California Law and Ethics

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Some Initial Helpful Information

This course is specifically intended to meet the BBS regulations requiring registrants to take 3 hours of continuing education coursework in California law and ethics during each renewal period in order to be eligible to renew their registration. First of all, congratulations on making it this far in the process. Be proud of yourself!! There are setbacks and struggles on this journey towards licensure, and there will be more, but just keep going. Overcoming the setback makes it that much sweeter in the end, and you can do it! Do not give up on yourself. If you do not pass the exam, take it again, and again. Whatever the setback, just keep going.

So, a couple things to know: The BBS does not actually approval numbers to providers of continuing education, anymore. They do accept courses from providers approved by other agencies. These agencies include the National Board for Certified Counselors (NBCC), which is the approval you will see on your certificate of completion after passing this course. This approval is accepted by the BBS for Marriage and Family Therapists, Social Workers, Educational Psychologists and Professional Clinical Counselors.

There are a host of legal and ethical requirements and issues, and we have both a six hour course and an 18 hours course, so this course will not contain everything, but we will try to hit some important issues.

The California Board of Behavioral Sciences

To begin, since this is the law governing this specific requirement, we provide you the FAQ from the BBS regarding this requirement, and the new changes to the Laws and Ethics re-exam process:

IMPORTANT INFORMATION FOR ALL REGISTRANTS

- **NEW ANNUAL CONTINUING EDUCATION REQUIREMENTS FOR REGISTRATION RENEWAL**
- **CHANGES TO THE CALIFORNIA LAW AND ETHICS RE-EXAM PROCESS**

EFFECTIVE JANUARY 1, 2023

Effective January 1, 2023, AB 1759 (Chapter 520, Statutes of 2022), makes two important changes that all registrants need to be aware of:

1. **New annual continuing education requirements for registration renewal**

2. **Changes to the California law and ethics re-exam process**

The changes are detailed below.

1. NEW ANNUAL CONTINUING EDUCATION REQUIREMENTS FOR REGISTRATION RENEWAL

All registrants who renew their registration or whose registration expires on or after **January 1, 2023** must take a minimum of 3 hours of continuing education (CE) coursework in California law and ethics during each renewal period to be eligible to renew their registration.

How do I certify completion of this coursework?

You will be required to sign under penalty of perjury as part of your registration renewal that you have completed the coursework. The coursework must be taken before you renew, and must have been taken within the past year of your renewal expiration date.

You will not be required to submit your records of course completion to the Board at the time of your registration renewal, but you will be required to submit them if the Board audits you. Therefore, we strongly encourage you to gather the documentation now, and save it in a safe place, so that you have it easily accessible when needed.

Where can I take coursework?

CE coursework must be taken from one of the acceptable providers listed below; otherwise the course will not count:

- An accredited school, college or university that meets the accreditation requirements specified in Business and Professions Code §4980.54 (for LMFTs), §4989.34 (for LEPs), §4996.22 (for LCSWs), or §4999.76 (for LPCCs);

- A school, college or university approved by the CA Bureau for Private Postsecondary Education;

- A Board-recognized approval agency as provided in Title 16, California Code of Regulations section 1887.4.1(a);

- A provider who has been approved by a Board-recognized approval agency; OR

- An organization, institution, association or entity that is recognized by the Board as a CE provider, as provided in Title 16, California Code of Regulations section 1887.4.3(a)(3).

What if I have already passed the California law and ethics exam?

All registrants are required to take this coursework each renewal period, before registration renewal, regardless of whether or not they have passed the California law and ethics exam, in order to ensure they stay current with law changes and best practices for their profession.

How often do I need to take this coursework?

The coursework must be taken during each one-year registration renewal period, before your registration renewal.

If I have two registrations with the Board, do I need to take two 3 hour courses?

No. You may apply your 3 hours of continuing education to both registrations AS LONG AS the coursework you completed relates to both scopes of practice.

How long do I need to save my records of course completion?

You are required to save your records of course completion for at least two years from the date of the registration renewal for which the course was completed.

2. CHANGES TO THE CALIFORNIA LAW AND ETHICS RE-EXAM PROCESS

Effective **January 1, 2023**, registrants who have failed the California law and ethics examination **no longer** need to take a 12 hour course in California law and ethics in order to take the exam again in their next renewal period.

Do I still need to take the California law and ethics exam each renewal period?

Yes. In order to renew your registration, you are required to attempt the California law and ethics exam each renewal period until passed. However, if you fail the exam, you no longer need to complete a 12 hour California law and ethics course to be eligible to take the exam again in the next renewal period.

Why did the bill delete the requirement for the 12 hour California law and ethics course?

The requirement to take the 12 hour California law and ethics course for those who failed the exam was deleted because all registrants are now required to take 3 hours of continuing education in California law and ethics each year before registration renewal.

What if I need a subsequent registration number?

The law has not changed in this regard; if you need a subsequent registration number (after 5 renewals, a registration number can no longer be renewed, and a subsequent number is needed) you must have passed the California law and ethics exam.

(CABBS, 2022)

It is suggested that you print out the sample or post-test prior to taking this course so you can fill it out as you go along.

Chapter 1. Introduction

Taking a course on laws and ethics does not exactly create excitement or anticipation. As a clinical professional you probably like working with people. If you wanted to work with laws and rules you would have been a lawyer. So you can ignore this information? Nope! You have to know this information for at least two reasons: to protect your client (the consumer) and you (the healthcare professional). So, don't plug your nose and swallow like taking nasty medicine. Learn it, love it, embrace it, make it yours, take it home with you…uh….wait a minute…that's a boundary issue.

The trip through laws and ethics is a trip you must take and we'll try to keep it straight and to the point. For this reason, in quoting some of the Laws and Regulations from CA law, we may only site that of one profession. There is a link provided if you want to do a deeper dive into all the laws and regulations governing all the professions. You will find that the laws, and especially the ethics governing each profession are very similar. This course is divided into four parts:

1. General Laws and Ethics
2. Some California Regulations for your profession

Need to Know

Laws and ethics permeate all services licensed professionals offer. ***They give the consumer protection and a set of expectations in the services they receive.*** They concurrently provide a road map for the professional healthcare practitioner. Unfortunately, licensed professionals occasionally fail to abide by legal and ethical standards. This often results in creating emotional harm for the client and the loss or suspension of the professional's license, and even incarceration. This course is designed to make clear some of the legal and ethical responsibilities of the professional healthcare practitioner.

Chapter 2. The Laws and Regulations

Each state governing board sets rules and regulations pertaining to the practice of the corresponding professions. You can usually find these regulations for your state by doing a web search for the board and following the links to the state's regulations. In this course the regulations for the state of California are more particularly made mention, because of the large number of healthcare professionals in the state, and the progressive nature of the governing board. It is also arguable that many of the California regulations pertain to the general practice of healthcare professionals. In California, the Board of Behavioral Sciences (BBS) has established a very thorough set of rules and regulations relating to the practice of social workers and marriage and family therapists. In addition, because nurses have extensive interaction with patients and must respond to their behaviors, it is worthwhile for them to be aware of the ethical standards and issues related to social workers and therapists. To see the code applicable to BBS licenses you go to the following link; however, the

section of the code applicable to Social Workers is provided in Part 3: https://www.bbs.ca.gov/pdf/publications/lawsregs.pdf

The following are some highlights from the laws and regulations mentioned:

A. Necessity of a License

Remember how happy you were when you graduated with your Masters Degree? Now you are working towards a crown jewel of your education; your License. This is not just about that moment or even the thousands of hours of internship, or studying for the exams. It will be the culmination of all your education, and that thought should provide you a sense of accomplishment and elation. You will provide services with confidence that your efforts will help others live a greater quality of life, and those who receive your services can have that same confidence in you.

As you know, consumers of healthcare services are protected by regulations that require individuals providing those services to be competent. This level of competence is acquired through formal education and supervised experience. Competence is then evaluated through an examination process. When the individual has received the education, the experiences, and shown a high level of competence (that's going to be you!) then the state issues a license as a notice to the consumer that the individual is capable of providing such services. In California, one who presents themselves as a licensed healthcare professional who has not meet these qualification is guilty of a misdemeanor.

The following are examples of Laws and Regulations (BBS, L&R Code) requiring individuals to possess a valid license from the state in California:

LCSWs

Only licensed clinical social workers can claim to be LCSWs or provide services that LCSWs do as permitted by law. If someone that does not hold a license in good standing uses any words or symbols in an attempt to portray themselves as a Licensed Clinical Social Worker, they are guilty of a misdemeanor.

The law reads thus:

> "(a) Only individuals who have received a license under this article may style themselves as "Licensed Clinical Social Workers." Every individual who styles himself or herself or who holds himself or herself out to be a licensed clinical social worker, or who uses any words or symbols indicating or tending to indicate that he or she is a licensed clinical social worker, without holding his or her license in good standing under this article, is guilty of a misdemeanor.
> (b) It is unlawful for any person to engage in the practice of clinical social work unless at the time of so doing such person holds a valid, unexpired, and unrevoked license under this article.
> (c) A clinical social worker licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5 pursuant to subdivision (b) of that section. "(BBS, L&R Code)

B. Application of Methods

The laws and regulations regarding healthcare professionals also address the application of methods for each license. This defines the purpose of the services and how the services are performed.

LCSWs

The application for social workers covers a wide array of services and techniques that assist individuals, families and groups, both with their life satisfaction as individuals and relationships, but also in their community. Social Workers have awareness about the psychosocial environment in which a person's experiences are played out, and in addition to psychotherapy, can also help the person influence their environment to make circumstances and responses to them more satisfying.

> "The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve ***more adequate, satisfying, and productive social adjustments***. The application of social work principles and methods includes, but is not restricted to, counseling and ***using applied psychotherapy*** of a nonmedical nature with individuals, families, or groups; providing information and referral services; providing or arranging for the provision of social services; explaining or interpreting the psychosocial aspects in the situations of individuals, families, or groups; helping communities to organize, to provide, or to improve social or health services; or doing research

related to social work.

Psychotherapy,…is the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions which affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes." (BBS, L&R Code)

When a Social Worker feels it would benefit the client, it is important to refer them to a psychiatrist for an evaluation for medication. It is out of the scope of social workers to prescribe or tell a client that they should be on medication outside of what has been prescribed by a medical doctor.

C. Hiring and Supervision of Interns /Associates

When hiring and/or supervising a Clinical Social Worker Associate/Intern the employer must provide appropriate supervision. Clinical supervision has been defined as "Responsibility for, and control of, the quality of clinical social work services being provided." This direct supervision must be performed with a qualified licensed professional, and must be performed each week with face to face contact of at least one hour of individual supervision or two hours of group supervision.

The supervisor and the associate/intern will need to develop a plan of supervision that describes the goals and objectives of supervision. The supervisory responsibility is a very active one as the supervisor helps the associate/intern reach the level of competence required for licensure. This is done through weekly direct supervision sessions, providing applicable, clinical experiences, and providing feedback and direction as laid out in the supervisory plan.

Each state has different pre-licensure requirements and it is important to be aware of those in the state you reside. Very often, the state will require some post graduate experience prior to becoming licensed. For example, in order to sit for the licensing examinations in California a Social worker must obtain at least 3200 supervised hours after obtaining their Masters Degree. In addition, the supervisor must be qualifies as such and may not supervise more than two unlicensed individuals. (BBS, L&R Code)

For a more detailed report of supervisory requirements and licensure requirements you can go to the BBS website at http://bbs.ca.gov

D. Disciplinary Issues

In the State of California BSS members have expressed concerns over the ethical violations in a number of disciplinary cases. It was expressed that the laws and ethics had not been taught sufficiently and the constant changing of laws and regulations required a revolving requirement of training. Thus the requirement of six hour of training is now required, the only such required course for each license renewal period. Additionally, as mentioned before, and the most likely reason you are reading this now, is the BBS requires registrants to take a 3 hour course in California aaw and ethics every year, effective January 1, 2023.

The following are some violations which can result in the suspension, revocation or denial of a license or registration:

Unprofessional conduct cited in the laws and regulations include but are not limited to:

- The conviction of a crime that affect or are related to the services provided under the license.
- Securing a license or registration by dishonestly.

- Substance abuse
- Gross negligence or incompetence
- Employing a non-qualified person (unlicensed, etc.) to provide services where a license, etc. is required
- Intentionally causing physically or emotional harm to a client.
- Engaging in sexual relations with a client, or a former client within two years following termination of therapy or soliciting sexual relations with a client.
- Performing, or holding oneself out as being able to perform, or offering to perform any service that fall outside the scope of the held license.
- Failure to maintain confidentiality, except as permitted by law.
- Failure to disclose to the client prior to the commencement of treatment the fee to be charged.
- Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered. (BBS, L&R Code)

E. Codes of Ethics

Professional organizations, such as the **National Association of Social Work Boards (NASW) and The National Board for Certified Counselors (NBCC)** have developed and, from time to time, revised codes of ethics to provide standards and guidance to licensed professionals. Each code is worthwhile to look at and become familiar with for all healthcare practitioners. Because there are innumerable ways to violate appropriate practices, the codes are not meant to be an exhaustive list of rules, but rather values and principles that guide healthcare professionals in their providing of services. If these values, purposes and principles are followed, along with a heavy dose of common sense, clients will reap the benefit of effective services and the healthcare professions will grow stronger still. As

stated in the NASW code of ethics Preamble **"A code of ethics cannot guarantee ethical behavior….Rather a code of ethics sets forth values, ethical principles, and ethical standards to which professional aspire and by which their actions can be judged."**

Chapter 3. Applying Ethical Principles in Practice

As already covered, **having a working knowledge of current laws and ethics empowers you both in being a more effective healthcare practitioner, and in strengthening you against the possibility of litigation, criminal action, or action against your license and livelihood.** Although reviewing laws and regulations can be tedious, the violation of such and the consequences that come, are worse. Laws, ethics and regulations also give the consumer confidence of what they can expect from you and will therefore be more likely to seek your services.

The importance of ethics in society is clear. Take the example of going to a mechanic…an evil, unethical mechanic. My wife took her car to one such person. Her car was making an unflattering noise. The mechanic told her he would need to replace the catalytic converter for close to $1000. She took the car to another mechanic and he fixed it for under $100. He just needed to replace a small part. Another, more recent example, is the issues we has with a plumber. We had a small leak in our home. The first plumber wanted over $1000 to repair the leak and all it entailed. We were referred to a different handyman who only charged $65.

Now, you could argue that most auto mechanics and plumbers are ethical and try to do the best they can and stand behind their work. However, one bad mechanic's or plumber's reputation can tarnish the reputation of all of them. When you practice your profession, you are not only representing

yourself, but all licensed professionals in your field. What will clients tell their friends and family about their experience in therapy? What happens when a bad story hits the news? People who really need help will be reluctant to do so because of what they have heard.

A. An Ethical Philosophy of Practice

It is wise for every professional to have a philosophy of practice made up of principles and values that help guide their services. The professional codes of ethics help define these principles and values. The following is also an example of such principles "gathered from a variety of sources and experiences" by Dean H. Hepworth and Jo Ann Larsen (1986).

1. People are capable of making their own choices and decisions. Although controlled to some extent by their environment, they are able to direct their lives more than they realize. They always have freedom and responsibility to exercise in shaping their own lives.
2. Helping persons have a responsibility to assist people to achieve maximal independence. Clients grow in strength as social workers promote independent action.
3. Helping persons have a responsibility to work toward changing the environmental influences that adversely impact upon clients.
4. Human behavior is purposive and goal directed, although the purpose and goals are often not readily discernible.
5. People are capable of learning new behaviors. Helping professionals have a responsibility to assist people to discover and employ their strengths and to affirm their capacity to grow and change.
6. Although problems of living may stem from past relationships and events, and although limited focus on the past may be beneficial in some instances, most difficulties can be resolved by focusing on present choices and by mobilizing extant and latent strengths and coping patterns.

7. Problems of living are often produced by inadequate knowledge and/or coping mechanisms. By gaining knowledge and learning new skills, people often not only resolve difficulties, but also achieve personal growth in the process.
8. Many problems of living are societal and systemic rather than personal or interpersonal. By learning to implement effective strategies, people can effect changes in various types of systems.
9. Adversity is an inherent part of the human condition, but human beings grow in strength through meeting adversities. Life's crises, therefore, represent opportunities for growth and mastery as well as sources of strain.
10. Human beings want and need to have self-esteem. To gain and maintain self-esteem, people need confirmation of their worth from significant others (spouse, parents, children, other relatives, and friends). Many interpersonal conflicts are indirect expressions of not feeling loved and esteemed.
11. Human growth occurs in the context of relationships with other human beings. Growth in helping relationships is fostered by the power of love, as manifested by acceptance, respect, concern, encouragement, and affirmation of clients' self-worth.
12. A prized aspect of human growth is becoming an open, authentic person. Open, authentic behavior by social workers fosters like behavior in clients.
13. Another prized aspect of human growth is becoming attuned to, concerned about, and responsive to the needs of loved ones and other people.
14. To live in the reality of the present moment is to exercise potentialities more fully.
15. Means to an end are equally important as the ends themselves. Any means of assisting clients to achieve goals should safeguard dignity, self-esteem, self-determination, and confidentiality.

16. Awareness of self is the first step to self-realization; astute and sensitive understanding by social workers facilitates self-understanding by clients. A genuine desire to understand is a gift of the self.
17. Peoples' right to their own values and belief systems are inviolate. Nevertheless, certain values and beliefs lead to dysfunctional and self-defeating behavior. When such is the case, social workers have a responsibility to assist clients to face these aspects of their difficulties.

(Pages 20-21)

B. The complexities in managing ethical dilemmas

"[Healthcare professionals] will inevitably encounter ethical dilemmas in their work. Ethical dilemmas can impact on [professionals] positively or negatively, at a number of levels, and in a range of ways" (McAuliffe, 2005). There are some rules that are clear cut. Most of these are written as laws or regulations. Other issues that confront the healthcare professional are written in ethical codes or rules of organizations. Sometimes the ethics of an organization and that of a profession may conflict.

McAuliffe points out that "identification of ethical dilemmas in practice situations is not always an easy task. While the social work literature provides many examples of definitions of the term 'ethical dilemma', a useful construct has been provided by Rothman (1998) to assist in determining the ethical components of a case, in order to decide whether an ethical *dilemma* actually exists. Rothman suggests applying a 'dilemma formulation' to a practice situation that will reduce the conflicting principles to "_____v. _____." An example might be an agency policy mandating communication

to parents of their daughter's desire to obtain an abortion **versus** maintaining confidentiality of the client.

As mentioned before, no code or laws can be written to cover every possible issue of ethics as it relates to the healthcare professional and their clients. For example: most of us, (hopefully all of us) would agree that it is not okay to steal—in fact, it is absolutely wrong to steal. But is it wrong in all circumstances?

For example: Many are familiar with the story of Jean Valjean in Victor Hugo's book, *Les Miserables.* Jean Valjean steals a loaf of bread, a crime for which he is sentenced to prison. Was stealing the loaf of bread wrong? It was against the law. Or was there a greater wrong in not stealing the loaf of bread. Jean Valjean stole the bread to feed his sister's starving children. He was not able to provide food for them any other way he had tried. What is the worse crime: to steal the bread, or allow the child to starve?

Regardless of your answer to such a dilemma, it is a good bet that a number of people would disagree with you. So there are times when there is not a clear cut path but differing opinions as to what is the right decision in a given set of circumstances.

Another ethical dilemma was presented on the television show *24:* Terrorists who had already shot down Air Force One, critically injured the President of the United States, and caused nuclear power plants to melt down where thousands died, have now gotten hold of a nuclear warhead, and the government does not know their location. They do, however, have an individual in custody who does know, and who has information that will help the agents recover the warhead and capture the terrorists responsible. The expectation is that the warhead will be used as quickly as

possible. The man they have in custody refuses to talk. Should he be tortured in violation of all such rules and regulations to the treatment of suspects?

Again, there are strong arguments and doubtless strong opinions for both sides of this question. The point of this course is not to debate the validity of the arguments, but to present some of the complexities as it applies to laws and ethics. These examples illustrate that there can be more than one answer to a problem, thus a dilemma is created. A dilemma is a situation where there are two competing principles that must be considered against each other. Either may seem like the right thing to do, or it may be a case of agency policy verses ethics. As Reamer stated, "…for a 'dilemma' to exist, there must be a weighing up of competing principles within a context of mutually exclusive courses of action" (1983).

> "Further clarification has been offered about the distinction between technical, legal and ethical issues, with the latter referring to those problematic situations that in some way relate to rights, responsibilities and obligations that have a moral and value-based foundation (Banks, 2001). As the debate about ethics and practice standards inhabits a contextual and often contested landscape within social work, it is acknowledged that what constitutes an ethical dilemma for one social worker, may not necessarily constitute an ethical dilemma for another social worker – even within the same workplace or in relation to the same practice situation. It is important then, to recognise that when a social worker becomes involved in what they consider to be a moral quandary, this can be an intensely personal experience that can cut deep to the heart of entrenched personal values."
> (McAuliffe, 2005)

Let us consider ethical dilemmas that are similar to those healthcare providers may have to address. Healthcare providers often have to make difficult decisions as to which ethic should take precedence in different situations. For example, a practitioner may recognize that a particular agency policy is detrimental to a client, but may not want to question it because it may threaten their position in that agency, or create conflict in relationships with coworkers. Another dilemma occurs when the client confides information that indicates they are a threat to the health or well being of another person. Intervening in such a situation means disclosing confidential information to others. (Hepworth and Larsen, 1986)

F.G. Reamer developed a general guideline to assist providers in making difficult decisions they typically encounter. According to Reamer, "one's actual duty in instances where prima facie duties conflict should be based on a determination of which duty is most necessary for the performance of action and represents the least threat to the well-being of individuals" (p. 583)

What was that again? <u>Prima Facie</u> means "as it seems at first sight."

The principles Reamer uses also help the practitioner in determining priorities in that "it is based on a ranking of goods and resources according to the extent to which they are necessary for individual well-being and the extent to which their absence threatens the opportunities and abilities of individuals to fulfill their intentions" (p. 583). **Reamer clarifies that "goods and resources can be ranked, qualitatively ranging from, on one hand, those which are necessary for the performance of any and all human action (life, physical health, food, shelter, and basic**

mental equilibrium) to, on the other, goods and resources which may enhance an individual's ability to fulfill his or her goal but are not, in the strict sense, necessary for human action (excessive wealth, recreational facilities, and artistic artifacts.)" (Pp.583-34).

It is obvious, then, that choices vital to enabling relevant others (clients, colleagues and employers) to take essential actions take precedence over choices that are less essential.

Reamer gives a specific situation of how these principles can be applied:

> "The duty to save a human life would take precedence over the duty to keep information shared by a client confidential…because the former is more necessary for the possibility of human action (that is, represents a greater threat to basic human well-being) than is the latter. Thus, if conflicts force practitioners to make hard choices, protecting individuals from threats to life itself…is more important than for, for example, keeping information confidential, telling the truth, keeping promises, and avoiding deception." (p. 584).

Ethical dilemmas in treatment may appear in many different scenarios. As a practitioner, you have seen, and will continue to see, all sorts of people with all sorts of problems—some you had probably not even considered to be in the realm of possibilities. McAuliffe studied ethical dilemmas that different social workers have to address and the effects of having to address them. A couple of possible dilemmas are illustrated here:

Case 1: A client dying of AIDS makes a confidential request that you supply him with information about euthanasia. Is it your ethical

responsibility to provide information to the client? Would you provide that information to the client? You may have very strong values that run contrary to euthanasia. Many religiously oppose it. If you are in agreement that it is somebody's right, what if you live in a state where it is illegal? Or, if it is legal, but against agency policy to provide such information. Also, do you make a note in the medical chart of his request, or even report it to somebody else? Or if you oppose it, but you live in a state where it is legal, do you provide the information to him?

Case 2: A client of a disability service requested that Nell, the social worker, arrange respite care for her child, as she was no longer able to cope. No respite care was available due to lack of resources. Nell decided to covertly assist the mother to 'abandon' the child so that she could receive emergency respite. The ethical dilemma, as framed by Nell, was that she assisted the mother to deceive the government, placing the client in a potentially difficult situation, and putting her own job at risk in the process. Was this the right thing to do?…the ethical thing to do?

Having to face such ethical dilemmas regularly can bring a lot of pressure on the practitioner. Hawkins and Shotet (1989) drew explicit links between work-related stress and moral indecision, claiming that stress caused by moral indecision may manifest on the emotional, cognitive, behavioral and physical levels, and could affect front-line workers either personally and/or professionally.

Healthcare Practitioners need to be mindful of the risks inherent in dealing with ethical dilemmas in direct practice settings. As ethical dilemmas, by their very nature, involve a conflict of principles, social workers need to be clear about what principles are underpinning

quality practice, and the professional responses that are expected by colleagues, managers, employers, and clients.

Social workers are strongly urged to consult others, to evaluate personal and professional value positions, to establish the legal, organizational and policy context, and have a sound working knowledge of ethical codes and standards of conduct (Congress 1999, Loewenberg, Dolgoff and Harrington 2001)

(McAuliffe, 2005).

C. Having a clinical self-awareness and counter-transference issues

Practitioners need to have awareness if the goals of the client are uncomfortable to the practitioner for reasons of differing value systems. It is doubtful that practitioners will ever have identical value systems to those of their clients, so it is important to maintain a self awareness regarding how your values may impact the different stages of treatment.

> "Certainly it is reasonable to assume that therapists who are upwardly mobile, socially marginal, non religious, divorced, and politically liberal will see social and moral issues differently from more socially integrated and conventional persons, and they will communicate quite different judgments. Because therapists' personalities and orientations are important aspects of therapy, and because psychotherapy is largely an influence process, the encounter inevitable involves the transmission of values. Therapists may wish to minimize personal biases, however, but they cannot help but transmit what they stand for. (Mechanic, 1989)

Indeed, we certainly all have values. It is doubtful that we would have become healthcare professionals if we did not have a very strong belief system based on some closely held values regarding helping people. We must be aware of the counter-transference issues of those who see things differently, behave differently, or express themselves differently than what we are comfortable with. We are all influenced by where we grew up, our socio-culture context, our experiences, and even by the agency cultures we work in and the school of training we attended. We may not be conscious of our own ideologies and orientations because they are so much a part of how we view the world. We must be careful with these values that we hold so dear that we do not go against the client's wishes, because they conflict with our own, or be careful that we automatically have a greater knowledge than the clients about what is best for them. (Mechanic, 1989)

When treating a client, issues of counter-transference (personal feelings and thoughts we have towards a client) will often exist that, going unchecked, can have harmful effects on the therapeutic process. These feelings may come up most strongly when somebody we treat resembles a person from our past in looks, mannerisms, behaviors, or opinions. These feelings can either be of fondness, as the client reminds us of a person we have good feelings for, or they can go to the other extreme, creating feelings in us of severe anger or fear. Maintaining a healthy self-awareness regarding counter-transference issues and obtaining consultation when needed are appropriate ways to make sure these feelings do not infringe on the treatment.

The following scenario can help increase awareness of our value system. This exercise, which is most enjoyable and effective when done as a group catalyst or a staff training, highlights how different cultures and upbringings cause people to make different judgments about the same circumstances. The activity is accomplished by passing out the story to

each participant, having them rank the characters in the story, and then discussing why they ranked them as they did. Feel free to do it yourself:

A Case Study, Author Unknown:

The Girl, the Old Man, and the Sailor…

On a beautiful and sunny day five people boarded a boat for an afternoon cruise: A girl, her Fiancé, her Fiancé's Best Friend, an Old Man, and a Sailor. A sudden storm blew in, sinking the boat. The five passengers were forced into two smaller boats to survive. In one boat was the Girl, the Old Man, and the Sailor. In the other boat was the girl's Fiancé, and his best friend.

The boats were separated in the swirl of the storm. The boat with the Girl, the Old Man and the Sailor ended up on one island and the boat with the Fiancé and his Best Friend on another island. The Girl was distraught being away from her Fiancé and kept searching the horizon looking for him. They knew there was another island nearby but the boat would need to be fixed to get to it. She went to the Sailor and asked him to fix the boat so she could be re-united with her Fiancé. The Sailor agreed to fix the boat but only on the condition the Girl sleep with him that night.

The Girl did not know what to do so she went to the Old Man for advice. The Old Man listened to her and then said, "I cannot tell you what you should do. Follow what your heart tells you." Confused and desperate she agreed to the Sailor's condition.

After the Sailor fixed the boat they sailed and reached the other Island. The Girl was very happy to see her Fiancé and rushed into his arms. He was very happy to see her and she then told him about sleeping with the Sailor to get there. The Fiancé became very angry and brushed her aside saying, "I never want to see you again. Crying profusely the Girl began walking down the beach. The Fiancé's Best Friend followed her and after about a quarter of a mile came to her and said, "I know you two have had a quarrel. I will try to work it out, but in the meantime I will take care of you."

PLEASE RANK THE FIVE PEOPLE IN ORDER THAT YOU LIKE THEM OR VALUE THEM THE MOST (1 IS HIGHEST AND 5 LOWEST)

The Girl _____
The Fiancé _____
The Old Man _____
The Sailor _____
The Best Friend _____

There are many issues and questions that can make a difference in how people rank the characters. For example, some like the Old Man the best. Others are very angry with him because he offered the Girl no assistance. Others think the Fiancé's best friend is taking the opportunity to move in on the Girl, but what if the Fiancé's best friend is a woman? Some find the Girl to be immoral and at fault, while others are touched at her sacrifice and very upset with her Fiancé for not understanding. The case illustrates how culture and upbringing can result in different views of the same scenario.

This example adds cultural diversity as an aspect to ethical dilemmas. It is the responsibility of the healthcare practitioners to be aware of these cultural differences.

D. Consulting with another professional when in doubt

When an ethical dilemma is complex, or occasionally when we are too close to a situation, we have difficulty seeing things clearly. It is a good idea to have an experienced professional with whom you can consult. A good consultant should be very helpful in the different ethical situations that may come up. Sometimes just being able to bounce ideas off another person can help you see the situation clearer. **Consultation should not violate the agreed upon confidentiality of the client. It should be conducted in such a way that the identification of the client is not violated, or that there is a written waiver for such consultation as part of informed consent. Standards state that the practitioners should provide the least amount of information about the client possible to have a productive consultation.** (NASW, Code of Ethics, 2.05c)

Another reason to refer a client is if the presenting issues are different than your current competencies or, as addressed later, the presenting issues are contrary to your value system in such a way as to interfere with treatment.

> "Engage only in activities in which you are competent. If clients require services you are not trained to provide, refer them to appropriate agencies. Do not try to go it alone. If there are services you wish to offer but have not been trained for, obtain adequate training and experienced [consultation]." (Mehr, 1986)

E. Having good judgment and using common sense

There is a saying that common sense is not so common. Well, if it were, we probably would not need so many rules and regulations and codes. Be that as it may, without good judgment and common sense, the healthcare practitioner will probably find themselves in trouble. Remember that whatever your decision, you are responsible for that decision. When making a decision you should take into consideration the construct you have learned regarding the priorities in making decisions, also, the client's best interest and how you would justify it in front of a review hearing. You need to feel that you could justify the decision in application to ethical principles. You are expected to follow not only the letter of the codes that govern ethics, but also the intent and "spirit" of them.

F. Clients right to informed consent

In order to provide services to an individual in voluntary settings they must be clear about what to expect from the services so they might provide informed consent. ***This information includes appointment cancellation policies, limits of confidentiality, expected number of sessions and length of sessions, and agreement on the goals of treatment and policy of termination. In addition, it is a violation if "Prior to the commencement of treatment, [you fail] to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed."*** (BBS Laws, p. 27) Along with fees there should be a clear policy on what happens when the client fails to pay fees. You also must have written informed consent prior to video taping sessions of clients. (AAMFT, Code of Ethics, 1.12)

G. Guidelines for Selecting and Defining Goals

As mentioned, part of informed consent is having clear and measurable goals decided upon in a process with the client. These guidelines offer assistance in formulating goals:

Goals must relate to the desired end result sought by the clients. The healthcare practitioner brings into therapy their own set of values and belief system about how people should behave and what makes somebody happy. When listening to a client's problem the provider needs to be wary of imposing their own desires of therapeutic outcomes on the client. The client needs to feel the set goals are those they have had input on, and that the accomplishment of such goals will enhance their life situations. Clients will only pursue those goals to which they are emotionally invested; therefore, practitioners who define goals unilaterally or attempt to impose goals on clients are unlikely to enlist their cooperation. The client should be the final authority in deciding the goals of treatment, although the practitioner should take an active role in the goal setting process.

Goals should be defined in explicit and measurable terms

In order to ensure the desired results, goals must specifically define the desired end result. The client and the practitioner should be clear on their responsibilities to help meet the goals and how things will be different as a result of obtaining the goals. When goals are too general it is difficult to create a path which leads there. The following provides examples of general vs. specifically stated goals including the tools or activities learned in therapy to accomplish the goals:

1. Global: Gain increased control over emotions.

Specific: Reduce frequency and intensity of anger outbursts by discerning cues that elicit anger, using internal dialogue that quells anger, and applying relaxation procedures that counter anger.

2. Global: Improve social relations.

Specific: Approach others and initiate and maintain conversations by employing listening skills and furthering responses.

3. Global: Enhance social environment.
Specific: Obtain living arrangements in a center for elderly persons that provide social activities.

4. Global: Enhance self-esteem.
Specific: Arrest habitual negative self-statements by engaging in self-dialogue about their destructive consequences: align performance expectations with realistic criteria; attend to strengths and positive qualities; express silent self-approval when merited.

5. Global: Improve quality of parenting.
Specific: Demonstrate competence and responsibility in assuring continuous child care, planning and preparing nutritional meals, and maintaining adequate sanitary and hygienic conditions.

6. Global: Increase social participation in a group context.
Specific: Resolve fears of "looking stupid," initiate discussion of personal views, ask questions, and participate in group exploring and problem-solving activities.

7. Global: Improve marital communication.
Specific: Express needs and wants to each other, listen without interrupting and check out meaning attributions, increase frequency of positive messages, avoid competitive interactions, reduce critical and blaming messages.

8. Global: Relate more comfortably with opposite sex.
Specific: Explore and resolve fears of rejections, introduce self and intimate conversation, ask for date, engage in appropriate activities.

Goals must be feasible. Practitioners should avoid setting goals with the client that are overly ambitious or most likely unattainable. As much as you would like to see all of the clients problems solved, and see them living at the highest levels of functioning, this is not realistic. Clients usually come to therapy because their life, their current behaviors, feelings, relationships and attitudes are not satisfactory for them. Goals should look to reach a level where their functioning becomes satisfactory for them again. Some clients may expect too much of themselves and/or their abilities, or environment may limit their level of goal attainment. If a client has a goal that is too grandiose, it is better to divide such a hopeful accomplishment into measurable smaller pieces. This way the client can make incremental improvements and gain satisfaction in accomplishments.

Goals should be commensurate with the knowledge and skill of the practitioner. Just as a client's abilities can determine the level and types of goals that are set, so can the abilities of the practitioner. You should agree to work with clients only on those goals for which you have requisite knowledge and skill. As in the medical profession, where doctors specialize in a variety of skills and service populations, so practitioners of therapy have some specific skills that are most useful for particular problems. It is not something to feel inadequate about, but rather understand that it is very difficult, with the variety of problems that a person may present in therapy, that you will be an expert in treating all of them. You can, however, work with the client on the goals that are within your scope and abilities.

Whenever possible, goals should be stated in positive terms that emphasize growth. Define a goal in ways that stress growth or highlight beneficial changes or gains that will occur in the life of the

client as a result of attaining the goal. In formulating goal statements, stipulating negative behaviors that must be eliminated tends to draw attention to what clients must give up. Defining goals in terms of gains rather than losses tends to enhance motivation and to mitigate opposition to change inherent in goal statements.

The following are examples of negative versus positive stated goals:

1. Negative: To reduce the frequency of criticism among family members.
   Positive: To increase the family members' awareness of each other's strengths and to increase the frequency of positive messages.

2. Negative: To eliminate pouting and cold wars between marital partners.
   Positive: To deal with disagreements openly, promptly, and constructively.

3. Negative: To eliminate subgroups and non-participatory behavior by group members.
   Positive: To unite efforts of group members in working collectively and to draw each member into participation.

4. Negative: To eliminate or reduce the frequency of drinking binges.
   Positive: To achieve ever-increasing periods of sobriety, taking one day at a time.

5. Negative: To eliminate yelling at the children and resorting to physical punishment.

Positive: To consistently apply new ways of influencing and disciplining children, such as utilizing "time out" procedures, increasing positive feedback, and employing a problem-solving approach with them.

Avoid agreeing to goals about which you have major reservations. If clients posed goals about which you have strong reservations because of contradicting your own moral values or life philosophies it is generally better to refer the client to another therapist. It is important, with sensitivity to explain why you are referring the client elsewhere. Occasionally, you may also have reservations about clients' goals that appear to be potentially harmful to the physical or mental well-being of themselves or others. Examples can include clients who want help exacting revenge on another person, or try in devious means to regain custody of children, or who want you to falsely testify for them in court. In cases like these you should explain why you have misgivings about such goals and express a willingness to work on other goals that would be more beneficial to the client and others.
(Hepworth and Larsen, 1986)

H. Record Keeping

Records should be kept according to professional standards and laws. It is a good idea to document services at the conclusion of a therapy session, if that is the service provided. The record needs to reflect the services provided and the progress of the client and should help maintain continuity in services. Records should not contain every story and detail of the client's personal life. "…documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is

directly relevant to the delivery of services." (NASW, Ethics, 3.04d) It is also important to safeguard client records so that confidentiality is maintained. Records, both clinical and financial should be kept as long as state law requires. Records disposed of should be done in such a way that protects the confidentiality of the client.

Chapter 4. Setting and Maintaining Boundaries

Violations of professional boundaries are one of the most common ways that the healthcare practitioner violates ethical and legal regulations. Boundaries can be weakened in any number of ways, from accepting or giving gifts to clients, to having sexual relationships with them. The therapeutic relationship is often an intense sharing of intimate information. The client, dissatisfied with his or her own relationships is vulnerable and may try to fill that void with you. There are many therapists who have lost their professional standing and many clients who have been emotionally damaged as a result of such relationships. It is important that the healthcare practitioner does not engage in behaviors that weaken boundaries, no matter how innocent they may appear.

We all have a desire to be accepted, and there is some level of desire in each of us to be well liked. This is normal and healthy; however, if our desire for acceptance is so great, we may create relationships that are damaging to both the client and the health care practitioner. You must always be aware that you are not there to get your own needs met.

A. The following is a list of some behaviors that weaken boundaries:

- Physical contact
- Inappropriate dress

- Horseplay
- Divulging too much personal information like your own marriage problems, dating life, use of alcohol, etc.
- Language
- Allowing clients to break client therapist agreement
- Selling or buying items to or from clients
- Seeing each other outside of counseling sessions /socially
- Dating
- Extending individual sessions longer than agreed upon
- Longer term therapy than necessary
- Flirting
- Dual relationship: Serving client you know outside of the therapeutic relationship.

B. Behaviors which strengthen therapeutic boundaries include:

- Maintain appropriate space
- Appropriate dress
- Professional consultation
- Keep time and number of session to agreed upon amount.
- Setting limits
- Consistency
- Role model appropriate behavior
- No personal favors
- Reinforce definition of relationship.

C. The use of appropriate boundaries to enhance therapeutic outcomes

People come to counseling for various reasons: usually as a result of some type of dissatisfaction with themselves, their lives and/or their

relationships. It is important for them to have a safe environment to share thoughts feelings and emotions. Clients offer a high level of vulnerability in sharing with therapists intimate personal details of their lives. When the client can feel that there is positive regard and respect for their feelings, and this is maintained through appropriate boundaries, then the relationship becomes a significant part of the therapy itself. If those boundaries are broken, then the client enters an environment that only repeats, but at a more intense level, the issues that are the cause of them coming to therapy.

Levels of self-disclosure play a large part in the therapeutic relationship that can damage or help the relationship depending on the motivation, timing and content of the disclosure. When not sure about what to disclose, it is probably best to follow the rule: less is more. Therapy is not about the therapist. Talking too much about yourself can weaken boundaries and redefine the relationship as something more social than therapeutic.

> "Maintain a professional helping relationship. Do not use your client to satisfy the needs that should be satisfied by your friends, spouses, and relatives. A warm, caring relationship with a client does not involve romantic love or sexual involvement." (Mehr, p.297, 1986)

When a client attempts to break down or bend the boundaries the therapist must be prepared to reinforce the relationship in a way that is clear, but not harsh. Experience and consultation are two tools that will help you maintain appropriate boundaries.

D. Risks of poor boundaries – How did that happen?

Violations of legal and ethical boundaries do not usually occur suddenly. There is usually a process by which boundaries gradually are

weakened until the therapist is before a disciplinary review board and asking him or herself, "How did that happen?" Maintaining the highest standards of ethics will keep you and your clients safe from what can turn out to be rather tragic events.

E. Illustration of How Boundaries may be Weakened

Jeff is a handsome 25 year-old man who is going through a divorce. The separation was initiated by his wife who was seeing a previous boyfriend. He does not have any children and Jeff describes his marriage as having been seemingly happy for them both, and says he still loves his wife. He wants to develop a meaningful relationship with another woman, but is somewhat insecure about going through the dating scene again.

The divorce dealt a major blow to his confidence and his willingness to trust someone to be close. That is the dilemma he presents: On the one hand he is lonely and would like to have a marital relationship again, on the other, he is insecure about initiating such a relationship and fearful what might occur if he does.

The therapist, a Licensed Clinical Social Worker named Anne, is a 32 year-old happily married woman with two children. She has been practicing for five years with a focus on couples therapy and families. She has counseled many individuals in relationships including males and has not had a problem with boundaries or inappropriate behaviors.

Anne notices that Jeff is not bad looking. She expresses empathic concern for his heartbreak and troubles. She feels for Jeff's sadness and he is very distraught. At the end of the first session, she thinks giving him a hug would be the natural thing to do to offer comfort. It is what she would do with a child, or even a woman who seemed to need such comfort. She chooses not

to because at the moment she decides it would be a weakening of the boundaries.

In a later session, however, she justifies to herself that it would be okay to give Jeff hugs to comfort him. She finds herself being more aware of her personal appearance on the days that Jeff is scheduled to be seen. They are developing a rapport and Jeff seems to be getting happier as he adjusts to the separation from his wife. In helping Jeff with his insecurity of initiating relationships, Anne roll plays as a date partner in phone and date conversations. Jeff thanks Anne for her assistance but states he is still very worried about how things will go on a date. He asks her if they could have a practice date---just out to dinner or lunch. She is hesitant, but agrees as Jeff expresses his need for the help.

The Poor Choices

Throughout this case there are turning points and decisions that Anne makes that either strengthen the therapeutic boundaries, or weaken them. In most decisions Anne is weakening them, in addition to passing over or disregarding the warning signs that she is on a slippery slope to losing her license, her career, and even worse, maybe her family. Anne is being faced with the same type of decisions that nearly every healthcare provider faces. Anne did not intend to begin a dual relationship. She had heretofore been very careful. In this case she gradually made those decisions that created that relationship.

First, Anne found Jeff to be handsome. Depending on Anne's internal response to this, it may or may not be a problem in itself; however, it would at least put up a red flag for her to be careful with her own thoughts, behaviors and emotions and to keep them in check. There are different rules of thought in regards to hugging clients, regardless of their age or

gender. In this case, Anne did show some awareness by not hugging him at the first session, but then justified it later. Decisions such as these when justified through the foggy lens of human emotion often end up being poor decisions.

It is next noted that she is becoming more aware of wanting to look attractive to Jeff. Being aware of one's personal appearance would be a positive thing (and one more therapists should pay attention to!), but the fact that she was paying extra attention in regards to how she would look to Jeff was a sure sign that her boundaries and feelings were going beyond the therapeutic relationship. Anne's self-awareness as a therapist should have been a warning bell, but she ignored it. It is doubtful that she was not aware of what she was doing, but she was ignoring the potential consequences. With the proper response, she may have referred Jeff to another therapist, or at least at this point, if she had not from the beginning, sought consultation.

The roll playing could have been a positive therapeutic technique, except that Anne had weakened the boundaries to the point where the roll play wasn't just a roll play, and obviously the practice date was not going to be just practice. Anne has then created a dual relationship under the guise of therapy, and the path, if she continued on it, becomes obviously difficult.

Fortunately, Anne suddenly got a hold of herself, realized what she was doing and where it was leading. She sought consultation and, instead of the practice date, asked Jeff to see her in the office for an appointment. In that appointment, as discussed in her consultation session, she stated to Mark that it was out of the scope of their therapy for her to go on a "practice date" with him, and that she should not have set such an appointment to do so. They discussed the progress that he had made thus far in his counseling and suggested to him that if he still felt a need to see a therapist that she could refer him to another very qualified therapist.

To her credit, Anne eventually stopped the relationship from moving further in the direction it was. It was unfortunate that she let it go as far as it did, having potentially harmed the client, depending on his response to it. This vignette illustrates the need for the provider to have vigilant self-awareness in order to maintain appropriate boundaries. The harm that comes from the failure to do so can be severe.

V. Reporting Requirements and Issues

Mandatory reporting laws have been put in place to protect the most vulnerable among us. Mandated reporters are often times the first line of defense. It is crucial mandated reporters do just that: report. Others who have been trained and have further legal responsibilities will come assess and investigate the possible abuse. The mandated reporter does not need to determine if there has been abuse, only to suspect abuse and then report it. Reports typically include an immediate phone call and then a written report within the next day or so. The following are reporting laws for the state of California:

A. Child Abuse & Neglect

The most common types of abuse are physical, sexual, and neglect. Healthcare practitioners are required to know the symptoms of child abuse and are mandated to report any suspicion of such abuse by the California Penal Code.

The following is a list of **mandatory reporters** of child abuse in the state of California. (**Bold Font** added)

(a) As used in this article, **"mandated reporter"** is defined as any of the following:

(1) A teacher.

(2) An instructional aide.

(3) A teacher's aide or teacher's assistant employed by any public or private school.

(4) A classified employee of any public school.

(5) An administrative officer or supervisor of child welfare and attendance, or a certificated pupil personnel employee of any public or private school.

(6) An administrator of a public or private day camp.

(7) An administrator or employee of a public or private youth center, youth recreation program, or youth organization.

(8) An administrator or employee of a public or private organization whose duties require direct contact and supervision of children.

(9) Any employee of a county office of education or the California Department of Education, whose duties bring the employee into contact with children on a regular basis.

(10) A licensee, an administrator, or an employee of a licensed community care or child day care facility.

(11) A Head Start program teacher.

(12) A licensing worker or licensing evaluator employed by a licensing agency.

(13) A public assistance worker.

(14) An employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities.

(15) A **social worker**, probation officer, or parole officer.
(16) An employee of a school district police or security department.
(17) Any person who is an administrator or presenter of, or a counselor in, a child abuse prevention program in any public or private school.
(18) A district attorney investigator, inspector, or local child support agency caseworker unless the investigator, inspector, or caseworker is working with an attorney appointed to represent a minor.
(19) A peace officer,
(20) A firefighter, except for volunteer firefighters.
(21) A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, **licensed nurse**, dental hygienist, optometrist, **marriage, family and child counselor, clinical social worker, or any other person who is currently licensed**
(22) Any emergency medical technician I or II, paramedic
(23) A psychological assistant registered
(24) **A marriage, family, and child therapist trainee**,
(25) An **unlicensed marriage, family, and child therapist intern**
(26) A state or county public health employee who treats a minor for venereal disease or any other condition.
(27) A coroner.
(28) A medical examiner, or any other person who performs autopsies.
(29) A commercial film and photographic print processor,
(30) A child visitation monitor.
(31) An animal control officer or humane society officer
(32) A clergy member
(33) Any custodian of records of a clergy member,
(34) Any employee of any police department, county sheriff's department, county probation department, or county welfare department.

(35) An employee or volunteer of a Court Appointed Special Advocate program

(36) A custodial officer

(37) Any person providing services to a minor child under Section 12300 or 12300.1 of the Welfare and Institutions Code.

(b) Except as provided in paragraph (35) of subdivision (a), volunteers of public or private organizations whose duties require direct contact with and supervision of children are not mandated reporters but are encouraged to obtain training in the identification and reporting of child abuse and neglect and are further encouraged to report known or suspected instances of child abuse or neglect to an agency specified in Section 11165.9.

(c) Employers are strongly encouraged to provide their employees who are mandated reporters with training in the duties imposed by this article. This training shall include training in child abuse and neglect identification and training in child abuse and neglect reporting. Whether or not employers provide their employees with training in child abuse and neglect identification and reporting, the employers shall provide their employees who are mandated reporters with the statement required pursuant to subdivision (a) of Section 11166.5.

(d) School districts that do not train their employees specified in subdivision (a) in the duties of mandated reporters under the child abuse reporting laws shall report to the State Department of Education the reasons why this training is not provided.

(e) Unless otherwise specifically provided, the absence of training shall not excuse a mandated reporter from the duties imposed by this article.

(f) Public and private organizations are encouraged to provide their volunteers whose duties require direct contact with and supervision of children with training in the identification and

reporting of child abuse and neglect." (CA Penal Code, 11165.7.)

To whom should the report be made?

Make sure that you have access to child abuse hotlines. Regardless of the information you have, you must make a report if you have a reasonable suspicion of the abuse. Reports must be made to those designated by law to take such reports. These include the police, probation department if designated to receive such reports, or county welfare department.

The code reads as follows:

> "Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department, not including a school district police or security department, county probation department, if designated by the county to receive mandated reports, or the county welfare department. Any of those agencies shall accept a report of suspected child abuse or neglect whether offered by a mandated reporter or another person, or referred by another agency, even if the agency to whom the report is being made lacks subject matter or geographical jurisdiction to investigate the reported case, unless the agency can immediately electronically transfer the call to an agency with proper jurisdiction. When an agency takes a report about a case of suspected child abuse or neglect in which that agency lacks jurisdiction, the agency shall immediately refer the case by telephone, fax, or electronic transmission to an agency with proper jurisdiction. (CA Penal Code, 11165.9)"

What does a reasonable suspicion mean?

"A "reasonable suspicion" means that ***it is objectively reasonable for a person to entertain a suspicion,*** based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect **child abuse** or neglect." (CA Penal Code, 11166)

What is the **reporting timetable**?
What are the possible legal penalties for **failing to report?**

Suspected child abuse must be reported immediately by telephone and followed up by a written report within 36 hours. Failure to do so can result in a $1000 fine and./or six months of incarceration or both for each instance.

B. Elder Abuse

For information on elder abuse and reporting it, you can go to the following link for Adult Protective Services in California: https://www.cdss.ca.gov/inforesources/adult-protective-services#:~:text=If%20you%20want%20to%20report,your%20local%20law%20enforcement%20agency.

The following from the California Welfare and Institutions Code regarding mandated reporters and penalties inked to from the NCEA website:

CALIFORNIA WELFARE AND **INSTITUTIONS CODE**
SECTION 15630

Who is a mandated reporter of Elder Abuse?

Anybody who has assumed care for an elderly person is a mandated reporter:

"15630. (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a **mandated reporter**.

(b) (1) Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days, as follows:

(A) If the abuse has occurred in a long-term care facility, except a state mental health hospital or a state developmental center, the report shall be made to the local ombudsperson or the local law enforcement agency."

What are the penalties for failure to report?

Penalties for failing to report become more severe if it is determined that, as a result of the failure to report, the elderly person is injured or killed:

> "(h) Failure to report physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, is a misdemeanor, punishable by not more than **six months in the county jail, by a fine of not more than one thousand dollars ($1,000), or by both that fine and imprisonment.** Any mandated reporter who willfully fails to report physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, where that abuse **results in death or great bodily injury,** shall be punished by not more than **one year in a county jail, by a fine of not more than five thousand dollars ($5,000), or by both that fine and imprisonment.** If a mandated reporter intentionally conceals his or her failure to report an incident known by the mandated reporter to be abuse or severe neglect under this section, the failure to report is a continuing offense until a law enforcement agency specified in paragraph (1) of subdivision (b) of Section 15630 of the Welfare and Institutions Code discovers the offense." **(Bolding font added)**

C. Domestic Violence

The clients of healthcare practitioners may be victims of domestic/family violence. These may not be child abuse or Elder abuse, but between a husband and wife or another type of adult on adult violence. The safety of the client is the primary concern. It is important for the healthcare practitioners to discuss with the victim of domestic violence the resources

available and to assist them to obtain those resources. This includes medical attention if needed, the involvement of law enforcement and shelters. There should also be an awareness of children in the home and their emotional health under such a situation, which can be abusive in itself.

There are many complex biopsychosocial issues surrounding abuse and violence. The purpose of this section has been to clarify the legal and ethical responsibilities of the licensed healthcare professional surrounding abuse.

D. Confidentiality vs. Need to Report: Tarasoff

The case of Tarasoff vs. Regents of the University of California established the duty of therapists to warn the public if the client or another identifiable person is in clear or imminent danger. The Tarasoff case concerns a University of California student, Prosenjit Poddar who was seeing a psychiatrist at the student healthcare center. Tatiana Tarasoff was a young woman who Mr. Poddar had feelings for, but she did not have the same for him.

Tarasoff had expressed his intention to the psychiatrist to buy a gun and as a result of their sessions together the psychiatrist felt that Mr. Poddar meant to do Ms. Tarasoff harm and informed the police. The police questioned Mr. Poddar, felt that he would not harm Ms. Tarasoff and made him commit to staying away from her. A couple of months later, Mr. Poddar killed Ms Tarasoff.

As a result of the killing, the parents of Ms Tarasoff sued the University, the healthcare center staff and the police, but the courts dismissed the case. In a later appeal to the California State Supreme Court it was ruled that the psychiatrist had responsibility to inform Ms. Tarasoff of the imminent danger she was in. As a result of this case, it is the legal duty of healthcare

practitioners to breach confidentiality if a client or an identifiable person is in danger. If it is another identifiable person that is in danger, the practitioner must warn them directly of the threat. Just calling the police does not fulfill the obligation of the "duty to warn."

VI. HIPAA and other Confidentiality Guidelines

A. Exercises in Confidentiality

You have probably already had to deal with situations where you questioned the extent you should go in keeping certain information confidential, and how much information should you reveal. Remember that a client may reveal some information you are required to reveal and report to proper authorities, but that does not give one license to be excessive. Indeed, one may argue that a provider should not reveal a greater amount of information than is expedient to fulfill their responsibilities as a mandated reporter. The following exercises are provided for you to consider how to handle different confidentiality dilemmas that may come up in the course of practice. There are doubtless as many situations as there are clients, so you cannot predict every situation that may come up. These situations (Hepworth and Larsen, 1986) generally address many of the possible scenarios and thinking them through may be of real assistance down the road.

For each situation consider the following:

1. How can you best discharge your ethical responsibilities in the situation?
2. Do you experience conflicting pulls regarding possible courses of action?
3. In situations that involve legal ramification, how would you handle it with the client in the event your planned action would be contrary to the client's request?

Situation 1. A male client confided in an individual marital therapy session several weeks ago that he is a practicing homosexual, although his wife does

not know this. The client's wife, who you have also seen conjointly with him, calls you today, troubled over the lack of progress in solving marital problems, and asks you point-blank whither you think her husband could be homosexual.

Situation 2. A client with whom you have had several sessions in a family agency confides to you that he is wanted by legal authorities for repeatedly ignoring court orders to pay child support to his wives from two previous marriages. The client, who has eluded authorities by assuming a false name and changing addresses frequently, also indicates that he has been warned he will be incarcerated if he is apprehended. With respect to such situations, you were recently advised by legal counsel in a staff meeting that withholding information regarding fugitives from the law also makes you culpable.

Situation 3. You are forming a group for youth in a state correctional facility. You know from the past experience that youth sometimes make references in the group to previous offenses that they have committed without being apprehended. You also know that they may talk about plans to run form the institution or about indiscretions or misdemeanors they (or others) may have committed or plan to commit within the institution, such as smoking marijuana or stealing institutional supplies or property from peers or staff.

Situation 4. In conducting an intake interview with a client in a family agency, you observe that both of her young children are withdrawn. Further, one of the children is badly bruised, and the other, an infant, also appears malnourished. Throughout the interview, the client seems defensive and suspicious and also ambivalent about having come for the interview. At one point, the client states that she feels overwhelmed with her parenting responsibilities and is having some difficulty in coping with her children. She

also alludes to her fear that she may hurt them but then abruptly changes the subject. As you encourage her to return to the discussion of her problems with the children, your client says she had changed her mind about wanting help, takes her children in hand, and leaves the office.

Situation 5. You have seen a husband and wife and their adolescent daughter twice regarding relationship problems between the parents and the girl. The parents are united in their approach to the problem—both extremely negative and blaming in their attitude toward their daughter, feeling that their troubles would be over if she would just "shape up." Today, during an individual interview with the girl, she breaks into tears and tells you that she is pregnant and plans to "go somewhere" with her boyfriend this weekend to get an abortion. She pleads with you not to tell her parents, who she feels would be extremely angry if they knew.

Situation 6 In a mental health agency, you have been working with a male client who has a past history, when angered, of becoming violent and physically abusive. He has been under extreme psychological pressure lately because of problems relating to a recent separation from his wife. In an interview today, he is extremely angry, clenching his fists as he tells you that he has heard that his wife has initiated divorce proceedings and plans to move to another state. "If this is true," he loudly protests, "she is doing it to take the kids away from me, and I'll kill her rather than let her do that."

Situation 7 A colleague and close friend sees you at a casual event and remarks that she knows you are seeing a friend in therapy. She begins to talk about problems she knows your client is experiencing and then asks you whether it is true that the client has been hospitalized previously for depression.

Situation 8 In the last several interviews, a 15-year-old girl has seemed troubled, but despite repeated inquiries and expressions of concern, she did not confide in you. In the course of today's interview, however, she blurts out that her brother-in-law has been making sexual advances and pressuring her to have intercourse with him. Your client, who has been living in the home of her brother-in-law and her sister, indicates that she has resisted the man's sexual attempts thus far, but it is evident that she is frightened and perplexed. Although embarrassed and guarded about disclosing details of the situation, she indicates strongly that she does not want her sister to know about this problem. After exploring the problem to the extent your client is willing and able, you discuss and role-play approaches she can take to confront her brother-in-law and quell his advances. But in view of her fright and the difficulty she has in rehearsing assertive behavior, you are worried that she may be unable to manage the situation if the brother-in-law were to intensify his pressure.
(pp72-73)

Each of these scenarios creates a type of dilemma regarding confidentiality, without being absolutely clear cut. The framework already provided from Reamer, and a solid knowledge of your professions code of ethics would be helpful in making decisions for each of these scenarios. Another resource to be seriously considered is that which has also already been discussed—a consultant.

B. HIPAA Regulations

No doubt either you or your agency had to make some significant changes in regards to how you gather and maintain clients' information. I have noticed as a patient/consumer such things as how sign-in sheets are handled differently at both doctors' offices and pharmacies. Somebody is making good money on those little adhesive strips that cover patients' names after

signing in. I have to admit that I had never given it a second thought before then that my name would be on a sign-in sheet. In fact if someone had presented the idea of it I would have told them that it was ridiculous and another instance of the government becoming over regulatory, and in some ways I probably still feel that way about a lot of regulations. However, if I were to go to have a procedure done, or go to counseling, that I would prefer others not know about, it would become more important to me that my name is not our there for all to see.

The regulations were primarily intended to provide patients with greater access and control of their records, which makes a lot of sense. We should have the freedom to transfer care providers and expect that if we desire our records would follow in a timely manner. Being able to send these records electronically provides the convenience and timeliness we would all like. It also cuts down on office work, having to make copies of large files, and then finding ways to physically transport them. With electronic means it is as easy as sending an email. So easy, in fact, that such information could be sent nearly anywhere and everywhere—probably not something that we would prefer as patients or consumers. As a result, regulations were put in place to ensure steps were taken for the private and secure transfer of this information. The caution is with reason: just look at the news on some of the private information, such as social security numbers and credit card information and that has accidentally been sent out to locations unintended. No doubt there will be mistakes made and we will be hearing about them, and lawsuits will be occurring as a result. Some will be because of the evil intentions of some; others will be caused by human error. Thus, it is important to implement the safeguards provided and to be able to show due diligence in complying with the regulations.

Whether we like them or not, it doesn't really matter. The fact is that we are now governed by the Health Insurance Portability and Accountability Act (HIPAA) and we need to comply in our practice as professionals. The

following is from the US department of Health and Human Services website. It contains information and FAQs that are helpful in our effort to understand and comply with the regulations. The following information is provided by the United States Department of Health and Human Services (HHS). It provides an overview of the regulations and the process by which privacy statutes became a part of the regulations. The link to this and further information is provided here. I have attempted to provide that which is most pertinent: **http://www.hhs.gov/ocr/hipaa.**

PROTECTING THE PRIVACY OF PATIENTS' HEALTH INFORMATION

Overview: *The first-ever federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Developed by the Department of Health and Human Services (HHS), these new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country. State laws providing additional protections to consumers are not affected by this new rule.*

Congress called on HHS to issue patient privacy protections as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA included provisions designed to encourage electronic transactions and also required new safeguards to protect the security and confidentiality of health information. The final regulation covers health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions (e.g., enrollment, billing and eligibility verification) electronically. Most health insurers, pharmacies, doctors and other health care providers were required to comply with these federal standards beginning April 14, 2003. As provided by Congress, certain small health plans have an additional year to comply. HHS has conducted

extensive outreach and provided guidance and technical assistant to these providers and businesses to make it as easy as possible for them to implement the new privacy protections. These efforts include answers to hundreds of common questions about the rule, as well as explanations and descriptions about key elements of the rule. These materials are available at http://www.hhs.gov/ocr/hipaa.

PATIENT PROTECTIONS

The new privacy regulations ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. Key provisions of these new standards include:

- **Access To Medical Records. Patients generally should be able to see and obtain copies of their medical records and request corrections if they identify errors and mistakes.** Health plans, doctors, hospitals, clinics, nursing homes and other covered entities generally should provide access these records within 30 days and may charge patients for the cost of copying and sending the records.

- **Notice of Privacy Practices.** Covered health plans, doctors and other health care providers must provide a notice to their patients how they may use personal medical information and their rights under the new privacy regulation. Doctors, hospitals and other direct-care providers generally will provide the notice on the patient's first visit following the April 14, 2003, compliance date and upon request. Patients generally will be asked to sign, initial or otherwise acknowledge that they received this notice. Health plans generally must mail the notice to their enrollees by April 14 and again if the notice changes significantly. Patients also may ask covered entities to restrict the use or disclosure of their

information beyond the practices included in the notice, but the covered entities would not have to agree to the changes.

- **Limits on Use of Personal Medical Information.** The privacy rule sets limits on how health plans and covered providers may use individually identifiable health information. To promote the best quality care for patients, the rule does not restrict the ability of doctors, nurses and other providers to share information needed to treat their patients. In other situations, though, personal health information generally may not be used for purposes not related to health care, and covered entities may use or share only the minimum amount of protected information needed for a particular purpose. In addition, patients would have to sign a specific authorization before a covered entity could release their medical information to a life insurer, a bank, a marketing firm or another outside business for purposes not related to their health care.

- **Prohibition on Marketing.** The final privacy rule sets new restrictions and limits on the use of patient information for marketing purposes. Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before disclosing their patient information for marketing. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.

- **Stronger State Laws.** The new federal privacy standards do not affect state laws that provide additional privacy protections for patients. The confidentiality protections are cumulative; the privacy rule will set a national "floor" of privacy standards that protect all Americans, and any state law providing additional protections would continue to apply. When a state law requires a certain disclosure -- such as reporting an infectious

disease outbreak to the public health authorities -- the federal privacy regulations would not preempt the state law.

- **Confidential communications.** Under the privacy rule, patients can request that their doctors, health plans and other covered entities take reasonable steps to ensure that their communications with the patient are confidential. For example, a patient could ask a doctor to call his or her office rather than home, and the doctor's office should comply with that request if it can be reasonably accommodated.

- **Complaints.** Consumers may file a formal complaint regarding the privacy practices of a covered health plan or provider. Such complaints can be made directly to the covered provider or health plan or to HHS' Office for Civil Rights (OCR), which is charged with investigating complaints and enforcing the privacy regulation. Information about filing complaints should be included in each covered entity's notice of privacy practices. Consumers can find out more information about filing a complaint at http://www.hhs.gov/ocr/hipaa or by calling (866) 627-7748.

HEALTH PLANS AND PROVIDERS

The privacy rule requires health plans, pharmacies, doctors and other covered entities to establish policies and procedures to protect the confidentiality of protected health information about their patients. These requirements are flexible and scalable to allow different covered entities to implement them as appropriate for their businesses or practices. Covered entities must provide all the protections for patients cited above, such as providing a notice of their privacy practices and limiting the use and disclosure of information as required under the rule. In addition, covered entities must take some additional steps to protect patient privacy:

- **Written Privacy Procedures. The rule requires covered entities to have written privacy procedures,** including a description of staff that has access to protected information, how it will be used and when it may be disclosed. Covered entities generally must take steps to ensure that any business associates who have access to protected information agree to the same limitations on the use and disclosure of that information.

- **Employee Training and Privacy Officer. Covered entities must train their employees in their privacy procedures and must designate an individual to be responsible for ensuring the procedures are followed.** If covered entities learn an employee failed to follow these procedures, they must take appropriate disciplinary action.

- **Public Responsibilities.** In limited circumstances, the final rule permits -- but does not require --covered entities to continue certain existing disclosures of health information for specific public responsibilities. These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or the cause of death; public health needs; research that involves limited data or has been independently approved by an Institutional Review Board or privacy board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. The privacy rule generally establishes new safeguards and limits on these disclosures. Where no other law requires disclosures in these situations, covered entities may continue to use their professional judgment to decide whether to make such disclosures based on their own policies and ethical principles.

- **Equivalent Requirements For Government.** The provisions of the final rule generally apply equally to private sector and public sector

covered entities. For example, private hospitals and government-run hospitals covered by the rule have to comply with the full range of requirements.

OUTREACH AND ENFORCEMENT

HHS' Office for Civil Rights (OCR) oversees and enforces the new federal privacy regulations. Led by OCR, HHS has issued extensive guidance and technical assistance materials to make it as easy as possible for covered entities to comply with the new requirements. Key elements of OCR's outreach and enforcement efforts include:

- **Guidance and technical assistance materials.** HHS has issued extensive guidance and technical materials to explain the privacy rule, including an extensive, searchable collection of frequently asked questions that address major aspects of the rule. HHS will continue to expand and update these materials to further assist covered entities in complying. These materials are available at http://www.hhs.gov/ocr/hipaa/assist.html.

- **Conferences and seminars.** HHS has participated in hundreds of conferences, trade association meetings and conference calls to explain and clarify the provisions of the privacy regulation. These included a series of regional conferences sponsored by HHS, as well as many held by professional associations and trade groups. HHS will continue these outreach efforts to encourage compliance with the privacy requirements.

- **Information line.** To help covered entities find out information about the privacy regulation and other administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, OCR and HHS' Centers for Medicare & Medicaid Services have established a toll-free information line. The number is (866) 627-7748.

- **Complaint investigations.** Enforcement will be primarily complaint-driven. OCR will investigate complaints and work to make sure that consumers receive the privacy rights and protections required under the new regulations. When appropriate, OCR can impose civil monetary penalties for violations of the privacy rule provisions. Potential criminal violations of the law would be referred to the U.S. Department of Justice for further investigation and appropriate action.

- **Civil and Criminal Penalties. Congress provided civil and criminal penalties for covered entities that misuse personal health information.** For civil violations of the standards, OCR may impose monetary penalties up to $100 per violation, up to $25,000 per year, for each requirement or prohibition violated. Criminal penalties apply for certain actions such as knowingly obtaining protected health information in violation of the law. Criminal penalties can range up to $50,000 and one year in prison for certain offenses; up to $100,000 and up to five years in prison if the offenses are committed under "false pretenses"; and up to $250,000 and up to 10 years in prison if the offenses are committed with the intent to sell, transfer or use protected health information for commercial advantage, personal gain or malicious harm.

C. COMMON HIPAA QUESTIONS AND THEIR ANSWERS

Below are some common HIPAA questions and answers. For a more expansive and up-to-date review, go to the searchable FAQ's on the US HHS website here: https://www.hhs.gov/hipaa/for-professionals/index.html

Question: Generally, what does the HIPAA Privacy Rule require the average provider or health plan to do?

Answer:

For the average health care provider or health plan, the Privacy Rule requires activities, such as:

- Notifying patients about their privacy rights and how their information can be used.
- Adopting and implementing privacy procedures for its practice, hospital or plan.
- Training employees so that they understand the privacy procedures.
- Designating an individual to be responsible for seeing that the privacy procedures are adopted and followed.
- Securing patient records containing individually identifiable health information so that they are not readily available to those who do not need them.

Responsible health care providers and businesses already take many of the kinds of steps required by the Rule to protect patients' privacy. Covered entities of all types and sizes are required to comply with the Privacy Rule. To ease the burden of complying with the new requirements, the Privacy Rule gives needed flexibility for providers and plans to create their own privacy procedures, tailored to fit their size and needs. The scalability of the Rule provides a more efficient and appropriate means of safeguarding protected health information than would any single standard.

For example,

- The privacy official at a small physician practice may be the office manager, who will have other non-privacy related duties; the privacy official at a large health plan may be a full-time position, and may have the regular support and advice of a privacy staff or board.

- The training requirement may be satisfied by a small physician practice's providing each new member of the workforce with a copy of its privacy policies and documenting that new members have reviewed

the policies; whereas a large health plan may provide training through live instruction, video presentations, or interactive software programs.

- The policies and procedures of small providers may be more limited under the Rule than those of a large hospital or health plan, based on the volume of health information maintained and the number of interactions with those within and outside of the health care system.

Question

Who must comply with these new HIPAA privacy standards?

Answer

As required by Congress in HIPAA, the Privacy Rule covers:

- Health plans
- Health care clearinghouses
- Health care providers who conduct certain financial and administrative transactions electronically. These electronic transactions are those for which standards have been adopted by the Secretary under HIPAA, such as electronic billing and fund transfers.

These entities (collectively called "covered entities") are bound by the new privacy standards even if they contract with others (called "business associates") to perform some of their essential functions. The law does not give the Department of Health and Human Services (HHS) the authority to regulate other types of private businesses or public agencies through this regulation. For example, HHS does not have the authority to regulate employers, life insurance companies, or public agencies that deliver social security or welfare benefits. See the fact sheet and frequently asked questions on this web site about the standards on "Business Associates" for

a more detailed discussion of the covered entities' responsibilities when they engage others to perform essential functions or services for them.

Question

Does the HIPAA Privacy Rule allow parents the right to see their children's medical records?

Answer

Yes, the Privacy Rule generally allows a parent to have access to the medical records about his or her child, as his or her minor child's personal representative when such access is not inconsistent with State or other law. There are three situations when the parent would not be the minor's personal representative under the Privacy Rule. These exceptions are: (1) when the minor is the one who consents to care and the consent of the parent is not required under State or other applicable law; (2) when the minor obtains care at the direction of a court or a person appointed by the court; and (3) when, and to the extent that, the parent agrees that the minor and the health care provider may have a confidential relationship. However, even in these exceptional situations, the parent may have access to the medical records of the minor related to this treatment when State or other applicable law requires or permits such parental access. Parental access would be denied when State or other law prohibits such access. If State or other applicable law is silent on a parent's right of access in these cases, the licensed health care provider may exercise his or her professional judgment to the extent allowed by law to grant or deny parental access to the minor's medical information.

Finally, as is the case with respect to all personal representatives under the Privacy Rule, a provider may choose not to treat a parent as a personal representative when the provider reasonably believes, in his or her professional judgment, that the child has been or may be subjected to

domestic violence, abuse or neglect, or that treating the parent as the child's personal representative could endanger the child.

Question

Can a physician's office FAX patient medical information to another physician's office?

Answer

The HIPAA Privacy Rule permits physicians to disclose protected health information to another health care provider for treatment purposes. This can be done by fax or by other means. Covered entities must have in place reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information that is disclosed using a fax machine. Examples of measures that could be reasonable and appropriate in such a situation include the sender confirming that the fax number to be used is in fact the correct one for the other physician's office, and placing the fax machine in a secure location to prevent unauthorized access to the information. See 45 CFR164.530(c).

Question

Does the HIPAA Privacy Rule strictly prohibit the use, disclosure, or request of an entire medical record? If not, are case-by-case justifications required each time the entire medical record is disclosed?

Answer

No. The Privacy Rule does not prohibit the use, disclosure, or request of an entire medical record; and a covered entity may use, disclose, or request an entire medical record without a case-by-case justification, if the covered entity has documented in its policies and procedures that the entire medical record is the amount reasonably necessary for certain identified purposes.

For uses, the policies and procedures would identify those persons or classes of person in the workforce that need to see the entire medical record and the conditions, if any, which are appropriate for such access. Policies and procedures for routine disclosures and requests and the criteria used for non-routine disclosures and requests would identify the circumstances under which disclosing or requesting the entire medical record is reasonably necessary for particular purposes. The Privacy Rule does not require that a justification be provided with respect to each distinct medical record.
Finally, no justification is needed in those instances where the minimum necessary standard does not apply, such as disclosures to or requests by a health care provider for treatment purposes or disclosures to the individual who is the subject of the protected health information.

Question

A provider might have a patient's medical record that contains older portions of a medical record that were created by another previous provider. Will the HIPAA Privacy Rule permit a provider who is a covered entity to disclose a complete medical record even though portions of the record were created by other providers?

Answer

Yes, the Privacy Rule permits a provider who is a covered entity to disclose a complete medical record including portions that were created by another provider, assuming that the disclosure is for a purpose permitted by the Privacy Rule, such as treatment.

Question

What is the difference between “consent” and “authorization” under the HIPAA Privacy Rule?

Answer

The Privacy Rule permits, but does not require, a covered entity voluntarily to obtain patient consent for uses and disclosures of protected health information for treatment, payment, and health care operations. Covered entities that do so have complete discretion to design a process that best suits their needs.

By contrast, an "authorization" is required by the Privacy Rule for uses and disclosures of protected health information not otherwise allowed by the Rule. Where the Privacy Rule requires patient authorization, voluntary consent is not sufficient to permit a use or disclosure of protected health information unless it also satisfies the requirements of a valid Authorization. An authorization is a detailed document that gives covered entities permission to use protected health information for specified purposes, which are generally other than treatment, payment, or health care operations, or to disclose protected health information to a third party specified by the individual. An authorization must specify a number of elements, including a description of the protected health information to be used and disclosed, the person authorized to make the use or disclosure, the person to whom the covered entity may make the disclosure, an expiration date, and, in some cases, the purpose for which the information may be used or disclosed. With limited exceptions, covered entities may not condition treatment or coverage on the individual providing an authorization.

Question

Are the following types of insurance covered under HIPAA: long/short term disability; workers' compensation; automobile liability that includes coverage for medical payments?

Answer

No, the listed types of policies are not health plans. The HIPAA Administrative Simplification regulations specifically exclude from the definition of a "health plan" any policy, plan, or program to the extent that it provides, or pays for

the cost of, excepted benefits, which are listed in section 2791(c)(1) of the Public Health Service Act, 42 U.S.C. 300gg-91(c)(1). See 45 CFR 160.103. As described in the statute, excepted benefits are one or more (or any combination thereof) of the following policies, plans or programs:

- Coverage only for accident, or disability income insurance, or any combination thereof.
- Coverage issued as a supplement to liability insurance.
- Liability insurance, including general liability insurance and automobile liability insurance.
- Workers' compensation or similar insurance.
- Automobile medical payment insurance.
- Credit-only insurance.
- Coverage for on-site medical clinics
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

Question

A clinic customarily places patient charts in the plastic box outside an exam room. It does not want the record left unattended with the patient, and physicians want the record close by for fast review right before they walk into the exam room. Will the HIPAA Privacy Rule allow the clinic to continue this practice?

Answer

Yes, the Privacy Rule permits this practice as long as the clinic takes reasonable and appropriate measures to protect the patient's privacy. The physician or other health care professionals use the patient charts for treatment purposes. Incidental disclosures to others that might occur as a result of the charts being left in the box are permitted, if the minimum

necessary and reasonable safeguards requirements are met. See 45 CFR 164.502(a)(1)(iii). As the purpose of leaving the chart in the box is to provide the physician with access to the medical information relevant to the examination, the minimum necessary requirement would be satisfied. Examples of measures that could be reasonable and appropriate to safeguard the patient chart in such a situation would be limiting access to certain areas, ensuring that the area is supervised, escorting non-employees in the area, or placing the patient chart in the box with the front cover facing the wall rather than having protected health information about the patient visible to anyone who walks by. Each covered entity must evaluate what measures are reasonable and appropriate in its environment. Covered entities may tailor measures to their particular circumstances.

Question

Does a physician need a patient's written authorization to send a copy of the patient's medical record to a specialist or other health care provider who will treat the patient?

Answer

No. The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual. See 45 CFR 164.506 and the definition of "treatment" at 45 CFR 164.501.

Question

When is a health care provider a business associate of another health care provider?

Answer

The HIPAA Privacy Rule explicitly excludes from the business associate requirements disclosures by a covered entity to a health care provider for treatment purposes. See 45 CFR 164.502(e)(1). Therefore, any covered health care provider (or other covered entity) may share protected health information with a health care provider for treatment purposes without a business associate contract. However, this exception does not preclude one health care provider from establishing a business associate relationship with another health care provider for some other purpose. For example, a hospital may enlist the services of another health care provider to assist in the hospital's training of medical students. In this case, a business associate contract would be required before the hospital could allow the health care provider access to patient health information.

Question

If patients request copies of their medical records as permitted by the Privacy Rule, are they required to pay for the copies?

Answer

The Privacy Rule permits the covered entity to impose reasonable, cost-based fees. The fee may include only the cost of copying (including supplies and labor) and postage, if the patient requests that the copy be mailed. If the patient has agreed to receive a summary or explanation of his or her protected health information, the covered entity may also charge a fee for preparation of the summary or explanation. The fee may not include costs associated with searching for and retrieving the requested information. See 45 CFR 164.524.

Question

Does the HIPAA Privacy Rule require hospitals and doctors' offices to be retrofitted, to provide private rooms, and soundproof walls to avoid any possibility that a conversation is overheard?

Answer

No, the Privacy Rule does not require these types of structural changes be made to facilities. Covered entities must have in place appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information. This standard requires that covered entities make reasonable efforts to prevent uses and disclosures not permitted by the Rule. The Department does not consider facility restructuring to be a requirement under this standard. For example, the Privacy Rule does not require the following types of structural or systems changes:

- Private rooms.
- Soundproofing of rooms.
- Encryption of wireless or other emergency medical radio communications which can be intercepted by scanners.
- Encryption of telephone systems.

Covered entities must implement reasonable safeguards to limit incidental, and avoid prohibited, uses and disclosures. The Privacy Rule does not require that all risk of protected health information disclosure be eliminated. Covered entities must review their own practices and determine what steps are reasonable to safeguard their patient information. In determining what is reasonable, covered entities should assess potential risks to patient privacy, as well as consider such issues as the potential effects on patient care, and any administrative or financial burden to be incurred from implementing particular safeguards. Covered entities also may take into consideration the steps that other prudent health care and health information professionals are taking to protect patient privacy.

Examples of the types of adjustments or modifications to facilities or systems that may constitute reasonable safeguards are:

- Pharmacies could ask waiting customers to stand a few feet back from a counter used for patient counseling.

- In an area where multiple patient-staff communications routinely occur, use of cubicles, dividers, shields, curtains, or similar barriers may constitute a reasonable safeguard. For example, a large clinic intake area may reasonably use cubicles or shield-type dividers, rather than separate rooms, or providers could add curtains or screens to areas where discussions often occur between doctors and patients or among professionals treating the patient.
- Hospitals could ensure that areas housing patient files are supervised or locked.

Question

Does the HIPAA Privacy Rule permit doctors, nurses, and other health care providers to share patient health information for treatment purposes without the patient's authorization?

Answer

Yes. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient.

Conclusion

As mentioned at the beginning of this course, Laws and Ethics are necessary to providing quality services to the consumer. Maybe nowhere is this more important than in the healthcare field. This course has covered many of the Laws, Regulations and Ethics pertaining to the professional conduct of Clinicians and Therapists. It is your challenge as a licensed professional to

implement the information in this course for the betterment of yourself as a clinician in helping the most vulnerable among us.

Well, it appears you have survived. Now, go take the CE test and get that certificate!