COMPARATIVE CONFIDENTIALITY IN PSYCHOANALYSIS

Edited by Penelope Garvey
and Alexander Layton

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FOREWORD

This study is the result of the work carried out by various psychoanalytical societies and psychoanalysts of different nationalities and overseen by a supervising committee, chaired by Penelope Garvey of the International Psychoanalytical Association (IPA) and composed of three regional representatives of the IPA and two representatives of the British Institute of International and Comparative Law.

In each country a lawyer and a psychoanalyst were appointed to compile data on legal and psychoanalytic practice. National contributors from Argentina, Brazil, Canada, England and Wales, Germany, Italy, and the United States were supplied with a questionnaire related to patient–analyst confidentiality to establish the rules in each country.

The purpose of this project was to study the extent to which the confidentiality of patients undergoing psychoanalytic treatment is protected by the law across seven countries. From this research, besides useful information, the contributors identify common themes and recommendations.

The topic we are dealing with has proved to be extremely important and has recently been the object of many discussions, both in the psychoanalytical and legal fields. This book offers the possibility to consider the essence of the important concept of confidentiality, and to make available useful and detailed information about the bases on which confidentiality is treated, from a psychoanalytical and legal point of view, in the countries considered. This allows us to analyse how the duty of confidentiality changes in different jurisdictions and is relative to the legal position of psychoanalysts in different countries.

Jorge Canestri
Chair of the IPA Ethics Committee

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TABLE OF CONTRIBUTORS AND METHODOLOGY

1. SUPERVISING COMMITTEE

The production of this study was overseen by a supervising committee chaired by Penelope Garvey of the International Psychoanalytical Association (IPA). This also comprised three regional representatives of the IPA and two representatives of the British Institute of International and Comparative Law (BIICL). These were as follows:

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Europe: Dr Andrea Marzi	*Società Psicoanalitica Italiana*
United States: Dr Robert Pyles	*American Psychoanalytic Society*
Latin America: Dr Romulo Lander	*Venezuelan Society*

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Alexander Layton QC

The Supervising Committee defined the scope of the project, selected the countries for inclusion, assisted in the development of the questionnaire, reviewed the progress of the study, and reviewed drafts of the final report. The IPA regional representatives identified the psychoanalytic societies and the participating psychoanalysts in each country and they, in turn, nominated the legal respondents.

The project was undertaken by three BIICL researchers: Dr Renato Nazzini, Lydia Sweeney, and Hugo Warner.

2. NATIONAL CONTRIBUTORS

For the purpose of compiling data on legal and psychoanalytical practice, a lawyer and psychoanalyst were appointed from each country studied. The analysts who have contributed to this study are as follows:

Argentina	Dr Samuel Arbiser	*Argentinian Psychoanalytic Association (ArPA) and Asociación Psicoanalitica de Buenos Aires (APdeBA)*
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Canada	Dr Mary Kay O'Neil	*Canadian Institute of Psychoanalysis*
England	Richard Rusbridger	*British Psychoanalytical Society (BPAS)*
Italy	Dr Andrea Marzi	*Società Psicoanalitica Italiana (SPI)*
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All information on the legal or the practitioner's position in each country is attributed to the relevant contributors.

3. METHODOLOGY

Geographical Scope

In order to keep the project within manageable bounds, it was necessary to limit the choice of countries for review. The countries included are Argentina, Brazil, Canada, England and Wales, Germany, Italy, and the United States. The criteria for selection were demographic, geographic, analytic, and legal.

Questionnaire

National contributors were supplied with a questionnaire, the aim of which was to establish the rules in each country under review as they related to analyst–patient confidentiality. In addition, national contributors were asked to examine the substance of these rules, the protection they offer to psychoanalysts and patients, and any limits imposed.

The questionnaire was divided into questions more suitably answered by the psychoanalytic correspondent and questions more suitably answered by the legal correspondent. It was not felt necessary for the lawyer and psychoanalyst to work together on completing the questionnaire or to submit their responses at the same time, but a certain amount of cooperation was preferable.

The questionnaire confined itself to the rules relating to psychoanalysts and their patients. It was not the intention to examine the same questions by reference to psychotherapists or other mental health professionals. Nevertheless, it was recognized that in many cases the law might not draw this distinction, and might draw other distinctions such that psychoanalysts could fall within one or more differently defined categories recognized by the law. Given this, it was necessary to identify those categories and the legal position as it related to psychoanalysts within them.

The material under examination by analysts related to codes of professional conduct established by the psychoanalytic profession itself, whether in the form of mandatory rules, guidance or otherwise; and in the absence of any such rules, established practice was to be described. The contributing lawyers focused on the law as it relates to psychoanalysts and their patients. They were requested to cite the principal pieces of legislation or cases where relevant.

1. INTRODUCTION

1.1 Scope of the Study

The aim of this study is to examine the extent to which the confidentiality of patients undergoing psychoanalytic treatment is protected by the law across seven countries: Italy, Germany, Brazil, Canada, the United States, Argentina, and England and Wales. In particular, it will examine the extent of the protection afforded by professional codes, the circumstances in and persons by which they may be overridden, issues of disclosure to third parties including other health professionals, law enforcement agencies, and courts. In examining the respective positions in the countries under review, the study will attempt to identify common themes and recommendations.

Only those psychoanalysts who are members of the International Psychoanalytical Association (IPA) have been considered. Practitioners who call themselves psychoanalysts but who have not undertaken training which meets the requirements and standards of the IPA do not fall within the remit of this study.

1.2 The Importance of Confidentiality in Psychoanalysis

The aim of the psychoanalytic method is to explore and by so doing to modify the emotional factors, both conscious and unconscious, that influence thought and behaviour. Psychoanalysis is both intensive and long term; patients commonly attend four or five 50-minute sessions per week with their psychoanalyst over a period of several years. Psychoanalysts may also conduct less intensive treatments of psychoanalytic psychotherapy.

The need for confidentiality of communications between psychoanalysts and patients is universally recognized by practitioners. The nature of psychoanalysis is such that the patient is encouraged to reveal not only inner thoughts but also dreams and fantasies in order to facilitate the therapeutic process. Psychoanalysis involves uncovering aspects of patients and their experience about which they would prefer to remain ignorant and which, when conscious, may cause them great pain, shame, or guilt. Patients, even while wishing to uncover unknown or forgotten aspects of themselves, often go to some lengths to prevent their discovery. To understand the patient and the way his mind works, the psychoanalyst will ask the patient to say whatever comes into his mind; this encourages uncensored irrational thought. Patients are invited not just to be themselves and to reveal intimate secrets, but at times to reveal their worst characteristics.

Confidentiality therefore goes to the very heart of the psychoanalytic process; it underpins the agreement between patient and analyst because of the extremely personal nature of the material shared with the psychoanalyst, and its establishment and maintenance is highly valued by analysts and patients alike. This surpasses the importance of confidentiality in other areas of clinical practice, whether applied by physicians, surgeons, or psychiatrists.[1] The success of the psychoanalytical process depends on the belief that, like the confessional, the secrecy of psychoanalyst's consulting room is sacrosanct. As one psychoanalyst, subpoenaed to give evidence in court, put it:

> For me the need to retain secrecy was not just a moral imperative such as might exist, for example, for a general practitioner who was treating a patient for pneumonia. If such a doctor were to talk indiscreetly about his patient, he might not be behaving ethically, but he might still have treated the pneumonia adequately. But if I were to speak indiscreetly about a patient, I should not only be behaving unethically, but I should also be destroying the very fabric of my therapy.[2]

A central feature of psychoanalysis is the focus on interpersonal processes, in particular the way in which the patient relates to the psychoanalyst and the feelings that he has towards him. Strong feelings are often stirred up in patients towards their psychoanalysts and towards the whole process ('transference'). Consequently, the patient's communications and behaviour have to be understood within the context of this relationship; this accentuates the sensitivity of the confidential information, and the care with which it should be disclosed if that measure proves necessary.

The present study was prompted by a belief that this need for confidentiality might be imperfectly protected by the legal and professional environment, and by a desire to examine the ways in which the imperative to protect confidentiality may conflict with other considerations. The most obvious of these are issues of health, civil or criminal liability, and the protection of children. As communications between international psychoanalytic and legal communities develop, the need for a common understanding of these issues becomes more pressing. This study will show that the disparities between the national laws and practices on psychoanalytic confidentiality present a relatively fragmented picture. That stated, one benefit of this study is that it may help psychoanalytic practitioners understand their position in relation to the laws of their country, highlighting for them areas of concern their own cause that needs to be advanced if they want to protect the therapeutic process.

[1] It is arguable that in these other spheres confidentiality has been such a central aspect of the practice of medicine and psychiatry that its importance is often taken for granted, its maintenance frequently less than rigorous, and the degree of its erosion in recent years underestimated: see DI Joseph and J Onek 'Confidentiality in Psychiatry' in S Bloch, P Chodoff, and SA Green (eds) *Psychiatric Ethics* (3rd edn Oxford OUP 1999).

[2] Anne Hayman, 'Psychoanalyst Subpoenaed' *The Lancet*, 16 Oct 1965, 785.

2. THE STATUS OF THE PSYCHOANALYTIC PROFESSION

Before addressing in detail the content of the law and professional codes of conduct in each country, it is necessary to set out here a brief summary of the status of psychoanalysts in each of the relevant countries. This will address (i) routes to qualification, and (ii) the extent to which psychoanalysis is publicly regulated and recognized in the laws of each country.

This information is vital to a more detailed treatment of the subject matter, particularly as in some of the countries the lack of public regulation may affect adversely the interpretation of the analyst's legal position by the courts and the extent of legal certainty afforded to the psychoanalyst. The situation is further complicated by the fact that regardless of whether or not an analyst's position in relation to the law is clear, the law may conflict with principles set out in their own professional code of ethics. Therefore legal certainty does not always advance the interests of psychoanalysis. The aim of the summary set out below deals only with the clarity of the analyst's position in relation to the law of their country, not whether the law upholds the aims of the profession; the latter will be brought out in the later sections of the report.

Psychoanalysts who are members of an IPA society are required to be postgraduates who have undertaken a training over a period of at least 4 years. The training includes theoretical and clinical seminars and supervised work with two intensive cases. Trainees also undergo their own personal analysis. The entry requirements for training vary across the IPA societies; in all societies there is a minimum requirement that candidates hold a degree and have experience of clinical or other relevant professional work. In some societies a medical qualification is an essential prerequisite for training,

The status accorded to psychoanalysts varies considerably across the seven countries where regulation, accreditation and the legal interpretation of the psychoanalyst's role is concerned. The countries first dealt with are those in which the analyst's position can be said to benefit from greater legal certainty: these are Italy, Germany, Brazil, Canada, and the United States.

In *Italy* there are two requirements for psychoanalytical practice: (i) a degree in medicine or in psychology, and (ii) permanent membership of one of a number of professional associations which benefit from legal recognition. It is only once an analyst has joined one of these associations that they are legally allowed to offer psychotherapy (which encompasses psychoanalysis too). However, psychoanalysis is not a legally recognized profession. In spite of this, there is strong awareness on the part of analysts that their conduct is regulated by the Medical Code of Ethics in addition to the professional code of ethics set out in the *Società*

Psicoanalitica Italiana (SPI) Code of Ethics. The Medical Code of Ethics substantially overlaps with relevant legal provisions and the professional rules, both the Medical Code and the SPI code of ethics, are recognized by the courts. Consequently, Italian psychoanalysts can be fully aware of their position in relation to the law; psychotherapy is a recognized profession bound by the general law relating to confidentiality.

Similarly in *Germany*, in order to qualify as a psychoanalyst it is necessary to be a qualified psychologist or doctor. In addition, it is necessary to be certified by the regional association of doctors licensed by the public insurance system in Germany. The general laws relating to any medical doctor or psychologist therefore cover any German psychoanalyst.

In *Brazil*, as in Italy, psychoanalysis is not considered a 'profession' in the strict sense. The majority of psychoanalytic societies are mostly composed of doctors and psychologists, but a medical qualification is not a prerequisite for psychoanalytical practice. But despite the non-necessity of such qualifications, it is generally accepted that the rules applicable to doctors are also applicable to psychoanalysts. The professional codes contain the same principles as those found in the Civil and Penal Codes regarding breach of confidentiality.

In *Canada*, it is possible for any person to call him or herself a psychoanalyst or to set up a psychoanalytical practice; the term 'psychoanalyst' is neither registered nor licensed. Consequently there is no legal regulation for those practising psychoanalysis. In practice, psychoanalysts are often:

(i) medical doctors, who require to be licensed and regulated;
(ii) psychologists, who are registered as such; or
(iii) social workers belonging to a professional association or a college.

In general, Canadian law does not distinguish significantly between medical doctors or non-medical analysts. Consequently psychologists, social workers, and family counsellors also practising as psychoanalysts would be held accountable to their professional bodies—analytic or otherwise—by the court.

In the *United States* there are three major groups of psychoanalytic institutes which meet with recognition by the IPA: the American Psychoanalytic Association (APA), the Independent Psychoanalytic Societies (IPS), and the so-called Division 39 of the American Psychological Association (Division 39).[3] Membership is dependent upon obtaining a graduate degree in a mental health discipline such as psychiatry, psychology, or social work with advanced training. Affiliation with

[3] Of these, by far the largest is the American Psychoanalytic Association <http://www.apsa.org> with twenty-eight institutes. The Confederation of Independent Psychoanalytic Societies has four institutes and Division 39 of the American Psychological Association <http://www.division39.org> has at least five institutes which are freestanding and independent.

any of these institutes is not compulsory, however; there are a number of independent groups that require much less training and whose graduates still call themselves psychoanalysts. But, given that these are not recognized by the three major associations, there is an element of uncertainty in the law as it relates to analysts.

Until recently there was virtually no licensing of either the profession of psychoanalysis or psychotherapy in the United States. Anyone in any of the states could style themselves as practising either profession without oversight by the state licensing board. By contrast, there are boards which govern the licensing of psychiatrists, psychologists, social workers, nurse therapists, and so forth. However, in recent years three states in the United States have passed a psychoanalyst licensing law; these are Vermont, New York, and New Jersey. A similar bill is, at the time of writing, pending in Pennsylvania.

In contrast to these jurisdictions, the legal position of psychoanalysts in Argentina and England is much less certain.

In *Argentina*, there is no specific statutory regulation of psychoanalysis. National laws regulate the practice of medicine and psychology in the City of Buenos Aires. These laws are interpreted by doctors and psychologists practising psychoanalysis as regulating their respective practice, but this approach has been neither confirmed nor challenged by any official authority and it is difficult to predict whether a judge would decide that psychoanalysts are subject to the obligations provided for in these statutes. No case law regarding the practice or confidentiality of psychoanalysis or the confidentiality of psychoanalytic psychotherapy has been found in the published records of the Argentine courts. As it relates to Argentina, this study is therefore restricted to the rules relating to the practice of medicine and psychology in addition to general legal principles.

In *England and Wales*, unlike in Argentina, the majority of psychoanalysts do not hold a medical qualification,[4] and many are qualified in other mental health professions such as clinical psychology. Minimum requirements for training are a degree or its equivalent and a background of relevant clinical experience. Like Argentina the English psychoanalytic profession is not regulated by statute (in contrast to the English medical profession). There is no legal restriction on the use of the term 'psychoanalyst' and some non-IPA qualified practitioners adopt the title. A great deal of work has been undertaken, since the recommendation of the Foster Report in 1971,[5] to reach agreement on the definition and restriction of professional titles in this field. More recently, the Psychotherapy Bill, introduced by Lord Alderdice for the second time in the House of Lords in

[4] A representative of BPAS has estimated that approximately 70 per cent of psychoanalysts do not hold a medical qualification.

[5] *Enquiry into the Practice and Effects of Scientology*, Report by Sir John Foster QC (London Stationery Office December 1971).

2001,[6] has been superseded by the Government's decision to register psychotherapy under the Health Professions Council.

Currently IPA psychoanalysts are registered under the British Confederation of Psychotherapists, one of two umbrella organizations set up to promote the definition of standards of selection training and professional conduct for psychoanalysts and psychotherapists in the UK, the other organization being the United Kingdom Council for Psychotherapy (UKCP). So far, attempts by non-IPA qualified practitioners to register as psychoanalysts with either body have failed.

There exists no reported case law which deals specifically with the psychoanalyst-patient relationship. For this study, principles established from cases and commentaries relating to the doctor–patient or psychiatrist–patient relationship or the law of confidentiality generally have been used.

Traditionally, English courts have placed significant reliance on the General Medical Council (GMC) Guidelines as a means of assessing the medical profession's behaviour.[7] However, this must partly be attributed to the fact that these guidelines are created under statutory authority. Given the lack of regulation of psychoanalysts in England, and the lack of reported cases fact that there has never been a case directly involving a psychoanalyst, the extent to which English courts would recognize the British Psychoanalytical Society's code of conduct or equate the conduct of psychoanalysis with that of the medical profession is uncertain.

The disparity between the regulatory regimes in each jurisdiction is marked. It may be that public regulation in all countries would create a level playing field when it comes to standards in patient treatment, thereby reducing the vulnerability of both patients and the profession. Furthermore, in some countries lack of public regulation and minimum qualification routes can be linked with the lack of legal certainty, which again makes the profession vulnerable. However, as previously suggested, legal certainty alone may not necessarily advance the 'psychoanalytic cause'. The law may simply set out provisions which conflict with ethical codes, imposing obligations and creating exceptions in relation to breaching confidentiality in circumstances where an analyst might prefer to maintain it. It is also interesting to consider those countries where the codes substantially reflect the law, and therefore where the two are in harmony, and what this means in the context of the psychoanalytic requirement to maintain patient confidentiality wherever possible.

[6] Available at <http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldbills/068/2000068.htm>.

[7] Available at <http://www.gmc-uk.org>.

3. THE DUTY OF CONFIDENTIALITY

A duty of confidentiality towards the patient exists in the laws of each of the countries under review and in the professional rules or standards of all the psychoanalytical organizations which are the subject of this study. Such a duty even finds generalized expression in international law. The Universal Declaration of Human Rights of 1948[8] (which sets standards, rather than being legally binding) declares in Article 12 that no-one shall be subject to arbitrary interference with their privacy, family, home, and correspondence. The Declaration has had a marked influence upon the constitutions of many States and upon the formulation of subsequent human rights treaties and resolutions,[9] and much of its content can be said to possess a customary law character.[10]

In systems of law which owe their origin to Roman law—in continental Europe and Latin America—the law provides a specific right to confidentiality or privacy. In Germany, Brazil, and Argentina, for example, such a right is enshrined in the constitution. In the Anglo-American systems, however, the equivalent rights have a less clear origin. In some cases they may be based on a statutory protection of privacy, while in others they have their origin in the common law or equitable doctrines which found the ability of the courts to restrain breaches of confidence. The extent to which, and the circumstances in which, the rights of confidence which exist under the law are subject to exceptions varies from country to country, and this is the subject of more detailed assessment later in this paper. In very general terms, however, the protection seems to be more far-reaching and more highly respected, and breaches of confidentiality more likely to be visited by penal sanctions, in those countries where the protection of confidentiality is founded on express rights, as distinct from piecemeal protection arising from the law of remedies.

Likewise, the protection afforded by the codes of practice or professional standards which apply to psychoanalysts varies from country to country. So far as one can venture to generalize in this detailed area, it seems that the weaker the protection afforded by the general law, the more vigorous the expressions of the relevant codes or standards. Thus, in Germany, where the right to privacy has a strong basis in statute, there is

[8] Available at <http://www.un.org/Overview/rights.html>.

[9] For example, the International Covenant on Civil and Political Rights, adopted by resolution 2200 (XXI) of the General Assembly of the United Nations, Art 17; the United Nations Convention on the Rights of the Child, adopted by the General Assembly on 20 Nov 1989, Art 24; the 1950 European Convention on Human Rights and Fundamental Freedoms, Art 8; and the American Convention on Human Rights 1969 (San José de Costa Rica Pact), Art 11.

[10] See UK Foreign and Commonwealth Office publication 'Human Rights in Foreign Policy' *United Kingdom Materials in International Law* (1991) 62 British Yearbook of International Law 592.

no general code of practice which expressly guarantees confidentiality of a patient's communications with his or her analyst. At the other end of the scale, in the United States where, despite the US Supreme Court's decision in *Jaffee v Redmond*, the degree of protection afforded by law is uncertain and variable from state to state, Article IV of the APA's *Principles and Standards of Ethics for Psychoanalysts* is rather specific in emphasizing the basic and essential nature of confidentiality for psychoanalytical practice.

What is clear, however, is that confidentiality is universally regarded within the profession as an essential requirement for psychoanalysis.

3.1 Italy

In Italy, there are several laws with application to analyst–patient confidentiality: the Act on Privacy 675/96, Article 622 of the Criminal Code, and Article 200 of the Criminal Procedure Code. Law 675/96 establishes a general system of data protection in Italy, covering data which exists in both electronic and hard copy. The law also establishes the *Garante per la protezione dei dati personali*, an independent body having, inter alia, the power to hear complaints, inspect premises and issue administrative penalties as well as cease and desist orders for violation of the law. Concurrent judicial protection is also established under law 675/96.

Personal data is defined by Article 1 as 'any information relating to a natural or legal person, body or association, identified or identifiable directly or indirectly by reference to any other information, including a personal identification number'. The definition of data is also construed as covering images insofar as they relate to the identification of a person. The law provides that personal data subject to processing shall be:

(i) processed fairly and lawfully;
(ii) collected and stored for specified, explicit and legitimate purposes, and not further processed in a way incompatible with those purposes;
(iii) accurate and, when necessary, kept up-to-date;
(iv) adequate, relevant and not excessive in relation to the purposes for which they are collected or further processed; and
(v) kept in a manner which allows identification of data subjects for no longer than necessary for the purposes for which the data were collected or for which they are further processed.

Under Law 675/96, as a general rule the data subject must freely consent to the processing. The data subject has the right to receive information on the processing of the data, and, in the case that the processing exceeds the purposes for which the data was given, such additional processing is to be expressly authorized by the data subject. Unlawful processing of personal data is a criminal offence under Article 35 of Law 675/96. Article 622 of the Criminal Code (*Codice Penale*) states that:

[a]nyone who has the knowledge of confidential information, due to his state and role, or due to his own profession, and reveals it without true and just cause, or profits by it, is liable by punishment if a damage derives from this occurrence.

There is no distinction in this obligation between Italian criminal and civil law. In Italian legislation the criminal code, criminal procedure code, civil code and civil procedure code are ruled by the same basic principles regarding confidentiality in its broader sense, which stems from Article 622 of the Criminal Code.

Professional codes applicable to Italian analysts reflect the legal position on confidentiality, although their breach is dealt with differently. There are two main sources of professional obligation: the Medical Code of Ethics and the SPI Code of Ethics.[11]

In Italy, the professional codes state that communications between the psychoanalyst and the patient are bound by a duty of confidentiality irrespective of the form such communications take. This duty is set out in the in Articles 8 (e), 13(2) and 15 of the SPI Code of Ethics,[12] which reflect Article 9(1) and (5) of the Medical Code of Ethics at Article 9, paragraphs 1 and 5. The consequence of these provisions is that the doctor or analyst must keep all he has been told by the patient strictly confidential. He must also keep all his professional services strictly confidential, respecting the principles of the law.

3.2 Germany

In German law, privacy (*privatsphäre*) is considered as being an integral part of a person's general personality right (*allgemeines Persönlichkeitsrecht*). The general personality right which exists as a matter of principle for legal entities as well as individuals is guaranteed in Article 2(1) read in conjunction with Article 1(1) of the Basic Law (*Grundgezetz*), Germany's constitution. Articles 2(1) and 1(1) of the Basic Law protect everyone's right to the free development of his or her personality insofar as that person does not violate the rights of others and does not breach the constitutional order of moral standards. The constitution further warrants

[11] Available at <http://www.spiweb.it>.

[12] Art 8(e) reads: 'An ethical offence consists in . . . breaches of professional secrecy'; Art 13 states that '[t]he confidentiality of the patient and his or her anonymity must be protected and guaranteed under all circumstances, in academic publications as well as discussions with colleagues. The confidentiality of the patient's communications must also be protected through the analyst's safeguarding and control of written texts or notes regarding the treatment, ensuring in advance, in the case of the analyst's death, that a family member or a colleague assumes the same task'; and Art 15 stipulates that: 'In the event the analyst is called upon to testify before judicial authorities, and is asked to reveal reserved information concerning a patient, he must use all the legal means available to him to defend his obligation to respect professional confidentiality.'

that the dignity of man is inviolable and that it is the duty of all State authorities to respect and protect such dignity.

The Federal Constitutional Court (*Bundesgerichtshof*) has further held that as a consequence of the general personality right, the individual is entitled to ask the State and courts for protection and that the civil courts have to observe in their decision-making the constitutional guarantees in order to determine their value determining character (*wertsetzender Gehalt*) in the application of the law.

Whilst the Constitution guarantees a general right to privacy—and appropriate sanctions for its violation—there is no formal code of conduct in place for the psychoanalytic profession which might deal specifically with the issue. More fundamentally, there is no universally applicable code of conduct for medical practitioners or psychoanalysts. To be in place, such guidelines (*richtlinien*) would require to be drawn up by private associations of doctors, the Federal Chamber of Medical Practitioners (*Bundesärztekammer*) or the Federal Chamber of Psychological Psychotherapists (*Bundespsychotherapeutenkammer*). As yet no such guidelines have been drawn up by any of these bodies which specifically address the issue of confidentiality.[13]

However, the obligation on analysts to treat their patients' personal data confidentially forms an essential part of their training. This duty is based on the obligations that attach to the professional status of a doctor or psychologist, which are found in the code of conduct for the medical profession. And in German law the duty to maintain confidentiality (*schweigepflicht*) is one of the basic ethical and legal obligations of any medical doctor or psychological therapist doing any kind of medical or psychotherapeutic treatment with a patient. It is part of a set of general state of the art rules (*kunstregeln*) and obligations of care and diligence (*sorgfaltspflichten*) to be kept in any treatment. These ethics and rules are developed primarily in the professional field and usually incorporated into a voluntary 'ethics code' or 'professional guidelines' by the associations of doctors and psychotherapists. Violations of these rules and guidelines are usually dealt with by disciplinary procedures on the basis of traditional rules of professional conduct (*standesrecht*). In addition, most of these rules and guidelines do develop a legal character where their breach forms the basis for actions for damages under contract and tort law.[14]

[13] Certain guidelines have been drafted by the Joint Federal Commission of Medical Practitioners and Health Insurance Companies (*Bundesausschuss der Ärzte und Krankenkassen*) and implemented by Arts 91 and 92 of the *Sozialgesetzbuch* 5 (SGB 5, vol 55). However, these are only binding on practitioners treating patients within the framework of the public health insurance system (*Gesetzliche Krankenversicherung*) in which fees are paid directly to practitioners by their association (*Kassenärztliche Vereinigung*). Such guidelines have been passed in relation to psychotherapy in accordance with Art 92 of SGB 5. In these, however, no mention is made of confidentiality.

[14] For example, ss 823 and 830 of the Civil Code (*Bürgerliches Gesetzbuch*).

In terms of sanctions for breach of confidentiality, where the rules are founded in the *Grundgesetz*, their breach is punishable under criminal statute law, such as where there is a lack of informed consent about any treatment or therapeutic measure or in cases of violation of the duty to maintain confidentiality. In the latter case Article 203 of the Criminal Code (*Strafgesetzbuch*) applies. This provides for punishment up to 5 years' imprisonment if the doctor or psychotherapist unwarrantedly discloses any secret (*privatgeheimnis*) which has been confided or disclosed to him (a) in his capacity as a therapist and in (b) the course of treatment. The term *privatgeheimnis* applies to the information on the patient's identity, personal details, diagnoses, treatment, and results. Even the simple fact that he or she is undergoing psychoanalysis falls within the definition of *privatgeheimnis*. From this one can conclude that—to the extent to which they have been adopted—the German medical profession's guidelines are similar to Italy's insofar as they reflect the legal position on confidentiality.

3.3 Brazil

In Brazil, a general right to privacy is set out in Article 5, items X and XII of the 1988 Federal Constitution. Item X guarantees the inviolability of the intimacy, private life, honour, and image of persons, as well as compensation for any resulting material or moral damages in the event of violation. Item XII guarantees the secrecy of the postal service and communication of data by telephone or other telegraphic means, except in the case of a judicial order. There is also a legal duty in Brazilian law to maintain confidentiality in all communications between psychoanalyst and the patient. There is no distinction in law as to the form of the communication, and consequently this could be said to apply to the psychoanalyst's own thoughts and observations about the patient.

The regulation of confidentiality in the professional codes is modelled on the equivalent legal provisions. Articles 102, 106, and 108 of the Code of Ethics contain principles that are broadly coterminous with Article 229 of the Civil Code, Article 406 II of the Civil Procedure Code, and Article 154 of the Penal Code.

Article 102 of the Code of Ethics states that it is forbidden for the psychoanalyst to 'disclose information that has come to knowledge by means of professional practice, except for just cause, legal duty or express authorization of the patient'. Article 106 stipulates that it is not permitted for the psychoanalyst to disclose to an insurance company any information on the circumstances regarding a patient's death beyond those included in the death certificate, except with express authorization by the legal responsible or successor. And Article 108 forbids the psychoanalyst from permitting the handling of any document regarding the patient related to medical secrecy, by persons not bound by the same obligations of confidentiality.

Article 229 of the Civil Code states that a person cannot be obliged to give evidence of facts which are required to be kept secret on the grounds of one's position or profession. Similarly, Article 406 II of the Civil Procedure Code states that a witness is not obliged to give evidence about facts that he or she is obliged to keep secret on the basis of his or her position or profession. Finally, Article 154 of the Penal Code prohibits the disclosure without just cause of confidential information that one is privy to by virtue of occupation or profession, and which may cause harm to another.

Article 105 of the Brazilian code of ethics sets out requirements for the maintenance of confidentiality in any kind of communication between the psychoanalyst and the patient. It does not matter if the information is in written or other permanent form. This rule also applies to the psychoanalyst's own thoughts and observations about the patient.

3.4 Canada

Because of its federal nature, any treatment of the Canadian concept of privacy—and by extension the duty of confidentiality—requires consideration of federal and provincial legislative jurisdictions as well as common and civil law initiatives.

Federal constitutional and legislative provisions that relate to privacy issues may be characterized as public law, especially in the context of criminal law sanctions, an exclusively federal jurisdiction. On the other hand, common law and (in Quebec) civil law is an exclusively provincial constitutional jurisdiction concerning private law relationships. Given that the relationship between analyst and patient is typically of a private law character, the content of provincial legislation on privacy is of greater concern to this study. On the whole, there is little direct protection of privacy at common law in Canada. In only four common law provinces has legislation created 'statutory torts of privacy', limited essentially to private relationships.[15]

In specific circumstances, however, confidentiality may be thought of as part of a professional's general duty of care, which is viewed as fundamental by the courts. In Quebec, for example, this is embraced by the Civil Code; other Provinces have confidentiality statutes. The obligation of confidentiality applies to all relevant communications and forms of information, including the analyst's own private thoughts or observations.

Insofar as the psychoanalytic profession is concerned, psychoanalysts are expected to adhere to the Canadian Psychoanalytic Society's *Principles*

[15] See Privacy Act RSBC 1996, c 373; Privacy Act, RSM 1987, c P-125; Privacy Act, Nfld RS, 1990 c P-22 and Privacy Act RSS, 1978, c P-24.

of Ethics for Psychoanalysts[16] which state in section II(D) (*Protection of Confidentiality*) that

> [a] psychoanalyst shall respect the confidentiality of his patient's information and documents. . . . When a psychoanalyst uses case material in exchanges with colleagues for scientific, educational or consultative purposes, he should make every reasonable effort to ensure that the identity of the analysand is protected.

Other than this obligation there exist no other professional rules for analysts relating to the duty of confidentiality towards patients or maintaining confidentiality.

3.5 United States

There is no explicit right to privacy in the United States Constitution. The Supreme Court has ruled that there is a limited constitutional right of privacy based on several provisions in the Bill of Rights.

The branch of the invasion of privacy tort known as 'disclosure of private facts' imposes liability for the dissemination of embarrassing and true private facts regarding an individual's life. This occurs where there has been a communication which satisfies four criteria:

(i) it must be public;
(ii) it must identify the plaintiff;
(iii) it must disclose facts which were private; and
(iv) the disclosure of the facts must be highly offensive to a reasonable person—which is an objective test.

According to the professional code, all patient information and records are expected to be kept confidential and not released without the patient's authorization. The form of such information is immaterial.

The American Psychoanalytic Association's *Principles and Standards of Ethics for Psychoanalysts* state in Article IV that confidentiality of the patient's communications is a basic patient's right and an essential condition for effective psychoanalytic treatment and research. A psychoanalyst must take all measures necessary to not reveal present or former patient confidences without permission, nor discuss the particularities observed or inferred about patients outside consultative, educational, or scientific contexts. If a psychoanalyst uses case material in exchanges with colleagues for consultative, educational or scientific purposes, the identity of the patient must be sufficiently disguised to prevent identification of the individual, or the patient's authorization must be obtained after frank discussion of the purpose(s) of the presentation, other options, the probable risks and benefits to the patient, and the patient's right to refuse or withdraw consent.

[16] Available at <http://www.psychoanalysis.ca>.

3.6 Argentina

Whilst there exist codes of conduct for the various psychoanalytic associations in Argentina, they do not give a thorough treatment of the approach their members should adopt in relation to analyst–patient confidentiality. The APdeBA Code of Ethics considers confidentiality as an essential condition of the psychoanalytic treatment. However, that document neither defines nor explicitly regulates confidentiality in the psychoanalytical process. By contrast, the Argentine Psychoanalytic Association's Code of Ethics provides in paragraph 3 that

> [p]sychoanalysts will respect the confidentiality of the information and the documents of their patients, in accordance with legal and professional rules, and taking into account their validity and appropriateness to the situation.

There are a number of legal duties which, subject to sufficient recognition of the profession, may be construed as governing the obligation of confidentiality owed by the analyst towards the patient. The first, and most fundamental, is the Argentine Constitution itself in which the duty of professional confidentiality may be understood as a protection of the constitutional and legal right to privacy.[17] Articles 18 and 19 of the National Constitution circumscribe the general right to privacy. They read, in relevant part, as follows:

> Article 18: a person's domicile may not be violated nor may their correspondence, letters or private papers or documents; a law shall determine in which cases and on which grounds they may be seized and opened.
>
> Article 19: the private acts of individuals which do nor adversely affect public order or morality, nor harm a third person, are only subject to the judgment of God, and out of the reach of judges.

Article 156 of the Criminal Code addresses the duty to uphold privacy which falls to those who possess confidential information by virtue of their profession:

> Any person who, due to their status, occupation, employment, profession or art, knows any secret, the disclosure of which may cause any injury, and discloses it without reasonable cause, shall be punished with a fine from 1,500 to 90,000 pesos and shall be disqualified from their profession.

One author speaks of a 'psychological privacy' deriving out of this constitutional right to privacy, which includes the 'right to privacy of customs, affections, states of pleasure and pain, and personal experiences a person wishes to preserve in secrecy'.[18]

[17] The Argentine National Constitution was enacted on 1 May 1853 and subsequently amended in 1860, 1866, 1951, and 1994.

[18] Roberto Sagayo 'El secreto médico' ['The Medical Secret'] *Jurisprudencia Argentina* 2001-IV-1273

In addition to the constitutionally based right to confidentiality, there are also a number of statutes in which the obligation is reinforced. Article 1071 *bis* of the Civil Code[19] establishes that:

> If a person arbitrarily interferes in other people's life publishing portraits, spreading correspondence, tormenting others in their customs or affections, and provided the action is not a criminal offence, that person shall be obliged to cease in those activities, if he has not yet ceased, and to pay a compensation established with equity by the judge. Upon request of the offended person, the judge may also order the publication of the judgment in a local newspaper, should this be needed for an adequate compensation.

Article 444 of the National Civil and Commercial Code of Procedure states that when giving evidence '[t]he witness may refuse to answer questions. . . . If he is unable to respond without disclosing a professional, military, scientific, artistic, or industrial secret.'

Finally, there are provisions in legislation which apply to the medical and psychological professions and which may be applicable in a psychoanalytical context. Article 11 of Law No 17.132 regulating the practice of medicine establishes that '[i]nformation received by persons whose activity is hereby regulated, in the course of their practice, may not be disclosed.' Article 8 of Law No. 23.277 regulating the practice of psychology establishes that

> [p]sychology professionals are obliged to: [k]eep the most rigorous professional secret over any prescription or act they perform in accordance with their specific work, and over the data or fact communicated to them on the basis of their professional activity, related to physical, psychological, or ideological aspects of persons.

3.7 England and Wales

In England and Wales, analysts are bound by the Ethical Code of the British Psychoanalytical Society, which specifies that:

> [p]sychoanalysts, students and staff members must respect the confidentiality of patient's information and documents. Except when clinically necessary, patient's anonymity must be preserved at all times.[20]

The legal basis for the obligation of confidence in English law is uncertain. However, the courts tend to approach confidentiality on the basis of a specific equitable obligation to keep a patient's details secret.[21]

[19] Incorporated into the Civil Code by Law 21.713 enacted on 15 Oct 1975.

[20] Para 2 1-L.

[21] Alternative legal bases could be contractual, either express or implied, or the general duty of care in negligence. The law of confidence resting on an equitable principle, rather than tort, is to be found in *Kitechnology BV v Unicor GmbH Plastmaschinen* [1995] FSR 765 in the speech of Evans LJ. See WHV Rogers *Winfield & Jolowicz on Tort* (16th edn London Sweet & Maxwell 2002), at 483. The equitable obligation is particularly important

Three conditions must be satisfied for this obligation to apply:

(i) the information must be of a confidential nature (this presents no difficulty for the content of the analyst and patient's discussions);
(ii) information imparted in circumstances importing an obligation of confidence (well established that doctor–patient relationship comes within this and would evidently apply to psychoanalyst–patient relationship); and
(iii) it is probably necessary that the subject would suffer from the breach—an invasion of personal privacy will suffice.[22]

Recent cases have considered information obtained and recorded by other health professionals and concluded that they too are relationships built on a legal expectation of confidence. In *Venables v News Group Newspapers*[23] Dame Elizabeth Butler Sloss stated, in relation to health information on the claimants, that

> [a]ll information about the claimants, whether during their detention or at any other time, whether by records or otherwise, which relates to their medical, psychological or therapeutic care is, in principle, confidential. That confidentiality would in my view extend to art, or any other form of therapy, and to all those taking part in group therapy, and not only the therapist.

4. CIRCUMSTANCES IN WHICH CONFIDENTIALITY MUST BE BREACHED BY LAW: COMPATIBILITY WITH PROFESSIONAL GUIDELINES

There are some key similarities between a number of the countries relating to situations in which a psychoanalyst would be obliged legally to disclose information. This obligation arises where the general prohibition on disclosure is overridden by other considerations. For instance, in Italy, Germany, Canada, and the United States this obligation arises where a serious crime is being contemplated against a third party (although this need not be contemplated by the patient).

in the healthcare context as the majority of patients do not see private doctors and therefore no contract exists. Because psychoanalysis is not available publicly through the National Health Service, a private contract will nearly always exist between the parties. Therefore an implied term of confidentiality would exist, in addition to any equitable obligation.

[22] See *Margaret, Duchess of Argyll v Duke of Argyll* [1965] 1 All ER 611. The need for detriment was left open in *A-G v Guardian* (no 2) ('*Spycatcher*') 639–40 (a case of public interest protecting government confidence). According to Toulson and Phipps, in *Confidentiality* (1996), in cases of private confidences, disclosure need not be positively harmful provided the confider has sufficient interest in maintaining the confidence, whereas in the case of public confidences, as in the *Spycatcher* case itself, disclosure must be injurious to the public interest.

[23] [2001] Fam 430; [2001] 1 All ER 908 at para 30.

The extent of this rule varies from country to country: in *Italy*, any crime to be committed by a third party (but not the patient) of which the analyst becomes aware of must be disclosed to the relevant authorities; in *Germany* the intention to commit a serious crime such as murder (including by the patient) must be disclosed by a doctor; in *Canada*, where a real danger exists for a third party, again disclosure is required; similarly in the *United States* where the patient represents a significant threat to another person, the analyst has a duty to warn that person. In *England*, no such general obligation exists, and there is no duty to report contemplated crimes generally; a statutory exception exists in relation to a threat of terrorism—such information which must be disclosed. Similarly, in *Argentina*, there is no duty to report crimes generally, with exceptions where there are obligations to prevent harm to minors, the elderly, handicapped, and the legally disabled in the context of domestic violence.

Other examples where there is a specific obligation to disclose include where the doctor or analyst becomes aware of a patient with an infectious disease. This is the case in Germany, Brazil, Canada, Argentina, and England and Wales. Admittedly this is more likely to affect a doctor than an analyst but could apply to an analyst as well. Furthermore, an analyst discovering that sexual abuse is being committed against a minor is another reason for obligatory disclosure in Italy, Brazil, and Canada. Such legal obligations to disclose are sometimes in conflict with the analyst's professional code or established practice.

4.1 Italy

Article 365 of the Criminal Code states that

> thehealth professional who, during his professional services knows facts which can show criminal characteristics [*fattispecie criminosa*] and does not refer to or is late in referring it to Judicial Authority, is liable to punishment.

This means that there is a duty to disclose if the crime is being committed by a third party against the patient or someone else. However, liability is excluded in the case where the author of the crime is the patient, and the analyst must never expose the patient to the risk of liability and punishment. Furthermore, the psychoanalyst is subject to the universal duty to report actual crimes committed against a patient (if the latter reports so) to the social control agencies for adequate investigation. For example, in the case of sexual abuse against a minor, who is one of his or her patients, the psychoanalyst has to report this. This is not considered to be a breach of confidentiality, but on the contrary a tool to safeguard the patient, who in this case is the victim.

The Italian Medical Code of Ethics sets out circumstances in which breach of confidentiality may be justified, namely where there is a 'true

and just cause'. This will be set out in further detail in the next section, but just cause may derive from the absolute necessity of the doctor or analyst to safeguard the life or health of third parties, even in the face of the patient's refusal, but only after obtaining the authorization from the Authority for the Protection of Privacy.

4.2 Germany

In German law there is only one situation in which there is an obligation to breach confidentiality. This is the general obligation, set out in Section 138 *StGB*, for every citizen to report serious crimes to law enforcement authorities.[24] At the time of writing there are moves to include certain sexual offences among such crimes, which would cause the obligation to report to be of greater relevance for the psychoanalyst. That said, section 139 III *StGB* stipulates that medical doctors or psychotherapists are exempt from the obligation to report such crimes where planned or committed by a patient if the former has made serious attempts to prevent commission by the latter. There is, however, a legal obligation to report sexually transferable diseases and there is often a contractual requirement to report certain data to the insurance companies system.

As there is no formal code of conduct for psychoanalysts in Germany, it has been submitted that each case would be assessed on its merits, weighing the avoidance of physical or mental damage against the requirements of analysis. It is clear that there may be a strong inclination on the part of the analyst to disclose if the safety of another person was jeopardized. But given that there is no legal duty which matches this sense of professional obligation, there can be said to exist a tension between the former and latter.

4.3 Brazil

In Brazil there is a legal duty to breach confidentiality where compulsory notification to public authorities is required, namely in the case of certain serious diseases or in the case of sexual abuse against minors.

The psychoanalyst is also obliged to breach confidentiality when a public authority declares that a crime was committed by the patient and the psychoanalyst is called as a witness.[25] Under these circumstances the

[24] This concerns capital, violent, and other very dangerous crimes. There is a distinction between contemplated crimes and those already committed. There is only an obligation in relation to the former. Not reporting such a crime can be punished be imprisonment of up to 5 years.

[25] In Brazil, the analyst is not allowed to bring criminal proceedings against his patient (Federal Medical Council Resolution 999/80 Art 2). However, three exceptions to the rule exist: legal duty; just cause or patient consent. If it is not one of the three situations, the analyst has to maintain confidentiality.

analyst acts in his capacity as a citizen, with the appropriate legal duty to provide information. Here, the interests of the wider community are held to override those of the patient. However, in acting as a witness an analyst is only obliged to disclose facts about the patient which relate to the crime; he or she is not under a duty to inform the court about the treatment received by the patient.

The Code of Ethics (which is not specific to psychoanalysts but also applies to medical doctors and psychologists) forbids disclosure of any fact about the patient of which the analyst has gained knowledge through professional means. There are certain exceptions, however, which reflect the legal position on breaching confidentiality. Therefore in Brazil there is no conflict between the law and the Code of Ethics so far as analysts are concerned.

4.4 Canada

The analyst has a duty to warn in the case of danger to third parties if there is:

(i) a serious risk;
(ii) the danger is imminent;
(iii) there is no other means of preventing it; and
(iv) the analyst knows the identity of the third party.

Fulfilment of this duty should be proportionate, however; and disclosure should only be made so long as it is necessary to prevent harm. These criteria were defined by the Supreme Court in *Smith v Jones*.[26] In addition to this duty to warn, it is also necessary for analysts to report abuse of minors or the presence of certain infectious diseases.

However, in the Canadian Psychoanalytic Society's *Principles of Ethics for Psychoanalysts* no exceptions to the confidentiality rule are listed. The reasoning for this is threefold. First, it was thought that because the making of exceptions is based on professional judgment as defined by acceptable and usual practice, there was little advantage in attempting to define such exceptions. Secondly, it was thought that setting out precisely what constituted exceptions would result in psychoanalysts adhering to the letter of the Code rather than their own judgment. Thirdly, it was thought that defining those instances where confidentiality could be overridden would make psychoanalysts more prone to complaints that they had breached the Code. Moreover, it would be more difficult for the psychoanalytic society or institute to defend an analyst on the basis of usual and acceptable practice based on good professional judgement if there was too much detail in the Code.

[26] [1999] 1 SCR 455.

For a similar reason, the phrase, 'except as required by law' was deleted in the Canadian Code. For example, a psychoanalyst may decide to refuse an order to testify in court for confidentiality or patient care reasons and accept the consequences. If the phrase 'except as required by law' is not included in the psychoanalytic code than the analyst would not be breaching the ethical code and could be supported by the society in the decision to refuse to testify. This is a clear example of significant divergence between the professional body's approach to maintaining patient confidentiality and the demands of the law.

4.5 United States

The *Tarasoff* case established that there is a specific duty to warn if a patient makes a threat to a third party.[27] Similarly, if a patient declares his or her intent to commit a crime, this is also a reason for mandatory reporting. The broader principle behind *Tarasoff* is that if one person believes that significant harm will come to another, mandatory reporting is necessary---regardless of whether the identity of the latter is known. Here, the professional rules of the American Psychoanalytic Association reflect the law.

However, there is some variance on how restrictively the *Tarasoff* ruling should be interpreted. Originally it appeared that the effect of the judgment was that a relationship between a psychotherapist and a mental patient could generate a duty of reasonable care on the part of the therapist. This would entail that the therapist should take steps to guard against foreseeable harms the patient might do to a third party with whom the therapist had no relationship.[28] However, in the case of *Thompson v County of Alameda*[29] the Californian Supreme Court reinterpreted the *Tarasoff* rule as requiring the therapist to have a relationship with both the patient and potential victim. Were this position to be adopted, the situation in the United States would be rendered very similar to that of Canada.

It should also be noted that sexual and child abuse is also subject to mandatory reporting in the United States.

4.6 Argentina

The law in Argentina takes a proportionate view to the maintenance of confidentiality. Article 12 of Law No 17.132 states that

[27] *Tarasoff v County of Alameda* (1976) 17 Cal 3d 425, 551 P 2d 334

[28] B Markesinis and S Deakin *Tort Law* (4th edn Oxford Clarendon Press 1999) at 227.

[29] (1980) 27 Cal 3d 741, 614 P 2d 728.

> [t]he obligation to maintain professional confidentiality is absolute. It may only be broken when special or general norms so request it or when the breach constitutes an attempt to avoid a greater and actual social harm . . . or in case of infectious diseases.

One such exception is set out in Law 24.417, whose object is the prevention of domestic violence. Article 2 states that

> [w]hen the harmed persons are minors, legally disabled, old or handicapped, the actions must be reported by their representatives or the state prosecutors. This obligation will apply also to social or educational services, public or private, health professionals, and all public officers in the exercise of their roles. The minor or disabled may also give notice to the state representative [*Ministerio Público*].

Only in relation to the analysis of minors does the Argentine code of ethics reflect in part this legal duty to inform when a minor is at risk of family violence. Although normally in the analysis of children and adolescents the information provided to the family must be evaluated taking into account the right of the family in charge of the child as well as the right of the child to the maintenance of his 'privacy'(even vis-à-vis his guardians), in the case of harmful situations for the health or personal integrity of a child or adolescent (such as sexual harassment, severe addictions, criminal, or other dangerous situations) the criteria must be refined and the guardians of the child or the person with disabilities must be informed.

4.7 England and Wales

There are several statutory exceptions to the duty of confidentiality, some of which affect the medical profession but which are unlikely to affect the psychoanalytic profession.[30] There are also certain, limited, statutory exceptions to confidentiality which might have application to psychoanalysts. Examples include where a person is bound to provide the police on request with any information that might identify a driver who is alleged to have committed a driving offence, set out in the Road Traffic Act 1988.[31] This was held to apply to health professionals in *Hunter v Mann*.[32] Alternatively, the Terrorism Act 2000 stipulates that a person is bound to disclose as soon as reasonably practicable suspicions of a person being involved in a terrorist activity, including where his belief or suspicion is from information which comes to his attention in the course of a trade, profession, business, or employment.[33]

[30] For example, the duty on a doctor to disclose to the relevant public authority if they are confronted with an actual or suspected case of a particular infectious disease as set out in the Public Health (Control of Diseases) Act 1984 and Public Health (Infectious Diseases) Regulations 1988 (SI 1988 No 1546).

[31] Section 172.

[32] [1974] QB 767.

[33] Sections 19 and 20.

According to the BPAS Code, there is a basic responsibility upon the analyst to preserve the patient's confidentiality,[34] and in practice analysts go to great lengths to do this. In each case, however, professional discretion might lead an analyst—usually after consultation with a senior colleague—to break confidentiality if it were felt to be in the patient's interest. An example might be where a patient came to a session saying that she had just taken some tablets with a view to killing herself, or in the case of the patient suffering a major psychotic breakdown. In any such cases, the aim would be to disclose the minimum necessary information.

The BPAS Code permits the psychoanalyst to consider a breach of confidentiality when it is in the best interests of the patient, but there is never an obligation to do so. By contrast, the statutes set out above oblige disclosure in the interests of the State, public safety, and the administration of justice. However, it is suggested that disclosure demanded by law but in conflict with the Code would not be in the interests of the patient; part of the therapeutic process is to allow such tendencies to emerge in order that they can be made more manageable.

5. CIRCUMSTANCES IN WHICH A BREACH OF CONFIDENTIALITY MAY BE LEGALLY JUSTIFIED

This section outlines the general circumstances under which a breach of confidentiality may be legally justified. Certain other examples where confidentiality may be breached which stem from psychoanalytic practice will be set out in the next section.

In all seven jurisdictions the law has the effect of justifying a breach of confidentiality where the patient presents a serious risk to (i) public safety (as distinct from a specifically contemplated crime, which often necessitates disclosure (see Section 4 above)) or (ii) a third party (which applies in those jurisdictions where there would otherwise be no positive duty to do so). The principles are realised differently, but the similarities are obvious. Certain countries phrase it broadly: in *Italy*, it is where there is a 'true and just cause'; in *Brazil*, where there is 'just cause'; in *Argentina*, where there is a 'greater social harm'; in *England and Wales*, where there is a 'public interest' in disclosing; and in *Germany* where there is danger to a legally defined good with a higher value than the patient's private interest exists. In *Canada* and the *United States* the law deals more specifically with imminent danger or where there is a threat to public safety. In most of the countries, this legal justification is also reflected in the codes. However, in England and Canada, as previously seen, disclosure in these circumstances is never explicitly encouraged in the professional codes.

[34] BPAS Code, s 3.

5.1 Italy

Article 622 of the Criminal Code makes clear that Italian law will not punish a breach of confidentiality where a 'true and just cause' exists for an analyst to do so.[35] In addition, criminal responsibility can be negated if the situation can be said to represent a 'state of necessity'. This is set out in Article 54 of the Code:

> The author of a certain crime cannot be punished if he has been forced to do so due to the *necessity to save himself or others* from the *actual risk of a severe personal injury*. This risk must not be caused by him, *must not be otherwise avoidable*. The crime committed has to be *in proportion to the above risk* of severe personal injury [emphasis added].

It is clear from this that the analyst would be justified in breaching confidentiality if the risk is sufficiently severe. It is also clear that for a state of necessity to exist the crime must be prospective; regardless of their severity, past crimes cannot be disclosed.

The Italian Code of Medical Ethics embraces the notion of 'true and just cause' and is therefore broadly coterminous with Article 622 of the Criminal Code. However, it qualifies the concept by reference to 'imperative' and 'permissive' just causes.[36] Imperative just cause obliges a health care professional to reveal confidential information in certain circumstances which include, for example, certificates and obligatory health statements, the expert's report and technical consulting, and medico-legal examinations for the public administration. Permissive just cause allows but does not require the revealing of confidential information. This covers those instances expressly provided for in the Criminal Code, such as unavoidable accident or *force majeur*, self-defence, physical force, the consent of the entitled party (which will usually be that of the patient).

Furthermore, the analyst has a discretion to breach confidentiality when he considers that the patient's condition is sufficiently severe to require compulsory hospitalization. The Medical Code of Ethics makes explicit reference to these laws (Acts 180 and 833 of the laws regulating health).

5.2 Germany

A breach of confidentiality may be legally justified on the basis of Article 34 *StGB*. This is the case when any legally defined 'good' (*rechtsgut*) which is considered to be of a higher value than the confidentiality and anonymity interest of the patient is placed in danger. The breach of

[35] See s 3.1 above for the wording of this article.

[36] See A Marzi *Confidentiality and the Psychoanalytic Setting in Italy: Some Problematic Issues*. EPF Annual Conference, Prague, 4–7 Apr 2002.

confidentiality must be the only means to prevent the realization of that danger; an example would be where a patient's mental disturbance might result in public harm. The German Supreme Court has developed a balancing test in its case law, which it applies when an individual's 'other right' (*sonstiges recht*) conflicts with the rights and freedoms of another.

5.3 Brazil

It is considered 'just cause' to breach confidentiality every time a public and social interest overrides the individual interest of the patient. This duty is created by Article 5(x) of the Brazilian Federal Constitution, the chapter of Civil Rights, and Articles 3 and 4 of the Federal Medical Council Resolution 999/80.

Just cause would arise when the analyst's silence would put at risk the life or the physical or mental health of the patient or the community. The breach of confidentiality in these circumstances is considered just cause because public and social interests override the private interest of the patient. Whenever the analyst is facing a 'just cause' situation, he or she has to decide (subjectively) whether to maintain or breach confidentiality.

This rule is reflected in the Code of Ethics; Article 102 states that a breach of confidentiality would be permitted where it would prevent risk to the life or health of the patient or a third party because it would be considered just cause. A breach of confidentiality is ethically permitted whenever it would prevent serious physical harm to a specific person. Similarly, when such breach was committed in order to prevent the patient's commission of a crime, this would satisfy the requirements of just cause. Here there is a social and public interest involved, which overrides the private and individual interest of the patient.

5.4 Canada

If there is serious risk, the danger is imminent and there is no other way of preventing it, but the identity of the intended victim is not known to the analyst then although there is no duty to warn, an analyst can use discretion and breach confidentiality. In addition, the analyst has the power to disclose confidential information as part of general duty of care in relation to minors, older or incapacitated people.

In practice, any action taken by the analyst that reveals the patient's identity is not considered a breach of confidentiality but good patient care, if it is in the best clinical judgment of the analyst. There are no formal rules except perhaps in the case of suicide. In that case, the analyst could be accused of malpractice and would have to defend him or herself by showing that all necessary precautions were taken to prevent the anticipated risk. However, it might be thought that disclosure for the greater public good, as required by the law, would not be good patient care as again it would disrupt the therapeutic process.

5.5 United States

The Health Insurance Portability and Accountability Act 1996 (HIPAA) sets forth the federal law in this area. The Act permits a 'covered entity' (a health plan, health care clearing house, or provider of health care) to use or disclose identifiable health information without the individual's permission:

> if the covered entity, in good faith, believes the use or disclosure
> (i) (a) is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and
> (b) is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or
> (ii) is necessary for law enforcement authorities to identify or apprehend an individual:
> (a) because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or
> (b) where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody.[37]

The above uses and disclosures can be made without permission where they are 'consistent with applicable law and standards of ethical conduct'.

Where the information is used or disclosed to allow law enforcement authorities to identify or apprehend an individual who has committed a violent crime, the information disclosed is only to be that information necessary to allow law enforcement authorities to identify and locate the person.[38]

The American Psychoanalytic Association's ethical rules follow the *Tarasoff* rule: if the patient is a danger to himself or others, then confidentiality may be broken.[39] Furthermore, the ethical rules also state that when the patient is a danger to himself, confidentiality may be broken to the extent that relatives, police, or even sometimes friends, may be contacted but the expectation is that the people contacted and information transmitted will be the minimum amount necessary to guarantee the safety of the patient.

[37] 45 CFR 164.512(j)

[38] Federal courts are divided over the question of whether the 'dangerous patient' exception to the therapist–patient privilege allows otherwise privileged communications to be used in court against an individual or merely allows it to be used to avert serious and imminent harm.

[39] See s 4.5 above.

5.6 Argentina

Article 12 of Law No 17.132 establishes a general 'balancing principle' pursuant to which the obligation to maintain professional confidentiality may only be broken 'when special or general norms require it' or in order 'to avoid a greater and actual social harm . . . or in case of infectious diseases'.[40]

In the case of risk to the life or mental health of a third person, the psychoanalyst would be justified in breaking confidentiality. The justification here would be that there was a 'state of necessity' (*estado de necesidad*), as defined in Article 34 of the Criminal Code. It is unclear if the psychoanalyst could be held criminally accountable if he failed to act in that way, but he could incur civil liability. The approach of the courts in Argentina is usually to appeal to a balancing of interests, with appeals to absolute rights and duties being very rare. Given this moderate approach, it can be assumed that under extreme circumstances, such as when life is at risk, judges will uphold or require a breach of confidentiality.

This obligation to disclose in order to protect third parties is reflected in the APdeBA Code of Ethics. Section E states that

> [i]t must be clearly agreed upon between the psychoanalyst and the patient that the preservation of confidentiality is on the service of the latter, so that such confidentiality may only be broken when the intentions and actions of the patient could carry, according to the judgment of the psychoanalyst, an actual threat to third persons.

In practice, the information to be disclosed is limited to that considered pertinent for each contingency. That information must only be disclosed to those persons in a position to protect the interests of the patient and third persons.

5.7 England and Wales

In England and Wales there can be said to be only four circumstances in which a breach of confidentiality is permissible. These are where:

(i) a patient gives his or her consent;
(ii) there is legal compulsion (as set out above in section 4.7);
(iii) the public interest so demands; it is hard to define the precise scope of this as there have been few decided cases on its application in the health care context. However, following the case of *W v Egdell* there is recognition by the courts of the public interest in maintaining medical confidentiality.[41] Consequently any breach committed in that interest is to strike a balance between the two competing interests. (However, it is possible that in the following scenarios, the public interest to maintain confidentiality would be outweighed.); and
(iv) the commission of a crime is likely.

Where the person claiming confidentiality presents a threat to the public interest, they cannot rely on the protection of the law. It may be therefore that disclosure is justified in the public interest. It should be made clear from the outset that a psychoanalyst is not under a duty to report a crime, but a psychoanalyst's decision to disclose details about a patient's involvement with a (serious) crime may not expose them to an action for breach of confidentiality if it is justified in the public interest.

The *Egdell* case demonstrates that the public interest in protecting the public from violence outweighed the public interest in maintaining medical confidences. The case established that professionals may disclose information in order to protect members of the public, but the exact scope of the licence is unclear. However, it can be said that three general guidelines emerge from the case law taken as a whole:

(i) there must be a real and serious risk of danger to the public;
(ii) disclosure must be to a person with a legitimate interest in receiving the information—thus criminal matters should be reported only to the police, although wider publicity may be justifiable in certain cases if it serves the public interest better; and
(iii) disclosure must be limited to the extent strictly necessary.[42]

Other circumstances in which the public interest might justify breach of confidentiality follow where:

(i) evidence comes to light that a patient may be abusing a child, disclosure to the police or social would be justifiable and lawful;[43] or
(ii) a doctor believes that a patient may be the victim of physical or sexual abuse and the patient is not capable of giving or withholding consent to disclosure, the patient's medical interests are paramount and may require the doctor to disclose information to an appropriate person or authority.[44]

A difficult area concerns the rights of those unable to give consent to disclosure as a consequence of mental incapacity. It is probable that the courts would regard such disclosure in relation to incompetent patients as

[40] Note that the Law No 23,277 regulating the practice of psychology does not contain any specific reference to the cases in which psychologists are allowed to breach the duty of confidentiality.

[41] [1990] 1 All ER 835,849.
[42] See *X v Y* [1988] 2 All ER 648.
[43] See *Re M* [1990] 1 All ER 205, 213.
[44] See C. Foster, T Wynn, and N Ainley *Disclosure and Confidentiality: A Practitioner's Guide* (London Sweet & Maxwell 1996), at 382.

permissible where professionals judge that it would be in the patient's best medical interests. In *F v W Berkshire Health Authority* Lords Bridge and Brandon observed that it would be a bad law which prevented incompetent patients being cared for properly merely because they could not consent.[45] The solution was to permit professionals to act in their patients' best interests, subject to the safeguard that their assessment of those interests must not be negligent.[46]

In exceptional circumstances, it may be undesirable to seek consent to disclosure of confidential information, and disclosure is in the patient's best medical interests.[47]

As previously stated, the BPAS guidelines do not detail where breach of confidentiality may be justified except where clinically necessary. In practice the analyst goes to great lengths to preserve confidentiality. Consequently it is more likely that breach occurs where the best interests of the patient are at stake; one example would be where there is a risk that the patient might commit suicide. However, given the emphasis on preserving confidentiality wherever possible, it would appear that—even though he or she may be legally justified in doing so—an analyst would not disrupt the therapeutic process if the patient demonstrated criminal tendencies.

6. CONFIDENTIALITY ISSUES

In addition to the direct obligation—be it legal or professional—upon the analyst to disclose confidential information, there are various issues which arise as a result of psychoanalytical practice. Some circumstances under which these issues can arise may be enumerated as where:

(i) the analyst's training organization is required to investigate a complaint against the psychoanalyst;
(ii) a psychoanalyst is undergoing analysis as part of his or her training;
(iii) a trainee psychoanalyst provides analysis as part of his or her training;
(iv) information is required to be shared between members of a mental health care team;
(v) information is to be published in case studies, professional journals and the like;
(vi) information is to be used for the purpose of psychoanalytic teaching or research; and

[45] [1989]2 All ER 545. [46] At 548–9, 551
[47] This was the effect of the House of Lords' judgment in *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402.

(vii) information may be used for supervision or clinical discussion in the course of professional practice.

There are many similarities between the countries in the approach adopted in relation to the above scenarios. In broad terms there are two common principles that emerge: first, that those within an organization or team who are privy to confidential information are bound by the same obligation of confidentiality as the analyst and, secondly, that where disclosure occurs to a wider audience, for example, in the case of publications, research and examinations, anonymity of patient data is necessary. Furthermore, in the majority of countries these principles are reflected in both professional practice and the legal system.

However, these principles are not prevalent in all countries; in some there is a conflict between professional practice and the law. The summaries below clarify the differences in practice. However, an example of a different approach to these two principles can be seen in the case of *Brazil*, where in the context of sharing information as part of a mental health care team, the extension of the obligation of confidentiality to team members does not apply. Instead, neither the law nor practice permits disclosure without patient consent.

One pertinent example of not only a different approach in principles but conflict between legal and psychoanalytic practice exists in the *United States*. Information may be shared by members of a mental health care team; in this context, professional guidelines state that no information can be released without patient consent. This approach would appear to reflect the Brazilian position. However, in contrast to practice, the Privacy Rule allows all health information, including psychotherapy notes, to be used by direct treatment providers for treatment purposes without patient consent.[48] Consequently, they can be shared as part of a mental health care team.

In this section, the approach taken by professional practice to the issues under scrutiny will be set out; this will be followed by the legal position.

6.1 Italy

In relation to the training of a psychoanalyst it is normal practice for the training analyst to inform the training organization about the trainee's progress (without too much detail). Anybody who obtains information within the organization must keep this absolutely confidential (*estensione del segreto professionale*). This extension of the professional's secret to other colleagues is reflected in the law, set out in Article 622 of the Criminal Code, which has general application.[49] This rule applies equally to sharing information as part of a mental health care team.

[48] 45 CFR 164.501, 164.508(a)(2)(i)(A).
[49] See s 3.1 above for the wording of this article.

In relation to teaching, research and case studies or other publications in professional journals, Article 13 of the *SPI* Code of Ethics states that confidentiality and anonymity must be strictly safeguarded in scientific publications and with colleagues. Furthermore, Article 10(3) of the medical code of ethics states that: '[i]n scientific publications about clinical data or observations regarding individual persons, the health professional must assure that they will not be identifiable.' A specific law safeguarding confidentiality in publications does not yet exist yet but general principles from Article 622 of the Criminal Code and the Law on Privacy 675/1996 would apply.

6.2 Germany

Professional practice in Germany permits disclosure where there has been a complaint by a patient against a doctor or psychotherapist. Such disclosure is limited, however, to the persons or organizations directly involved; these may be law enforcement personnel or the ethics committee of a professional organization, both of whom are subject to the same obligation of confidentiality.

The law reflects this position; if an analyst's employer or professional organization instigates disciplinary procedures for misconduct, the former may be required to disclose a patient's information. Ordinarily a patient would formally permit the analyst to do so, given that it is in their interests to resolve such matters swiftly. Where such permission has not been granted, it will be necessary to limit the circulation of confidential information to those directly involved in proceedings.

In criminal proceedings the analyst's position as defendant gives him or her the right to disclose such confidential information as is necessary for his or her defence. In such cases public rights of access to the court can be suspended in order that the patient's confidentiality is—to a degree—maintained.

The context of sharing information as part of a mental health care team represents a clash between psychoanalytic principles and those aimed at protecting the working alliance. Information should only be conveyed on the basis of informed consent of the patient. But the legal position is different. Whenever cases are discussed in the clinical environment, in a hospital or other public health institution, the team members are themselves subject to the extended principle of confidentiality. Therefore the patient cannot legally claim a breach of confidentiality. However, the principles of proportionality and professional diligence require that information be kept as limited as possible and the risks of confidentiality breaches be minimized.

German psychoanalytic practice does not permit the trainee's psychoanalyst to breach confidentiality to the training organization. Trainees undergo psychoanalysis as a requirement of their training and a trainee's psychoanalyst will be asked when the trainee analyst is undergoing analysis as part of his or her training. The analyst of the trainee analyst must not report any detail from the training analysis. He is only asked whether he has any objection to the trainee being graduated. The analyst must not report any details but may say whether or not he has any objections.

Similarly, a breach of confidentiality is not permitted to satisfy the training organization or analyst's supervisors when the trainee analyst is giving sessions of analysis. The supervisors of every individual training case usually supervise several sessions. At the end of the training phase they provide a summary to the examination committee about the outcome and quality of the trainee analyst's work. However, they must not disclose details of the treatment which would make a patient recognizable.

Legally, however, the position is the same as sharing information in the context of a team. Thus, whenever cases are reported or discussed in the professional or training organization the teachers, representatives, and supervisors are themselves subject to the extended principle of confidentiality. Therefore the patient cannot legally claim a breach of confidentiality. So in such cases the following persons—and only they—can be informed without any condition: the analyst's employers and the professional psychotherapy body when the patient is a trainee.

In these scenarios therefore, practice is more stringent than the law. Professional practice does not permit a breach of confidentiality, or only on the basis of informed consent, whereas the law does not regard it as a breach due to the concept of the extension of the duty of confidentiality.

For the purpose of case studies, publications, teaching, research, audit, examination and supervision in training, and in the course of professional practice, most analysts feel bound by the ethical commitment to disguise confidential material of patients before publishing it. Furthermore, ethical and professional rules require that the patient should be informed if any publication about his case is planned.

In German criminal law there is no difference between protection of confidentiality and anonymity, as any breach of the former may lift the latter.[50] So in relation to case studies, publications, psychotherapy teaching, research, or audit, any information about the patient must be disguised and modified so that identification will not be possible.

The law makes a distinction in relation to examination and supervision in training and in the course of professional practice. If a significant audience is present at examination or supervision events, then the rules relating to anonymity apply, as set out above. If only a small group of examiners or supervisors are present, then the extended confidentiality principle applies.

[50] Section 203 *StGB*.

6.3 Brazil

In Brazil, breach of confidentiality by the analyst presents a difficult situation; there is no specific rule dealing with sanctions for professional misconduct. If the patient accuses the psychoanalyst of professional misconduct, the therapist has a constitutional right to defend him or herself. Each case is to be judged on its merits in accordance with the Code of Ethics. As a result of this it will be decided whether or not there was sufficient just cause to breach confidentiality.

Training organizations or other institutions may not be granted a right to information about the patient's data or treatment unless the latter has given formal authorization. Where the case is the object of study or supervision, the psychoanalyst has to keep the identity of the patient anonymous. This rule is set out in the Code of Ethics in Articles 11, 102, 103, 104, 105, and 106. It is also a general rule in Civil Code Article 104, and in Resolution 999/80 Article 5.

6.4 Canada

The Canadian Psychoanalytic Society's *Principles of Ethics for Psychoanalysts* states that if the complaint is made against the analyst himself, the patient revokes confidentiality by the act of filing a complaint. The analyst is obliged to provide a report in response to the complaint. The material provided by the analyst is confidential to the committee until a complaint has been dealt with. Only where serious penalties (such as expulsion) are levied is the name of the analyst revealed to the Society at the local, national and international levels. The name of the complaining patient is not revealed. Analysts do not have to disclose their clinical records to the Society, but the Canadian College of Physicians and Surgeons can demand all clinical records from a physician.[51]

Concerning the requirement for trainee analysts to undergo analysis as part of their training, all Canadian training institutes have a non-reporting policy for training analysts. The institute has only to be satisfied that the candidate is having or has had an analysis with a training analyst, no further details are required. This principle would be upheld by the law, since any analyst is bound by the general legal principles of confidentiality. This obligation would apply towards the trainee, and any disclosure would amount to a breach.

In order to satisfy the training organization when the trainee psychoanalyst is the provider of psychoanalysis, the candidate must submit 6-monthly reports on all such cases during the time the case is under supervision and until the required supervision is complete and the supervisor is satisfied with the analytic work of the candidate. The case reports are submitted anonymously. Legally, the Institute and supervisors are entitled to know about the treatment (but are not permitted to disclose what they know) and usually the identity of the patient is protected. One exception to this is where there is a danger of injury to the patient or an ethics complaint against the trainee. This stems again from the common law duty of care. The supervisor of team members must have the same information as the person directly responsible for the treatment. Otherwise the supervisor or team members cannot make responsible decisions about treatment.

In practice the sharing of information as part of a mental health care team is usually done with the patient's permission or in such a way as to preserve the patient's identity. If the analyst seeks supervision or consultation without the patient's permission, the identity of the patient is not revealed. Legally, the information must be shared with the treating team, as stated above. The supervisor of a team must have the same information as the person directly responsible for the treatment. However, the team members are bound by the same rules of confidentiality.

For the purpose of psychoanalytic teaching, research, examination, and supervision in training, case studies or publications in professional journals, the Principles of Ethics state that:

> When a psychoanalyst uses case material in exchanges with colleagues for scientific, educational or consultative purposes, he should make every reasonable effort to ensure that the identity of the analysand is protected.

No guidelines are outlined in the Canadian Psychoanalytic Principles. In law, psychoanalytic research must protect the identity of the patient in the same way that identity must be protected in all research with human subjects. Disguise is a legally acceptable way of maintaining confidentiality.

6.5 United States

In practice, when the psychoanalyst defends himself against a complaint, he may use whatever information he possesses to defend himself before the disciplinary board, if the complaint has been brought by the patient.[52] Reporting of a psychoanalyst's alleged professional misconduct is not permitted.

Under the Privacy Rule, identifiable health information may be disclosed without permission to 'a health oversight agency' for oversight

[51] This is encompassed by the legislation governing health professions, examples of which include the Regulated Health Professions Act in Ontario, 1999; The Alberta Health Discipline Act Revised 2000; and the Quebec Civil Code 1980.

[52] Psychoanalysts employed in the public sector, however, are not entitled to information without patient consent.

activities authorized by law.[53] Such permitted disclosures include for the purpose of 'licensure or disciplinary actions'. This is also one of the exceptions to the authorization requirement for psychotherapy notes, so it would appear that even such notes may be disclosed in these circumstances.

Where the psychoanalyst is a trainee the only record that is kept by the Institute is of the number of hours of supervision. Furthermore, in the context of research, examination, and supervision the guidelines state that no information can be released without patient consent.

The Privacy Rule would appear to permit uses and disclosures of patient information in relation to training, psychoanalytic teaching, research, examination, clinical discussion, and supervision. It would permit disclosure without the individual's permission even if they involved psychotherapy notes. Health care operations (for which general identifiable health information can be used and disclosed without consent) include 'conducting training programs' under supervision to practice or improve skills as a provider.[54] Furthermore, psychotherapy notes can be used or disclosed by the covered entity without the patient's authorization for 'training programs in which students, trainees, or practitioners in mental health learn under supervision'.[55]

In the context of sharing information as part of a mental health care team or for teaching, no information can be released without patient consent

The Privacy Rule allows all health information, including psychotherapy notes, to be used by direct treatment providers for treatment purposes without patient consent.[56] Consequently, they can be shared as part of a mental health care team.

In relation to case studies, the professional guidelines state that key information for case studies or publication is expected to be completely de-identified.

In relation to publications, the law states that use of identifiable health information for this purpose probably would require the individual's authorization, waiver, or modification of authorization by an institutional review board or a 'privacy board'.[57] It is also possible to use 'de-identified' health information that has certain identifiers removed,[58] or to use a 'limited data set' where the entity receiving the information enters into a data use agreement limiting its further use or disclosure.[59]

[53] 45 CFR 164.512(d).
[54] 45 CFR 164.501.
[55] 45 CFR 164.508(a)(2)(i)(B).
[56] 45 CFR 164.501; 164.508(a)(2)(i)(A).
[57] 45 CFR 164.512(i).
[58] 45 CFR 164.514.
[59] 45 CFR 164.514(e).

6.6 Argentina

Where the psychoanalyst is responding to a complaint made to the disciplinary body, there applies an inalienable right to defend him or herself. However, the psychoanalyst must exercise this right in accordance with certain requirements and the particularities of the situation she or he is facing. From a legal perspective, if the misconduct is alleged by the patient, it would be admissible to disclose only the information relevant to decide the allegation.

In relation to satisfying the training organization when the trainee psychoanalyst is having psychoanalysis as part of his or her training, section E, point 4 of the APdeBA Code of Ethics states that '[d]uring the training of a psychoanalyst it is mandatory to keep the most rigorous reserve with respect to any personal information received.'

The law does not permit breach of confidentiality except where the information is simply administrative in nature. It has been suggested that the protection of confidentiality set forth in the Criminal Code and the Code of Conduct adequately deals with this situation.

To satisfy the training organization when the trainee psychoanalyst is the provider of psychoanalysis, he or she must present to the Training Institutes (*Institutos de Formación* several reports about the supervision as part of their training programme. These reports contain clinical information about their patients. The Psychoanalytic Association must keep these reports in confidence, and their anonymity must be strictly respected.

In the context of sharing information as part of a mental health care team, all the members of the mental health care team have access to and share the information about the patient. By extension, there is a legal obligation to maintain confidentiality on all members of such an organization. The assumption is that this automatic access to confidential information, together with the obligation not to disclose its content, is a necessary precondition for the effective functioning of the mental health care team.

Case studies have always been one of the most essential sources for the development of the psychoanalytic discipline and for its accumulation of theoretical and practical experience. Consequently, it is usual that clinical information is widely circulated within the psychoanalytic profession; but the guarantee of anonymity must be respected. Anonymity applies equally to publications, teaching and research. For the purpose of examination and supervision of training in these cases, clinical information is overtly exposed but the anonymity of the patient is always maintained. In practice, anonymity is not as strictly respected as it should be, but psychoanalysts reasonably rely on the supervisor's discretion.

It has been suggested that the general legal principle of preservation of anonymity applies to teaching, research, case studies, publications, examination, and supervision. This suggestion derives from psychoanalytic

practice (which is considered authoritative as shaping a custom), the general principles forbidding disclosure, and the absence of any explicit rule to the contrary.

6.7 England and Wales

In the course of investigating alleged breaches of the BPAS Ethical Code, the Ethics Committee might need to ask the analyst—with the patient's permission—to reveal details of the analysis. This established practice is not likely to be considered to be a breach of confidentiality in English law. If a patient complains to the professional body, it is possible he will consent to disclosure in order that the complaint can be investigated. Without express consent, provided the complaint was instigated at the patient's initiative, implied consent[60] would probably suffice. If allegations come from a third party, such as another staff member, just as there is an implied qualification to the duty of confidence for bankers in the interests of the bank,[61] it has been said that 'it would be surprising if there was no similar qualification in the case of a doctor'.[62] However, whether this could be applied to an analyst in the context of the training organization remains uncertain.

For the purposes of training, further education (including teaching), and continuing professional development, analysts need to exchange clinical details about their work. In addition they need, for the development of ideas and technique, to publish papers about their work. Both of these activities potentially infringe confidentiality, which is why the profession has evolved ways of disguising and making anonymous the cases they discuss. The International Journal of Psychoanalysis has published advice about disguise, which are very similar to those followed when analysts present work to their colleagues.

The use of anonymized information does not raise confidentiality problems on a legal level; it cannot be traced back to an individual and consequently represents no intrusion on their privacy.[63] If the information is anonymized before disclosure takes place, then there is no breach of confidentiality.[64] This is essential given the typical uses to which such anonmyized information is put: teaching, clinical discussions, case studies and

[60] This is where, taking into consideration all the circumstances and the patient's conduct a 'reasonable person would, looking on, believe that the patient was consenting'. See I Kennedy and A Grubb *Medical Law* (London Butterworths 2000) at 1084–5.

[61] *Tournier v National Provincial and Union Bank of England* [1924] 1 KB 461.

[62] R Toulson and C Phipps *Confidentiality* (London Sweet & Maxwell 1996) at 151.

[63] *R v Dept of Health, ex p Source Informatics Ltd* [2000] 1 All ER 786 (CA).

[64] Kennedy and Grubb suggest that the process of anonymization falls within the meaning of processing in the Data Protection Act 1998 and that should patients be unaware that this anonymization takes place, this could amount to 'unfair' processing within the meaning of the Act. See Kennedy and Grubb *Medical Law* at 1069.

publications in professional journals. If it were not to be anonymized, the patient's express consent would need to be obtained. Explicitly in relation to this issue, Bingham LJ said in *W v Egdell*:

> It has never been doubted that the circumstances here were such as to impose on Dr Egdell a duty of confidence owed to W. He could not lawfully sell the contents of his report to a newspaper. . . . Nor could he, without a breach of the law as well as professional etiquette, discuss the case in a learned article or in his memoirs or in gossiping with friends, unless he took appropriate steps to conceal the identity of W.[65]

Where the analyst is the patient, undergoing analysis as part of his or her training, the training analyst gives permission to the training organization so that the trainee can proceed to the next stage of the training. This occurs at three stages—starting formal lectures; starting to treat a first patient; and at qualification. This normally takes the form of a one line letter of the type: 'I have no objections to X starting lectures.' Moreover, the candidate accepts this departure from an ordinary analysis as part of his or her training.

The legal position is that where the information requiring disclosure is so limited, implied consent would constitute a sufficient basis for this practice. Where the trainee understands and accepts the implications of this training, and the nature of the information that his or her analyst is to communicate, then express consent is not necessary.

Where the trainee analyst has patients, the analyst's supervisor may discuss the trainee's work in relation to the notes they keep, but it is always anonymized and therefore, for the reasons previously stated, this does not amount to a breach of confidentiality.

7. PATIENT RECORDS AND CONFIDENTIALITY

In all the countries under review, the records which a psychoanalyst maintains are required—by professional standards and usually by law—to be kept confidential, although in some cases this duty may be overridden in the public interest, as for example, for the purposes of criminal investigations. In most countries, psychoanalysts are not required to keep records—except in some cases records of factual data concerning the patient, but to some extent this varies depending on the extent to which analysts are subject to the same regimes as medical practitioners.

There is greater variation, however, in the extent to which a patient may access these records (or the information in them). In most countries, patients have a right of access to the records, but the strength of this right,

[65] *W v Egdell* (CA) [1990] Ch 359 at 419.

and its limits vary considerably. In Germany and Italy, for example, the right of access is qualified in circumstances where the patient's interests would be harmed by disclosure to the patient, while in the United States the right seems to be largely unqualified and in England, the situation is very unclear.

As regards the related question of the extent to which confidentiality is maintained after the death of the patient, in most civil law countries, the right to confidentiality is maintained indefinitely, whereas the law in the United States, Canada and England is much less protective of confidentiality after death, although in these countries, the professional rules require the continued protection of confidentiality after death. If it is the analyst who dies, the patient's right to confidentiality is maintained in all the countries under review.

This section outlines the professional and legal rules in each jurisdiction which govern:

(i) the duty to maintain records and the maintenance of confidentiality (where the latter differs from the general duty to uphold confidentiality);
(ii) the ability of patients to access the records held on them by the analyst; and
(iii) the way in which records are to be treated in the event of the analyst's or patient's death.

These circumstances are salient; as pressure gradually increases on psychoanalysts to display professional accountability and the maintenance of high standards, it is appropriate that there be some clarification of the form and content of the records they keep. It is equally important to set out the precise nature of the patient's right of access to his or her records; whilst this may be construed as a reasonable wish on the part of the patient, it may interfere with the process of treatment. It is necessary, therefore, to set out the options available to the analyst if he thinks that disclosure of this sort poses a threat. Finally, the third situation will be useful as a matter of contingency.

7.1 Italy

7.1.1 Patient Records

In Italy the professional rules relating to the keeping of patient records, and maintaining confidentiality are set out in Articles 9, 10, and 11 of the Medical Code of Ethics and in Articles 8, 13, and 21 of the SPI Code of Ethics. It is immaterial in what form such records are held. In particular, Article 13 of the SPI Code of Ethics states that the confidentiality and anonymity of the patient's communications must be guaranteed through

the analyst's safeguarding and control of written texts or notes regarding the treatment.

Furthermore, in Italian legislation, there is no distinction between the keeping of records and maintaining the confidentiality of those records, nor as regards the form they take. Both aspects are ruled by Article 622 of the Criminal Code (*Codice Penale*) and by the Law on Privacy (and in particular Article 23).[66]

7.1.2 Patient Access to Records

Patients in psychoanalysis may require access to their personal files or records or may ask the analyst for an opinion about their state of mind. This may present the analyst with obvious difficulties. The Law on Privacy allows access to one's own personal data,[67] but, in the case of a psychoanalyst's patient, access to data could adversely affect the psychoanalytic process or even the patient. Consequently, the health professional can refuse access, citing a state of necessity under Article 54 of the Criminal Code. Article 51 of the criminal code may also be applied, incorporating as it does the basic ethical principle of *non nocere*. This may justify the refusal to disclose without breaching the law, since the duty to treat and not harm the patient overrides the latter's ordinary right of access to information.

7.1.3 Death of Patient/Analyst

On the death of a patient, neither the professional rules nor the law alter the obligation of confidentiality; this is to be maintained indefinitely. Similarly, on the death of a psychoanalyst, the obligation remains unchanged. Article 13(2) of the SPI ethical guidelines specifically states that in case of psychoanalyst's death, a member of the family or a colleague must assure the safeguarding of the analyst's records and files.

7.2 Germany

7.2.1 Patient Records

In Germany there are no professional guidelines which govern the keeping of patient records. However, there do exist legal obligations upon medical practitioners which have been developed by the courts as a contractual requirement in, for example, personal injury cases. Where patients have sued medical practitioners for damages as a consequence of the acts of the

[66] See Law No 675 (1996) and in particular Art 23.
[67] Art 13(a).

latter, the courts have stated that there is a basic obligation to keep adequate records. The reason for this is to facilitate the court's attempt to determine precisely that which the medical practitioner has done or failed to do. It can therefore be said that the maintenance of adequate records constitutes an obligation which coexists with the main contractual relationship between doctor and patient.

More specifically, in the framework of the special medical contract between the doctor or psychoanalyst and the patient the former is obliged to record the entire process. This obligation stems from two sources: first, from the ethical and professional rules *(standespflicht)* which are set out in section 10 of the 1997 law regulating the medical profession (*Muster-Berufsordnung für die deutschen Ärztinnen und Ärzte*), and secondly, from the laws of the Länder establishing medical and psychotherapy practices (*Ärzte- und Psychotherapeutenkammern*).

Records underpin treatment, and provide accountability for measures taken and their outcomes. Records should always be kept in writing. Documentation must include examination, diagnosis and treatment, as well as any significant incident which occurs during these processes. The form and quality of documentation is a matter for the therapist's discretion; brief sentences, notes, keywords or even symbols may suffice, but such records must be current.

7.2.2 *Patient Access to Records*

The patient is legally entitled to have access to any document written or kept by the doctor or psychotherapist which relates to his treatment any way *(einsichtsrecht in krankenunterlagen)*. Such a right derives from the existence of a civil law contract between doctor and patient. Even if there is no such contract a citizen is able to demand access to documents concerning his or her treatment.[68]

The courts have applied this right of access to two slightly differing contexts: the first concerns a patient's wish to access the records of his or her treatment where they are otherwise held in confidence; the second is where the patient's records have already been disclosed to a third party during legal proceedings.

In the first situation, a patient's right of access to documents concerning his or her treatment must be justified objectively. It can be refused if the patient abuses this right or—especially in psychotherapy and psychiatric treatment—if it is feared that such insight will disturb the treatment process. At any rate, however, the right has been legally interpreted as limited to objective findings and notes about treatment measures. The *Bundesgerichtsof* (German Supreme Court) has ruled that the right of the

[68] Section 810 *BGB*.

patient must be weighed against the personal interest of the thetapist. It follows that this right does not extend to the personal notes of the therapist—which may contain highly subjective material.

It is important that a patient's request to access their records does not result in a conflict for the analyst. One practical consequence of this restriction on the right of access to records by the patient is that it may be prudent for the analyst to maintain records in a form that enables him or her easily to withhold that information which is not deemed necessary for disclosure.

In the second situation there is a legal obligation for the therapist to disclose treatment records during legal proceedings when the court so demands.[69] Once these documents are part of the court file the patient, as a party to proceedings, automatically has a right to see the contents of that file. It is important to note that in this context the information to which the patient has access is more comprehensive than in the previous situation. The therapist here is unable to override the exercise of the right on therapeutic grounds, and there is therefore a risk that the patient's treatment will be adversely affected by access to such records.

7.2.3 *Death of Patient/Analyst*

In principle there is no change in the legal obligation of confidentiality after a patient's death. Only if the patient explicitly determines otherwise in his will or if a pertaining relevant intention can be deduced or assumed on the basis of the facts could the decision be different.

Access to documents may must be granted to the heirs, but only where financial issues require to be resolved. In spite of this, however, the *Bundesgerichtshof* has decided that close family members may have access to the treatment documents. It is only if a desire to the contrary on the part of the deceased patient has been expressed, or may be implied, that such access can be refused.

If the analyst dies, the obligation to maintain confidentiality is passed on in its entirety to any legal successor of the analyst after death or infirmity. This applies to the heirs of the analyst just as much as to a successor in his office.

7.3 Brazil

7.3.1 *Patient Records*

The Code of Ethical and Professional Conduct determines in Article 102 that any kind of record of factual data about the patient (regardless of the

[69] Section 422 *ZPO*.

form in which they are kept) must be kept by the psychoanalyst; only the patient is able to consent to a breach of confidentiality.[70] Such authorization has to be given formally. The professional association considers that the records belong to the patient; the psychoanalyst is their guardian and therefore obliged to prevent their unwarranted disclosure.

There are occasions on which this general duty can be overridden, however. During criminal proceedings, a psychoanalyst must comply with the court's request for access to a patient's records. Here the public interest is considered to take priority over the general duty to maintain confidentiality. In civil proceedings, however, the situation is quite different. The court cannot make a request for disclosure of confidential information where that disclosure conflicts with the psychoanalyst's professional duty to maintain confidentiality.[71]

7.3.2 *Patient Access to Records*

Article 59 of the Code of Ethics states that any information on diagnoses, prognoses, risks and objectives of the treatment has to be given to the patient, at his or her request. Article 70 stipulates that the patient has the right to see the records related to his or her state of mind and even has the right to a clear explanation about his or her problem in order to understand it.

The Penal Code says that the professional can only breach confidentiality when there is 'just cause'.[72] A request by a patient to see his or her records is considered as constituting sufficiently just cause to permit a breach of confidentiality.

7.3.3 *Patient/Analyst Death*

According to both the professional and legal provisions, the duty of confidentiality does not change on the death of a patient.[73] The legal authority for this requirement derives from a basic constitutional right to privacy,[74] which may be overridden only where there is 'just cause' to do so. Consequently, any person with access to psychoanalytical records after the death of a patient has a duty to maintain confidentiality.

Similarly, professional and legal rules stipulate that confidentiality must be maintained after the death of an analyst (a requirement that also applies to infirmity of the analyst). The right to privacy and intimacy is present in Article 5(x) of the Federal Constitution; this is a general rule which is

[70] Art 105 of the Code of Ethical and Professional Conduct.
[71] See Art 363 IV of the Civil Procedure Code.
[72] Art 154.
[73] Resolution 1.359 of the Federal Medical Council.
[74] Art 5(x) of the Federal Constitution.

required to be upheld by all persons. So, as the records belong to the patient, nobody has the right to breach confidentiality, not even after the psychoanalyst's death because the privacy of the patient has to be respected. If someone does, he or she can be sued because he or she did not respect a constitutional duty.

7.4 Canada

7.4.1 *Patient Records*

Concerning an analyst's professional duty to keep records and maintain their confidentiality, *Principles of Ethics for Psychoanalysts* simply states that a psychoanalyst shall respect the confidentiality of his patient's information and documents. Given the broad fashion in which this requirement is phrased, it is possible to infer that the form of the records is immaterial.

The law sets out as part of the 'general duty of care' the requirements regarding the keeping of factual data. An analyst is required to maintain factual data, which covers information relevant to patient care such as names, addresses, diagnoses, prescriptions, and dates of treatment. The duty to maintain the confidentiality of these records is also part of the professional's general duty (see section 3 above). The precise form in which the records are kept is immaterial.

7.4.2 *Patient Access to Records*

There are no rules in the psychoanalytic code which deal specifically with a patient's request to see their records. This would be left to the discretion of the analyst and based on usual, acceptable and good analytic practice. A physician is required to disclose records to a patient; but reasonable notice must be given by the patient in order for such a request to be satisfied. When a physician is acting as analyst it is uncertain whether or not the physician is required divulge the clinical record or the notes that he or she has made. There are also separate rules for psychologists and social workers.

The Supreme Court of Canada in 1992 ruled in *McInerney v MacDonald* that the information in the record belongs to the patient but the fabric of the record belongs to the doctor.[75] This means that the patient has the right to know the contents of the medical or clinical record but does not have the right to read or hold the record. The effect of this judgment is that the analyst can convey the content of his or her records to the patient and give a satisfactory explanation to the patient about their precise content. If the patient is not satisfied or does not trust the analyst,

[75] *McInerney v MacDonald* 1992, vol 93 Dominion Law Reports (4th series) 415.

then the patient has the right to ask that the raw material be turned over to a trusted third party who is in a position to interpret the record. This may present difficulties where the patient's condition is such that he or she is incapable of dealing objectively with the analyst's statements (for instance, in the case of a paranoid transference).

7.4.3 *Patient/Analyst Death*

Whilst the professional rules of confidentiality do not change on a patient's death, the legal position does. Any right of action which the patient might possess expires on his or her death. For instance, a patient cannot sue for defamation of character after death; and—unlike certain civil jurisdictions—nor can any of his or her heirs do so.[76] There is no legal sanction against an analyst writing about the patient after death. So here there is a tension between the legal and professional rules where the latter—which are less binding—impose stricter requirements on the analysts.

Although not set out in the Code it is generally understood that analysts should make provisions for their records to be destroyed if they are unable to do so themselves—either by a colleague, a family member, the analytic society or a legal representative. To this end, there have been attempts to introduce a 'professional will' for those analysts not employed by a State institution (which apply their own rules to maintenance or destruction of records).

7.5 United States

7.5.1 *Patient Records*

The American Psychoanalytic Association has no rules regarding the keeping of records of factual data. Rather their practice guidelines, *Charting Psychoanalysis*, recommend that only factual data be kept and that any further data concerning the process of analysis not be kept. All records including factual data are expected to be kept confidential and not released without the patient's authorization. The form in which such records are kept is immaterial.

The law is not specific on the requirements for maintenance of factual data on the patient. However, many of the managed care health plans in the United States elect to be accredited by a national accrediting organization that include as a standard that participating providers keep accurate medical records on all of their patients.

[76] It is a basic principle in Canadian common law that only living persons can be defamed. See AM Linden *Canadian Tort Law* (4th edn London Butterworths 1998) 637.

Prior to 14 April 2003, all medical records were generally considered confidential to the extent that an individual's consent had to be obtained in order for the information to be used or disclosed. Under the HIPAA privacy rule such information can now be used and disclosed without the individual's knowledge or consent for treatment, payment, and health care operations.[77] Those terms, particularly health care operations, were defined to include uses that are not directly related to the patient's treatment or payment of an insurance claim for that treatment. Patient permission, in the form of a specific written authorization, is still required for uses and disclosures that fall outside of treatment, payment or health care operations[78] unless the uses and disclosures fall within one or more of twelve 'national priorities'.[79] These priorities concern:

(i) legal requirements;
(ii) public health activities;
(iii) disclosure to public officials regarding victims of abuse, neglect, or domestic violence;
(iv) health oversight;
(v) judicial and administrative proceedings;
(vi) law enforcement;
(vii) specified purposes regarding decedents;
(viii) organ donation and transplantation;
(ix) research;
(x) the aversion of imminent threats to health or safety;
(xi) specialized government functions (such as for intelligence and national security activities); and
(xii) compliance with workers' compensation laws.

The Privacy Rule contains special protections for 'psychotherapy notes' under which an express written authorization is required for use and disclosure of mental health information falling within the definition even where the information is to be used for treatment, payment and health care operations.[80] However, the effectiveness of this special protection is limited by the fact that there are numerous exceptions to the application of the special protections and exceptions to the definition of psychotherapy notes. For example, the special protections do not apply to psychotherapy notes used or disclosed for the following treatment, payment or health care operations purposes:

(i) use by the originator for treatment;
(ii) use or disclosure by the covered entity for its own training programmes;

[77] 45 CFR 164.506(a).
[78] 45 CFR 164.508.
[79] 45 CFR 164.512.
[80] 45 CFR 164.508(A)(2).

(iii) use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual;
(iv) use or disclosure to determine compliance with the Rule;
(v) use or disclosure required by law;
(vi) use or disclosure to conduct oversight or the originator as authorized by law;
(vii) disclosure to a coroner or medical examiner to identify a deceased individual;
(viii) use or disclosure to avert a serious and imminent threat to health and safety.[81]

In addition, in order for the information to come within the definition of psychotherapy notes, they must be:

(i) notes recorded in any medium;
(ii) created by a health care provider who is a mental health professional;
(iii) the documentation or analysis of the contents of conversation during a private group, joint, or family counselling session; and
(iv) separated from the rest of the individual's medical record.[82]

The last requirement is problematical because the Rule eliminates the individual's right of consent for information contained in the medical record even *prior* to the 14 April 2003 compliance date.[83] Consequently mental health information that might otherwise be entitled to protection as 'psychotherapy notes' might not qualify if it was not separated by the mental health professional from the rest of the patient's medical record in the past. Furthermore, the special protection for psychotherapy notes could be lost in the future without the patient's knowledge or permission if the mental health professional fails to separate the information.

In addition, mental health information that meets all of the above requirements for psychotherapy notes would still not receive the special protection if it falls within one of the following ten exceptions to the definition:

(i) medication prescription and monitoring;
(ii) counselling session start and stop times;
(iii) the modalities and frequencies of treatment furnished;
(iv) results of clinical tests;
(v) summaries of diagnosis;
(vi) summaries of functional status;
(vii) summaries of the treatment plan;
(viii) summaries of symptoms;
(ix) summaries of prognosis; and
(x) summaries of progress to date.

[81] 45 CFR 164.508(a)(2)(i).
[82] 45 CFR 164.501.
[83] 67 Fed Reg at 53, 211.

In addition to the Privacy Rule, federal common law recognizes that there is a 'therapist–patient privilege' which extends to 'confidential communications' between licensed psychiatrists, psychologists and social workers under which such communications cannot be used or disclosed without the permission of the individual. In *Jaffee v Redmond*[84] the Supreme Court noted that all fifty states and the District of Columbia recognize some form of this privilege. While the decision has been followed in more than 160 cases since 1996, the 'full contours' of the privilege have not been determined. The Original HIPAA Privacy Rule stated that it did not eliminate any federal or state therapist–patient privileges, that discussion was in the context of a version of the Rule that preserved the right of consent. It is unclear whether the Amended Rule, which eliminates the right of consent, allows the privilege to remain intact.

Notwithstanding variations in criminal, public civil, and private civil and family law, violations of the HIPAA Privacy Rule can be punished by civil fines and criminal penalties.[85] The privileges are enforced by court injunction, as are violations of the US Constitution. Monetary damages can be awarded for breach of privacy under state tort laws.

7.5.2 *Patient Access to Records*

According to psychoanalytic practice, the patient's records are his or her own. If he or she requests to see them, they must be supplied. Individuals have a legal right to obtain access to and make copies of identifiable health information.[86]

7.5.3 *Patient/Analyst Death*

The professional rules of confidentiality continue even after the patient's death. The legal rules generally do not alter upon death of the patient except that covered entities may disclose psychotherapy notes to a coroner or medical examiner for the purpose of identifying a deceased individual.[87]

On the death of an analyst there is no change in the application of professional rules to confidentiality of patient records. Nor is there any change in the legal position; non-disclosure requires to be maintained.

[84] 116 SCt 1923 (1996).
[85] The civil penalty entails a fine of $100 for each violation up to a maximum of $25,000. The criminal penalty applies where the disclosure is for commercial advantage, personal gain, or malicious harm and may be punished by fines of up to $250,000 and 10 years' imprisonment.
[86] It should be noted that there is no such obligation in relation to psychotherapy notes, however (45 CFR 164.524).
[87] 45 CFR 164.508(a)(2).

7.6 Argentina

7.6.1 *Patient Records*

The APdeBA Code of Ethics does not regulate explicitly the keeping of records and the maintenance of data. It only includes suggestions to protect the confidentiality of the records. Psychoanalysts are used to taking notes which record factual data about their patients, and it is the responsibility of each analyst to keep them as if they were private possessions. Records are usually written on cards and filed in the psychoanalyst's archive or on his or her computer. The psychotherapist must ensure that their notes are protected from any indiscretion.

As there is no express legal regulation of psychoanalysis in Argentina, there is no rule requiring psychoanalysts to keep records of factual data. In the case of medicine, however, there are rules that oblige doctors to do so. There are no specifications as to the way in which doctors should keep these records. The obligation of doctors to keep a clinical record was established in 1967 by the Decree 6216. Although this duty was directed to the medical directors of hospitals and clinics, the courts have extended this duty to all doctors. In the case of psychologists, there is no express obligation to keep records of factual data.

Article 11 of Law No 17.132 regulating the practice of medicine requires the maintenance of the confidentiality of the 'information' received in the course of the practice. Furthermore, point 4 of Article 8 of Law No 23.277 regulating the practice of psychology requires the maintenance of the confidentiality about any 'data or fact' known to the psychologist in the practice of his or her activity. There is no further regulation in this connection.

7.6.2 *Patient Access to Records*

The Argentine view is that adoption of the most restrictive attitude towards disclosure of information is crucial to the psychoanalytic technique. It is possible to answer the patient's questions about the psychoanalytic method when the psychoanalyst deems it appropriate. However, in some situations, the psychoanalyst must not inform the patient about his or her person or circumstances; rather, it depends on the type of request. If the request is justified, the psychoanalyst must provide the requested information about the symptomatic evolution in restricted terms. If the patient insists on seeing his or her background data, the psychoanalyst may eventually provide his or her clinical records.[88]

[88] In almost 40 years of professional practice of psychoanalysis the Argentine analyst stated that he had never received this type of request; nor had any of his colleagues.

In any case, it is appropriate to differentiate in this situation between general data (such as the name, address, marital status, occupation, diagnosis, and suggested prognosis) from clinical records or reports about the patient, and the psychoanalyst's own thoughts about the case, all of which are private to the psychoanalyst.

Legally, there is no express provision in the regulations of medicine and psychology creating to the right of the patient to access his or her clinical record. However, Article 43 of the Argentine Constitution provides for a summary procedure known as *habeas data*, which allows citizens to request a judge to order the disclosure of personal information in the hands of persons acting in a private or public actor's capacity when these latter deny it to the citizen. In the field of medicine, it is undisputed that the patient has the right to access his clinical records when doctors are obliged to have them. There are no legal rules specifically addressing this issue for psychoanalysts or psychologists. *Habeas data* would not apply to the reflections of the psychoanalyst, only to information about the patient.

7.6.3 *Patient/Analyst Death*

The general rule on the death of the patient is that the death of the patient does not release the psychoanalyst from his or her obligation to keep the confidentiality of the patient's information. However, in practice, we know that with the lapse of time the identities of the clinical histories, published by Freud with fictitious names, have become publicly known. Having said that, a clear distinction can be made between the interest aroused by the patients of the creator of psychoanalysis and by the mass of psychoanalytic patients in general.

There is no formal legal provision referring to the maintenance of confidentiality after the death of a patient. However, the interpretation of different legal principles and the constitutional right to privacy can support the conclusion that the duty of confidentiality is not altered on a patient's death.

The right to privacy was construed by the Supreme Court of Justice as enshrined in section 19 of the Constitution.[89] Courts have protected the right to privacy of a dead person.[90] The recognition of this right even after the death of a person could be considered as a general restriction to the disclosure of private information about a patient after his death. The heirs of the deceased have the right to request judicial protection of this expectation.

[89] *Ponzetti de Balbín, Indalia v Editorial Atlántida SA* CSJN, 1984, Fallos T 336.

[90] '*Valdez, José vs Editorial Perfil*', National Civil Courts of Appeals, Sala F, 10/14/1999, JA-2000-III-457.

Furthermore, general principles of contract law may also be invoked to interpret that one of the basic clauses of the agreement between the psychoanalyst and the patient was constituted by the duty of confidentiality and that such a clause should remain enforceable after his death. In this situation, the heirs of the dead patient may have the right to legally enforce the agreement. The enforcement of this duty would be ruled by the general law of contract and would entail different consequences depending on the existence of an oral or a written agreement. General principles of contract law would regulate the enforcement of the contract in this situation.

Regarding the professional rules of confidentiality on the psychoanalyst's death, section E, point 3, of the APdeBA Code of Ethics contains a series of provisions regarding the psychoanalyst's archives in case of the irdeath. For such purposes, the Code establishes that:

> The psychoanalyst is obliged to make a will providing for the future of his archives as from his death. A psychoanalyst's death does not imply the termination of his obligation to keep the confidentiality of his patients' information.

However, in practice, in Argentina, it is not usual to make wills, probably because the law of succession provides for a great portion of the assets to be directly and compulsorily transferred to a person's 'mandatory' heirs.

There is no express legal provision in any of the express regulations of professional confidentiality as to this matter. General principles of contract law applied to the interpretation of the agreement between the psychoanalyst and the patient will require the professional to take all the necessary steps while alive to fulfil the obligation undertaken in the oral or written agreement to safeguard the confidentiality of the patient's information after his death. There is no case law in this regard, and it may be contested whether the successors are obliged to maintain the confidentiality of the documents pertaining to the psychoanalyst. In any case, it would depend on whether the documents of the psychoanalysts are part of the assets received and accepted by the successors as part of the inheritance.

7.7 England and Wales

7.7.1 Patient Records

All analysts are required by their professional rules to keep records of their patients' names and addresses and to lodge these with a colleague but this is so that, in the event of the analyst's illness or death, a colleague would be able to help the patients with finding further help if they wished to do so. BPAS does not request that the analyst keep any other records.

Regarding maintaining confidentiality, there is no separate duty in respect of records. Analysts are bound by general duty set out in paragraph 2 of the BPAS Ethical Code and which covers 'documents'.[91]

Analysts differ in their note-keeping practices. Some keep very few formal notes, while others believe that it is their responsibility to keep some record, however broad in nature, of the treatment. If such records are kept, they would not be revealed to anyone, before or after the patient's or the analyst's death, except possibly in fulfilment of a court order.[92]

The Data Protection Act 1998 is the statutory legal framework in England which sets out legal obligations on any company or individual who 'processes' personal data either manually or electronically. 'Processing' of a patient's data has a very broad definition and covers 'almost any conceivable use of data, from the moment the data are obtained to the method of recording, retrieving, disclosing and destroying the data'.[93]

The definition of data includes any information 'recorded as part of a relevant filing system or with the intention that it should form part of the relevant filing system.'[94] In order to determine whether a manual filing system comes within the scope of the Act, regard must be had to whether the 'ease of access to personal data is facilitated by virtue of the structured nature of the system'.[95] For example, a card index system set out in a standardized order would constitute this, whereas general correspondence files with no internal structure would not. In addition, health information is subject to special protection as 'sensitive personal data'.[96]

Assuming that an independent psychoanalyst's records of a patient were held in a structured filing system, organized by reference to the individual patient or by criteria relating to them, then they would come within the scope of the Act.

'Processing' data is acceptable if any of the following criteria are satisfied:[97]

[91] See s 3.7 above for the wording.

[92] There is not much precedent about even this situation, and in one well-known case (to British analysts) the analyst, Dr Anne Hayman, refused not only to reveal to the Court any notes but also even to confirm whether or not the person in question was a patient of hers. She took the view that to act otherwise would be to undermine the confidence that any patient could place in his or her analyst. She took this stance even though it placed her in contempt of court: in the event, the Court respected her position.

[93] P Leigh-Pollitt J Mullock, and O Clarke *The Point of Law: Data Protection Act Explained* (London Stationery Office 2002) at 5.

[94] Section 1 of the Act.

[95] See Recital 15 of the Data Protection Directive.

[96] Section 2 (e).

[97] See Schedule 2 of the Act.

(i) that the patient consents to use of data;
(ii) that it is necessary to use the data in the patient's 'vital interests'; or
(iii) that it is necessary to process the data to carry out a statutory or government function.

It is most likely that psychoanalysts would seek to rely on either the first or second condition since, unlike doctors, they cannot meet the third criterion. Commentators suggest that implied consent would probably constitute a legal basis provided that the patient has a basic understanding of how the data is used. However, it has been suggested that the protection of vital interests is probably limited to significant threats to life and may not cover all aspects of care.[98]

However, as 'sensitive personal data', the processing or use of health records also needs to comply with at least one of a second group of criteria where:[99]

(i) the patient has given explicit consent (implicit consent is not sufficient);
(ii) data processing is necessary to protect the vital interests of the patient;
(iii) the data to be used is that which has been placed in the public domain by the data subject;
(iv) the health care organization or professional needs to use the information to seek legal advice or take part in legal proceedings;
(v) processing is necessary for the purpose of statutory or government functions; or
(vi) it is necessary for medical purposes and the information is used by a health professional or someone with an equivalent obligation of confidentiality.

It is suggested that the definition of someone 'with an equivalent obligation' would also extend to psychoanalysts. 'Medical purposes' is given a broad definition in this context and includes preventative medicine, diagnosis, research, the provision of care and treatment, and the management of health care services. Psychoanalysts could fall within this, given the broad definition, as providers of care and treatment. Furthermore, under section 69 of the Act, a health professional includes 'a clinical psychologist, child psychotherapist or speech therapist', each of whom impliedly has a medical purpose. Therefore, it is suggested that psychoanalysts would come within this provision. In any case, paragraph 8(2) states that 'medical purposes' includes the specified purposes. And therefore, as Kennedy and Grubb point out, other purposes might be covered.[100]

[98] See J Montgomery *Health Care Law* (Oxford OUP 2003) at 259.
[99] Set out in Schedule 1 of the Act.
[100] Kennedy and Grubb *Medical Law* at 1069.

Schedule 1 to the Act sets out basic principles, namely that:

(i) data be processed 'fairly and lawfully';
(ii) data are obtained for lawful purposes;
(iii) data stored is accurate and (where necessary) up to date;
(iv) processing is in accordance with data subject rights; and
(v) personal data are not subject to unauthorized or unlawful processing or accidental loss, damage or destruction.

The Act gives the data subject rights to:

(i) have information as to whether or not their personal data are being processed;
(ii) have details about the data (that is, a description of the data, the purpose of processing and the likely or actual recipients of the data) and a copy of all personal data of which he or she is the subject;[101]
(iii) prevent processing likely to cause damage or distress;[102]
(iv) prevent direct marketing;[103]
(v) require a data controller;[104]
(vi) not to make a decision based solely on automated means which significantly affects him or her;[105]
(vii) receive compensation from a data controller for the latter's breach of the DPA (if the breach has caused the data subject financial loss);[106] and
(viii) have inaccurate personal data blocked, erased, or destroyed.[107]

The Act imposes an obligation on the data controller to protect the rights of the patient in respect of the security and integrity of the records. Individuals who feel that they are directly affected by the processing of data can request that the Information Commissioner assesses whether there has been compliance with the Act.[108] Failure to comply with the Act is a criminal offence.[109]

7.7.2 *Patient Access to Records*

The BPAS Code does not set out what analysts should do when patients seek access to their records; rather they see themselves governed by the provisions of the DPA 1998.

[101] Sections 7 and 8. There are exceptions relating to the medical profession in relation to the obligation to provide the data subject with a copy of their data.
[102] Section 10.
[103] Section 11.
[104] Defined as the person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any personal data are, or are to be, processed.
[105] Section 12.
[106] Section 13.
[107] Section 14.
[108] Section 42.
[109] Section 47.

As stated above, the Act gives the data subject certain rights to access data held on them. Sections 7 and 8 of the DPA 1998 deals with patients' rights of access to their records. On a written application a patient is entitled to be informed whether their personal data are being processed and if so, they can request a description of the data, the purposes for which they are being processed, and the classes of people to whom they will be disclosed.

In practice this means that they are entitled to a copy of their records together with an explanation of any terms.[110] Having viewed their records, they are able to request that the data are not processed—if continuing to do so would cause substantial and unwarranted distress to the patient or another.[111] The patient may also apply to the court to have data, which they consider to be inaccurate, rectified. This is likely to mean in the healthcare context the court will require that the patient's views on the accuracy of the records are included.[112]

However, the following limitation is placed on a patient's right to access their records: if and to the extent that access would be likely to cause serious harm to the physical or mental health of the data subject or any other person, then access should be denied.[113] This provision is therefore of particular relevance to any notes that the analyst holds on the patient and which the analyst considers potentially harmful to the patient's mental health.

7.7.3 *Patient/Analyst Death*

Professional practice indicates there to be no change to the obligation of confidence on the patient's death. The law offers less clarity, however. Toulson and Phipps state that equity may impose a duty of confidentiality towards another after the death of the original confider.[114] This is because the conscience of the confidant is bound. It is open to the courts to regard the divulgence by a doctor of information supplied by a patient who has since died as being unconscionable as well as being unprofessional.[115] They give the example of a doctor who treats a celebrity with AIDS who subsequently dies. If the doctor took the details of the celebrity's treatment to the press, they state that

> in such a case it could not be said that the deceased would suffer detriment from the publication, but it would seem contrary to justice that the doctor should make a windfall from his breach of obligation.[116]

[110] See s 8 (2). [111] Section 10. [112] Section 14.
[113] See the Data Protection (Subject Access Modification) (Health) Order 2000, SI 2000 No 413, at 5(1).
[114] *Morison v Moat* (1851) 9 Hare 241.
[115] Toulson and Phipps *Confidentiality* (1996) at 155.
[116] Ibid at 72.

This approach of 'unconscionability' is also the basis for their reasoning that a doctor may owe a duty of care towards third parties. If for instance the patient disclosed information to the doctor about X, and the patient died soon afterwards, it would be 'most unsatisfactory if . . . the doctor became free to make disclosure (about X)'.[117]

Kennedy and Grubb adopt a different approach. They argue that the deceased's estate could only bring a claim if it inherits the right of the deceased which is then interfered with after his or her death. Therefore the question is whether the obligation of confidentiality should pass to the estate. They argue that what might be at issue is the deceased's reputation and feelings, and that therefore an analogy could be drawn with the law of defamation, namely that the cause of action does not survive on the individual's death.[118] This approach was actually adopted by the Law Commission in its proposal *Breach of Confidence* in 1981.[119]

On the death of the psychoanalyst, the professional guidelines state that the confidentiality of the analyst's records must be respected. Legally, the position is uncertain. There is no case law dealing directly with this point. Between a patient and private practitioner, general principles of contract law might apply to the interpretation of the agreement between the psychoanalyst and the patient. It would probably be implied that as confidentiality formed part of the agreement when the analyst was alive, there was an obligation on the analyst to safeguard the confidentiality of the patient's information on his or her death.

8. CONCLUSION

From the above, there should be little issue as to whether the psychoanalytic process is a confidential one, for this is clearly the case. Rather, the difficulty stems from reconciling two opposing arguments. First, that absolute confidentiality is the only solution, with any breach resulting in damage to the functioning of the profession as a whole. Secondly, that whilst confidentiality is crucial, there may be limited situations where other factors take precedence and the relationship of privacy between patient and analyst is overridden.

The first position is impracticable from a legal perspective; almost all legal instruments promoting a right to privacy—be they at domestic or international level—provide for a balancing of individual interests against those of wider society. Where the latter considerations outweigh the former, the right to privacy can be circumvented. This does little to aid the

[117] Ibid at 156.
[118] Kennedy and Grubb, *Medical Law* (2000) at 1084.
[119] *Breach of Confidence* (1981) Law Com No 110.

psychoanalytical process, however, where free association is crucial. A patient needs to be in a position where he or she is free to express any or all of their thoughts. The prerequisite for this is that they must believe that these acutely sensitive thoughts are to remain confidential, and that only the analyst will be privy to their content. Also of importance is the basic knowledge that an individual is actually undergoing analysis, which is arguably less sensitive but the confidentiality of which should be maintained with no less rigour. If the right to privacy in this context is conditional, then the effectiveness of the psychoanalytic process is jeopardized. It has been suggested here that the practice of psychoanalysis without the guarantee of absolute confidentiality is analogous to performing surgery without sterilized equipment.

Part of the difficulty stems from the uncertainty on the part of analysts worldwide as to their position in law—an uncertainty that this study has attempted to ameliorate. There are issues which remain to be developed, however; recognition of the precise nature of psychoanalytic practice is still nascent. It is submitted that the lack of case law dealing directly with issues arising from psychoanalysis means that this is difficult to gauge or predict.

For example, courts in certain of the jurisdictions in this study—Italy, Brazil, and Canada—hold the professional codes which bind psychoanalysts in high regard. In this sense they are accorded a weight not unlike that given to pieces of legislation or binding cases. In others, the courts are more inclined to use professional guidelines as tools for interpretation. In Germany, for example, the limited codes of conduct as developed by professional organizations will have to be taken into account, although the courts enjoy some autonomy in their interpretation. In Argentina, little reference is made to codes of ethics in the case law dealing with confidentiality within the medical profession. In England and Wales, the courts have shown a willingness to use professional guidelines—such as those of the General Medical Council—as an influential aid to their interpretation. And in America, courts often look to professional rules in considering an alleged breach of privacy, principally to determine whether the individual had a reasonable expectation of privacy and whether the practitioner had a duty of due care.

There is the argument that in any claim brought against an analyst which is tortious or delictual in nature the court would rely on professional guidelines as the standard by which the analyst's conduct would be judged. But the approach of the courts falling within the latter category is still problematic, and there is a need for their practice to be developed. One means of doing this could be by the application of comparative law; significant developments—in both legislation and case law—can be used at least persuasively by courts in other jurisdictions. This is less satisfactory than hearing a case directly which deals with analyst–patient confidentiality. But it may provide a useful foundation for the development of a

sophisticated doctrine for dealing with psychoanalytic confidentiality in each jurisdiction.

There is a more basic issue, however, which concerns the disjunction between psychoanalysts and lawyers. Psychoanalysts have been occasionally ordered to divulge information on their patients by the courts, but in order to preserve the psychoanalytic process as much as possible the latter need to be made fully aware of what is at stake. The use of identifiable information gained from a patient undergoing psychoanalysis for a purpose apart from the analysis itself has the potential to undermine the process. As the body of the study shows, certain courts have shown sufficient understanding. But the situation in each jurisdiction has yet to be resolved satisfactorily.

9. FURTHER READING

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Internet Resources

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Canada
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England and Wales
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Italy
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United States
<http://www.apsa.org>.
<http://www.division39.org>
P Mosher *Psychotherapist–Patient Privilege: The History and Significance of the US Supreme Court's Decision in the Case* Jaffee v Redmond, available at http://psa-uny.org/jr/articles/mosher.htm.

Data Protection and Confidentiality

<http://www.bka.gv.at/datenschutz>
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