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Privilege, Confidentiality, and Patient Privacy: Status 1980

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ABSTRACT: The principle of patient privacy has evolved from the Hippocratic Oath to current medical ethics guidelines and to legal protections for doctor-patient communications. Privilege statutes now abound in the United States with considerable difference from state jurisdiction to state jurisdiction. Recently several bills have been introduced to establish a federal standard for patient privacy. These bills are critically examined—particularly in regard to the conflict between the need to keep doctor-patient interactions private and the demand by law enforcement agencies for information. The federal bills lean towards the latter at the expense of the protection of confidentiality and therefore should not be adopted. The narrowness of the scope of the proposed laws is reflected in a comparison with a proposed model privacy act.

KEYWORDS: psychiatry, doctor-patient privilege, privacy

Confidentiality, as an ethical imperative of many professions, is long established. Physicians are not alone in their concern for patient privacy; attorneys, clergymen, newspaper reporters, bank trust officers, and numerous others proclaim their commitment to privacy in their professional relations.

Concurrent with the legitimate desire of people to keep their private affairs a nonpublic matter is the ever-growing demand by the law and government to have information they deem necessary for their functions. Thus an inherent clash of interests occurs where conflicting social policies form a battleground with control of privacy at stake. The evolution of the concept of the right to privacy as applied to medical practice is the focus of this paper, with particular emphasis on recent developments that may drastically affect the status quo.

Medicine has for generations broadly attempted to follow the principle of Hippocrates that "whatever, in connection with my profession, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad, I will not divulge as reckoning that all should be kept secret." This principle has been adopted by the American Medical Association and the American Psychiatric Association, which state in their ethical guidelines:

> A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or others.

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The American Psychiatric Association [*1*], in elaborating on this stand, notes that confidentiality is essential to psychiatric treatment and that information can be released only with the authorization of the patient or under proper legal compulsion and that only relevant information should be released.

These simple guidelines provide the base for a professional ethical stance. Violation may be the cause for action by a professional organization to reprimand, suspend, or expel a member. Violation of privacy may also provide a basis for a disciplinary action by a medical licensing board. Gross violation may lead to loss of licensure. In at least one state, violation of a patient's privacy is a criminal act. Furthermore, an aggrieved patient may have grounds for civil action for breach of privacy.

The courts have not hesitated to protect patient privacy in a situation where the patient complained about public exposure by a psychotherapist who wrote a book about the patient's treatment [*2*]. The attempt to hide the patient's identity was felt to be inadequate, and an injunction against publication of the book was granted.

Evolution of Privilege Laws

As usual in the American legal system, the controlling law has come from two sources—statutory law and case decisions. Despite prolonged legal action in both areas, much ambiguity remains, compounded by the fact that the United States has at least 50 jurisdictions (states, District of Columbia, commonwealths, territories, and so forth). Thus no national standard exists.

Similarly, no historical standard exists, at least in terms of common law traditions. The Anglo-American legal system does have a history of attorney-client communication protection that has periodically been statutorily defined but always traditionally recognized. While English law does not recognize a strict priest-penitent or clergyman-parishioner relationship, such a policy has often existed for practical purposes and has been specifically recognized in many of the states.

The doctor-patient privilege has slowly evolved from political and judicial action in the face of much legal hostility. Many lawyers view any protection of privacy as the means by which truth is suppressed.

The legal term, privilege, means that communications of certain types are protected from legal intervention and thus from government or administrative scrutiny, as well as from attempts by others to use legal means to obtain such information.

The first such state law in the United States was that of New York, which in 1828 proclaimed:

> No person duly authorized to practice physic or surgery shall be allowed to disclose any information which he may have acquired in attending any patient, in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon.

Current Laws

The current New York law [*3*] is not much different from the 1828 law. It states that a person authorized to practice medicine, registered professional nursing, licensed practical nursing, or dentistry shall not be allowed to disclose information acquired professionally and necessary for the provision of such professional service. An exception is the release of information about a deceased patient where there is no objection or where the privilege was waived by next of kin, by a judge where the interests of the personal representative are deemed adverse to the estate of the deceased, and in a will contest. An interesting exception to such release is "information which would tend to disgrace the memory of the decedent." By case law, New York has clarified the statute by indicating that a patient waives his

privacy privilege by testifying concerning his condition or brings or defends an action in which his condition is affirmatively put in issue [*4*].

The situation nationally is quite varied. At least three dozen states do have some type of doctor-patient privilege statute. Another ten have a psychiatrist or psychotherapist-patient statute. Roughly 35 states have a psychologist-client statute, usually in terms identical to the attorney-client statute but apparently often interpreted in terms of a doctor-patient statute. Various states have special provisions for some social workers or marriage counselors.

The English have not yet formally recognized a doctor-patient protection [*5*] but have done so on a case-to-case basis. Similarly, Illinois (before its current statute), South Carolina, and Ottawa have recognized such a right to privacy despite lack of statutory support.

The existing laws provide great variation. Pennsylvania has an archaic statute, protecting information that doctors obtain "in attending the patient in a professional capacity and . . . which shall tend to blacken the character of the patient." Also to be determined is "whether material emerging in the context of treatment, when presented in the courtroom situation, would blacken the patient's character."

At least three states (North Carolina, Virginia, and Maine) would allow disclosure for the proper administration of justice or, to put it differently, at the discretion of the judge if the material is needed for proper disposition of the case. This, of course, provides very little clear-cut protection.

The North Carolina statute states:

> Provided that the court either at the trial or prior thereto, may compel such disclosure if in his opinion, the same is necessary for proper administration of justice.

Some jurisdictions differ in their protection of information in criminal as opposed to civil cases or in their dependency on the type of criminal case. For example, Wisconsin and the District of Columbia provide no privilege in homicide cases. California provides no protection in a criminal proceeding under the doctor-patient statute but does do so under its psychotherapist-patient statute. California is unusual in that it has parallel statutes.

Maine also has double statutes. Its psychiatrist-patient statute is unique in that it provides for protection of communications between a patient and a board-certified psychiatrist; thus it is the only state that limits such rights to a board-certified medical specialist. Others will allow the specialist to be defined by the type of practice. For example, Connecticut defines a psychiatrist as a licensed physician who "devotes a substantial portion of his time to the practice of psychiatry" or one believed by the patient to do so.

New Jersey's doctor-patient statute, a relatively new one effective in 1968, allows for exceptions for commitment of a patient because of mental incompetence, will contests, where the condition is an element of a claim or defense, where information is required to be reported by law, or where there has been prior testimony on the same subject.

States having a psychiatrist-patient or psychotherapist-patient statute include Georgia, Tennessee, Connecticut, Illinois, Massachusetts, California, Maine, Texas, Florida, Maryland, and New Mexico.

Massachusetts provides that there is an exception to privilege in custody cases when either party raises the mental condition of the other as part of a claim or defense and where a psychotherapist believes disclosure is necessary because of serious impairment of the patient to care for the child. The Illinois statute, on the other hand, protects information about parents in custody cases.

Both the American Psychiatric Association [*6*] and the American Bar Association Commission on the Mentally Disabled [*7*] have prepared very complex bills dealing with protection of psychiatric or mental health records. The APA proposal is similar to the Illinois statute. They deal in particular with consent issues involving minors [*8*].

Many matters have been left unclear or have been decided in a way that vitiates the concept of privacy. Thus group therapy, family therapy, child guidance therapy, conjoint

therapy, and marital therapy are usually ignored in the various statutes. Three jurisdictions (Illinois, Rhode Island, and the District of Columbia) specifically protect communications in group therapy; on the other hand, a recent Virginia case excluded protection for marital or group therapy under the Virginia statute because more parties were involved than a doctor and a single patient [*9*].

Recommendations

The complexities of modern society have brought about situations where other parties have a pertinent interest in on-going therapy, either from the standpoint of peer review or third-party monetary coverage for treatment. Those who pay want to know the justification for such payment; such third-party payers may be either government or private insurers. Expanding research creates information bank situations where patient material resides in another control system. Fraud by a physician or therapist requires investigation. Computers allow for the impersonal storage of patient information without control by either patient or therapist; this, of course, applies more pertinently to institutional rather than private office care.

Crucial issues involve the chaos of conflicting jurisdictions, the archaic nature of many statutes, and for good or bad, the lack of a national standard.

In a previous paper [*10*], I have described what I believe to be the adequate ingredients of a doctor-patient privacy statute. While I recognize that psychiatrists have a much greater need for protection of patient communications than other physicians, I believe that such principles should apply broadly in all health care and that nonpsychiatric physicians have a legitimate need for similar protections. Fragmentation of medical care or rights is not in the best interest of patients.

A model privacy act should state that communications involving health care matters may not be released without consent and should be private and immune to *all* legal action except:

(1) to accomplish psychiatric hospitalization, involuntary or otherwise, or evaluation to weigh the necessity for such;

(2) to inform relatives, next of kin, or appropriate parties about the general condition of the patient, in conformance with medical, psychiatric, or mental health practice;

(3) to communicate with other physicians and care providers involved in the management of the patient, in conformance with professional practice;

(4) to intervene in emergency situations where there is apparent significant threat to life, health, or property, the discretion being that of the care provider;

(5) to aid in the settlement of will disputes where testamentary capacity is at issue;

(6) to clarify, as necessary, eligibility for insurance benefits after the death of the patient and to provide information necessary for disposition of claims on behalf of or on the estate of the deceased patient;

(7) to report those diseases stipulated by law for public health purposes or to make available medical records of minors in accord with abuse or neglected child acts;

(8) in civil litigation where the patient is a party and the illness is a basis of a claim or defense. This exception shall not apply to any action for damages for pain and suffering alone that does not include a claim based on consequences or treatment of a mental condition as an element of such pain and suffering. This exception shall also not apply to domestic relations cases involving divorce, separation, or custody;

(9) in a criminal case where mental or physical disease is an element of the defense or where clarification of such status is required for procedural reasons. This shall include fitness to stand trial and related issues;

(10) as reasonably necessary for medical and statistical research;

(11) as reasonably necessary to establish the basis for payment by third parties, public or private;

(12) as reasonably necessary to establish conformity with the policies of government-supported programs;

(13) as reasonably necessary to effect peer review or similar review of hospitals' or physicians' procedures.

Other pertinent issues that will not be explored here deal with the authority and protection of minors, restriction to pertinent material, and exclusion of prejudicial or inflammatory matter or data irrelevant to the needs of the situation.

Congressional Proposals

Of great import is the absolute protection for patients charged with or being investigated for criminal activities. The history of this country, particularly in recent times, is striped with the abuses of investigative officers and political manipulators whose ardor in similarly controversial areas has been dampened by judicial decree and legislative act.

These remarks are preface to the more recent developments at the national level at which various congressional proposals to effect a national standard have been made in both the Senate and the House. The intent of these bills is to provide access to medical records for patients, to create opportunities for patients to correct erroneous data, and to set standards for the protection of privacy by creating rigid rules for restriction of release of information combined with a series of exceptions that do not require patient authorization. I will focus on the latter aspects of the bills and point out some of the areas in which they differ from the recommendations described earlier. None of the bills deals with the broad dimension of issues that have been discussed—particularly joint treatment, cases involving wills, civil litigation, and so forth. The greatest defect is the ambiguity in criminal matters and the opportunity for abuse. The important feature of these bills is not the misleading statement of principles as to privacy but the long list of stipulations that allows doctor-patient communications and medical information to be scrutinized without permission—the aptly named "exceptions."

H.R. 3444 is a lengthy bill dealing with health care providers. It would allow release of information to agents of a facility to carry out their duties; to health care providers in connection with health care services; to next of kin for the health and safety of another person; for research and statistics activities to meet medical emergencies or prevent a crime or in compliance with a judicial order in inquiry of a violation of a law by the research unit; for government investigation of a facility; and for investigations of fraud, abuse, waste, audits, evaluation, and payment. Similarly, exceptions exist (1) for third-party payers; (2) compulsory to legal process; and (3) when the individual and the government are parties to a suit.

The picture becomes more complicated with the numerous exceptions for law enforcement authorities. The presence of a patient within an institution, location, and general medical condition may be released if a person does not object or if the inquiry is pursuant to a legitimate law enforcement inquiry. The door is open to administrative summonses, subpoenas, search warrants, and judicial subpoenas; to prevent serious property damage or flight; to the FBI, Secret Service, armed forces (for people in the armed forces), penal authorities (for those so incarcerated), Veterans Administration (for those in VA facilities), and grand juries.

S-865 is a similar bill, but it would also allow release of information [Sec. 310 (6)] to "any local unit of government of any state, or any officer, employee, or agent thereof, but does not include a state legislature." Thus, theoretically, a city mayor could arrange to obtain records of a citizen by making him the subject of an investigation.

S-503 would allow access to information where the data could indicate that the patient "may have been involved in, or a victim of, a violation of law." Thus the records not only of alleged criminals would be open to fishing expeditions but also those of alleged victims—certainly a most unusual breach of privacy. Specific reference is also made to the needs involved in conducting foreign counterintelligence.

These laws would supersede state laws and therefore would render all existing state laws and protections inoperative. Thus, if adopted, the result would be that there would be a marked diminution of legal protection of confidentiality in many states.

H.R. 2979 is a bill that would not exclude additional protections by federal, state, or local law and would specifically protect medical records relating to psychiatric, psychologic, or mental health treatment. Exceptions under this law include employee use, medical consultation, the fact of admission, and information needed in health research situations and for audits and evaluations. Once again, there would be no privilege for a variety of law enforcement functions—investigation of fraud, abuse, or waste; to assist in the location of a suspect or fugitive in a legitimate law enforcement inquiry; for judicial-administrative purposes (civil or criminal procedures where in the individual is a party); and for the usual summonses, subpoenas, and search warrants.

A later, extensive bill introduced in the House, H.R. 5935, clarifies some of the matters raised in the earlier bills and allows for much more flexibility. It is the only bill that defines a patient as a living individual, thereby opening up records of the deceased. It does allow for restriction by federal, state, or local laws on the "disclosure of medical information relating to psychiatric, psychological, or mental health examination, care, or treatment." It further allows a state to prohibit disclosure of medical information under that part of the bill dealing with exceptions. (It is not clear about that part of the bill dealing with procedures so there is a possible ambiguity.)

This bill is permissive. It states that hospitals "may" release information when requested under the various exceptions including the usual long list of law enforcement agencies. This places the responsibility and power in the health facility but at the same time makes the health facility peculiarly vulnerable to pressure by governmental authorities. Records of one patient could be obtained to seek information about crimes possibly committed by other patients. One of the most striking sections in the bill is Section 132 dealing with subpoenas, summonses, and search warrants. Part (a) states that a medical care facility *may* disclose information, while part (c) states:

> Nothing in this section shall be construed as authority for a medical care facility to refuse to comply with a valid, administrative summons, subpoena, or warrant, or a valid judicial summons, subpoena, or search warrant.

Another interesting clause allows for information to be obtained at federal medical care facilities by the uniformed services to determine eligibility of a member of the uniformed service for service, promotion, assignments, or training (this without the person's knowledge or permission).

Numerous other exceptions for law enforcement purposes are specified. H.R. 5935 lacks clarity in that it is permissive both for states and health facilities. In the absence of state action, health facilities would be placed in a very awkward position in attempting to fend off law investigators in the absence of any standards or criteria. No consistency would be present. Theoretically it might open the door to litigation by parties whose records were revealed under circumstances that are injurious to the individual.

Other matters dealing with procedure, notification, and time factors will not be delineated here.

The major point to be made is that the proposed federal bills either diminish protections existing in many parts of the country or create an ambiguous situation where certainty is desirable. Second, they adopt the premise that law enforcement investigations supersede the right to privacy and therefore they propose changes that are in opposition to their stated intent. Third, they do not deal with the many legitimate areas of privacy that have been listed earlier in this article, areas where protections should reasonably be allowed.

Special circumstances deal with security and foreign intelligence. One particular area of study is the need to know the location and approximate status of those who have threatened selected federal officials. American history does leave one with a sense of disquiet in this

regard. On the other hand, American history does not seemingly provide past cases where such information would have made any difference.

The use of a federal standard would be considered possibly treacherous by those interested in civil rights and patient privacy. Unless carefully considered, such a standard can result in a loss of civil rights, as the discussion of the proposed bills indicates. Fear of government would be magnified. One might speculate, for example, on the effect of such legislation on federal employees and their sense of security in seeking therapy for themselves. If a national standard were to be adopted, not only would states' rights be lost but so would the flexibility inherent in dealing with a smaller entity. Changing a federal law, once passed, is no simple task. Pressures for "law and order" are themselves threatening, and once passed, an inappropriate bill might be difficult to alter. Professional persons can lobby in their own states for improvement by pointing to achievements in other states. This would not be possible if there were a national rule. One might even attack the constitutional basis for such acts that loosely declare that medical care is a matter of interstate commerce and therefore subject to federal regulation. This is, of course, a fiction necessarily used for the exercise of power. Those who fear centralized power and who shudder at the record of government in so many recent years may feel compelled to oppose militantly the imposition of such regulations.

In any event, those who feel that confidentiality is a necessary cornerstone for the appropriate provision of medical services will continue to press for clear-cut guidelines that will inform patient and physician alike of their rights. The principles of an adequate privilege bill should carefully reflect the specific and limited exceptions allowable by law. Otherwise, the concept of privacy and, with it, freedom becomes just a sham.

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