THE OBSTACLE OF THERAPEUTIC PRIVILEGE IN HEALTHCARE MEDIATION

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Abstract: Mediators may find themselves in a situation where a patient has been prevented from knowing medical information about his or her diagnosis. It is morally problematic for a mediator to be an accessory to concealing the discovery of undisclosed information; however, the impediment of confidentiality restrains the mediator from discussing this matter outside of mediation. This paper will explain how a specific interpretation of the Uniform Mediation Act allows the mediator to breach confidentiality and create an *ad hoc* mediation, where the information can be disclosed to the patient in a safe and gentle manner.

Mediations promote an environment of confidentiality.[1] Confidentiality fosters trust, which is critical in mediation.[2] Prior to agenda-setting, mediators identify themselves as someone whom all the parties can trust. Mediators may reference the fact that the proceedings of the mediation are confidential in order to facilitate open dialog among the parties that are present. However, a mediator cannot buttress their assurance of absolute confidentiality, since there are circumstances when a mediator can, and sometimes ought to, break the promise of confidentiality.[3] For example, a healthcare mediator should be allowed to breach confidentiality when a mediator becomes privy to medical information about a patient that the physician has intentionally not disclosed to the patient.

When a physician decides to intentionally abstain from disclosing medical information to their patient, this is called ‘therapeutic

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[1] Bergman EJ, Fiester A. 2009. Mediation and healthcare, in *The Penn Center Guide to Bioethics* ed Vardit Ravitsky, Autumn Fiester, and Arthur L Caplan. Springer: New York, 172.

[2] Act of July 27, i98i, i98i N.Y. Laws 2262, amended by Act of May 29, I984, I984 N.Y. Laws 285.

[3] Felstiner W, Williams L. I978. Mediation as an alternative to criminal prosecution: ideology and limitations. *Law and Human Behavior* 2: 223-227.

privilege'.[4] Applying therapeutic privilege can be a dangerous practice, as there is a fine line between using the privilege compassionately and abusing it. As Ernest Jones reported, some physicians can experience a God complex when they intentionally withhold information from a patient, creating an information-based superiority over the patient.[5] In Canterbury vs. Spence, the District of Columbia court of appeals suggested that physicians are under an obligation to disclose all medical information when reasonable care calls for it, and must alert patients on body abnormalities.[6] However, it is not uncommon to find cases of misused therapeutic privilege in contemporary medicine.

Mediators may discover the use of therapeutic privilege through many means. A physician may directly inform the mediator that diagnostic information was withheld from a patient. A mediator may discover the information in the medical records, or through questioning the parties that are present. It is not uncommon that parents are responsible for wanting to hide diagnostic information from their child, especially if the child is dying. However, it is unclear at what age a healthcare provider should cease to withhold information from a child. Patients with Disorders of Sex Development (DSD) are often victims of therapeutic privilege. While disclosure of DSDs has increased in the last twenty years, mostly due to efforts taken by patient advocacy groups, the amount of information that is disclosed varies from physician to physician.[7] When a mediator is confronted with information that has not been disclosed, they must decide how necessary it is to inform the patient.

There are four categories under which undisclosed information can fall. The first category includes facts that are irrelevant to maintaining care, such as blood type or physician reactions that may appear in the patient's charts. In the second category are facts that are relevant to

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[4] Beauchamp and Childress 2009. *Principles of Biomedical Ethics* 6th edition, 124.

[5] Jones E. 1913. The God Complex, in E. Jones (Ed.), *Essays in Applied Psychoanalysis*. New York: International Universities Press, 244-265.

[6] Canterbury v Spence, No. 22099 (1972) 2nd Series 772, section 29.

[7] Diamond. 2007. Is it a boy or a girl?: intersex children reshape medical practice. *Science & Spirit* 18(4): 36-38.

care but irrelevant to the case for which the mediator has been requested. This may include the knowledge of previously prescribed overdoses of medication relating to another health concern. These first two categories do not necessarily warrant the mediator to pursue disclosure. The third category contains information relevant to the care of the patient and relevant to the case that the mediator is handling. Examples may include medical errors or treatment information that is withheld from a child by parents or guardians. The last category contains information intrinsic to the patient, the basis of their healthcare, which includes knowledge of patients being withheld from knowing their diagnoses. DSD cases frequently fall into this category. Information that falls into the latter two categories should prompt the mediator to suspend mediation and pursue avenues of assuring that the undisclosed information is disclosed to the patient.

The Uniform Mediation Act allows for a mediator to break the promise of confidentiality. The nature of breaching the confidentiality in the Uniform Mediation Act is not precisely prescribed for the matter of resolving the discovery of therapeutic privilege in healthcare mediation. Normally, when a party in mediation wants to be removed from the burden of confidentiality, they seek a waiver by all the parties in the mediation.[8] In this specific circumstance, the party that desires to break the confidentiality is the mediator, and their request to break confidentiality on grounds of discovering undisclosed information may become problematic. It would take a mastery of deception to convince the physician, who is the root of the non-disclosure, and the patient, who is not aware they are being lied to by people they trust, that confidentiality needs to be breached because undisclosed information was discovered – and still maintain the trust later when mediation continues. Instead, mediators can avoid this type of conflict and transform the situation into a constructive process.[9]

One interpretation of Section 7(b)(3) of the Uniform Mediation Act may allow a mediator to break confidentiality when therapeutic privilege is discovered. The Act states that a mediator may disclose information if mediation communication evidences abuse or

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[8] Olam v. Congress Mortgage Co., 68 F.Supp.2d 1110, 1131-33 (N.D. Cal. 1999).

[9] Smith DN. I978. A warmer way of disputing: mediation and conciliation. *American Journal of Comparative Law* 205: 207-208.

exploitation of an individual to an agency that is responsible for protecting individuals from mistreatment.[10] This statement was designed to allow a mediator to testify against a mediation party, if the party confessed to criminal activity, or intended to commit a crime. While keeping information from a patient is not a criminal activity, the ability for the mediator to break confidentiality is contingent upon the interpretation of what is meant by 'mediation communication', if lying to a patient is 'abuse' or 'exploitation', and if the continuation of therapeutic privilege is 'mistreatment'. It can be favorably argued to the affirmative, as follows.

1. Mediation communication can be interpreted to include materials read in medical documentation for the purpose of mediation. If a mediator asked questions to the physician and patient independently in caucuses, and discovered potential undisclosed information, the inclusion of the questions and answers (and therefore the discovery of therapeutic privilege), would fall under the umbrella of mediation communication.

2. Lying to a patient is a form of abuse. In 2004, Milton Diamond studied the effects of the trauma caused by the use of therapeutic privilege on patients with DSDs.[11] Of the patients in the study who were surveyed, 62% of respondents considered suicide, and 23% attempted suicide out of utter frustration from their physicians not disclosing the truth of their condition.[12] It is vexatious to imagine how many patients with DSDs were unable to respond to the survey because they succeeded at their planned demise. These lives lost could have been prevented if their doctors had not lied to them about their diagnosis. This is just one case example, based on one intensely studied medical condition where non-disclosure is commensurate with abuse. If more patients with medical anomalies were surveyed who

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[10] Uniform Mediation Act 7(b)(3): section 7 gives primacy to the exclusion of 'prohibited mediator reports', and is slanted towards benefaction of victims of mistreatment in public agencies. A private health facility may be inviolable from this section of the Act since it is not a public agency.

[11] Diamond M, Yates A. 2004. Androgen insensitivity syndrome and klinefelter's syndrome. *Child and Adolescent Psychiatric Clinics of North America* 13: 630.

[12] Ibid.

were not informed of their diagnoses or options, the data is likely to corroborate with these statistics.

3. If lying to a patient is a form of abuse, then lying to a patient can be considered mistreatment, which the mediator can prevent by commencing a procedure for disclosure.

It is reasonable for a mediator to adopt this suggested interpretation of Section 7(b)(3) of the Uniform Mediation Act, and break the promise of confidentiality when therapeutic privilege is discovered. A mediator may inform parties outside of the mediation to intervene and safely disclose hidden information to the patient.

Mediators are in a unique and useful position to help organize an *ad hoc* mediation, whereby the patient can be informed of medical information that was not previously disclosed. Mediators should not attempt to disclose medical information to a patient by themselves, foremost because they are not in the professional position to do so, and also to avoid losing their status of neutrality. While mediators may have advanced degrees in psychology or counseling,[13] the mediator should remain neutral and invite other parties with professional experience in disclosure, to join the *ad hoc* disclosure mediation. Healthcare centers that have experts in disclosure conversations should be consulted.[14] However, if a healthcare center does not have disclosure experts, the mediator will have to take the responsibility of organizing a disclosure conversation. It is up to the mediator's discretion as to who should be included in the disclosure conversation. Invited parties can include, but not be limited to, another physician who is familiar with the patient's condition, a nurse who is familiar with the patient's condition, a patient advocate, a social worker, or even a chaplain. The task of disclosing information hidden by therapeutic privilege is difficult, and disclosing the information

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[13] According to Trina Grillo, mediators should have at least a master's degree in social work, psychology, psychotherapy, social work, counseling, or another behavioral science. See Grillo T. 1991. The mediation alternative: process dangers for women. *The Yale Law Journal* 100(6): 1553.

[14] Liebman CB, Hyman CS. 2004. A mediation skills model to manage disclosure of errors and adverse events to patients. *Health Affairs* 23(4): 24.

incorrectly can lead to a breakdown of the patient's trust, emotions, or even lead to litigation in the future.[15] It is very important to design the best possible environment with the most experienced professionals available to participate in the disclosure process.[16]

An *ad hoc* mediation is the best environment for the disclosure process. Healthcare mediators are skilled in creating an atmosphere of compassion and understanding for patients. Mediation can direct a potential conflict into a constructive process.[17] One of the goals of mediation in general is to reduce the negative effects of conflict.[18] The *ad hoc* mediation can become a place where the patient can express their feelings and vent strong emotions to an audience who can sympathize with their situation and foster solutions.[19] There may be situations where the patient is not in the best emotional state to receive serious medical information. Reibl vs. Hughes suggested that if disclosure of information is unbearable for a patient to hear, a physician or experienced professional can at least generalize the information in an effort to disclose the information to the patient.[20] Successful disclosure of medical information to the patient in an *ad hoc* mediation will help facilitate a more open and successful general mediation.

Once a patient has been informed of the previously undisclosed information, the mediator plays a crucial role in making the overall mediation successful. Pursuing the initial mediation gives the patient and physician a chance to preserve their relationship, or if it is not reconcilable, the end of the relationship can be less destructive.[21] Bringing the disputing parties together can help each party try to

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[15] Ibid, 25.
[16] Ibid, 26.
[17] Smith DN. I978. A warmer way of disputing: mediation and conciliation. *American Journal of Comparative Law* 205: 207-208.
[18] Folberg, J, Taylor A. 1984. *Mediation: a comprehensive guide to resolving conflicts without litigation.* Jossey-Bass: San Francisco.
[19] Davis AM. 1989. The logic behind the magic of mediation. *Negotiation Journal* 5: 17-24.
[20] Johnston C, Holt,G. 2006. The legal and ethical implications of therapeutic privilege. *Clinical Ethics* 1: 146-151.
[21] Protecting confidentiality in mediation. Harvard Law Review 1984(98)(2): 441-459.

understand the reasons why information was not disclosed.[22] It gives the opportunity for parties to explain their underlying intentions and emotions. The mediation setting can also provide parties with the ability to converse through private caucuses led by the mediator, if one party feels threatened or hopeless in the presence of another party.[23] Often the intimidating party is the physician who withheld information, but the physicians may be victims as well.

Mediators must assume neutrality, and just as they aided the patient in a safe and gentle disclosing conversation, the mediator can assist medical staff in a similar way. Physicians have confessed that discussing adverse events or medical errors with other physicians is helpful.[24] Mediators can facilitate a change in hospital culture by bringing in senior staff to discuss their past mistakes and answer questions that the medical staff who participated in intentional non-disclosure may have.[25] Medical staff who are emotionally supported by their colleagues are more comfortable speaking with their patients once an error has been made.[26] Having trust in physicians is a resource, and the mediator can help in the continuity of that trust by helping medical staff avoid misusing therapeutic privilege in the future.[27] By creating another *ad hoc* mediation with the medical staff and empathetic senior staff, the mediator can make the discussion of better communication a priority on the agenda. Many patients pursue litigation not entirely due to malpractice, but also out of frustration from poor physician-patient communication.[28] Negligence and poor

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[22] Lampe M. 2001. Mediation as an ethical adjunct of stakeholder theory. *Journal of Business Ethics* 31(2): 165-173.
[23] Emery RE. 1995. Divorce mediation: negotiating agreements and renegotiating relationships. *Family Relations* 44(4): 377.
[24] Liebman and Hyman, 28. See supra-note 14.
[25] Ibid, 28.
[26] Ibid, 28.
[27] Hall MA. 2002. Law, medicine, and trust. *Stanford Law Review* 55: 526.
[28] Hickson GB, Clayton EW, Githens PB, Sloan FA. 1992. Factors that prompted families to file medical malpractice claims following perinatal injuries. *Journal of the American Medical Association* 267(10): 1359-1363. And, Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. 2003. Patients' and physicians' attitudes

quality of medical care do not causally prompt patients to pursue litigation, but rather, ineffective communication is often the catalyst to litigation.[29]

In 2002, Pennsylvania made a statute that placed a duty on hospitals to inform patients or their families of any serious events that compromised the patient's safety, necessitating additional health care services.[30] The disclosure was to be made within seven days, in writing. Soon after, Florida and Nevada followed the lead of the Pennsylvanian courts, but imposed that the information delivery should be in person rather than by letter.[31] As more states require hospitals to admit errors and extinguish the opportunity to misuse therapeutic privilege, the onus of successful communication of disclosure usually rests on physicians. Nevertheless, mediators can still play a vital role in promoting better communication among physicians who are caught misusing therapeutic privilege, by creating a safe and gentle mediation space with those physicians and empathetic senior staff who can guide them. When a mediator establishes *ad hoc* mediations with medical staff, the results of the mediation can reduce future litigation against the hospital while also improving care for future patients.

The use of therapeutic privilege, by not disclosing pertinent information to a patient, is popularly seen outside of the medical context as a dishonorable action. When a mediator discovers that a patient has not been disclosed information about their diagnosis, the mediator can help turn a potential conflict into a constructive process. Mediators confined by the Uniform Mediation Act may break the confidentiality entrusted to them within the context of mediation, in order to create *ad hoc* mediations to facilitate a safe and gentle

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regarding the disclosure of medical errors. *Journal of the American Medical Association* 289(8): 1001-1007.

[29] Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. 1997. Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. *Journal of the American Medical Association* 277(7): 553-555. And see supra-note 28 for corroborating papers.

[30] Liebman and Hyman, 22-32. See supra-note 14.

[31] Nevada Revised Statutes title 40, sec. 439,835 (2003); and Florida Revised Statutes title 29, sec, 395,1051 (2003).

disclosure conversation for the patient. It is also useful for the mediator to create an additional *ad hoc* mediation to assist the physician in peer support and enhanced communication, to avoid future uses of therapeutic privilege. With an increased popularity of skilled mediation, the misuse of therapeutic privilege will become a practice of the past.

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