Since the beginning of the epidemic, HIV disease has raised new and complex ethical challenges, which leaves providers uncomfortable with their clinical and ethical decisions and anxious about their potential legal liability. Although using an ethical decision making model does not furnish definitive answers, it does provide a deliberate, well-documented process that guides decision-making, facilitates appropriate care, and minimizes legal liability.

In 1995, the American Psychological Association (APA) convened a panel of HIV mental health and legal experts to review the literature and develop a simple, user-friendly process that would facilitate sound ethical and clinical decision making. Their model is based on the five ethical principles of autonomy, beneficence, nonmaleficence, fidelity, and justice, and provides a common vocabulary for communicating with other service providers. This article discusses how the model applies to the hypothetical case of Ruben, a private practice client of Susan Lim, PhD, and their consultants, all fictitious characters.

The Case of Non-Disclosure

Ruben is a 31-year-old Latino man who while married to Elena had a six-month relationship with a male partner, Jim. Ruben and Elena emigrated from Mexico, are legal U.S. residents, and have two young children. Ruben clearly cares for his family, enjoys being a father, and speaks openly about the stress of keeping secret his relationship with Jim. He began therapy with Dr. Lim when Jim tested HIV-positive six weeks ago. At that time, he also cut off all sexual contact with Elena—without offering her an explanation—and all contact with Jim.

Recently, Ruben tested seropositive at a confidential test site. He refused to tell Elena, because the news would hurt her and bring shame to himself and his family. He also feared that if Elena found out, she might try to keep the children from him. During his previous session, Ruben said that he had unprotected intercourse twice with Elena, because she has been "more seductive" and was too difficult to resist. He said he hoped he was lucky enough not to infect Elena and that he doubted he could stop having unprotected sex with her. Ruben still refused to tell Elena about his serostatus even though he said he understood the risks involved.

Ruben also refused to seek medical care because he "feels fine" and does not want the doctor to tell Elena his HIV status. Should Dr. Lim breach confidentiality and tell Elena Ruben's HIV status? Does Elena's need to know about her possible HIV infection from Ruben supersede his right to confidentiality?

The Decision-Making Process

The APA Model is an eight-step process that directs clinicians to: 1) assess their personal responses, 2) determine the facts of the case, 3) conceptualize an initial plan based on clinical issues, 4) consult professional ethical codes and assess issues based on the five ethical issues, 5) identify legal issues, 6) evaluate options based on information gathered in the preceding steps, 7) choose course of action, 8) implement action and monitor and discuss outcomes. The model also recommends documenting each step and seeking consultation whenever clinicians experience any doubt.
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Robert Marks, Editor

Editorial: The Inevitable Muddiness

Most of the time, the influence of ethical principles on our decisions is invisible. It is only when faced with a dilemma—formally defined as "an argument presenting two or more equally conclusive alternatives," "a situation involving two equally unsatisfactory alternatives," or "a problem seemingly incapable of a satisfactory solution"—that we become aware of the painfully gray area between right and wrong and the role of ethics in decision making.

At that point, we rarely apply a systematic approach. Instead, we rely on early learning from our parents, teachers, and perhaps religious figures and the experience of resolving conflicts in our lives—even if this experience has not always been satisfactory. In the context of mental health practice, ethics may easily collide with clinical criteria and legal requirements. The likelihood and complexity of ethical dilemmas multiples when you add to the mix HIV disease and its overlay of life, death, fear, and stigma, its jungle of inconclusive and evolving law, and its continuing transformation as treatable medical condition.

In this issue of FOCUS, Sally Jue makes a strong argument that ethical decision-making can be systematized, even if it cannot be painlessly simplified. Her approach will not reduce the number of dilemmas providers may face but it can tame the confusion that may result in the midst of conflict. In particular, her model defines the foundation of ethical principles, the awareness of which can inform the process of considering what may seem "equally unsatisfactory alternatives." Steve Heilig's article complements Jue's approach by connecting the right to die with the desire for control, an insight that can help resolve ethical challenges in this area.

The idea of an ethical decision-making system sounds quite wonderful to me, in part, I think, because it suggests that I can be freed from the responsibility of making a difficult decision. But a system ensures only that the decision maker has considered all the elements of the situation and all the aspects of the dilemma. It gives us an opportunity to become comfortable with what will always be about trading one good for another. That painfully gray area between right and wrong rarely becomes purely black or white. Part of the ethical decision-making process is learning to appreciate or at least accept the inevitable muddiness of being.

Applying this model, Dr. Lim first needs to pause and identify her feelings and beliefs about Ruben and his situation, assessing how they might affect her clinical judgment and her perception of Ruben's behaviors and desires. This is crucial because anxiety about a case often produces pressure to take action quickly instead of thoroughly conceptualizing the clinical issues and systematically working through them.

When a case elicits strong feelings, it can be difficult to separate those feelings from a consideration of the actual facts of the case, the second step in the process. To isolate the facts, Dr. Lim can review what Ruben actually said and did rather than simply treating her interpretations and assumptions as fact. In this case, the most relevant facts are that Ruben and Jim are HIV-positive, Ruben had unprotected intercourse twice with Elena since he discovered he was HIV-positive (and several times before he tested but after he knew he had been exposed), and Ruben does not have a physician and refuses to see one. Dr. Lim also knows that Elena does not know about Ruben's relationship with Jim or about either man's serostatus. Dr. Lim then identifies the relevant clinical issues. She knows that Ruben is mentally competent and has no history of drug or alcohol abuse or mental illness. He currently displays no symptoms of dementia, major depression, or anxiety, and has clearly stated he would never consider suicide or abandoning his family. Although avoidance appears to be Ruben's primary coping mechanism, he is committed to continuing counseling.

After completing this assessment, Dr. Lim outlines an initial plan—a clinical course of action—that takes into consideration Ruben's current treatment plan, its goals and strategies, and the current state of their relationship. Dr. Lim knows Ruben's behavior puts Elena at risk for HIV infection. Ruben's decision makes Dr. Lim particularly uncomfortable because, based on what Ruben has told her, Elena has no reason to suspect she is at risk of HIV from Ruben and therefore no reason to consider taking precautions to protect herself. Dr. Lim believes she may have to breach Ruben's confidentiality, but fears this because it may damage her therapeutic relationship with Ruben.

Ethical Principles and Legal Interpretations

Following the APA model, at this junc-
tute, Dr. Lim turns to her profession's code of ethics for assistance. When it is required by law, the ethics code gives psychologists permission to break confidentiality when a client's action pose a danger to a third party, but also requires minimizing harm to the client. The code does not define the degree of responsibility a therapist has for a client's partner, but given the circumstances, Dr. Lim feels she may need to warn Elena.

Needing more input, Dr. Lim arrange to meet with a colleague, Sam Parker, for consultation. After reviewing the case, Mr. Parker suggests they evaluate Dr. Lim's plan to breach confidentiality based on the ethical principles of autonomy, beneficence, nonmaleficence, fidelity, and justice.

Autonomy is the right of individuals to decide how to live their lives as long as their actions do not interfere with the welfare of others; it presumes that a person is competent to make decisions. If Dr. Lim were to breach Ruben's confidentiality, she would clearly be violating his autonomy. However, Mr. Parker points out that the degree to which she violates this principle can be minimized based on how and to whom she will disclose Ruben's HIV status. If Dr. Lim shares her decision with Ruben and gives him the option to participate in its implementation, she will violate Ruben's autonomy far less than if she were to contact the public health department or call Elena without telling Ruben first.

Beneficence presumes an obligation to improve and enhance the welfare of others, even when such enhancements might inconvenience or limit the freedom of the person offering aid. When all other factors are equal, clinicians must act in a way which benefits their clients based on an understanding of their clients' perspectives. Although the immediate consequences of disclosure would create severe conflict and stress for all parties involved, might Ruben and his family benefit more in the long run if Dr. Lim breaches confidentiality? If Ruben and Elena can work through the immediate crisis (with Dr. Lim's assistance, if they desire), both can take steps to optimize their health outcomes and thus their ability to care for their children in the future.

Nonmaleficence is the obligation to avoid harming others physically and emotionally as well as to avoid actions that risk harming clients. At the heart of ethical conflicts involving both beneficence and nonmaleficence is the challenge to balance the rights of clients against those of other individuals and society at large. By not disclosing Ruben's HIV status, Dr. Lim may be putting Elena at greater risk for harm. Should Elena discover Ruben's HIV status through finding his medications or because he develops an HIV-related illness, might she feel so betrayed that she decides to take the children and leave Ruben, thus creating the outcome he most fears?

Fidelity means that clinicians keep the promises they make to their clients, tell the truth, and maintain respect and civility in all client interactions. Dr. Lim believes that the trustworthiness that stems from fidelity is especially crucial to working with clients with HIV because of the continued stigma that surrounds the disease and its associated risk behaviors. She fears that by breaching Ruben's confidentiality, she will violate his trust not only in her, but the profession in general and possibly deter Ruben from seeking help elsewhere. However, Mr. Parker reminds her that Ruben did sign and discuss with Dr. Lim the limits of confidentiality before they began treatment. To maintain fidelity, Dr. Lim should review this information again with Ruben when she shares her plan with him.

Justice mandates that clinicians treat everyone fairly. It also presumes reciprocity, impartiality, and equality when allocating resources and determining the nature and quality of services provided. Dr. Lim wonders if there might be cultural differences that prevent her from empathizing more with Ruben's perspective or that might help her motivate Ruben towards disclosure. She seeks cultural consultation with a clinician who has had more experience working with Latino families and HIV. The consultant reassures Dr. Lim that respectfully appealing to Ruben's cultural role as family provider and protector to persuade him to tell Elena his serostatus is an appropriate intervention.

Finally, Dr. Lim discusses the case with a lawyer who is knowledgeable about HIV confidentiality law and mental health malpractice. The lawyer, Louise Bass, tells

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Dr. Lim that unfortunately, none of the relevant laws governing HIV confidentiality and the duty to warn an identified victim of potential harm unambiguously addresses Dr. Lim’s situation. Ms. Bass can give advice based only on possible interpretations of the law and her own experience with the social factors that influence legal interpretation.

In this case, Ms. Bass feels that Elena would make a very sympathetic plaintiff were Elena to sue Dr. Lim for allowing her to become HIV infected. For this, as much as any other reason, Ms. Bass advises Dr. Lim that she must take action if she believes that she is all that stands between Elena’s infection by Ruben. Unless Dr. Lim’s judgment or execution is wildly unreasonable, it is unlikely she would end up paying damages to Ruben if he sued her for breaching confidentiality. Ms. Bass also recommends that Dr. Lim carefully document all events, clinical assessments, consultations, and rationale for all decisions she makes. Such documentation demonstrates that she sought different perspectives and experience to enable her to perform a thorough and critical analysis of the case.

Implementing the Plan

After reviewing the information obtained from her consultations, Dr. Lim decides she needs to tell Elena that Ruben is HIV-positive. She must now examine her options for how to implement her plan. Dr. Lim rules out calling the police or public health department. She feels these options would be the most traumatic to Ruben and his family and would violate all the ethical principles.

In order to minimize harm to Ruben, maintain his autonomy and trust as possible, Dr. Lim decides that she must tell Ruben her decision before she talks to Elena. Although any disclosure Dr. Lim makes will violate some of Ruben’s autonomy and create some emotional distress for the family, Dr. Lim believes her actions are based on good ethical reasons and would create the greatest balance of positive over negative effects.

Now that Dr. Lim has decided to inform Elena of Ruben’s HIV status, she wonders what would be the best way for her to raise the issue with Ruben? Dr. Lim feels that Ruben may be more receptive if she shares her reasons for her decision, her concerns for Ruben, and how he might feel about their relationship after hearing her decision. She does not think Ruben will actually harm or threaten her, but she fears that he could decide to stop treatment. She wants to let Ruben know that she is willing to help him deal with the outcome of her decision. If Ruben stays in treatment, Dr. Lim would continue to monitor, discuss, and thoroughly document the impact of her plan on Ruben and his family.

Conclusion

Although an ethical decision-making model provides no clear-cut solutions, it does provide a systematic framework for analyzing the issues and making clinically sound ethical decisions. The model’s emphasis on basic ethical principles provides a multidisciplinary foundation for evaluating potential options, and its use of consultation enhances competence and reduces the isolation many clinicians experience when called upon to make the tough choices.

Clearinghouse: Ethics and Therapy

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For the first dozen or so years of the HIV epidemic, being diagnosed with AIDS was widely seen as equivalent to a death sentence. It should hardly be surprising, then, that the issue of “assisted dying” surfaced among the various AIDS-related debates. But, even at a time when new treatments are extending life, the issue of the right to die may be as much about the need for control as it is about the process of dying.

The Desire for Death

In general, the diagnosis of terminal illness triggers thoughts about death in almost everyone. Indeed, it would seem strange if such thoughts did not arise. Considerations about actively hastening death are less universal but still common. In general, serious and persisting thoughts about death are often correlated with unresolved clinical depression or with physical pain, as well as with lack of family or social support. Unfortunately, all of these problems are common elements in the lives of terminally-ill patients. Nonetheless, it appears that for most people, it is not “normal” to desire death even under the duress of terminal illness; with an acceptable standard of medical and psychosocial care, the survival instinct can remain strong right up to, or close to, the time of death. For people with HIV, however, data from early in the epidemic indicated an increased risk of suicide, although the degree of such risk remains debatable.

There is also a perennial debate about whether suicide is ever a “rational” act or whether it is always psychologically pathologic. From Socrates to Camus to any person with HIV disease or cancer, the answer to this question is more personal than professional. As countless people, both patients and physicians, have argued, “There may be things worse than dying.”

In recent years, particularly in the context of HIV disease, physician-assisted dying has become part of the suicide debate, and numerous surveys have indicated that a substantial proportion of the public and physicians support the practice of physician-hastened dying under some circumstances. Surveys also indicate that people with HIV disease and HIV-experienced physicians are perhaps more likely than other patients and clinicians to approve of and participate in this practice, and that this approval may have increased as the epidemic has progressed. The practice remains illegal in all U.S. states except Oregon, however, and occurs within clinical and legal “gray areas.” For example, the use of opiates as “terminal sedatives” may mask the actual intent to hasten death.

It is likely that requests for assisted death have declined among people with HIV disease since the advent of effective combination therapy. In addition, the evolving demographics of the epidemic to include a higher proportion of people from lower socioeconomic groups and communities of color may also decrease requests for assisted dying, since these groups tend to be less supportive of assisted dying in concept.

Issues of Control and Choice

Two issues related to “control”—both societal and personal—are of primary importance to the assisted dying debate. The societal issue is about creating “safeguards” to ensure that every hastened death is truly a voluntary act of last

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See also references cited in articles in this issue.
Pull quote goes here

Some cases of assisted dying are actually "preemptive strikes," when patients choose to end their lives before the choice is unavailable to them. This fear of loss of physical or mental control can be a strong motivator in this regard. In fact, this was the dynamic at work in the suicide of Janet Adkins, 89-year-old Alzheimer's patient who was Jack Kevorkian’s first public case. Her surviving husband has expressed much anger that other medical professionals would not guarantee his wife that they would assist in her future death, which she planned for a time when she believed her dementia would disable her. Had his wife received such assurances, Mr. Adkins felt, she might have chosen to remain alive substantially longer.

Conclusions

For all our anguished and heated debates about the ethics, law, and clinical details, abstractions recede when the intensely personal time of death draws near. Since the prospect of death tends to concentrate the mind and strip away superfluous concerns, it is the person who is doing the dying who probably knows which choices are best for him or her, and who thus should be granted, perhaps in every sense, the final say.

Comments and Submissions

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

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Ethical Codes and Euthanasia
Hadjistavropoulos T. The systematic application of ethical codes in the counseling of persons who are considering euthanasia. Journal of Social Issues. 1996; 52(2): 169-178. (University of Regina, Canada.)

A comprehensive review of the professional ethical codes for counseling clients considering euthanasia suggests that no single professional code can summarily address the moral and ethical complexities of end-of-life decision making. Because treating terminally ill individuals is an increasingly collaborative effort, understanding all of the codes—for physicians, psychologists, and social workers—may provide a better perspective and facilitate ethical decision making.

The study surveyed the codes of ethics of the American Psychological Association (APA), the Canadian Psychological Association (CPA), the Canadian Medical Association (CMA) (and the Canadian Psychiatric Association), the American Medical Association (AMA) (and the American Psychiatric Association), the Canadian Association of Social Workers (CASW), and the National Association of Social Workers (NASW).

Although there are many differences among the codes, each individual code's set of principles is based largely on four principles: autonomy, a client's right to think and decide for him or herself; nonmaleficence, the importance of not inflicting harm or evil; beneficence, the importance of doing good and preventing harm; and justice. Each code differs in the emphasis it places on a particular principle.

The AMA code discusses euthanasia more extensively than any of the others, explicitly stating that physicians are required to respect the decisions of competent, terminally ill patients to forego life-sustaining treatments. The AMA's code also stresses the role of the physician as healer, and the fact that euthanasia and assisted suicide conflict with this role. Accordingly, the physician must effectively respond to the needs of the patient at all times, either by providing comfort, support, or respect for patient autonomy and self-determination.

The CPA guidelines are especially helpful because they are the only ones that prioritize ethical principles, guiding the resolution of conflicts that may arise between two or more principles. For example, the CPA's first principle, respect for the dignity of persons, would take precedence over the its three other principles: responsibility for caring, integrity in relationships, and responsibility to society.

According to the APA code of ethics, the only code that directly addresses competency of the provider to counsel terminally ill patients, psychologists and other professionals need to be aware of all the options available for clients considering euthanasia because some clients may contemplate ending their lives only to escape potentially controllable physical pain.

The Ethics of Client Confidentiality

When HIV-infected clients engaging in unprotected sex refuse to inform their partners of their serostatus, family therapists are not required to warn these third parties if the clients' actions are legally permissible, according to a review of the legal and ethical issues surrounding disclosure.

The landmark case Tarasoff v. Regents of University of California set a precedent mandating a therapist's duty to warn potential victims of his or her clients' dangerous behavior. The court held that “When a therapist determines... that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.”

Although there are similarities between clients who pose a violent threat and HIV-infected clients who refuse to inform partners with whom they engage in unprotected sex, the laws of many states do not require individuals to disclose their HIV status to sexual partners. To minimize their own liability, it is important for therapists to understand local laws governing privacy and the duty to warn.
the event that the law is unclear, therapists must use their best judgment to decide whether it is more important to maintain confidentiality or to protect the welfare of third parties.

Disclosure of a client's serostatus should be the therapist's last option. To avoid conflicts of interests between therapists and clients, therapists should make their clients fully aware of their policies of disclosure, preferably by distributing a written statement before therapy commences and then reinforcing the statement with oral discussion. When HIV-infected clients state that they will continue to engage in unprotected sex with partners unaware of their infection, therapists should make every effort to persuade these clients to inform their partners of the associated risks. When clients prove unwilling to inform their partners, therapists should consult local laws to pursue the most ethical and legal recourse.

Therapists who feel they must disclose client information to outside sources should consider their responsibility to the client in question, the effect of disclosure on their integrity, the overall benefits of their actions on the client, and the effects of the disclosure on the client's autonomy. Informing third parties does not violate a client's autonomy if the disclosure is consistent with the therapist's policy, if the therapist has made this policy clear to the client, and if the disclosure is in the client's best interest. Informing third parties does not violate a client's autonomy if the disclosure is consistent with the therapist's policy, if the therapist has made this policy clear to the client, and if the client freely decides to reveal the information to the therapist without pressure or coercion.

Maintaining Boundaries


A task force established to develop guidelines for the maintenance of boundaries between patients and psychiatrists concluded that the responsibility of preserving the professionalism within the relationship lies with the psychiatrist. Boundaries are necessary in all psychotherapeutic relationships to help maintain the efficacy of therapy and to protect vulnerable patients who have exposed feelings from potentially compromising and harmful situations.

The task force was a collaborative effort among the Massachusetts Board of Registration in Medicine, the Massachusetts Psychiatric and Medical Societies, and the Boston Psychoanalytical Institute. The guidelines apply only to adult patients and to individual psychotherapy. The task force sought to address, in particular, ambiguous situations.

The guidelines are not regulations: their purpose is to provide an ethical framework within which psychiatrists can effectively counsel their patients. Visiting a patient's home, for example, is inappropriate within the context of the guidelines, but if a patient is unable to leave his or her home or has other extenuating circumstances, a psychiatrist would be justified in altering professional boundary limits.

Although a psychiatrist's disclosure of his or her own personal struggles with addiction or substance abuse may prove to be therapeutically relevant in counseling sessions with patients facing similar problems, the task force could find no instances when it would be professionally appropriate for psychiatrists to reveal personal emotional problems or details of their sexual lives to their patients. Similarly, there may be situations in which the guidelines allow psychiatrists to make purchases from clients, for example, if psychiatrist and patient live in a remote location and there are limited alternatives.
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