Chapter 5
Ethics and the Law

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Introduction

Strong health care rests within a foundation of respect and humanity. When people seek health care, not only do they seek the wisdom and knowledge of providers but they also seek a professional connection that makes them feel comfortable. They make sometimes difficult decisions based on the information they are given as it applies to their individual situation and to their family, community, and cultural context. They do so privately, within a network of confidentiality. The work of health care providers is guided by ethical principles, broader philosophical principles, and relevant legislation. Recent legislation, and updates to that legislation, in the form of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, also known as the Kennedy–Kassebaum Act, were drafted to protect privacy in the electronic era. It contains prongs designed to improve efficiency of health care delivery, to standardize electronic data interchange, to protect confidentiality and security of health data, and to protect the confidentiality and integrity of individually identifiable health care information. Ethical principles do not carry

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the weight of the law, but they are applied within professions and they traditionally have been used as touchstones to provide a lens through which professional conduct may be examined, measured, debated, modified, and improved. Philosophical principles reflect higher-order constructs, beliefs, approaches to individuals and work, and values within work. This chapter aims to integrate these three approaches to professional conduct as they apply to clinical health psychology in medical centers. In the ever-evolving ethical and legal contours of heath care, the bases for shaping the interface between professionals and consumers lie in the law, ethics codes, and philosophical notions of what constitutes professionalism. Within each of these sources, it is possible to enrich dialogue on the impact of a professional's conduct on the individual patient, the community of consumers (the public), public perceptions of the profession of clinical health psychology, and the community of clinical health psychology providers.

Ethical Principles and Resources

The basic benchmarks and norms about appropriateness of conduct within a profession are set forth in ethical principles [25]. Some of these basic notions date back to the first written ethics code, the Code of Hammurabi (*Codex Hammurabi*), created ca. 1790 BCE in ancient Babylon [33], and containing 282 laws, each no more than a sentence or two [21]. Psychologists are guided by the *Ethical Principles of Psychology and Code of Conduct* [3]. Because of the diversity of practice within the field of psychology, divisions or joint task forces sometimes develop specialty guidelines that are meant to further guide practice. See, for example, the *Record Keeping Guidelines* [7], the *APA Statement on Services by Telephone, Teleconferencing, and Internet* [1], the *Guidelines on Multicultural Proficiency for Psychologists* [4], the *Guidelines for Psychological Practice with Older Adults* [6], and the *Criteria for Evaluating Treatment Guidelines* [2]. Whereas ethical principles are mandatory, guidelines for practice are aspirational and they are designed to facilitate competent and appropriate practice within a defined area. Embedded in ethical principles and guidelines is an expectation that providers have a substantial understanding of the issues of relevance to their work [5].

Psychologists prepare for practice through formal and informal education and training, attending specialized continuing education workshops, seeking consultation, reading relevant scientific literature, and referring to ethical principles and guidelines for practice. Training in the comprehension and implementation of ethical principles begins in graduate school and continues as a career-long pursuit. Ethical principles and practice guidelines are intended to facilitate the development of the psychologist and the profession to assure a consistently high quality of research and practice. These sources are not meant to be exhaustive. Although meant to be comprehensive, no set of principles or guidelines could possibly anticipate the expanse of ethical dilemmas or research and practice settings that might be faced by individuals. In some cases, federal and state statutes may supersede standards and guidelines [6]. Psychologists are trained to be aware that potential conflicts sometimes arise between the law, the ethics of the profession, and guidelines for practice. Although legal, ethical, and guideline resources provide useful strategies and approaches to ethical practice, there are a host of complex concerns faced by providers and sometimes unique to particular settings [13]. The *Ethical Principles of Psychology and Code of Conduct* [3] was written broadly for applicability to the varied roles of psychologists. Most members of ethical bodies in medical centers try to minimize the potential for ethical complexity by anticipating possible permutations of ethical questions, establishing internal standards and procedures, providing mechanisms for consultation, and carefully considering the impact of practice on the populations served by the medical center [13, 16].

The practitioner in a medical setting should be familiar with internal standards, ethical principles relevant to their profession, and relevant federal and state legislation written to guide practice. The most recent examples of each of these domains include the HIPAA, Public Law 104–191; the American Psychological Association's *Ethical Principles of Psychology and Code of Conduct* [3]; relevant specialty guidelines for practice; and internal standards and regulations for the medical center. Fundamental ethical issues include determining who the patient or consumer of services is, the role of the psychologist, informed consent, confidentiality and privilege, standards of record keeping in medical centers, professional responsibility, professional competence and specialization, and practicing in a manner that appropriately satisfies legal standards. Legal and ethical issues in medical centers may sometimes differ from those in other clinical settings. Unique legal and/or ethical concerns may arise when research and practice are combined, because electronic or paper records are accessible to multiple providers, when medical records departments develop internal standards for the routine distribution of clinical notes to referring physicians, and because multiple professions contribute information with varying degrees of sensitivity to medical charts.

Ethical Principles

Ethical principles are mandatory and binding and they carry an enforcement mechanism through regulatory ethics bodies of state, provincial, and territorial associations and through national associations such as the American Psychological Association. Although traditionally judicial in their structure, there is a growing trend among state psychological associations to shift the judicial functions of ethics committees to educative and consultative structures. The most recent version of the *Ethical Principles of Psychologists and Code of Conduct* was published in 2002 (there were nine previous versions). They provide enforceable standards for the conduct of psychologists. They are used by the American Psychological Association, state and provincial psychology boards, courts, and other public bodies to enforce the standards of professional conduct relevant to the practice of psychology. Compliance with or violations of ethical principles is not isomorphic with legal liability, but rules based on the ethical principles may be admissible as evidence in civil and criminal proceedings for some legal matters [13, 30]. The ethical issues that are unique to medical centers cover a spectrum of concerns that are contained in the *Ethical Principles,* but in some cases issues may be more comprehensive than or different from those addressed by the ethical principles of the profession. Psychologists are obligated to seek training and guidance in anticipation of ethical concerns that are unique to their settings and specialties [30]. The introduction of the ethics code states that psychologists must meet the standard of conduct established by the *Ethical Principles of Psychologists and Code of Conduct* [3] if that standard is higher than required by law. If there is conflict between the ethical principles and the requirements of the law, then the psychologist is required to take steps to resolve the conflict in a responsible manner. If an ethical concern arises that is addressed neither by the law nor the ethical principles, the psychologist is obliged to consider other professional materials (such as practice guidelines or relevant scientific articles), to seek consultation, and to consider his or her own conscience [3].

Professional and Specialty Guidelines

The term *guidelines* refers to pronouncements, statements, or declarations recommending specific professional endeavors or conduct for psychologists [5]. They are intended to be neither mandatory nor exhaustive, and they are sometimes applicable only to specific areas of practice. They are intended to supplement but not supersede sound reasoning and judgment of psychologists [6]. Guidelines usually are developed by national task forces (e.g., the Committee on Professional Practice and Standards, American Psychological Association). They tend to evolve over time and they are based on existing empirically validated practice and scientific literature relevant to a specific domain of practice [13]. They address knowledge and research relevant to the domain of practice, clinical issues relevant to the domain of practice, assessment, intervention, consultation, other service provision, and education and training. Because of the relative complexity of some areas of practice, guidelines are designed to elucidate those complexities and to offer procedures and methods that promote competent and effective practice. They are intended to assist psychologists and to facilitate practice rather than to restrict or exclude psychologists from specialized practice. They recognize that some psychologists will seek specialization by entering into more extensive training or earning formally recognized proficiency or certification [5–6].

Biomedical Ethics and Principles

Although ethical principles are distinct from moral or philosophical principles, their implementation exists in the context of both explicit and implicit higher-order principles that are drawn from constructs or beliefs about how individuals are expected to relate to one another. Interwoven within any implementation of ethical principles or codes, practice guidelines, and legislative requirements to protect patients' rights are philosophical or moral principles and rationales [10]. Legislative requirements or ethical principles may specify particular courses of action, but the rationale behind the legislation or ethical principles, as well as the form the implementation takes, reflects higher-order principles. To offer an illustration, people in health care roles frequently face difficult undertakings. Examples include how to tell patients they have serious health problems, how to include relevant individuals in treatment decision-making processes while honoring patient autonomy, how far to extend helpfulness or beneficence in the administration of treatment, multiple views of the helpfulness of medicine and psychology, and how to do no harm in the course of treatment decisions and treatment provision [22]. One can act in a legally correct or ethically appropriate manner as a provider, but still assume a great deal of latitude in choosing the tone and an approach to recommending a particular course of treatment or a menu of treatment options.

Examples of principles that support the actions of treating professional and their interactions with patients include the concepts of patient autonomy, paternalism, nonmaleficence, beneficence, respect, veracity, fidelity, and justice. Examples of rules or doctrines that emanate from those principles include informed consent, the right to refuse treatment, proxy decision makers, analyses of what constitute optional and relatively obligatory (e.g., some immunization) forms of treatment, and risk/benefit analyses [10]. Philosophical principles have been used to describe the bases of differing approaches to care and treatment. Differing approaches lie at the root of dilemmas that arise when patients are faced with complex decisions about health care [31]. Although decisions take place in the context of a scientific context involving evidence-based treatments, to learn that a treatment is based on evidence is only one dimension of the complexities faced by patients. Dilemmas arise when one can appeal to moral or philosophical considerations for taking different courses of action. Judgments about what ought to be done in particular situations are justified by explicit or implicit rules governing behavior. Those rules are justified, whether manifestly or not, by underlying philosophical or moral principles that ultimately weave their way into ethical theories and standards [10]. A judgment expresses a decision or conclusion made by a patient about a particular action proposed or taken by a doctor or treatment team. Rules underlying judgments state that actions of a certain kind are indicated (or contraindicated) because they reflect the right course of action. Principles are more general and fundamental than rules, and they serve as the foundation or justification of the rules. For example, the philosophical or moral principle of respect supports the rule, "It is wrong to lie to patients" [10]. Theories are bodies of principles and rules that are systematically related. The most commonly recognized philosophical theories relevant to health care ethics and decision making are deontological (relatively paternalistic and rule based) and utilitarian (relatively individualistic and situational). Broad scientific, metaphysical, or religious beliefs often underlie the interpretations of situations in which patients and treatment providers must act [31]. Disputes over actions and policies often involve quite complex disagreements about factual beliefs, moral or philosophical rules, and moral or philosophical principles [10].

Ethical scholars make a distinction between the relevance and the adequacy of the reasons justifying the actions of patients and doctors. General normative ethics is a field of inquiry that attempts to answer the question of which actions are worthy of acceptance and for what reasons [10]. Professional ethical principles or codes grow from these questions and answers. They represent articulated statements of professional roles, obligations, and actions. Professional principles and codes operate best when they are internally consistent and coherent [22]. Comprehensive principles without major gaps are preferred, but either overly broad or overly detailed principles can be problematic [10, 26]. Patients and psychologists or physicians participate in daily decision making and judgments, and in reasoning through or identifying rationales for their recommendations or choices. Ethical theories and standards build on, systematize, and critique these daily ordinary communications [10, 22].

Positive Approaches to Ethics and Standards of Practice

Clinical health psychologists have a long history of building upon the strengths of patients. Treatment providers must consider the illness in the fullness of its complexity while not losing sight of the aim of catalyzing change [31]. The aim of positive approaches to ethics and standards of practice is to focus not only on repairing the worst things in life and disease but also on building the best qualities in the context of treatment. Patient well-being and satisfaction emanate from effective treatment, but there are multiple dimensions to any treatment that include not only the technical administration of treatment but also standards that emanate from constructs of optimism, hope, and faith. At the individual level, positive approaches to putting ethics and standards into practice can be drawn from individual capacities for empathy, courage, interpersonal skills, aesthetic sensibilities, perseverance, originality, future mindedness, talent, and wisdom [35]. At a group or institutional level, these capacities translate into professional concepts of citizenship, responsibility, nurturance, altruism, civility, moderation, tolerance, and work ethic [18, 36]. Psychologists, like other health care providers, must work to stay focused on the positive goals of the profession. There has been a heavy emphasis on empirically validated treatments for mental illness and various forms of individual suffering. More positive approaches utilize these approaches but they also emphasize individual strength and resilience. Treatment does not focus solely on ameliorating the illness but upon human behavior in all its complexity and upon enhancing the strengths of the individual [35].

Clinical health psychologists have been on the forefront of a shift in the emphasis of treatment of illness to a broader model of treatment, consultation, and prevention. Strategies and techniques for enhancing the quality of patient's lives are not just treatment focused, but educational, relational, social, and political [28]. Although regulations and manuals designed to illustrate the implementation of standards, codes, and guidelines focus on task-oriented and illness-focused strategies, it takes individual, group, and agency creativity to address the broader spectrum of patient needs [16, 20]. A collaborative approach best serves these goals. There is an ongoing tension, however, between the legal and ethical duties of treatment providers to protect patients from the consequences of their decision, and the legal and ethical duties to include patients as partners and collaborators in decision making and treatment participation [17, 39].

Primary Goals of Providers

Training in ethics is a significant component of clinical health psychology curriculum [37]. There are issues that are fundamental to the proper execution of ethical and legal standards in clinical health psychology. They include but are not limited to competence, collaboration, intervention, consent, benefits, diversity, self-monitoring, and standards of practice [37]. Experiences of health and illness are subjective, but the assumptions embedded in large systems of care sometimes place unintentional pressure on patients and treatment providers to potentially perpetuate an objectification and depersonalization experienced by many consumers of health care [14]. One of the goals of ethical and legal standards of care is to promote the human element of health care. These goals stand juxtaposed to organizational goals of productivity and efficiency. Recognizing the potential conflicts among these goals is one of the necessary steps of facing the complexities of practice in medical centers. In the daily work life of the psychologist, it is useful to begin with a reminder of the fundamentals of ethical practice.

In the context of clinical health psychology in medical settings, ethicists recommend that the psychologist should stay within his or her area of competence as determined by the psychologist's education, training, and experience. Psychologists should seek appropriate collaboration with other psychologists and with other medical professionals. Psychologists should be aware of both the direct and indirect consequences of experimental or research procedures and interventions used in clinical research trials. Explicit and detailed informed consent is necessary in both clinical and applied research contexts. Risks and benefits should be included in informed consent documents and explanations. Possible value conflicts should be explored when a diversity of perspectives exists. Understanding those conflicts begins with self-examination of the psychologist's own health-seeking and utilization behaviors [37]. Health psychology constitutes a large domain of research and practice that center upon predicting health- and illness-related behavior and managing and changing those behaviors through the application of scientific theories and the implementation of empirically validated treatment and consultation [14]. Treatment models of risk behavior, disease, pain, and attitudes toward death sometimes fall short of fully encapsulating the subjective dimensions of these phenomena. Dealing with significant and traumatizing serious and painful illnesses, people sometimes find themselves examining their own behavior from a novel but nonetheless stressful perspective. Patients may be busy exploring the implications of life, illness, and death for their lives, while treatment providers may be focused on the technical steps necessary to begin treatment or palliative care [14, 27].

Responsibilities and Obligations of Providers

Providers are required to treat patients regardless of the reasons for their illnesses and without reference to who they are as individuals [17]. While remaining focused on respect for patients, beneficence, and patient autonomy, providers in medical centers offer state-of-the-art treatment for advanced and serious illness. They face a delicate balance between the technical and human aspects of care [27]. Responsibilities and obligations of providers typically center upon informed consent, effective communication of all components of the relevant information, assessment of the patient's competence for treatment decision making, patient autonomy in deciding for themselves the course of their treatment or whether to be treated at all, persuading patients of a reasonable course of action without coercing them, and abiding by the decision that the patient makes while preserving their confidentiality [17]. Modern medicine presents countless new technologies and treatment choices to patients, increasing the complexity and difficulty of health care decisions. The clinical health psychologist's role may be central or supportive in these decision-making processes. The first step faced by the treatment team in optimizing decision making is to define whether the goals of care are: curative therapies, supportive or maintenance therapies, a focus on prolonging life, or palliative care without concern for disease-modifying interventions. Although these goals may be relatively clear in late-stage disease, withholding or withdrawing treatment in the early phase of an incurable disease is a more complicated decision-making process. Providers and patients consider the prognosis and related uncertainty, possible treatment options, personal values and goals, the patient's subjective values and hopes, and the dynamic nature of decisions that may change rapidly and may sometimes be contradictory [27]. Systems of cure and systems of care in modern medicine are not dichotomous and may overlap considerably. In reality, numerous goals are possible, and it is sometimes possible to pursue more than one. The psychologist's role may span discussions of avoidance of premature death, maintenance or improvements in function, relief of suffering, maintenance of quality of life, control, and preparation for death [27, 34]. Treatment teams often turn to the proportionality principle, which states that a treatment is ethically mandatory to the degree that the benefits are likely to outweigh the burdens upon or risks to the patient. Identifying the appropriate treatment goals and avoiding futile treatments are overriding goals in medicine and in psychology [27].

The doctrine of informed consent is rooted in the legal right to self-determination and the ethical and philosophical principle of autonomy. Decisions about treatment are made in a collaborative manner between the patient and the treatment provider, and informed consent is obtained before the treatment may be administered. The patient is provided with relevant information in the form of a disclosure, so that he or she may make a well-considered decision and express consent (or decide not to consent). The information that is provided to the patient must be understood and it must be sufficient in breadth and depth for the patient to make the best decision possible under the current circumstances and in light of the current and most up-to-date knowledge and technology available in the relevant field of inquiry [26–27]. Disclosure includes information about the nature and purpose of the proposed treatment or procedures, its risks and benefits, and any available alternatives [27]. To be valid, consent to treatment must be granted by a competent patient or his or her designated decision-making proxy. Determination of competence to grant informed consent begins with a clinical inquiry, but it sometimes culminates in a legal venue in which a judge is asked to determine the competence of the patient to make informed decisions or to grant that decision-making authority to another individual who then exercises it in the form of substituted judgment [19, 27]. Advance directives are oral or written instructions specifying the wishes of a person for future treatment, in case future incapacity precludes the patient's decision-making capacity at the time that the decision is relevant. Withholding takes place when a treatment is not provided, and withdrawing treatment is defined as ending treatment that has no demonstrated effectiveness. These procedures are relevant when it is no longer reasonable or beneficial to provide aggressive treatments or interventions. These terms are often used in situations in which a serious and terminal illness is reaching the phase of culmination. Examples include ventilator support, hemodialysis, extension of chemotherapy, artificial hydration, nutrition, and other therapies that may prolong life beyond expectations or delay death [27]. The relevance to clinical health psychology is seen in the support and accompaniment that patients might desire as they face difficult and complex decisions. At another level, however, the clinical health psychologist might work with the patient to help him or her sort through the relative level of presence or withdrawal of support and accompaniment desired from family members and friends, or the development, transitions, and malleability of the patient's day-to-day preferences in their desired level of support. Support, even when well intended, may be a source of comfort or stress depending upon the patient's state of mind and the capacity of the person providing support to do so in a manner that is helpful and relevant to the patient's concerns. People with serious illness face psychological, social, and spiritual issues with a heightened awareness and their reactions can be quite complicated intrapsychically and interpersonally [29]. The psychologist serves and supports the roles of determining the need for and providing interventions relevant to the patient's mental state, subjective experience of illness, vulnerability, pain, acceptance and denial, disavowal, and use or rejection of other support resources such as family members, friends, and support groups [34, 37].

The ethical and philosophical or moral framework of clinical health psychology serves as a backdrop to the work, and it also highlights the complexity of the work. Recent legislative initiatives have included fairly straightforward goals of streamlining some of the more tedious or mundane aspects of the work. Juxtaposed with these rather straightforward goals was the more human element of granting patients easier access to their own medical records and giving them well-defined information about what constitutes personally identifiable health care information and how they may exert control over the release of their medical records. We turn now to a description of recent legislation relevant to clinical health psychology practice in medical centers.

Legal and Record-Keeping Requirements in Medical Settings

The foregoing analysis provided an illustration of the distinct but interlinked nature of moral and philosophical principles and ethical principles. Ethical principles also are distinct from legal requirements, codified in state and federal legislation, but ethical principles or standards sometimes overlap with legislative initiatives in their intent (and vice versa). Each of the three domains of moral/philosophical principles, ethical principles, and legal requirements provides the bases for institutional internal policies and regulations that are designed to fine-tune those requirements to fit the institution's health care goals and objectives [34]. Each community of providers takes on a distinct community identity or set of identities. Although ethical and legal requirements are standardized in written or codified form, their proper implementation may take many forms, depending upon the range of services that are provided by an institution. Even within institutions, there may be different requirements for different providers due to varying risk–benefit considerations in medical decision making and treatment provision [19].

For some ethical principles and legal regulations, it is possible to distill the complications of both sets of requirements into fairly straightforward internal regulations. Credentialing requirements is one example. Before the psychologist is appointed to a staff position, there is an administrative review of the psychologist's educational and clinical preparation for practice, and his or her credentials. The review of the psychologist's credentials is intended to document their preparedness for the range of patients they will treat, the extent of their clinical privileges, and the scope of their practice within the medical center. Privileges may be limited or extensive, depending upon the psychologist's intended role, educational background, clinical training, and areas of expertise. Medical center bylaws, policies, and procedures define what is meant by hospital privileges, the scope of practice definitions, the description of the structure of professional staff organizations and committees, medical record-keeping requirements, quality improvement expectations, human resource rules, admission and discharge practices, emergency and disaster preparedness plans, and voting rights of attending staff members [34]. Local applications of relevant legislation are reflected in medical center policies and procedures. How an agency implements legislative requirements depends on the size and complexity of the practice or institution.

Other internal standards drawn from legislative requirements are less straightforward because of their broad reach. The most recent and most notable example is the HIPAA, Public Law 104–191. In this section, we will describe how HIPAA serves as an example of the sometimes interwoven nature of ethical and legal requirements, especially those related to confidentiality and privacy of communications. HIPAA compliance is essential to psychological practice because the health care industry is fast moving toward electronic transactions. HIPAA helps protect patients, it reflects sound business practice, compliance is a matter of law, and following HIPAA specifications can help providers avoid potential risks. The Privacy and Security Rules have quickly come to reflect the prevailing standard of care [9].

HIPAA and Other Relevant Federal Legislation

The HIPAA, Public Law 104–191, was passed on August 2, 1996, and it was signed into federal law on August 21, 1996. The act amends the Internal Revenue Code of 1986. It contains four sections: Title I: Health care access, portability, and renewability; Title II: Preventing health care fraud and abuse, administrative simplification, medical liability reform; Title III: Tax-related health provisions; and Title IV: Application and enforcement of group health plan requirements. The general goals of HIPAA are to improve health care portability and continuity of health insurance coverage (i.e., to protect Americans who were previously ill from losing their health insurance after changing jobs or residences), to streamline health insurance claims through the adoption of consistent standards for transmitting uniform electronic health care claims, and to reduce waste and fraud in the health insurance and health care industries [8, 16]. The Centers for Medicare and Medicaid Services in the Department of Health and Human Services is responsible for the implementation and the provision of HIPAA, and the Office of Civil Rights has responsibility for enforcement. Title II, Section F, of HIPAA, Administrative Simplification, is the pivotal section that generated the high level of scrutiny and activity surrounding the act. Because of the provisions of the Administrative Simplification, the health care industry virtually revamped many of its administrative and financial systems, and enhanced the security of business offices and computer systems in order to ensure the confidentiality and privacy of protected health care information [11, 16]. The Administrative Simplification provisions were designed to eliminate administrative costs, to standardize the format of electronic data interchange of certain types of health care administrative and financial transactions, to safeguard the security and confidentiality of health care information, to set standard codes for diagnoses and procedures, to set unique health identifiers for employers and providers, to set unique health identifiers for individuals and health plans, to codify civil penalties for compliance failures, and to codify criminal penalties for wrongful disclosure of individually identifiable health information [16]. The privacy rule of HIPAA addresses the application of policies, procedures, and business service agreements designed to control access to and use of patient information. The security rule addresses the institution's physical infrastructure. Examples include access to offices, files, and computers containing secure and private communications. It addresses mechanisms for assuring the maintenance of confidentiality of patient information [8].

Protecting confidential patient information is a familiar standard for psychologists. Liability for releasing certain kinds of information without proper authorization or consent already exists under state and federal laws, and it is supported by relevant ethical principles. Before HIPAA, psychologists already were required to seek patient authorization or consent to the release of confidential information for all purposes, including treatment and billing goals. HIPAA reinforced or added to existing legislative and ethical principles by requiring the use of specific documents designated as consents and authorizations, and by explicitly listing the necessary elements that must be contained in consent and authorization forms [32]. HIPAA consent refers to permission to release protected information for the purpose of treatment, payment, and other health care activities such as utilization review, peer review, continuity of care, and quality assurance. Patients must provide consent in writing and they may revoke consent in writing. Authorization is required for all other disclosures that are made for purposes other than treatment, payment, or other health care activities. An example of an authorization is when a patient requests that records be released to a third party such as an attorney or a school [32]. Examples of explicit information include a specific definition of the information to be used or disclosed, to whom the information will be disclosed, the purpose of the disclosure, an expiration date, the right to revoke the authorization, and the right not to authorize the disclosure [8]. Authorizations must be in writing and in specific terms, and they may be revoked in writing [32]. Neither consent nor authorization is required for protected health information when it is required by law, by a health oversight agency, by a coroner or medical examiner identification/cause of death purposes or other duties authorized by law or state pre-emption, by the military or Veterans Affairs for national security purposes, to avert a serious threat to the health or safety of a person or the public, to satisfy Workers' Compensation laws, to protect victims of abuse and neglect as provided by statute, and to protect victims of domestic violence as provided by statute [8].

HIPAA Privacy and Security Rules are triggered when a psychologist or an entity acting on behalf of the psychologist transmits electronic information (Internet, extranet, private networks, computer-generated faxes) in connection with health care claims, health care eligibility and payment, coordination of benefits, inquiries regarding subscriber enrollment information in a health plan, health care claim status, subscriber coverage eligibility to receive services, health plan premium payments, referral certifications and authorizations, reports of injury for workers' compensation claims, and any extraction of relevant information from the medical records to demonstrate the rationale for service provision and subsequent claims [9, 11]. The privacy rule applies to health care providers, health plans, and health care clearing houses. The type of information protected by the act includes health information, whether oral or in recorded form, created or used by health care professionals or health care entities; individually identifiable health information; information that relates to the past, present, or future physical and/or mental health condition of an individual; the provision of health care to an individual; and the past, present, or future payment for the provision of health care to an individual or that identifies the individual or that could be reasonably used to identify the individual [8]. Prior to treatment or other interventions, psychologists must obtain patient consent prior to using protected health information for treatment, payment, or other health care operations. The generalized consent form used for HIPAA purposes differs from and is not a substitute for informed consent forms that are obtained prior to the initiation of treatment. When protected health information is disclosed, the privacy rule requires that the psychologist disclose only the minimum amount of information necessary to conduct the billing or insurance activity of relevance [8].

State Privilege Statutes

State statutes and regulations offering less privacy protection are superceded by the HIPAA privacy rules, except for some notable exceptions. In state statutes across the 50 states, one finds requirements for the reporting of child abuse and injury, certain diseases for public health surveillance, and births and deaths. State law provides for health plans to report information relevant to business management and financial audits, licensure of facilities, and evaluation or monitoring of facilities. The government sanctioned requests for information to prevent fraud or abuse related to health care, to satisfy reporting requirements for health care delivery statistics or costs, to serve a compelling emergent public health or safety need as provided by state statutes or regulations, and to ensure appropriate state regulation of the health insurance industry. State privacy or privilege statutes in some states may be more stringent than HIPAA, in which instance the state law would supercede HIPAA [8]. For example, in states with privilege statutes, if called to testify or provide documents for a legal review, one must first assert privilege on behalf of the patient and then await a judicial determination as to whether privilege pertains or is waived [13]. It would be up to the individual providers to determine if their state privilege statute is more or less stringent than HIPAA requirements. Relevant information is often found on the state board of psychology Web sites and in their dissemination of relevant data. Under HIPAA, personal health information may be disclosed for research for a limited set of circumstances, such as de-identified information, in the setting of an approved waiver from an institutional review board, or for deceased individuals [8].

How HIPAA and State Statutes Differ from Ethical Principles

HIPAA applies only to practices using electronic transactions relevant to health plan and payment functions. A psychologist in solo or group practice who accepts no insurance would find most portions of HIPAA inapplicable. Another psychologist in a solo or group practice who bills by mail and conducts authorizations by telephone may not find it relevant now, but would need to be prepared for the possibility of future electronic transmission requirements by HIPAA. A third psychologist in a solo or group practice who routinely uses electronic transition for payment and billing activities would be considered a “covered entity” by HIPAA regulations. Yet another psychologist who uses e-mail for office functions unrelated to payment and billing activities would find HIPAA applicable in limited circumstances. HIPAA is triggered primarily by electronic transition of payment and billing activities. There are many nuances to the regulations, however, and it is best to consult a variety of resources and colleagues before concluding that it is inapplicable. HIPAA reflects a balancing between confidentiality of patient records and the practicalities of billing and insurance concerns. It actually facilitates rather than protects disclosure as it applies to billing and insurance purposes [11]. The disclosure elements of HIPAA do have their limitations. HIPAA did not alter the applicability of privilege where state statutes provide for it, or the applicability of ethical principles. The traditional duties of informed consent and psychologist–patient confidentiality require psychologists and physicians to keep information private unless a patient signs a release of information form. There are certain well-known exceptions related to emergencies, mandated reporting requirements, and public safety concerns. In other words, HIPAA does not create a minimum standard for psychologists and physicians. It is a supplement to already existing ethical and legal standards [9, 11].

Medical Center Internal Policies and Regulations

In response to HIPAA regulations, institutions have developed internal standards that specify procedures for establishing and terminating a user's access to electronic patient health information, preserving patient confidentiality in the setting of periods of computer session inactivity, employee violations and related sanctions for unauthorized viewing of medical records irrelevant to their practice or for allowing other individuals unauthorized access to their computers or passwords, preventing security violations, containing and correcting security violations, regularly reviewing records of information system activity, network firewalls and routers, security access controls, remote access infrastructures and authentication, encryption software, Internet and wireless security, repair and maintenance of hardware, and antivirus software. Institutions need specific policies for introducing new hires to and deleting terminated employees from electronic medical record access, security of data provided to outsourced individuals and contractors with access to protected health information, institution-wide security program plans, and a variety of other computer hardware and software management issues. The impact on the individual clinical health psychologist or other providers is, at a minimum, a set of specific internal standards for accessing medical records, viewing records, refraining from viewing records irrelevant to practice, and closing records upon departure.

Clinic Notes

Clinic notes are distinct from psychotherapy notes. Clinic notes record assessment data, observations, and consultations to physicians, but do not contain sensitive psychotherapy data. They appear in the general medical record, according to the HIPAA record-keeping standards. This standard was already in place in many institutions. The narrow exception criteria relevant to psychotherapy notes are described below. At the outset of patient consultation, it is best to discuss the rules of privacy and confidentiality, as they apply to the particular practices of clinical health psychologists or other psychological specialties in medical centers. The discussion might include how e-mails, calls to the receptionist, note-taking, clinical notes, and psychotherapy notes are handled in the practice. Patient consent is needed to discuss treatment or to release clinical notes to primary- or specialty-care clinicians outside the institution. Clinic notes subject to disclosure should be limited to relevant treatment or consultation data. All required and relevant information must be documented in the medical record. Minors must be informed of the psychologist's obligations to the minor's parents or guardians. Know in advance to whom to direct confidentiality questions, disclosure questions, and HIPAA questions. According to HIPAA regulations, every institution must appoint a designated HIPAA officer. Local and national organizations also provide HIPAA guidance for members [11].

Psychotherapy Notes

HIPAA recognizes that some information in the course of psychological or psychiatric treatment should always remain private and makes a specific exception to patient direct access to psychotherapy notes. The notes cannot be released for treatment, payment, or health care operations without specific patient consent. Psychotherapy notes, however, are narrowly defined as having three key features. They (a) document or analyze the content of conversations (b) during private, group, or family sessions, and (c) are separated from the rest of the individual's medical record [11]. Even if they are kept in a separate psychotherapy record, notes that include information properly regarded as part of the medical records (medications prescribed, test results, treatment plans, diagnoses, prognoses, and clinical progress) are still considered part of the medical record and therefore not protected by the psychotherapy exception. Psychotherapy notes, though part of the exception, may not be protected from other formal requests such as subpoenas or court orders in the context of litigation [8, 11]. There is no prohibition on the release of psychotherapy notes to patients, but it is wise for clinicians to develop policies regarding their release to patients so that the conditions of release are given reasonable foresight. HIPAA has had an unintentional, though possibly enhancing, effect on the principle of patient autonomy by encouraging active patient participation in care, patient review of treatment progress, and documentation that does not fall in the narrow exception criteria; but, internal policies may be needed to define or fine-tune the best practice relevant to information that does fit into the narrow exception criteria [11]. Mental health professionals retain a duty to their patients to do no harm to the physical or mental well-being of patients through careless entries into a medical record. In a post-HIPAA era in which patients have broad access to their medical charts, the duty has not changed, but the likelihood of patient review has increased in frequency. The narrow exception criteria do afford special status to sensitive information, but record-keeping practices must reflect the narrowness of the criteria and avoid fragmentation of the record [11].

Electronic Medical Records

One of the results of HIPAA regulations has been a structural change in the access of other fields of medicine to psychiatry and psychology clinic notes (not psychotherapy notes), and vice versa. In the past, the mental health record was often separated and treated differently from the general medical records. Medical providers needed a separate consent to view psychiatric records, and patient access to psychiatric records was relatively limited. HIPAA eliminated the distinction by allowing mental health information not covered by the narrow exception criteria to be shared with other treatment clinicians within the same institution without a specific consent requirement [11]. Electronic records introduce a significant advantage, particularly in large institutions, to access to data relevant to clinical health psychology encounters. Written background, consultative, or treatment information by other professionals that, in the past, was slowly gathered by psychologists from a paper record is now quickly available in electronic form.

Electronic medical records are being used increasingly for the potential advantages of their durability, confidentiality, accessibility, and efficiency. They have addressed some limitations of paper records in work flow, improved quality of patient care and safety, decreased medical errors, and access to the medical records by multiple providers at the same time and anywhere or at anytime within a network. Electronic medical records have paved the way for clinical health psychologists to use electronically enhanced means to keep track of behavioral data relevant to disease, such as monitoring patient access and utilization of therapeutic and preventive health services that may affect illness outcomes [41]. Access to some information is available to credentialed providers on their private computers via virtual private networks or VPNs, making the electronic medical records, or portions of it, portable in some instances. To comply with HIPAA, internal medical center standards usually require that computers must be encrypted if they are to be used to access data via VPNs.

The adjustment to the electronic medical record was not without its ups and downs for most providers, but studies have shown that individuals who use electronic medical records, relative to those using paper records, are more likely to find the records up to date, find the records more accessible, and report greater satisfaction with electronic medical records. Increased duration of use was related to greater satisfaction with electronic medical records relative to paper records. The benefits included increased access to relevant information from multiple providers, the ability to search the system for relevant records, improved quality of patient records, and improved quality of documentation. Records were viewed as accessible, modifiable, timely, and of satisfactory quality. There were no differences in perceptions of quality of care delivery when providers using electronic records were compared to those using paper records. In some cases, electronic medical record systems were associated with a more efficient use of time, improved management of illness, and improved preventive care [23]. Electronic medical records carry the potential to mitigate delays in diagnoses and treatment provision, to facilitate monitoring of duration of follow-up, and to facilitate monitoring missed appointments and providing support for transportation or other issues that may be impeding patient access to desired health care [41].

Clinical Health Psychology Practice in Medical Centers

Clinical health psychology is a field in which providers seek to apply the contributions of psychology to the understanding of health and illness. They seek to integrate biomedical information about health and illness with current psychological knowledge. Psychologists provide consultation on how biology, behavior, culture and ethnicity, and social context influence health and illness. They work alongside other medical professionals in a variety of settings. The most common theme within the work is that health and illness are products of a combination of biological characteristics, genetic predispositions, lifestyle, stress and coping strategies, health beliefs, cultural influences, family influences, and social influences. Clinical health psychologists work toward promoting prevention strategies, and they investigate the effects of illness on psychological well-being. Because their role is often consultative, the ethical contours of their work sometimes take place within a relatively broad context.

Individual Confidentiality and Networks of Confidentiality

Patient confidentiality in the context of a medical center exists within a network of confidentiality rather than a dyad confidentiality offered by an individual provider toward an individual patient [40]. With increased accessibility of medical records, it is possible for a clinical health psychologist to quickly review a patient's neurology records, ophthalmology records, and surgical records before providing consultation. Although that same access was possible using a paper record, access is more efficient and more easily accessible with electronic medical records. In addition to relying upon the patient to be a historian about his or her health history, the health records of patients can be quickly reviewed, and interview questions can query relevant topics. Although the clinical health psychologist quickly has access to relevant data, the information must be treated with appropriate respect and sensitivity to the patient's concerns. Information must not be dispensed to anyone outside the network of confidentiality without the patient's permission. In the new world of electronic medical record keeping, it is advisable to remind the patient that others responsible for their care within the institution will have ready access to the clinic notes of the clinical health psychologist (and the clinical health psychologist will have access to the clinic notes of other providers). HIPAA regulations and internal standards disallow providers from viewing the records of any patient not in their care, but they have ready access to the records of all patients and may quickly access the records of their own patients. Networks within the institution may be small or large depending upon how many providers are responsible for a patient's health care. When records are to be sent outside the institution, a release must be obtained [41].

The Medical Center as a Community of Providers

HIPAA regulations affect how clinicians may access existing health information and how to handle identifiable information created as a result of clinical activities. It applies not only to records but also to conversations among providers. When a team of providers discusses a patient, it is required that they do so in a private venue such as an office with a closed door. Records or conversations should be limited to identified patients. When families are seen together, records for one family member must respect the privacy of other family members. Joint records are not permitted. When a team of clinical providers produces a joint document on an individual patient, there should be appropriate coordination of records and meetings so that all members of the team appropriately adhere to record-keeping requirements. The notice of privacy relevant to HIPAA is applicable to all team members as individual providers and not to the team as a whole. The complications and permutations of releases, restrictions on uses and disclosures of health care information, and revocations of releases must be anticipated for team reports. Report-preparation provisions must anticipate the possible revocation of release for one team member but not other team members. If a team report is prepared and a release is revoked for one member of the team and not the other members, there must be a mechanism for releasing only those portions of the report that the patient has agreed to release [38].

Clinical health psychologists work in a community of providers, usually in a team model but sometimes somewhat more individually. Behavioral medicine, education, behavior change, and work-related health initiatives are common foci in clinical health psychology. The duty of confidentiality remains relevant, but it is likely to be handled differently than traditional psychotherapy. Team models of treatment require an acknowledgment at the outset, in verbal and paper form, that the members of the team will be in communication with one another. If there is cross-consultation with other professionals in the same institution, the patient must be informed of who will be included in the network of confidentiality and they must be in agreement with cross-consultation. If there are sensitive data that the patient prefers to keep private, there must be provisions for preserving that sensitivity. When patient care utilizes family and community support services, the limitations to confidentiality must be stated in advance of care. Services must be appropriately contractual, confidentiality and the limits thereof must be communicated effectively, and the psychologist must remain within the bounds of his or her competence. Patients have the right to view and request a copy of their mental health records (except those that fall within the exception provision), and they have a right to request that corrections be made to incorrectly recorded data [24, 38].

Professionalism

Professionalism is central to sustaining the public's trust in the integrity of health care providers. It reflects the essence of the provider–patient relationship. Academic institutions are beginning to recognize that emphasis is needed on strengthening the resolve of providers to sustain their commitments to the ethics of professionalism. Professionalism is a component of the competence of providers and it begins with selection processes, instruction, role modeling in learning environments, and student feedback specific to professionalism. Professionalism reflects a set of skills, some of which are easily defined and quantified, and others of which are a bit amorphous and individual. Society explicitly and implicitly assumes that health care providers ought to be trustworthy in their pursuit of their professional goals and that they should be served by the public interest in the integrity of the health care professions. Professionalism reflects the means by which individual providers fulfill their profession's contract with society, and they include qualities such as altruism, respect, honesty, integrity, dutifulness, honor, excellence, and accountability [12].

There is growing concern about professionalism within medical centers due to increasingly relaxed views of individual and family privacy at a societal level, and due to changing standards of manners and civility. Professionalism, from an ethical and legal standpoint, centers upon the need to apply ethical and legal standards in the context of ever-evolving roles and responsibilities of psychologists within constantly shifting moral, cultural, economic, political, and legal contours. Trends of current relevance include the advent of Internet-mediated research and supervision sites, electronic telemedicine, the use of electronic media for the dissemination of research literature and health information, increased sensitivity to the research and treatment needs of disadvantaged populations, and the ebb and flow between paternalistic and autonomy-based attitudes and regulations relevant to informed consent and patient privacy.

Community Parameters for Individual Patients

Whether the treatment community consists of individual providers within the medical center, a network of providers, the inclusion of family members or other social partners in treatment, group treatment modalities, or electronic communities, attention must be given to patient views of the sensitivity of their health care information. Patients have varying attitudes about the sensitivity of their health care information. What is personally embarrassing to one patient may seem relatively innocuous to another. To determine the patient's level of comfort with the sharing of information within the medical community, it is important to specify in advance the advantages of collaborative communication between providers, to determine any reservations the patient might have about those collaborations, and to determine what information they might view as sensitive regardless of whether it is classified as such by treatment providers [26].

Couples, families, or groups of clients seen together can promote a patient's sense of belonging within the context of a network of supportive individuals or those going through the same illnesses. It also raises the possibility of conflicting interests. There may be competing medical, social, and political interests within the network or hierarchy of individuals involved either centrally or peripherally in an individual patient's care. In the context of group treatment, patients may not experience the same degree of benefit from treatment, support may be seen by some patients as intrusiveness, and patients may not share the same understanding of group confidentiality. By focusing on the welfare and best interests of the most vulnerable parties in the social community, legitimate professional duty is made more clear and it enhances the likelihood of a good outcome [24, 40]. Similar dynamics may apply to treatment teams. A team of providers may be responsible for the well-being of patients but individual members of those teams may have different priorities. Team structure, size, form, and role composition must be clearly delineated and coordinated. Teams of providers must communicate well in order to appropriately address the patients' needs and provide effective service coordination.

Clinical health psychologists typically provide services in the context of a team of providers that focus on particular categories of illnesses, disabilities, or services. Team size may affect patient outcomes in a bimodal manner. Too few or too many providers can yield problems in meeting the team's treatment objectives. Responsibilities must be divided according to professional competencies, with due attention given to limiting the potential for dual roles or spreading responsibilities too broadly. Effective teams tend to be moderately sized, include patient perspectives, include family perspectives when relevant, and take advantage of the positive influence of key players. Consultations and interventions are optimized when they take place within a planned sequence of interventions and when they take advantage of a patient's readiness to incorporate advice and suggestions. Coordinated reporting of information is optimized when both verbal and written communication of data are planned in advance. Information that is communicated in writing must correspond to that which has been communicated verbally. Cogency is important both within teams and across other consultations so that the most critical information is effectively gleaned by those who will use the information at a later time in the patient's treatment course [40]. The readership should be considered, and both written documents and verbal exchanges should be communicated in a tone that is appropriately respectful of patients as consumers of health care [13].

Communicating with Individuals and Families

The question of allowing family members to participate in or be present during critical or other care of patients, whether during emergency or routine procedures, is a question that revolves around basic values more than treatment outcomes [19]. The presence of family members can help orient patients coming out of anesthesia, give courage to patients who must endure pain, and give treatment providers a better understanding of the patient as a person enduring illness. The question of the value of the presence of a family member becomes more complicated when health care providers are faced with potentially stressful procedures (to the patients, the family members, and the providers). The benefits of having a family member present in these circumstances is difficult to predict, calculate, or compare due to different attitudes toward emergent treatment, unpredictable vicarious trauma reactions of family members, and a host of other potential complications. Attitudes toward the presence or exclusion of family members have their basis in theoretical views of whether the individual patient is the only appropriate focus of care (and that this focus ought not be distracted by family members or violations in confidentiality and privacy), or whether the socially embedded nature of existence is the norm and that family members may have curative influences and they will and properly may influence individual choices [15]. Health care providers never really know what kind of relationships any given patient has with his or her family members, whether the family members might wield too much influence or improper kinds of influence, and whether the patient might decide or behave differently if family members remain peripheral to the decision-making processes [15]. It is appropriate to view the patient as an individual who lives in a web of relationships with family members and community members, but the individual's preference for unitary or family-supported decisions must be discerned to the best degree possible and respected when possible.

Communication with Patients via Electronic Means

Modern microelectronics have made possible the provision of clinical health psychology services via e-mail, Internet chat rooms, Web sites, and interactive audio and video technology. The nature and terms of how the clinical health psychologist relates to patients are changed significantly in these media. Consent forms must be modified to anticipate the potential permutations of communications via these media. The geographic expanse of consultations must be considered in light of licensing regulations and prohibitions against practice across jurisdictions. Relevant consumer information must be posted on professional Web sites. Providers must consider a myriad of new contractual issues and related liability components. Providers must consider to what extent it is appropriate to provide services via these media. There is little research to date that is relevant to the quality of therapeutic alliances formed via electronic exchanges or how they compare to in vivo alliances. Caution is in order as providers make ethical and service delivery adaptations to these media. There is potential for therapeutic value as well as the potential challenges to the adequacy of treatment and consultation [24].

The use of new technologies has created innovations and opportunities for the provision of psychological services that move beyond the in vivo dyad. For example, behavioral telehealth is one of the fastest growing dimensions of telehealth. Psychologists who wish to expand the scope of their practice to techniques or technologies that are new to them are ethically bound to undertake relevant education, training, and consultation to reach the necessary qualifications established by the field. The ethical competence standard of the American Psychological Association's ethical principles [3] addresses the utilization of technologies and emerging technologies in practice. Psychologists must take reasonable steps to ensure the competence and safety of their work in new or emerging areas of practice. Emerging areas of practice must draw upon sound and established scientific or professional knowledge in the discipline of psychology. Steps must be taken to ensure that e-mail or Internet-mediated consultations are undertaken in a manner that preserves the competence of the provider's work and the confidentiality of the patient's concerns. The obligation of informed consent applies to Internet services. Psychologists who provide Internet-based assessments or e-therapy must ensure that the individual who provided consent is in fact the individual utilizing the services. The age and legal status of service recipients must be verified, and there must be provisions for individuals with impaired consent capacities. Fees, third-party involvement, confidentiality (and limits to confidentiality), and the implications of HIPAA must be addressed. Formal consultative services provided by e-mail must anticipate confidentiality concerns, lack of immediacy, and the limited range of therapeutic services available through this medium. When sensitive information is transmitted, it is advisable to use encrypted data transmission, password-protected data storage, and firewall techniques [24, 34].

Teaching Hospitals

Teaching, Supervision, and Observation

Within teaching hospitals, it is customary to inform patients when their care includes interventions or procedures delivered by interns, residents, or fellows. It is customary to inform them of who has supervisory responsibility over the trainees. Internal medical center regulations and insurance regulations require that the attending physician or psychologist meet individually with the patient rather than supervising the trainees from a distance. Under HIPAA, patients must be informed of a myriad of nuanced ways in which their health care information will be used. Patient authorization is needed for a variety of activities, from the mundane to the formal. Examples include appointment reminders, offering treatment alternatives, consultations about health-related benefits and services, fund-raising activities, patient directories, and marketing. Teaching and clinical supervision is no exception. Patients must be informed when trainees are part of the treatment team. Student observers must be cleared by administrative procedures. Even people who serve as hospital volunteers are subject to HIPAA regulations. Patient permission is needed for the inclusion of student observers, trainees, consultants, other teachers, or any other individuals who might be in a training/trainee role. If a patient's case is to be used to illustrate a teaching point, the patient's permission must be secured and all identifying information must be removed [38].

Ethics education shapes relevant attitudes and values of students who will become the next generation of clinicians and researchers working with persons with serious physical and mental illnesses. Ethics and professionalism preparation heightens the sensitivity and facilitates appropriate professional attitudes, and it strengthens the skills of future clinicians and researchers in preserving, enhancing, and fostering a humanistic view of treatment and research. Case-based, experiential, and small-group learning experiences are particularly valuable in ethics education. In research ethics, considerable debate persists about participant motivations, participant understanding of research goals, the perceived vulnerability of physically or mentally ill research participants, capacities for independent decision making, and appropriate levels of professionalism among researchers (Roberts et al. 2007).

Research and publication

The legal component of research is seen in the higher standards introduced by HIPAA for researchers. Researchers that provide health care to individuals in clinical trials are directly covered as health care providers. Researchers who access existing protected health information from medical records or computer databases must comply with the HIPAA Privacy Rule because they operate in medical centers that are "covered entities." They are obliged to protect the privacy of individually identified health care information used or released for research. From a clinical investigator's perspective, HIPAA affects how researchers access health information and how they handle identifiable information created as a result of clinical research activities. In addition to informed consent requirements, investigators must obtain an authorization, with more detailed information, in order to use and release identified protected health information for research. The criteria used by Institutional Review Boards to waive the authorization and informed consent for medical record or database reviews are much more stringent than before HIPAA went into effect. Investigators must provide more detailed information on protocol applications about the use, disclosure, and necessity of accessing protected health information. HIPAA requires that the hospital, and investigators using hospital records, track any individually identified information that is released for research when waivers of authorization are granted. The purpose of tracking is to provide patients, upon their request, with a list of how the information about them was released for research or other nontreatment purposes without their knowledge. A "business associate" agreement may be needed if organizations collaborate on research [38].

Summary

Clinical health psychologists are committed to improving the condition of individuals, organizations, and society through the application of scientific theories and research to people's behavior and their understanding of themselves and others. Clinical health psychologists respect the autonomy of patients in their roles of granting informed consent, using judgment and reasoning to make health care decisions, forming opinions or perspectives on health and illness, coping with illness, and participating in research. The work of clinical health psychologists is guided by ethical principles, standards of practice, medical center regulations, and relevant legislation. In the implementation of these sources of guidance, it is possible to discern higher-order moral or philosophical principles that are interwoven throughout the sources of guidance and the work itself. Although each of these mechanisms carry with them the ingredients for healthy scientific debate about appropriate practice, and although they may sometimes offer conflicting guidance, they provide a wealth of common standards upon which clinical health psychologists base their professional and scientific endeavors. These mechanisms have a common goal of protecting the welfare of individuals and groups seeking health care.

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