

## **The President's Message: Doctor-Patient Confidentiality — Suggested Legal Protections**

In a previous Bulletin editorial, "Congressional Proposals and the New Assault on Privacy," I have strongly criticized the content of four bills now before Congress. These bills were described, to put it politely, in most unkind terms as a threat to professional practice, patient security, and basic civil rights. Reflecting the chaos of extant policy, cross-currents of legislative and judicial actions at the same time have stressed the counter-ideology of the protection of privacy — a principle that has now obtained support on constitutional grounds.

The judge in a recent California case<sup>1</sup> pointed out that in that state legislative action was a response to "a public awareness and concern that proliferation of governmental snooping and data collecting is threatening to destroy our traditional freedoms. Government agencies seem to be competing to compile the most extensive sets of dossiers of American citizens. Computerization of records makes it possible to create cradle-to-grave profiles of every American."

The court stated further that, "The individual's right to privacy encompasses not only the state of his mind, but also his viscera, detailed complaints of physical ills and their emotional overtones. The state of a person's gastrointestinal tract is as much entitled to privacy from unauthorized or bureaucratic snooping as is that person's bank account, the contents of his library or his membership in the NAACP."

Courts have taken an increasingly stringent stand against violation of privacy by physicians, particularly psychiatrists, pointing out the potential tortious conduct involved. Thus a book by a psychiatrist about a patient was suppressed by the court for violation of privacy (*Doe v. Roe*<sup>2</sup>). The court stated, "a physician, who enters into an agreement with a patient to provide medical attention, impliedly covenants to keep in confidence all disclosures made to the physician in the course of examination or treatment. This is particularly true of the psychiatric relationship, for in the dynamics of psychotherapy the patient is called upon to discuss in a candid and frank manner personal material of the utmost intimate and disturbing nature. . . . He is expected to bring up all manner of socially unacceptable instincts and urges, immature wishes, perverse sexual thoughts — in short, the unspeakable, the unthinkable, the repressed. To speak of such things to another human being requires an atmosphere of unusual trust, confidence, and tolerance."

These two excerpts reflect the developing tradition in support of privacy of the doctor-patient relationship. This basic right to privacy needs to be clearly supported in all doctor-patient privilege legislation. While specific

rights have been given to psychiatrists in various states, we should not be satisfied with this splitting off and separation of psychiatric material from general medicine, even though the psychiatrist-patient relationship is more poignantly vulnerable to lapses in such protection. Nonetheless, the need to counterbalance privacy with the "right to know" reflects a contrary principle also strongly entrenched in the law, and as the bills before Congress demonstrate, influential forces have marshalled their efforts to waive privacy for other allegedly beneficial social ends. Thus the balance of individual and social needs must be keenly scrutinized in the consideration and modernization of privacy bills.

The American Psychiatric Association itself has proposed a model law on Confidentiality of Health and Social Service Records.<sup>3</sup> While a worthy attempt, this effort merits criticism. The model law reflects its origins in the Committee on Confidentiality and in the Task Force on Confidentiality of Children's and Adolescents' Clinical Records. The amalgamation of health and social service records into one bill is a precedent that many physicians might find distasteful, particularly the use of the expression "client," a word which characterizes the attempt to split off psychiatry from the rest of medicine. Illinois's use of "recipient" is at least as repugnant.

This bill, as well as the closely related Illinois bill,<sup>4</sup> puts the age for release of consent at 12. The protections in Illinois are included in the Mental Health and Developmental Disabilities Confidentiality Act, again a piece of separatist legislation which lumps psychiatrists as therapists with psychologists, social workers, nurses, or "any other person not prohibited by law from providing such services." The APA bill refers to "service providers" — another expression minimizing the role of the physician as a physician.

The APA uses age 12 as a simple dividing line for capacity to authorize release of information. The Illinois statute requires written consent by both the "recipient" (from age 12 to 18) and the parent or guardian. If the "recipient" refuses to consent under these conditions, the therapist may allow such release if he or she feels that consent is in the best interest of the recipient and the parent or guardian agrees. If the latter does not, no disclosure will be made. Many of these issues as well as the unbelievably complicated and legalistic approach of the model act of the American Bar Association Commission on the Mentally Disabled are discussed by Weinapple and Perr.<sup>5</sup>

In any case, all these procedures are cumbersome and not of imposing rationality in that the standards have no relationship to maturity, judgment, or rights of minors in other legal contexts. This is particularly so now that the Supreme Court has clarified, to some degree, the authority of parents to hospitalize minors in the Parham case.<sup>6</sup> It would indeed be anomalous to allow a child patient to release information about a hospitalization to which he cannot agree or consent.

Both bills do provide well-thought out provisions for the protection of privacy, albeit expressed in excessively complex verbiage. Many of the principles embodied in these bills merit support. One could argue that the information allowed to be released for billings and claims in the APA bill is inadequate (names, addresses, dates, and charges — with no indication as to nature of services). One noteworthy innovation is the delineation of personal

notes, including information from other parties and speculations, as exempt from any legal process.

The American Medical Association has opposed all federal acts dealing with privacy, preferring that this issue be handled on a state-by-state basis. As might be expected, the AMA model confidentiality bill defines "health care provider" much more broadly than the APA or Illinois acts. For example, it would include dentists, optometrists, nurses, podiatrists, psychologists, and physical therapists but not social workers by name. An important AMA consideration is the use of patient material in peer review.

Because of the complexities involved in the creation of a confidentiality or privacy bill, it would perhaps be helpful to review some of the issues with recommendations of those principles that should be part of such proposed bills.

The basic premise of any privacy act should be that no information obtained in communications between patients and physicians, their agents, and staff members of a health care facility, including the fact of patient status, should be made public or transmitted to others without consent. In view of changing realities of health care provision, such statutes should deal broadly with all health care providers reasonably involved. Those supporting medical confidentiality, however, will opt for broad definitions of providers while clearly indicating that such privacy acts should be for the benefit of patients as patients. The concept of "client" or "recipient" should be rejected. Mental health patients should be included in any doctor-patient or health care provider-patient bill; separation for psychiatric patients can no longer be justified or condoned.

Confidentiality should extend to all communications made in a diagnostic or therapeutic context and presented in circumstances where confidentiality or privacy was reasonably presumed to exist. Thus evaluations for the benefit of third parties — employers, insurance companies, courts, lawyers, and agencies — would not be protected by a privacy statute. Communications of examinations to attorneys for legal purposes would be incorporated within the attorney-client privilege unless specifically noted in the privacy statute. Rules governing confidentiality would not apply to communications and records within a health care facility where such are necessary for the care of the patient, teaching, or research or statistical studies where there is no reasonable likelihood of patient identification in public or professional reports.

Authorization for release of information should require the consent of the individual or one authorized to act on behalf of the patient. Parents, next of kin, or guardians should be empowered to authorize release of information for those incompetent to do so. The signature of one parent should be sufficient for this purpose. Attorneys or mental health advocates should not have this function unless duly appointed as guardian.

The age of consent for minors to release information should either be arbitrary — set at the age of majority or at another chosen age, such as 16, based on reasonable capacity to make such judgments at that age — or discretionary, based more broadly on that understanding and comprehension which are utilized as a standard for minors to assent to medical treatment. Release of information dealing with venereal disease, drug and chemical

abuse (including alcohol), and pregnancy, its termination or complications should depend upon the consent of the minor of whatever age.

The treatment of minors provides unique problems because of the nature of the disorders requiring intervention. Release might best be left to the health care provider in cases of evaluation or treatment of behavior or mental disorders in minors. In the various psychotherapies of children and adolescents, certain kinds of information are ordinarily shared with parents; others are not. It is difficult to codify such a system. Parents constantly seek information about the sex lives, drug use, criminal acts, and other behaviors of their children. Confidentiality is most important in dealing with this group. Professional workers share information with parents or agencies depending on the circumstances. Perhaps this is one area where reference to "professional standards" implying flexibility and judgment is advisable.

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

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

(5) 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;

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

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

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

(9) in civil litigation where the patient is a party and the illness is a basis of the 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;

(10) 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;

(11) as reasonably necessary to effectuate peer review or similar review of hospital or physician procedures;

(12) 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 report acts.

The expressions "as necessary" or "as reasonably necessary" shall refer to

a consideration of the need and relevance of information specific to the legal or other issue, the exclusion of all material not necessary for legal or other disposition, probative value, and the prejudicial or inflammatory nature of the information. Where the issue of necessity is raised, the judge shall make such a determination by in camera review. Thus courts should restrict the extent of information made available at judicial or administrative proceedings to that required for appropriate disposition and should exclude inflammatory or prejudicial material not required for reasonable disposition.

A model law should specifically recognize that confidentiality of medical records, unless waived, is absolute in criminal cases other than those exceptions noted in (10) and (12).

The right to privacy should be extended to include group therapy, conjoint therapy, marital therapy, family therapy, and child guidance therapy. In such cases, the permission of all parties and those empowered to act for them shall be required for release of information. The exception to an automatic waiver for civil litigation involving domestic relations cases involving divorce, separation, or custody is an important change that has been recognized by the Illinois statute. If the mental status of a party is relevant to the disposition of such cases, then independent or collateral sources should be utilized if the patient does not wish to authorize release of information.

The right to privacy or confidentiality may be asserted by the patient, by an authorized representative, or in their absence by the physician or other health care provider or their representatives.

A privacy act that would incorporate these principles would provide reasonable protection for patients, access to appropriate care and treatment, and substantial and pertinent availability of information where required. Such a privacy act would in all likelihood be enthusiastically endorsed by health care providers and those advocates of the fiduciary relationship required in the adequate provision of health care.

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### References

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6. *Parham v. J.L.*, 47 U.S.L.W. 4740 (1979)