The President's Message: Congressional Proposals and the New Assault on Privacy

Psychiatrists are keenly aware that their professional role provides sociolegal interactions that in the past only infrequently bedeviled other physicians. Psychiatrists have long been involved in the involuntary imposition of treatment, segregation of patients from the community, concern over professional communications, interaction with government, multidisciplinary therapies, medical economics, informed consent, administrative authority, and utilization of available resources before many of these issues became significant in general medical practice. As a result, psychiatrists are perhaps uniquely qualified to act as spokesmen on such issues, or at least as advisers to the medical profession at large.

The issue of privacy is one such current issue well-known to psychiatrists. For years, psychiatrists have been involved in seeking legal clarification of patients' and therapists' rights in professional communications. The terminology used to refer to privacy issues has traditionally referred to "confidentiality" and "privilege." Confidentiality is a standard guaranteeing or promulgating the right to secrecy or privacy and is used medically to refer to such a principle governing ethical professional conduct. Confidentiality is not unique to medicine; it is an ethical standard recognized in the legal, theological, and myriad other fiduciary professions. The principle of confidentiality has been recognized formally in the law by common-law and statutory protections for certain types of communications. These communications are provided immunity from governmental or legal intervention; they are privileged from ordinary legal or administrative processes. Usually they are referred to in the law as privileged communications. Overlapping the concept of confidentiality and privilege is the newly evolving right to privacy, a constitutional right which has been utilized to bar state interventions in a number of areas, particularly those involving sexual habits, the marital bedroom, or reproductive decisions.

Hippocrates codified the peculiar needs of the medical profession: "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." Hippocrates did not quibble.

The Principles of Medical Ethics of the American Medical Association (Section 9) states: "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 community."

The American Psychiatric Association statement of medical ethics states

that confidentiality is essential to psychiatric treatment.

The right to privacy as a principle of medical ethics has received further recognition in that violation of that right by physicians may lead to loss of medical licensure or even to criminal sanctions.

While the English have been hesitant to extend a formal common law privilege to physicians, scattered cases in Britain have allowed for such a claim of privilege by physicians. New York in 1828 inaugurated formal statutory protections for doctor-patient communications, a policy followed by numerous other states.

Today the situation in the United States is extremely variable. Some states have detailed laws governing the extent of doctor-patient privilege. Some states have nothing; others provide for privilege at the discretion of the judge with no guidelines (for example, a North Carolina judge can compel such disclosure if in his opinion the same is necessary to a proper administration of justice). Pennsylvania allows for privilege for information "which shall tend to blacken the character of the patient." Many statutes cover both civil and criminal procedures; others just one. Federal courts, in civil cases, follow the law of the jurisdiction in which they are located.

The details of the various state laws will not be reviewed here because of their complexity and the variance from state to state. Obviously each physician must know the law of his own jurisdiction. In a state such as New Jersey, where the first doctor-patient law was adopted in 1968, many physicians and lawyers are still apparently uninformed as to the legal protections available. Most state laws provide absolute protection in criminal law matters.

Occasional litigation has clarified or extended statutory law. Several California cases have indicated that material in records, otherwise admissible, can be screened by a judge to rule out the irrelevant. Generally the use of medical information in a legal proceeding by a patient waives his right to control admissibility. On the other hand, in a state like New Jersey, if a patient does not waive his right to privilege, the physician can claim it on his behalf.

Thus state law varies considerably, with numerous gaps and different policies. Many lawyers do not like doctor-patient privilege laws because they feel that suppression of material leads to fraud. Obviously law enforcement personnel and prosecutors feel that medical records might provide information that would facilitate conviction. Some may have the fantasy that open records will lessen violence in the community. The misuse of the role of the physician as an information-seeker for law enforcement purposes was pinpointed in the notorious *Leyra v. Denno* case in New York, where a psychiatrist, masquerading as a jail physician, obtained damaging admissions.

Most psychiatrists and other physicians would find themselves in an ethically abhorrent position if they were to serve as police informers, as some in authority would have us do.

Changing treatment techniques have resulted in situations where traditional doctor-patient privilege statutes are unclear. This vagueness has brought about efforts to change such laws at the state level and to expand them to meet current needs.

With this sketchy introduction, I will now proceed to present a discussion of proposed federal statutes which would have momentous effects on psychiatric and other practice. The motivation for the proposed federal bills is unclear. The

complete denial of the protection of confidence in criminal matters would indicate a strong influence of law-and-order ideology. Surprisingly it also seems apparent that some unsophisticated libertarians actually believe that the proposed laws would offer more privacy to individual citizens rather than less. Perhaps for this reason, some traditionally liberal legislators have been persuaded to be sponsors of such legislation.

These laws have been complicated by provisions for patient access to records and for the opportunity for patients to "correct" their medical records. These provisions will not be discussed as not relevant to the issue of privacy. The laws would also dictate extremely cumbersome paper work and notification procedures which alone would justify their rejection.

But the nub of the privacy issue is the fraudulent content of the proposed bills in that they would in fact result in abuse of privacy statutes, accomplishing the opposite of their intended purpose.

Ironically, while a recent California court warned of "bureaucratic snooping," we are now confronted with four bills now in committee – H.R. 3444 and H.R. 2979 in the House of Representatives and S. 503 and S. 865 in the Senate – which would destroy many of the privacy protections now available in the various states. Although their presentation is simplified and generalized, all represent an attack on the concept of privacy.

All the bills open the door to the use of medical records in criminal procedures and investigation and in civil litigation. All provide for notification to patients of the fact that information is being sought and then provide for court-ordered suppression of this fact under certain circumstances.

The bills go so far as to eliminate privacy in the face of demands from the following groups and/or for the following purposes – government health investigators for audit purposes; investigators for fraud, abuse, and waste, including demands for information concerning health or safety of the individual or another person or pursuant to compulsory legal process; a law enforcement authority pursuant to law requiring release; revealing the presence of the individual at a facility under certain circumstances; state and federal authorities pursuant to administrative summons or subpoena, search warrant, judicial subpoena, or formal written request of federal or state authorities; government authorities claiming possible serious property damage or flight; government authorities where the government and the individual are parties (civil or criminal); intelligence and secret service operatives, the military (within the military); penal authorities (within the penal system); grand juries; persons other than Government authority pursuant to legal process; the Veterans Administration (for benefits); third party payers, etc. (from both S. 865 and H.R. 3444).

S. 503 would provide information to federal, state, or local law enforcement officials from the service provider as required by the law to report such information that indicates "that the patient may have been involved in, or a victim of, a violation of a law" – certainly loose criteria indeed!

These bills would generally provide specific protections to those under the alcohol and drug acts. H.R. 2979 would maintain or recognize federal or state laws dealing with psychiatric, psychological, or mental health treatment. Thus, only H.R. 2979 would continue some semblance of confidentiality, and then only to a narrowly defined group of patients. Otherwise, these new acts would

supersede all state statutes and therefore render them inoperative.

These bills would give an undefined authority to the Secretary of Health, Education, and Welfare to implement the various procedures – an open-ended invitation to government by administrative regulation.

One bill (H.R. 3444) would give the right of release to twelve-year-olds – a standard that has no relationship to maturity, judgment, or legal rights of minors for other purposes. Another bill (S. 865) defines "State authority" to include any state agency or department or any local unit of government or any officer, employee, or agent thereof. Only members of the state legislature are excluded from the open door to patient information.

While there are other objectionable features to these acts, the most unacceptable features of the acts are the loss of the physician-patient privilege in all states (other than those under the psychiatrist-patient communications of H.R. 2979), the opening of the records to government at all levels, the loss of protection in criminal matters, and the loose opening of information for purposes of litigation in general. These so-called privacy acts are in reality police state statutes. Biegler has labeled them as "discovery statutes" – laws which open the door to medical records to an armada of people seeking information about others. The role of physician as healer would be subverted to that of informer. Patients should have to be cautioned that whatever was said might be forcibly made public under a wide variety of circumstances. Certainly federal and other public employees and officials could seek therapy only with fear and trepidation; that is, if they sought help at all.

The proposed bills in committee represent an unbelievably crude attack on civil liberties – an authoritarian rape of rights already granted in many jurisdictions.

This cursory summary is presented because of its timeliness. The bills discussed are still in committee. Psychiatrists versed both in the medical profession and its relationship with the law need to be aware of this insidious attack on civil and professional liberties. We urgently need to be kept informed about the progress of H.R. 2979, H.R. 3444, S. 503 and S. 865. Psychiatrists must vociferously engage themselves in the battle against these alien offspring of unseen bureaucrats. If ever there was a justification for a therapeutic abortion, this is it.

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