision,²⁵¹ the Privacy Rule is too weak to protect mental health patients from the potential harm caused by unauthorized disclosure of sensitive information. As exemplified by the Grace example in Part I, if a health-care provider follows only the limited protections for psychotherapy notes set forth in the Privacy Rule, it is likely that a patient's sensitive information will be disclosed to persons other than the mental health practitioner in whom the patient confided.²⁵² Furthermore, there is the risk that a patient's most sensi-

²⁴⁵ See generally Vince Veneziani, *Big Brother Facebook: Does Anyone Care?*, TECHCRUNCH (Nov. 25, 2007), <http://techcrunch.com/2007/11/25/big-brother-facebook-does-anyone-care/>.

²⁴⁶ See SURGEON GENERAL REPORT, *supra* note 48, at 438–41.

²⁴⁷ *Id.*

²⁴⁸ *Id.* at 440.

²⁴⁹ *Id.* The Surgeon General noted that some people chose to not file insurance claims or forego care altogether due to privacy concerns. *Id.* at 440–41.

²⁵⁰ See *supra* Part III.

²⁵¹ Mermelstein & Wallack, *supra* note 17, at 100.

²⁵² See *id.*

tive information will end up in the wrong hands because of careless mistakes or malicious actions.²⁵³

In analyzing the best way to strengthen the Privacy Rule, there are a number of factors that should be considered, including competing ethical goals, risk to the psychotherapist-patient relationship, stigma, use of technology, multidisciplinary care, and growing access to EHR. The most important factor to consider, however, is whether the Privacy Rule, in its current form, actually supports effective psychotherapy. Unfortunately, evidence indicates that it does not. Studies show that persons with mental illness, including medical students, are so concerned about unauthorized disclosure that they are willing to forego treatment.²⁵⁴ Studies also show that as medical records pass through a greater number of hands, individuals increasingly fear unauthorized disclosure.²⁵⁵ This may be encouraging the worst case scenario, in which patients completely forgo important treatment for mental illness.

Again, consider the hospital gown. Exposing a patient's body as a result of a poorly designed gown, negatively impacts patients.²⁵⁶ As a result, many hospitals have redesigned their gowns to better maintain patient privacy and dignity.²⁵⁷ The Cleveland Clinic even sought out fashion designer Dianne Von Furstenberg to help design a new gown.²⁵⁸ HHS should follow suit and redesign its protection for psychotherapy notes. High fashion design teams are unnecessary, but more privacy is a must.

²⁵³ See *supra* Part III.C.

²⁵⁴ See *supra* Part III.B.

²⁵⁵ See *supra* Part III.C.

²⁵⁶ See Louise Denner, *Benchmarking Patient Privacy to Improve Essence of Care*, NURSING TIMES (July 27, 2004), <http://www.nursingtimes.net/nursing-practice-clinical-research/benchmarking-patient-privacy-to-improve-essence-of-care/204213.article>.

²⁵⁷ See Kaye Spector, *Designer Diane Von Furstenberg Helps Clinic to Design a New Hospital Gown*, PLAIN DEALER, Sept. 7, 2010, at E1, E6; *Hospital Gowns that Are Fit to Be Tied*, MSNBC.COM (May 1, 2008, 5:06:09 PM), http://today.msnbc.msn.com/id/24412645/ns/today-today_fashion_and_beauty; *New Hospital Gown Ensures Patient Privacy, Dignity*, MEDICAL NEWS (June 24, 2010, 12:52 AM), <http://www.news-medical.net/news/20100624/New-hospital-gown-ensures-patient-privacy-dignity.aspx>.

²⁵⁸ Spector, *supra* note 257.