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Disclosure of HIV Status to an Infected Child: Confidentiality, Duty to Warn, and Ethical Practice

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INTRODUCTION

What are the ethical and legal imperatives of client confidentiality and safety and how do they impact a decision to disclose a child's HIV diagnosis? This is the issue that Charles D. Mitchell and colleagues as well as Robert Klitzman and colleagues wish to address in their respective works.[1] The authors of each article describe the complexities of disclosure when the child is infected perinatally and the mother does not wish to inform her child, for various reasons. Each set of authors presents stimulating discussion and case material that assists the reader in navigating the ethically and legally murky waters of determining how and when disclosure or nondisclosure is the best practice alternative.

THERAPEUTIC JURISPRUDENCE

Therapeutic jurisprudence is a term coined by David Wexler and Bruce Winick that describes the problem-solving process between two systems: a study of the impact of the system of law on mental health as well as the impact of the social sciences on the law.[2] Wexler and Winick describe a problem-solving process between two systems whose rules and procedures do not always coincide. This concept includes the idea that each system has an impact the other, and dedicates a field of study to this convergence.

The issue of HIV disclosure becomes a matter of best medical practice as well as an issue that has therapeutic, legal, and ethical relevance. Healthcare institutions' bioethics committees are often charged with spanning the divide between ethical imperatives (including client confidentiality, autonomy, beneficence, and nonmalfeasance), moral and legal issues (such as the vicissitudes of *duty to warn,* various state laws, and safety), institutional policies, and best medical practice (including issues of treatment compliance).

The authors of these articles describe how the problem of disclosure has emerged more recently due to improved treatment and the related phenomenon of "super-vertical transmission" — infants who were infected with the virus perinatally who grow up to have children of their own who are in turn infected with the virus.

THE CONUNDRUM OF CONFIDENTIALITY

One of the issues that is often in contention between these systems is the ethical responsibility to maintain a client's confidentiality. Professionals in each field recognize its importance and have parallel processes in this regard: attorney/client privilege (in the realm of law) and client/clinician confidentiality (in the field of allied healthcare practice). It is one of the basic tenets of therapeutic relationship and one that is an essential agent in the helping process for attorneys as well as clinicians. Indeed, it is clinicians' ethical responsibility to maintain the privacy and confidentiality of our clients and to practice within the confines of the law and in an ethical manner.[3]

The codes of ethics of the National Association of Social Workers and of the Clinical Social Work Association, for instance, outline the values and principles that govern social work practice and guide its profession in making ethical decisions. They compel licensed social workers to maintain clients' privacy and confidentiality except under very specific circumstances.[4]

SUMMARY OF THE *TARASOFF* DUTY — MANDATED REPORTING AND THE DUTY TO WARN

Allied health professionals are often compelled to reveal confidential information about clients when they are a harm to themselves or others. As well, all professionals (mental health, educational, and healthcare) who work with minors are mandated to report incidents of alleged child abuse whether the child-client or parent agrees or not.[5] The California Supreme Court decision in *Tarasoff v. Regents of the University of California* set a standard for practitioners to reveal confidential information in their *duty to warn* others of the potential dangers from a client.[6]

In the majority decision, the court found that the "protective privilege ends where the public peril begins."[7] The decision has a significant impact on the legal requirements for a clinician and certainly impacts clients' confidentiality. If, during the course of treatment, a clinician assesses a client as a danger to someone, the clinician has a duty, and is legally compelled to warn the intended victim.[8]

CASE LAW RELATED TO THE LIMITS OF CONFIDENTIALITY AND PRIVILEGE: A LEGAL ANALYSIS

Often the terms *confidentiality* and *privilege* are used interchangeably to describe the same general phenomenon — keeping information about a client private. However, the two terms can be distinguished from one another. The professional necessity of keeping a client's information private (for attorneys and allied healthcare professionals) is referred to as maintaining a client's confidentiality and is, as Stein notes, "rooted in the ethical codes of each profession as well as in statutory law."[9] On the other hand, privilege "refers to the right to withhold confidential information in a court of law . . . [and] is conferred by the legislature of the courts."[10] In a general sense, the conduct of the professional practitioner must be, as *Tarasoff* states, "measured against the traditional negligence standard of the rendition of reasonable care under the circumstances."[11] State laws vary, so practitioners must familiarize themselves with the appropriate statutes in their state.

The history of confidentiality and how it has been guarded and breached can be traced through pertinent case law. Familiarity with pertinent case law related to confidentiality can also be helpful in guiding practitioners negotiating work with a client, for example, who poses potential danger (through action or inaction). As discussed earlier, the *Tarasoff* ruling in 1976 formed the foundation of case law that guided practice with regard to a clinician's duty to warn others of a client's intent to harm.

However, subsequent rulings have helped to clarify (in most cases) what constitutes such things as *imminent harm*, the *intended victim*, and what actions constitute a warning. The ruling in the case of *Mavroudis v. Superior Court* clarified that threats must pose an "imminent threat of serious danger to a readily identifi-

able victim."[12] This was further clarified during a subsequent ruling in *Thompson v. County of Almeda* when the court ruled that the threat must be specific.[13] Thus, clinicians should take heed to their ethical and potential legal obligations to protect others from a patient posing an imminent danger.

It is clear that work with a patient who is noncompliant with treatment or is suspected to be engaging in unsafe sexual practices poses many therapeutic and ethical challenges. Clinicians may be concerned about the liability that a breach of confidentiality may pose. Dickson notes, "When there is no statutory protection, consultation combined with careful documentation should minimize the chances of successful litigation."[14] In many states, mental health practitioners are protected from litigation when they are following, for instance, mandated reporting guidelines. However, clinicians must balance their obligations and be aware of state law and statutes that protect the rights of HIV-infected individuals, for example, the Omnibus AIDS Act.[15]

A careful assessment and consultation with a supervisor or bioethics committee are often the first steps in making an appropriate plan of action. Reamer further outlines steps to be taken by a clinician if the patient poses a threat to another party:

- Consult an attorney who is familiar with state law concerning the duty to warn and/or protect third parties
- Consider asking the client to warn the victim (unless the [professional] believes this contact would only increase the risk)
- Seek the client's consent for the [professional] to warn the potential victim
- Disclose only the minimum amount necessary to protect the potential victim and/or the public
- Encourage the client to agree to a joint session with the potential victim in order to discuss the issues surrounding the threat (unless this might increase the risk)
- Increase the frequency of . . . sessions and other forms of monitoring
- Be available or have a backup available, at least by telephone
- Refer the client to a psychiatrist if medication might be appropriate and helpful or if a psychiatric evaluation appears to be warranted
- Consider hospitalization, preferably voluntary, if appropriate.[16]

Not all clinical situations involving disclosure of HIV status and confidentiality are quite so clear. Work with children is certainly specialized in that clinicians must balance the confidentiality of their clients and address issues regarding safety while simultaneously maintaining an appropriate alliance with their caregivers and/or legal guardian(s).

PRACTICAL IMPLICATIONS FOR CLINICAL PRACTICE

So what practical implications do any of these aforementioned guidelines provide? Who, what, when, and how does a healthcare practitioner disclose such information? These are indeed the questions that face clinicians in this situation.

WHO SHOULD DISCLOSE?

The clinician who has the closest working relationship with the client and professional experience with children should be selected to discuss this matter with the child and mother. This decision is both a practical and therapeutic one. Bioethics committees and other multidisciplinary panels should address this important issue and may decide that the treating physician is the obvious and best choice. Other practitioners who are involved in the treatment process and team may be appropriate options as well. For instance, a hospital social worker who has a working knowledge of the case and appropriate training and experience with children and families may be a suitable option because of her or his working knowledge of various macro systems that may be helpful to the family post-disclosure.

WHAT SHOULD BE DISCLOSED?

The simple answer to this question in regard to what information should be disclosed to a child is, *it depends*. It depends on the child's age and developmental level. Therapeutically, the child should know (as soon as the child is able to grasp the concepts of sickness and illness) that he or she has a special condition that requires specialized treatment. All questions that arise from the child should be answered in a straightforward and truthful manner that provides information without overwhelming the child (particularly, a young child) with unnecessary detail (such as detailed information about how Mother was exposed to the virus). Ideally, this would involve a joint effort by the professionals involved, as well as Mother and/or other immediate adult family (like Father). Of course, this depends on Mother's wishes for her minor child and confidentiality regarding her own status. Medical professionals should be present to answer questions about the course and treatment of any illnesses that arise due to immune deficiency.

If the mother strongly objects, the careprovider or staff should allow this discussion to continue over greater lengths of time, since different persons require different amounts of time to adjust to and accept new stresses that they know will be extremely painful. The time may arise, though, when giving the information can no longer be deferred, as when the child may engage in sex, since it may endanger another, and not be at all what the child would want. Accordingly, the staff should try as best they can to prepare the mother so that she has advance notice that this time will come — and when.

Staff may be rightfully concerned about giving the mother notice, knowing that the mother may use the information to leave and not return. Giving the mother notice that the time will come is, however, the only way to respect the mother's dignity and autonomy. The law may provide a remedy if and when the mother and child disappear, but whether or not it does, and what the remedy may be, may lie outside what the staff can ethically decide. Staff may have no better choice than to be open with such a mother well in advance, regardless of the risk of flight.

WHEN SHOULD DISCLOSURE OCCUR?

Ideally, a mother should be counseled to discuss the advantages (and risks) of disclosure and should have final say in most matters of disclosure, including timing. Little information should be disclosed about the details of the child's health without her consent As our authors indicate, this is really where the issue becomes most critical — for example, what if a mother delays — or worse, refuses to allow disclosure to the child for various reasons. This is when the support of other allied healthcare professionals such as social workers or psychiatric professionals can be of some assistance. These professionals often have the necessary mental health training to address issues of resistance, fear, and anxiety that arise out of this situation and related decision-making processes.

The developmental level and capacities of the child should always factor into the timing of disclosure. However, there exists little evidence that a parent's denial about the child's condition is helpful or even healthy to the child in the long term. The timing of disclosure is even more critical as the child ages, when (as discussed by our authors) a child may become sexually active and risks infecting another child. As suggested earlier, a situation in which a parent chooses not to disclose at this point becomes a matter subject to pertinent legal obligations such as the *duty to warn* an innocent third party. This duty and legal statutes relevant to the situation should be discussed with the mother as part of the disclosure process.

HOW SHOULD THE DISCLOSURE OCCUR?

The disclosure should occur in the professional setting; however, the parent (mother) is the key figure in how this meeting or meetings will transpire. The mother should be counseled about her role in the disclosure and how the professionals involved will make themselves available as sources of support and information. One potential scenario that may arise is a parent's wish to disclose to the child in the home or outside the professional realm. This request should be honored; however, the relative advantages and disadvantages of having other professionals immediately available should also be discussed.

A question that staff might encounter at this point is whether or not they should "check up" to be sure that the child has been informed. It would be ideal to anticipate with the mother, in advance, the future course for herself and her child. Staff could offer to work with the mother to support and work with the child while the child is told, and afterward — regardless of the time and the setting in which this actually takes place.

While there may be room for different views on this, one that seems paramount is for the child to know that she or he could endanger another by having unprotected sex, so that the child does not do this unknowingly. To allow this to happen to respect the mother's autonomy — notwithstanding legal concerns — seems inhumane. Regardless, the tone and therapeutic aim of the disclosure should be one of support, help-giving, and openness to questions.

CONCLUSION

The ethical, legal, and therapeutic difficulties that arise out of the scenarios described challenge even the most seasoned professional. For this reason, professional collaboration and consultation is critical and can help guide the process in a way that is both practical and therapeutic and within the ethical and legal guidelines of our professions.

NOTES

1. This is a commentary on two articles, "Disclosure of HIV Status to an Infected Child: Medical, Psychological, Ethical, and Legal Perspectives in an Era of 'Super-Vertical' Transmission," by C.D. Mitchell, F.D. Armstrong, K.W. Goodman, and A. Cava, and "Ethical Issues Concerning Disclosures of HIV Diagnoses to Perinatally Infected Children and Adolescents," by R. Klitzman, S. Marhefka, C. Mellins, and Lori Wiener, both in this issue of *JCE*. Some material for this article is adapted from J. Corbin, "Confidentiality and Duty to Warn: Ethical and and Legal Implications for the Therapeutic Relationship," in *New Social Worker* 14, no. 4 (2007): 4-7.

2. The term *therapeutic jurisprudence* and related theory and practice are described in the following sources: D.B. Wexler, *Therapeutic jurisprudence: The law as a therapeutic agent* (Durham, N.C.: Carolina Academic Press, 1990); D.B. Wexler and B.J. Winick, *Essays in therapeutic jurisprudence* (Durham, N.C.: Carolina Academic Press, 1991); D.B. Wexler and B.J. Winick, "Introduction," in *Law in a therapeutic key (*Durham, NC: Carolina Academic Press, 1997), xvii-xx; and B.J. Winick, "The jurisprudence of therapeutic jurisprudence," *Psychology, Public Policy, and the Law* 3, no. 1 (1997): 184-206.

3. Ethical guidelines regarding confidentiality in the behavioral and allied health fields appear in the following sources: American Psychological Association — Committee on Ethical Guidelines for Forensic Psychologists, "Specialty guidelines for forensic psychologists," *Law and Human Behavior* 15 (1991): 655-65; American Psychological Association, "Guidelines for child custody evaluations in divorce proceedings," *American Psychologist* 49 (1994): 677-80; Clinical Social Work Association, *Code of ethics* (Arlington, Va.: Clinical Social Work Association and National Association of Social Workers, 1997); National Association of Social Workers, *Code of ethics* (Washington, D.C.: NASW Press, 1996); Omnibus AIDS Act (Fla. Stat. §381.004); American Academy of Pediatrics Committee on Pediatric AIDS: Disclosure of Illness Status to Children and Adolescents with HIV Infection," *Pediatrics* 103 (1999), 164-6.

4. Clinical Social Work Association. *Code of ethics,* see note 3 above; National Association of Social Workers, *Code of ethics*, see note 3 above.

5. M. Levine and L. Wallach, *Psychological problems, social issue, and law* (Boston: Allyn and Bacon, 2002).

6. *Tarasoff v. Regents of the University of California*, 108 Cal. Rptr. 878 (Ct. App. 1973); reversed and remanded, 13 Cal. 3d 177 (1974); modified, 17 Cal. 3d 425 (1976).

7. Ibid.

8. Levine and Wallach, *Psychological problems, social issue, and law*, see note 5 above.

9. T.J. Stein, *The role of law in social work practice and administration* (New York: Columbia University Press, 2004), 11.

10. Ibid., 105.

11. *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425, 439-440 (1976).

12. F. Reamer, *Social work malpractice and liability*, 2nd ed. (New York: Columbia University Press, 2003), 31.

13. Ibid.

14. D.T. Dickson, *Confidentiality and Privacy in Social Work* (New York: Free Press, 1988), 164.

15. Omnibus AIDS Act (Fla. Stat. §381.004).

16. Reamer, *Social work malpractice and liability*, see note 12 above, p. 41.