Confidentiality in End-of-Life and After-Death Situations

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Confidentiality is one of the foundations on which psychotherapy is built. Limitations on confidentiality in the therapeutic process have been explained and explored by many authors and organizations. However, controversy and confusion continue to exist with regard to the limitations on confidentiality in situations where clients are considering their options at the end of life and after a client has died. This article reviews these 2 areas and provides some suggestions for future research.

Key words: confidentiality, end of life, postdeath

Violating the public’s trust that the contents of counseling sessions are confidential could have disastrous consequences on psychotherapeutic practice. Clinicians and courts alike have argued that current clients must believe that what they say
will remain in the therapist’s office or else they will be reluctant to openly share their concerns. Further, without trust in the confidential nature of counseling, potential future clients will be inhibited from even making appointments. In fact, confidentiality is believed to be such a crucial component of psychotherapy that therapists will violate laws (e.g., mandatory reporting statutes) to preserve confidentiality. As a result, confidentiality in therapy is accepted in law, ethics codes, and clinical standards of care.

However, even though confidentiality about clients being in counseling and about the content of sessions is viewed in this light, there are limits to confidentiality. Most clinicians are aware that in some situations confidentiality must be broken, and in other cases the therapist has the option of breaking confidentiality. The awareness of these facts by each client will depend on what he or she brings to the first session and the thoroughness of the therapist’s informed consent process.

The purpose of this article is to examine the interface of confidentiality and situations where death is imminent and where the client has already died. After a brief review of the limits of confidentiality, we focus on issues of confidentiality in clinical situations where a client has a physical illness and a desire to die and on the confidentiality of records after a client has died. When discussing both of these situations, attention is given to the ethical codes, the legal requirements, and the attitudes of mental health professionals. We also discuss the informed consent process. We close with a discussion of research that needs to be done associated with confidentiality immediately before and after death.

**LIMITS OF CONFIDENTIALITY**

Until recently, there were few generally recognized and accepted exceptions to complete confidentiality in the practice of psychotherapy (Beck, 1990). Early breaches of confidentiality were normally made in the patient’s interest, such as when civil commitment or consultation with a treatment team was needed (Beck, 1990). Over time, however, the right to absolute confidentiality has been more difficult for psychotherapists to maintain. There have been dramatic increases in the legal and ethical dilemmas that have tested the limits of confidentiality in the therapist–client relationship (Boylan, Malley, & Scott, 1995). Unlike earlier cases where confidentiality was breached, these limits to confidentiality are not necessarily intended for the benefit of the client (Beck, 1990).

Boylan et al. (1995) believed that changes in the legal mandates led to changes in the ethical codes under which professionals operate. They cited three legal constraints that have been placed on therapists that have directly impacted the limits of confidentiality in the therapeutic relationship. The first is the famous *Tarasoff v. Regents of the University of California* (1976) case, in which the court held that therapists might need to breach confidentiality to protect
third parties who may be in danger from a client being seen in therapy. The second legal constraint is the enactment of mandatory child (and elder) abuse reporting laws, which require therapists to breach confidentiality. The third legal consideration is the lawsuits brought against physicians and institutions for failing to provide adequate care to suicidal clients or patients. Beck (1990) noted that the requirement for psychotherapists to report information to third-party payers as a condition of payment is another change that has affected the limits of confidentiality. The changes in the legal climate and in ethical thinking have led therapists to view confidentiality in the therapeutic relationship as limited and no longer an absolute.

Although no longer all encompassing, confidentiality remains one of the cornerstones of the therapeutic relationship (Remley & Herlihy, 2001). Clients need to be educated about confidentiality, privileged communication, and privacy to ensure trust in the therapeutic relationship (Corey, Corey, & Callanan, 1998). One of the best ways to accomplish this is through the process of informed consent. Bednar, Bednar, Lambert, and Waite (1991) stated that it is essential for clients to understand the treatment that will be provided to them and to give their consent voluntarily and that it is the responsibility of the therapist to assess the level of the client’s understanding and to make sure the choice to enter counseling was made freely. The limits of confidentiality are an important element of any informed consent.

Clients need to be aware that confidentiality and privilege belong to them, not the therapist. As such, clients have the right to waive their privacy. Clients may ask a therapist to release information regarding the therapeutic relationship to third parties (Remley & Herlihy, 2001). According to Knapp and VandeCreek (1987), clients may also implicitly waive privilege and confidentiality if they file a lawsuit or malpractice suit against a professional.

The most well-known limit to confidentiality—but one that still needs to be explained to clients—is that the therapist may decide to break confidentiality in cases where the client makes threats to harm others. In 1974, the California Supreme Court ruled in the Tarasoff case that a psychotherapist has a duty to warn third parties who have been threatened by a client being seen in therapy (Felthous, 1989). In 1976, the court issued a different holding that resulted in a broader, more robust announcement. The court held that the therapist’s duty was to protect the intended victim, rather than to warn (Bednar et al., 1991). Although the Tarasoff doctrine only applies in the state of California, many states have adopted similar laws, and therapists must have knowledge of their current state laws (Knapp & VandeCreek, 1993).

Similarly, although there may be no legal duty to do so in a particular state, therapists have an ethical duty to protect clients who may be a harm to themselves due to mental illness. In terms of preventing harm, Furrow (1980) discussed the duty to prevent suicide in a hospital, the duty to control dangerous
conduct, and the duty to protect. A therapist must exercise reasonable care to prevent foreseeable harm or danger that may result from a client's mental or physical incapacity (Furrow, 1980). The courts have upheld that an additional duty to protect a client is established when the client is a danger to themself (Bongar, 1991). The duty to protect has been upheld by the courts many times for clients who were hospitalized (Bongar, Maris, Berman, & Litman, 1992). It has been more difficult to hold a therapist responsible for the actions of an outpatient client (Furrow, 1980).

In addition, there are instances when the therapist may need to share client information with others. In these instances, Remley and Herlihy (2001) suggested that the “umbrella” of confidentiality be extended to cover other people. Potentially, clerical staff and other employees may handle confidential client information. In these cases, the therapist is responsible for any breaches of confidentiality that may take place. In some cases, therapists may need to consult with fellow colleagues or experts in a particular area. Although this potentially can be accomplished without revealing client identity, there may be times when providing such information is unavoidable. In these situations, it would be wise for the therapist to inform the client (Remley & Herlihy, 2001). A final instance where confidential client information is shared is when the therapist is working under supervision. One difference is that in this situation the client’s identity cannot be concealed (Corey et al., 1998). Therapists in training have an ethical obligation to disclose to clients that they will be working under supervision and that confidentiality is limited (Remley & Herlihy, 2001).

CONFIDENTIALITY IN DEATH-RELATED SITUATIONS

With the foregoing as a foundation, we now analyze the application of confidentiality in two death-related situations. First, we review the application of confidentiality when a client has a terminal illness and expresses a desire to die. Then we turn to confidentiality after a death—by whatever means—has occurred.

Terminal Illness and the Desire to Die

Although therapists providing services to clients with the HIV disease have been attentive to end-of-life issues and decisions (e.g., Kain, 1996), there has been limited discussion in the rest of the literature on the roles of mental health professionals when working with clients who are dying. However, this is changing, with several articles appearing recently in this journal (e.g., Werth, 1999) and a few others, and with the publication of a policy statement from the National Association of Social Workers (NASW, 1994) and the reports from the American
Psychological Association’s (APA’s) first two working groups on end-of-life decisions (Farberman, 1997; Working Group on Assisted Suicide and End-of-Life Decisions, 2000).

Many of these publications have examined the issue of confidentiality. This section reviews the conclusions of the individuals and groups that have discussed the ethical and legal issues associated with confidentiality when working with clients who are dying; discuss the empirical research done on psychologists’ and other mental health professionals’ attitudes about their obligations in these situations; and highlight how the informed consent process can accommodate the data on ethics, laws, and attitudes. We want to emphasize that although much of the focus has been on assisted suicide, the discussion that follows relates to terminally ill clients who have a desire to die and are considering any option that may affect the timing and manner of death (e.g., withholding or withdrawing life-sustaining treatment as well as assisted suicide).

**Ethics.** The ethical responsibilities of mental health professionals working with clients who are dying have been examined by a variety of individuals and groups, and there are discrepancies in the conclusions of these commentators. The most common and detailed analyses have related to psychologists. For example, Peruzzi, Canapary, and Bongar (1996) discussed the roles of psychologists when working with a client who is considering assisted suicide, and they concluded that the APA ethics code (1992) mandates breaking confidentiality when a client is perceived to be at risk of harming himself or herself. Abeles and Barlev (1999) cited Peruzzi and colleagues’ conclusion with approval.

However, in an article reviewing the ethical codes and the public statements about end-of-life issues of the major mental health organizations, Werth (1999) stated that the APA (1992) ethics code does not require breaking confidentiality when a client wants to hasten his or her death through assisted suicide (see also Barret, Kitchener, & Burris, 2001). Werth (1999) even said that psychologists have more leeway than most mental health professionals in the courses of action they can take in these situations, and he provided a set of practice guidelines that he claimed fit within the codes of ethics of the APA and the other mental health organizations.

Although their statement (Farberman, 1997) did not create official APA policy, the first working group on assisted suicide and end-of-life decisions of the APA appeared to take the position that a psychologist does not have an obligation to break confidentiality when a client wants to hasten death in any way, including assisted suicide. In fact, the group said that the psychologist’s role in such situations is to protect the client’s rights, support significant others, not allow the affixation of a mental illness diagnosis if it is inappropriate, and help evaluate whether or not the client has decision-making capacity.
The APA’s second working group on end-of-life decisions recommended that the organization take a position that neither endorses nor opposes assisted suicide (Working Group on Assisted Suicide and End-of-Life Decisions, 2000). The group’s proposed resolution indicated that it did not believe a psychologist has a mandate to break confidentiality in situations involving assisted suicide. Specifically, it called for the APA to help provide direction for psychologists who have clients considering assisted suicide and other end-of-life decisions. After much debate, and with only minor revisions, the proposed resolution (along with a more general resolution on improving end-of-life care for adults) was passed by the APA Council of Representatives in early 2001 (Thomas, 2001), meaning that the APA is now on record, like the NASW (1994), with official statements about the appropriate roles of members in end-of-life situations.

Thus, although some have argued otherwise, the most thorough analyses of the APA ethics code (1992) and the statements by the first two APA groups on assisted suicide and end-of-life decisions indicate that a psychologist does not have an ethical obligation to break confidentiality if a client who is dying is considering taking action that may end his or her life.

Law. Ethical and legal behavior are not synonymous. One can be within the letter of the law and still be unethical. The current ethics code for psychologists (APA, 1992) states, “Psychologists disclose confidential information without the consent of the individual only as mandated by law” (5.05a). Because similar provisions are present for other mental health professionals, a therapist may also be forced to violate an ethical principle to comply with the law.

To examine whether this is the case in regard to end-of-life issues, Werth (1999) also discussed, along with his analysis of ethical codes, the legal requirements of psychologists and other mental health professionals when working with a client who wants to hasten death. In a follow-up study (Werth, 2001), he demonstrated that state laws require harm to self to be the result of a documentable mental illness before a person could be considered eligible for involuntary hospitalization. Further, only a handful of states require an attempt at hospitalization when a mental health professional deems a client to be at risk of self-harm as a result of mental illness. In 48 states, such an intervention is allowed but not required.

This finding regarding state statutes and involuntary hospitalization parallels the Bellah v. Greenson (1978) decision in California, in which the court stated that a therapist has a duty to take some action when a client is determined to be at risk of self-harm but declined to say what should be done. In the case, the plaintiffs contended that under Tarasoff (1976), the psychiatrist treating their daughter had a duty to warn them of her “suicidality”. The court
expressly refused to extend Tarasoff requirements to situations involving harm to self. Further, the court noted that Tarasoff required a “duty to protect” not a “duty to warn.” The court said that whether a therapist’s intervention to protect the client was acceptable should be determined based on the norms of the therapeutic community. The reasoning in Bellah has not been contradicted by more recent decisions.

Although there is a requirement to do something when a client is considering taking some action that may result in death, there is not an automatic legal obligation to break confidentiality or to attempt to involuntarily hospitalize the client (see also Barret et al., 2001). The intervention by the therapist merely needs to comport with an action that would be acceptable according to other professionals (i.e., comport with the standards of care). Because of the importance of the perspective of colleagues, the attitudes and experiences of mental health professionals in situations where a client is perceived to be at risk of self-harm are important.

**Attitudes of professionals.** The results of research on the attitudes of mental health professionals in situations where a client has a terminal illness, is approaching death, and is considering taking some action to hasten her or his death are remarkably consistent. Several studies of psychologists have found that over 80% of the respondents believe that people can make well-reasoned decisions that death may be their best option (Aulbach, 1997; Fenn & Ganzini, 1999; Werth, 1996; Werth & Liddle, 1994; Wilcox, Thomas, & Hersen, in press). Similar results have been found with psychiatrists (Ganzini, Fenn, Lee, Heintz, & Bloom, 1996; Ganzini, Leong, Fenn, Silva, & Weinstock, 2000), professional counselors (Rogers, Guellette, Abbey-Hines, Carney, & Werth, 2001), and social workers (Ogden & Young, 1998). Research has also revealed that 20% or more of respondents in a variety of surveys have reported having one or more clients whose suicidality they considered to be “rational” (Werth, 1996; Wilcox et al., in press).

Several attitudinal studies have focused on the perspectives of psychiatrists and psychologists in Oregon (Fenn & Ganzini, 1999; Ganzini et al., 1996; Wilcox et al., in press). This is because Oregon is the only state with a law—the Death with Dignity Act (1995)—that specifically allows terminally ill individuals to request medication from physicians with the intent of using it to die, and

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1Research with physicians has demonstrated that although there appears to be a greater range of attitudes regarding assisted suicide and euthanasia, a substantial percentage both believe that these, and other, forms of hastening death are acceptable and have assisted their patients to die. A review of these studies is beyond the purview of this article. The key question examined herein is how the attitudes of mental health professionals, combined with ethical and legal considerations, affect the standard of care and therapeutic work with clients.
this law has provisions built in for the involvement of psychologists and psychiatrists. Without going into details about the law (see Task Force to Improve the Care of Terminally Ill Oregonians, 1998, for information), if the terminally ill individual’s attending or consulting physician is concerned that the dying person’s judgment may be impaired, the physician is to refer the requestor to a licensed psychologist or psychiatrist for an evaluation (see Werth, Benjamin, & Farrenkopf, 2000, for a suggested assessment protocol). Other proposals (e.g., the Maine Death with Dignity Act, which was defeated in November 2000) have also included psychiatrists and psychologists as evaluators, so we expect that such provisions will be present in future efforts. It is important to note that psychologists and psychiatrists who participate in evaluations under the Oregon Death with Dignity Act obviously cannot be accused of violating a law, but it is also noteworthy that neither have they been brought up on ethics charges.

Given the consistent national findings regarding attitudes, as well as the opinions and experiences of psychiatrists and psychologists in Oregon, it appears safe to say that at least a significant minority if not a majority of mental health professionals believe that it would be acceptable to allow some clients to follow through with their desires to hasten death. In such instances, it may be proper to speak of a “duty to assess” (i.e., assess the decision-making process involved) and to conclude that this evaluation would satisfy the need for intervention typically assumed to be mandated under “duty to protect” requirements (Werth, 1999).

Many authors have proposed assessment protocols in situations where a person is considering hastening his or her death through assisted suicide or some other means (e.g., Block & Billings, 1998; Farrenkopf & Bryan, 1999; Goldblum & Martin, 1999; Miller, Hedlund, & Murphy, 1998; Werth et al., 2000), including one fairly detailed set of guidelines in this journal (Werth, 1999). Probably the most comprehensive set of issues for review when people are making end-of-life decisions was prepared by the APA’s Working Group on Assisted Suicide and End-of-Life Decisions (2000, Appendix F; see Table 1 for a summary). The Working Group stated that these issues may be relevant whenever someone is making a decision that may affect the timing and manner of death, which prompted Werth and Rogers (2001) to propose that this same list could be used in situations involving potential harm to self—in essence allowing for the differentiation between “rational” and “irrational” suicide. These authors argued that all situations where death may result from a client’s actions (e.g., withholding or withdrawing treatment as well as suicide) should be treated consistently. They argued that the assessment process outlined was rigorous and thorough enough that it would allow for the detection of situations in which the person’s quality of life could be improved or where there was a problem in the decision-making process so that interventions could take place. This balances the need for intervention in
**Informed consent.** When clients present for counseling, they typically are given an informed consent form to review and sign. These forms often discuss, among other things, limits to confidentiality and may have a phrase along the lines of “The content of our sessions will be treated as confidential, unless there is a concern that you may harm yourself or someone else, or a child or older adult has been or is in danger of being neglected or abused.” The implication of such a statement is that if one of these conditions is believed to exist, then confidentiality can, and will, be broken. However, as just reviewed, the “can” aspect may be correct for self-harm, but the “will” part does not necessarily need to occur. As a result, the informed consent form and discussion needs to be carefully worded to accurately reflect the psychologist’s position. As noted earlier, it could be both ethical and legal to break confidentiality if a terminally ill client mentions desiring death. However, it would also be ethical and legal to maintain confidentiality while an assessment is performed to

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**TABLE 1**  
Summary of Issues to Consider When Exploring End-of-Life Decisions

| 1. Assess for presence of capacity to give informed consent to participate in the review and the capacity to make informed health care decisions. |
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| 2. Review decision-making process, including the possible influence of the following: |
| a. Physical pain and suffering |
| b. Comorbid psychological conditions |
| c. Other psychological issues |
| d. Fear of loss of control/loss of autonomy/loss of dignity |
| e. Financial concerns |
| f. Cultural factors |
| g. Review possible underlying issues |
| h. Overall quality of life |
| i. Other issues to explore |
| 3. Discuss the person’s social support system |
| a. Consideration of significant others |
| b. Involvement of significant others |
| c. Interviews with significant others |
| 4. Evaluate for the influence of systemic and environmental issues |
| a. Indirect external coercion |
| b. Direct external coercion |

determine if the client still has decision-making capacity and whether her or his judgment is impaired (Werth, 1999).

Postdeath
If confidentiality assumes a relationship of trust (Grabois, 1997), what happens to the confidential records of a client who has died? Is confidentiality and the trust in the therapist to keep confidentiality then terminated?

Ethics. This question of postdeath confidentiality first reached public debate a decade ago, when psychiatrist Martin Orne was given permission by a client—Pulitzer Prize–winning-poet Anne Sexton—to release her therapy tapes to her legal executor, Linda Gray Sexton, after the poet’s death. Following her suicide in 1974, 300 hr of Anne Sexton’s therapy tapes were given by the executor to author Diane Middlebrook and used, sometimes verbatim, in a comprehensive biography of Sexton’s life (Middlebrook, 1991).

The debate that followed was not about whether the release of the tapes was ethical, as their release was technically acceptable, for example, according to the APA’s ethics code (1992): “(b) Psychologists also may disclose confidential information with the appropriate consent of the patient or the individual or organizational client (or another legally authorized person on behalf of the patient or client), unless prohibited by law” (5.05b Disclosures).

Similarly, psychiatrists also have an ethical code (American Psychiatric Association, 1995) to which they are bound: “Psychiatric records…must be protected with extreme care. Confidentiality is essential to psychiatric treatment…. A psychiatrist may release confidential information only with the authorization of the patient or under legal compulsion” (pp. 5–6). This statement is in keeping with the Hippocratic Oath, which states, “Whatever I shall see or hear in the course of my profession…if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.” Social workers also have a similar statement of confidentiality in their code of ethics (NASW, 1999): “(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client” (1.07 Privacy and Confidentiality). The codes of other mental health professionals have similar statements about confidentiality.

Instead of focusing on Orne’s compliance with the “letter of the law” in releasing the tapes, the debate was centered on his choice—the “spirit of the law”—as Orne released the tapes from psychotherapist, to executor, to biographer, to millions of readers (Burke, 1995; Goldstein, 1992; Harayda, 1991; Koocher & Keith-Spiegel, 1998; Lord, 1991; Orne, 1991; Stanley, 1991). The Sexton–Orne case underscores Bersoff’s (1999) statement that “there is
probably no ethical duty more misunderstood or honored by its breach rather
than by its fulfillment” (p. 149). Although a breach did not technically occur
in this situation, a breach may have occurred in the spirit of maintaining
confidentiality.

The general nature of confidentiality in psychology, psychiatry, social work,
and the entire medical and mental health communities obliges an individual to
only very rarely disclose information to anyone. It assumes a promise that no
information will be revealed except under certain circumstances agreed to by
both parties (Kitchener, 2000; Koocher & Keith-Spiegel, 1998; Smith-Bell &
Winslade, 1994). It is therefore important that although it was ethical for Orne to
hand over the therapy tapes according to all the professional ethics codes to
which he was bound,2 it has not been documented that Sexton wanted them
specifically used for the certain circumstance of her biography.

Another ethic to which psychologists and other mental health professionals are
often bound is that of avoiding harm (e.g., APA, 1992): “Psychologists take rea-
sonable steps to avoid harming their patients or clients, research participants, stu-
dents, and others with whom they work, and to minimize harm where it is fore-
seeable and unavoidable” (Section 1.14). The postdeath release of records by Orne
to the legal executor did not harm Sexton herself. However, it has been argued that
harm may have occurred. The public, whose trust mental health workers try to en-
sure (Everstine et al., 1980), may now fear that Orne’s release of information to a
biographer may lead other therapists to hand over client information to tabloids
and talk shows (Burke, 1995; Lewin, 1991).3 This very real fear potentially breaks
down trust in the mental health professions.

Additionally, harm has occurred if—due to Orne’s decision to hand over the
tapes—the result is that one or more individuals changed their minds to enter ther-
apy due to the fear that their confidentiality may be breached after they die (Burke,
1995). When reading the ethical code (APA, 1992) as it currently stands, persons
near the end of their lives, whether due to cancer, age, or HIV, must be cautious in
disclosing the contents and struggles of their hearts and minds to their therapists
due to the reality that one day their loved ones, or the public at large, may
obtain the contents of these sessions.

Further, although ethical codes (e.g., APA, 1992) usually technically allow a re-
lease of information to a client’s legal representative, the therapist is not mandated
to release the information if he or she “deems that it is not in the best interest of the

2Orne joined the APA in 1960 and was a member at the time that the events described occurred.
Therefore, he was required to abide by the ethics codes of both the APA and the American Psychiatric
Association.

3In the O. J. Simpson murder trials, the therapist of the deceased Nicole Simpson received national
attention when some of the contents of therapy sessions were released to the public. That therapist re-
ceived disciplinary sanctions from the California Licensing Board due to the violation of confiden-
tiality (Koocher & Keith-Spiegel, 1998).
client to do so” (Vasquez, 1994, p. 324). As a result, in addition to the client’s best interests, therapists must consider whether allowing a release of information is in the best interest of the public trust or the reputation of the professions.

Given the earlier discussion, it is clear that codes of ethics are not explicit enough in this area; they should perhaps be revised more in line with the following (using the APA’s code, 1992, as a template): “Psychologists also may disclose confidential information with the appropriate consent of the patient or the individual or organizational client (or of another legally authorized person on behalf of the patient or client) only when it is deemed absolutely necessary to do so and under only the most unusual circumstances.”

**Law.** All mental health professionals are trained to know where therapeutic confidentiality ends and the legal system begins. “In some circumstances the law specifically dictates a duty to notify certain public authorities of information that might be acquired in the context of a [therapeutic] relationship” (Koocher & Keith-Spiegel, 1998, p. 119). This information typically surrounds issues of child abuse, self-harm, and planned, intended harm to another. Additionally, a court may mandate a mental health professional to provide material gathered in the course of a client–therapist relationship. Although these disclosures may indeed negatively impact a current therapist–client relationship, it is in the spirit of ultimately being helpful that they are handed over.

Currently, the law does not fully prohibit the release of confidential records following the death of a client; therefore, a court can potentially mandate that a psychologist hand over material obtained during a client’s course of therapy. To our knowledge, there have been no court cases addressing this issue, so the best direction may come from how the confidentiality of records following death is handled by other professionals. According to a recent U.S. Supreme Court decision (*Swindler & Berlin and James Hamilton v. United States*, 1998), attorney–client privilege survives the death of the client. The only exception is in testamentary situations where a will is in dispute and the court believes that opening up records and allowing an attorney to discuss what had been shared would further the intent of the deceased.

A more similar profession is medicine. The American Medical Association Council on Ethical and Judicial Affairs (2000) recently issued a report entitled “Confidentiality of Health Information Postmortem.” The council noted that the proposed rule of the U.S. Department of Health and Human Services on “Standards for Privacy of Individually Identifiable Health Information” indicated that protection of medical information should end 2 years after the person dies. However, the council recommended the following:

All information contained within a deceased patient’s medical record, including information entered postmortem, should be kept confidential to the greatest possible
degree. However, the obligation to safeguard patient confidences is subject to certain exceptions that are ethically and legally justifiable because of overriding societal considerations (Opinion 5.05: Confidentiality). At their strongest, confidentiality protections after death would be equal to those in force during a patient’s life. Thus, if information about a patient may be ethically disclosed during life, it likewise may be disclosed after the patient has died.…

Otherwise, in determining whether to disclose identified information after the death of a patient, physicians should consider the following factors:

(1) the imminence of harm to identifiable individuals or the public health;
(2) the potential benefit to at-risk individuals or the public health (e.g., if a communicable or inherited disease is preventable or treatable);
(3) any statement or directive made by the patient regarding postmortem disclosure;
(4) the impact disclosure may have on the reputation of the deceased person;
(5) personal gain for the physician that may unduly influence professional obligations of confidentiality. (p. 5)

In her analysis of postmortem confidentiality, Berg (2001) focused on medical professionals but noted that her discussion and conclusions would hold for mental health professionals (she also used some psychotherapy examples in her article). Berg’s conclusions parallel the American Medical Association’s in that she would allow disclosure in the interest of health; however, she also indicated that in situations involving general interest (the category into which most mental health-related disclosures would fall), disclosure should not occur.

Thus, although there may be some limited exceptions to confidentiality after death, the bulk of the formal analysis to this point indicates that disclosures should be limited to instances where breaking confidentiality would further the deceased person’s wishes or where specific individuals or the public needs information to protect themselves. Only in rare situations would either of these apply. However, because case and statutory law appears largely silent on the issue (Berg, in press), it appears as if a mental health professional can ethically and legally release records but is neither ethically nor legally mandated to do so.

**Attitudes of professionals.** Currently, no data have been collected regarding clinicians’ interpretation of the wording of ethics codes that allows information to be released to clients’ legal representatives following their deaths (or at any other time). How do clinicians regard the ability to release information to executors? With ease? With utmost caution? Only in the most extreme circumstances?

Through research, vital information can be gathered from the public and the professionals that will assist in answering these questions and the questions that began a decade ago with the Sexton case and the ensuing debate and
controversy surrounding it. One of the most pressing questions is how therapists protect the best interests of their current clients, their future clients, and the mental health professions at large when considering their clients’ records following death (Burke, 1995; Chodoff, 1992; Goldstein, 1992; Joseph, 1992; Rosenbaum, 1994).

Informed consent. Informed consent “allows people to make decisions about events that may affect them and to weigh the risks and benefits for themselves” (Kitchener, 2000, p. 57). Therapists often use a process of informed consent as standard clinical practice and may include confidentiality in general as well as the counselor’s legal obligation to disclose information if, for example, it is learned that the client may harm either her- or himself or someone else.

Some data have been gathered on the impact that various general forms of informed consent have on the treatment process (Handelsman, 1990; Handelsman & Martin, 1992). However, there are no current data on the assumptions that clients make regarding confidentiality and treatment records following death. Additionally, data have not been gathered regarding whether clients are being warned of the potential release of their records following their deaths. Should clinicians inform clients that, following death, records about their treatment may be released to their legal representatives? What should a therapist communicate to clients about the fact that their legal executors will be able to obtain therapy records following death?

A written informed consent form could contain a clause stating, “If the file still exists, the contents of your therapy record may be available to the executor of your estate after your death unless you make legal provisions otherwise.” Similarly, during the verbal explanation of confidentiality, perhaps there should be a statement of caution, such as:

You need to know before you disclose anything to me that, following your death, the executor of your estate may be legally able to obtain information and materials accumulated in the course of this psychotherapy. You and I need to discuss how you would like to proceed regarding highly sensitive material. In addition, you may want to consult with an attorney to request that these materials continue to be confidential following your death.

The mental health professions need to clarify the place of confidentiality “beyond the grave.” Harm may occur both to the public trust as well as to some individuals (those who may choose not to enter therapy due to the unknown nature of what happens to their records after they die). The degree of the harm is not known, but the awareness that it may have occurred, and may potentially occur again, begs for further study.
CONCLUSION

This article has highlighted the need to address confidentiality in end-of-life and postdeath situations. An unanswered question is whether harm is done when confidential therapy information is released either while a client is trying to make an end-of-life decision or after a client’s death. Such harm may occur to the individual as well as to the public’s confidence in psychology as a profession. A clear understanding of the public’s opinion on this matter, as well as the attitudes and experiences of professionals and their governing bodies, is necessary to guide practice and policy development.

Thus, although the dearth of data to this point reveal that virtually any research would be helpful, there are two areas in particular we want to recommend for investigation: (a) gathering information on actual end-of-life and postdeath cases where a lack of clear ethical guidelines have been actually, or potentially, problematic, and (b) determining the effects on clients’ perceptions of confidentiality when remarks about end-of-life and postdeath eventualities are included in an informed consent statement. This research can then be used to inform educators about what students and professionals need to know in order to respond in an ethically appropriate way when faced with end-of-life and postdeath situations.

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