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PRESCRIBING PRIVACY: THE UNCERTAIN ROLE OF THE PHYSICIAN IN THE PROTECTION OF PATIENT PRIVACY

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Because medical records are now more comprehensive than ever before, they increasingly are being demanded for uses both inside and outside of the medical profession. Mr. Gellman contends that existing ethical and legal guidance is inadequate to aid physicians in dealing with the confidentiality issues raised when patient information is requested or demanded from them, and supports this contention by examining the dilemmas faced by physicians presented with such requests or demands. He concludes that ethical and judicial guidance will continue to be inadequate, and that the only practical way to develop suitable guidance is through legislation.

Since the dawn of medical practice, confidentiality has been recognized as essential to the physician-patient relationship. Until the maintenance of complete medical records became common earlier this century, however, little written patient information was available. Consequently, physicians were rarely asked to breach patient confidentiality. Available legal and ethical guidance on confidentiality questions, although limited, was generally sufficient to permit physicians to respond to requests for patient information in a consistent and suitable manner.

Now that medical records are a more reliable and comprehensive source of information about patients, requests for the disclosure of identifiable medical information are made more frequently and by a wider variety of institutions than ever before. As patient information is increasingly sought for purposes not directly related to medical treatment, conflicts over the use of medical records become more acute. Because the complexity of the physician's responsibility has not been fully recognized, however, traditional legal and ethical confidentiality principles provide little assistance in resolving these conflicts.

This Article considers the problem largely from the perspective of the physician who has the primary responsibility for the medical records of his patients.¹ Since those seeking access to medical records frequently approach the record keeper rather than the patient, privacy interests will be protected

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1. The physician does not always have primary responsibility for his patient's medical records. In a hospital, for example, significant portions of the hospital records are compiled by nurses and other nonphysician health professionals. The records are owned by the hospital. See

only to the extent that the patient's physician is aware of those interests and has the knowledge, guidance, and ability to take appropriate action.

Part I of this Article describes the major factors that have heightened the importance of medical confidentiality issues in modern society. Part II considers existing ethical and legal approaches to confidentiality questions and argues that these approaches do not adequately guide physicians. Part III explores some of the dilemmas that physicians may face in deciding how to respond to requests for disclosure of patient information, and suggests that, in at least some instances, there are no options consistent with all relevant principles. The Article concludes that ethical and judicial guidance will continue to be inadequate, and that the only practical way to develop suitable guidance is through legislation.

I. GROWING INTEREST IN MEDICAL RECORDS

Although the protection of personal privacy has evolved as a public policy issue largely in the last hundred years,² privacy of medical information has always been recognized as essential to the practice of medicine. The Privacy

IIA HEALTH LAW CENTER, HOSPITAL LAW MANUAL ¶ 3-1 (Attorney's Volume 1973). This may also be true in a group or corporate practice or in other institutional practice settings.

This Article will not consider the confidentiality problems that can arise in these other settings. While the discussion may be slightly oversimplified, the basic conclusions are not significantly distorted. The purpose of medical confidentiality is the protection of the patient and physician-patient relationship. See *infra* text accompanying note 4. Regardless of the institutional setting, however, the need for confidentiality in the physician-patient relationship continues to exist, and the patient's interest in protecting the confidentiality of information is identical. By concentrating on confidentiality issues in the simplest setting, the nature of the problems can be more clearly described.

Considerable additional complexities may arise in an institutional setting. The presence of an institutional care provider means that there is another party, besides the patient and the physician, with a set of potentially different interests. In a particular circumstance, a hospital might be willing to disclose information even though the physician and the patient do not approve. For example, a disclosure might be necessary to fulfill a contractual obligation of the hospital unrelated to the treatment of the patient. In another instance, a hospital might be willing to disclose patient information to assist research that neither the patient nor physician supports. A situation may be complicated by the possibility that the institutional care providers' ethical obligations and the ethical obligations of medical care providers other than physicians may be different than the obligations of physicians. For example, only physicians subscribe to the Hippocratic Oath. See *infra* text accompanying notes 51 & 52.

The additional problems that can arise when a third party is involved in record keeping have not been fully explored. Some who have considered the need for legislation, however, have suggested that it may be appropriate to apply different standards to institutions than to private practitioners. See H.R. REP. NO. 832 pt. I, 96th Cong., 2d Sess. 30-31 (1980) [hereinafter cited as HOUSE REPORT]; PRIVACY PROTECTION STUDY COMMISSION, PERSONAL PRIVACY IN AN INFORMATION SOCIETY 292-93 (1977) [hereinafter cited as PRIVACY COMMISSION REPORT].

2. The usual starting point for a discussion of personal privacy is Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890). Prosser mentioned the Warren and Brandeis article in his discussion of the right of privacy, noting that "[t]he recognition and development of the so-called 'right of privacy,' is perhaps the outstanding illustration of the influence of legal periodicals upon the courts." W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 117, at 802 (4th ed. 1971).

Interest in privacy has grown dramatically in recent years, along with the ability of society to store, disseminate, and use personal data. This interest is evidenced by a sizeable number of reports and laws on the subject. Recent reports include: PRIVACY COMMISSION REPORT, *supra* note 1; COMMISSION ON FEDERAL PAPERWORK, CONFIDENTIALITY AND PRIVACY (1977); UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, SECRETARY'S ADVISORY COMMITTEE ON AUTOMATED PERSONAL DATA SYSTEMS, RECORDS, COMPUTERS, AND THE RIGHTS OF

Protection Study Commission noted that physicians have recognized the duty to keep information confidential "since time immemorial."³ In testimony before a congressional committee, a representative of the American Medical Association set out the basic case for medical confidentiality:

First, much of the information related by patients to their physicians is highly personal. Patients have every right to expect that the intimate, personal information communicated to physicians will remain private. Second, the assurance of confidentiality encourages patients to be candid with their physicians, and candor is essential to effective diagnosis and medical management of the patient's ailments.⁴

The protection of confidential medical information is a more important concern now than it has been in the past.⁵ Of the factors that have contributed to the increased importance of confidentiality, some are internal to the medical treatment process (for example, modern medical record keeping practices);⁶ some are the result of changes in the payment system (for example, third party payment plans);⁷ and some are external to the practice of medicine (e.g., increased use of medical information outside of the treatment and payment process).⁸

A. Medical Record Keeping Practices

The amount of medical information about patients that is routinely recorded has increased tremendously in recent decades. In a 1977 report on privacy, the Privacy Protection Study Commission described the record keeping practices of physicians at the beginning of the twentieth century:

CITIZENS (1973); A. WESTIN, COMPUTERS, HEALTH RECORDS, AND CITIZEN RIGHTS (National Bureau of Standards, Monograph No. 157, 1976).

Recent federal laws include the Privacy Act of 1974, 5 U.S.C. § 552a (1976); Right to Financial Privacy Act of 1978, 12 U.S.C. § 3401 (Supp. V 1981); Family Educational Rights and Privacy Act of 1974, 20 U.S.C. § 1681 (1974); Privacy Protection Act of 1980, 42 U.S.C. §§ 2000aa (Supp. V 1981). For state privacy laws, see R. SMITH, COMPILATION OF STATE AND FEDERAL PRIVACY LAWS (1981). For a compilation of state laws on health records confidentiality, see NATIONAL COMMISSION ON CONFIDENTIALITY OF HEALTH RECORDS, HEALTH RECORDS CONFIDENTIALITY LAW IN THE STATES (1979).

3. PRIVACY COMMISSION REPORT, *supra* note 1, at 283.

4. *Privacy of Medical Records: Hearings on H.R. 2979 and H.R. 3444 Before the Government Information and Individual Rights Subcomm. of the House Comm. on Government Operations*, 96th Cong., 1st Sess. 1129 (1979) (statement of James H. Sammons, M.D., Executive Vice President, American Medical Association) [hereinafter cited as *House Medical Privacy Hearings*].

5. A national opinion research survey of attitudes toward privacy conducted in December, 1978, found that 64% of Americans were somewhat or very concerned about threats to personal privacy. This was an increase of 17 percentage points in eleven months. See LOUIS HARRIS & ASSOCIATES, INC. & A. WESTIN, THE DIMENSIONS OF PRIVACY, *reprinted in Public Reaction to Privacy Issues: Hearing Before the Government Information and Individual Rights Subcomm. of the House Comm. on Government Operations*, 96th Cong., 1st Sess. 6-109 (1979).

The specific findings on questions relating to medical confidentiality, however, were less definitive. When asked if hospitals and doctors should be doing more to keep personal information confidential, 23% of the public surveyed said that hospitals should be doing more and 17% said that doctors should be doing more. *Id.* at 62. Sixty-five percent, however, thought that it was important that Congress pass privacy legislation in the area of medicine and health. *Id.* at 102.

6. See *infra* text accompanying notes 9-14.

7. See *infra* text accompanying notes 15-26.

8. See *infra* text accompanying notes 27-41.

Earlier in this century, when most medical professionals were family physicians in solo practice, the typical medical record was simply a small ledger card with entries showing the dates of the patient's visits, the medications prescribed, and the charges. The physician was usually able to file the intimate details of a patient's medical or emotional condition in the "safe crevices of his mind."⁹

During this same period, hospital records also contained limited patient information. A 1918 survey of record keeping practices of hospitals found that less than two percent met a minimum requirement that accurate and complete case records be written for all patients and filed in an accessible manner.¹⁰

In contrast to the medical record of the past, the modern hospital record is a warehouse of information. The American Medical Records Association describes the contents of a typical hospital medical record today:

A typical hospital medical record includes the patient's name, address, age, next of kin, names of parents, date and place of birth, marital status, religion, military service, social security or medicare number, source of reimbursement coverage (insurance or governmental), and the identification number assigned by the hospital.

The medical history includes the chief complaint, details of present illness, past medical, social and family histories, previous treatment, an inventory of history related to each body system, medications taken in the past and at present, use of alcohol and tobacco, prenatal history if an obstetrical patient, and the provisional diagnosis.

The physical examination record contains positive and negative findings of a comprehensive current physical assessment and a preliminary diagnosis.

The record contains, by date and identification of the recorder, all findings of diagnostic tests administered, consultations sought and rendered, all orders for medications and treatments, all treatments provided, drugs administered, findings, observations, progress, reactions or incidents. Finally, there is a comprehensive summary written at the time of discharge.¹¹

It is apparent from this description that a hospital record may contain considerable amounts of nonmedical data, including information about a patient's relatives, financial status, education, employment history, life style, and any other aspect of a patient's life that is deemed to be relevant to treatment or research. The Executive Director of the American Medical Records Association told the Privacy Protection Study Commission that "a complete medical record [today] may contain more intimate details about an individual than could be found in any single document."¹²

The growth of psychiatry as a medical specialty has further contributed to

9. PRIVACY COMMISSION REPORT, *supra* note 1, at 282.

10. E.K. HUFFMAN, *MEDICAL RECORD MANAGEMENT* 22 (7th ed. 1981).

11. *House Medical Privacy Hearings*, *supra* note 4, at 282.

12. PRIVACY COMMISSION REPORT, *supra* note 1, at 282.

the increase in the type and volume of information in medical records. Psychiatric treatment requires a patient to disclose his most intimate and private thoughts to the physician, including "information concerning the patient's relationships to everything and everybody in the outside world."¹³ As a result, psychiatric records contain even more comprehensive personal information than records of other types of medical treatment. Also, the sensitivity of the information in psychiatric records may be greater. In many cases, that an individual is consulting a psychiatrist is considered to be the most sensitive information of all.¹⁴

B. Payment System Changes

The health care payment system has undergone extensive changes in the past fifty years, and one result is an increase in the amount of medical information that is recorded and transferred. The chief cause of this increase has been the growth of third party payment plans.¹⁵ When bills were presented by the physician to the patient and paid by the patient, little medical information was necessary to support the bill. Unlike the patient paying his own bill, however, the third party payor has no independent knowledge of the nature of the services provided. Thus, when a third party is paying the bill, information must be provided by the physician to the third party in order to describe and support the charges.

Along with this shift in funding sources came an increase in the amount of health care purchased.¹⁶ As more health care services are provided to consumers, more information is recorded in connection with the provision of those services. Much of this information is disclosed to third party payors. In

13. *Legislation To Protect The Privacy Of Medical Records: Hearings before the Senate Comm. on Governmental Affairs*, 96th Cong., 1st Sess. 309-10 (1979) (statement of Marcia Kraft Goin, M.D., Chairperson, Committee on Confidentiality, American Psychiatric Association) [hereinafter cited as *Senate Medical Privacy Hearings*].

14. The New York Times recently reported that thousands of people with mental health insurance coverage may be paying for psychotherapy out of their own pockets rather than applying for insurance provided by their employers. "Dr. Steven S. Sharfstein, associate director for behavioral medicine at the National Institute of Mental Health, guesses that some 15 percent of all adults who have such insurance and are currently in therapy—or about 150,000 people—waive reimbursement in favor of confidentiality. He made no estimate of the number of insured employees who cannot afford to pay for psychiatric care and who forgo treatment rather than let their employers know they are using their mental health benefits." *Thousands with Mental Health Insurance Choose to Pay Own Bill*, N.Y. Times, Aug. 4, 1981, at C1, col. 1. See also *House Medical Privacy Hearings*, *supra* note 4, at 357-59 (statement of Jerome S. Beigler, M.D., chairperson, Committee on Confidentiality, American Psychiatric Association).

15. Accelerated growth of third party payments for health care began at the end of World War II. Before the war, such payments, except by philanthropic organizations, were not significant. Gibson & Waldo, *National Health Expenditures, 1980*, 3 HEALTH CARE FIN. REV., Sept. 1981, at 1, 11. In 1950, private insurance paid 9% of total national expenditures for personal health care. Gibson & Waldo, *National Health Expenditures, 1981*, 4 HEALTH CARE FIN. REV., Sept. 1982, at 1, 23. By 1981, the share of health expenditures covered by private insurance had grown to 26.2%. *Id.* at 11.

16. National health expenditures in 1950 were \$12.7 billion, or 4.4% of the gross national product. Gibson & Waldo, *National Health Expenditures, 1981*, 4 HEALTH CARE FIN. REV., Sept. 1982, at 1, 20. By 1981 total expenditures amounted to \$286 billion, or 9.8% of the gross national product. *Id.* at 19. Per capita spending on personal health care increased from \$70 to \$1090 between 1950 and 1981. *Id.* at 23.

fact, the most frequent disclosure of medical record information is to third party payors.¹⁷

Third party payors require an extensive amount of information to support payment of a claim. According to the Blue Cross and Blue Shield Association, the information disclosed, "must be sufficient to establish that services billed were included under the benefit agreements, necessary and warranted, and actually delivered. Information needed includes identity of the patient, the physician, and the facility, diagnosis, treatment description, length of stay, and billed charges."¹⁸ In addition, when Blue Cross serves as an intermediary for government programs, other items of personal information may be necessary to satisfy the program requirements.¹⁹

A representative of the American Medical Records Association testified before a congressional committee that the amount of information demanded by third party payors is increasing:

The demands of third party payors were, in the past, reasonably limited. Increasingly during the past several years, demands for more extensive documentation in connection with claims processing have expanded to include copies of discharge summaries or, more and more frequently especially for medicare or medicaid reimbursement, *photocopies of the entire record.*²⁰

Thus, the third party payment system requires physicians to disclose significant amounts of recorded medical information.

Increased government spending for health care has further increased the required number of disclosures. With the implementation of Medicare and Medicaid in 1966, the share of the nation's health bill paid by government increased significantly.²¹ A major consequence of increased government spending for health care is the growth of government programs to control the cost and improve the delivery and quality of health care. These programs, which include routine audits,²² medical peer review,²³ and fraud, abuse, and

17. *House Medical Privacy Hearings*, *supra* note 4, at 350 (statement of Jane Rogers, Director of Legislative Affairs and Communications, American Medical Records Association).

18. *Id.* at 565 (statement of Marshall R. Crawford, Senior Director, Legislative Director, Blue Cross and Blue Shield Association).

19. *Id.* at 566.

20. *Id.* at 350 (statement of Jane Rogers, Director of Legislative Affairs and Communications, American Medical Record Association) (emphasis in original).

21. Gibson & Waldo, *National Health Expenditures*, 1981, 4 HEALTH CARE FIN. REV., Sept. 1982, at 1, 22.

22. *See, e.g.*, 42 U.S.C. § 13951(e) (1976) (prohibiting payments to Medicare providers unless information necessary to determine amounts due has been provided); 42 U.S.C. § 1396a(a)(42) (Supp. V 1981) (a state Medicaid plan must provide that the records of a participating entity providing services on a cost-reimbursable basis will be audited by the Secretary of Health and Human Services).

23. *See* 42 U.S.C. § 1320c (1976) (establishing Professional Standards Review Organizations); Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, §§ 141-50, 96 Stat. 381-95 (1982) (codified at 42 U.S.C. § 1320, 1395, 1396) (replacing Professional Standards Review Organizations with "utilization and quality control peer review organizations").

The concern of the medical establishment for the protection of patient records pales in comparison to the concern over the protection of peer review activities. The American Medical Association model state law would permit numerous nonconsensual disclosures of patient information,

waste investigations,²⁴ frequently require access to identifiable patient information to carry out their functions.²⁵ Thus, in addition to disclosures necessary to justify payment of claims, government involvement in health care may require additional levels of disclosure to support oversight and control mechanisms.²⁶ One consequence is that both physicians and patients have become used to the routine disclosure of medical information that was previously disclosed, if at all, only on rare occasions.

C. *Medical Information as a Valuable Resource*

The medical record is viewed as a rich repository of information by third parties. While the early physician's sketchy ledger card was of little general interest, a modern medical record can be used in many different ways outside the treatment process. The growing awareness of medical records as a source of information is one reason why disclosure of the record is increasingly demanded.

The value of medical information for uses outside the medical treatment and payment system has not been popularly recognized, and even medical professionals are largely unaware of the many uses to which the information may be put. Medical information increasingly is used to make nonmedical decisions about individuals as well as for purposes unrelated to the individuals who are the subject of the records.²⁷

The large number of medical data users illustrates the general value of medical information. The American Medical Records Association has identified twelve broad categories of "social users" and twenty-four ways medical information is used outside the medical treatment and payment process. Most of these uses require access to data that identifies the patient. These users and uses are as follows:

1. Public Health Agencies

1. in surveillance of diseases of epidemiologic significance through statistical analysis of information abstracted from medical records

but the proceedings and minutes of medical peer review committees would be protected absolutely from discovery or from introduction into evidence. See CONFIDENTIALITY OF HEALTH CARE INFORMATION ACT § 7(c), reprinted in *House Medical Privacy Hearings*, *supra* note 4, at 1141.

24. See, e.g., 42 U.S.C. § 3525 (1976) (granting the Inspector General of the Department of Health and Human Services subpoena power to be used to prevent fraud and abuse in Department programs). See also text accompanying notes 145-46.

25. See *infra* text accompanying notes 143-65.

26. See generally HOUSE REPORT, *supra* note 1, at 54-58.

27. An increase in the use of medical information for nonmedical purposes has also magnified the consequences of disclosure. In a 1976 work on health records and confidentiality, Professor Alan Westin described some of the ways that medical information is used to make important, nonmedical decisions: "[T]he outward flow of medical data . . . has enormous impact on people's lives. It affects decisions on whether they are hired or fired; whether they can secure business licenses and life insurance; whether they are permitted to drive cars; whether they are placed under police surveillance or labelled a security risk; or even whether they get nominated for and elected to political office." A. WESTIN, *supra* note 2, at 60.

2. Medical and Social Researchers, institutional and extrainstitutional
 1. for investigations of disease patterns, effects of disease on functions of daily living, including occupational health and safety
3. Rehabilitation and Social Welfare Programs
 1. in determination of need for specific types of rehabilitation programs through analysis of incidence data
 2. in development of individual rehabilitation and training plans for participants in programs for the handicapped, retarded and drug and alcohol abusers
4. Employers
 1. for administration of employer-provided health insurance plans
 2. for determination of employment suitability
 3. in treatment of job related injuries and correction of occupational hazards
 4. to determine disability
5. Insurance Companies
 1. in determination of risks in writing insurance
 2. in determination of liability for claims
6. Government Agencies: federal, state and local
 1. for allocation of government resources for schools, health care facilities, education institutions, etc. based on vital statistics submitted from medical records
7. Education Institutions
 1. for assessment of suitability for admission to selected education programs
 2. for maintenance of student and employee health programs
8. Judicial Process
 1. in adjudication of civil and criminal matters through use of the medical record as evidence through the legal process
 2. in judicial process for involuntary admission of mentally ill
9. Law Enforcement and Investigation
 1. in criminal investigation
 2. for security clearance programs
10. Credit Investigation Agencies
 1. for determination of credit eligibility
11. Accrediting, Licensing and Certifying Agencies
 1. for demonstration of individual fulfillment of criteria for professional licensing by a state government agency
 2. to ascertain competence of practitioners
 3. for determination of compliance with criteria for hospital based education programs
 4. as documentation of compliance with standards for institutional accreditation
12. Media: Press, Radio, TV

1. for announcements of developments in medical research
2. for reporting of health hazards, diseases affecting the public health and newsworthy events.²⁸

This list requires some explanation and comment. First, the list only includes those identified by the American Medical Records Association as "social users." Health care providers and payors for services appear on a separate list containing nine uses for providers and four for payors.²⁹

Second, the list is not complete either with respect to social users or their uses. For example, the need for access to patient-identifiable medical records is claimed by the Secret Service and by agencies involved in foreign intelligence activities.³⁰ The list of uses is also not complete for the identified users. One example of an omitted use by the media is for reporting health information on newsworthy individuals.³¹ Notwithstanding the omissions, the list is reasonably representative of disclosures that are routinely or occasionally made and compares favorably in this respect with compilations made by the Privacy Protection Study Commission and congressional committees that considered privacy legislation.³²

Third, the American Medical Records Association notes that not all of the uses are necessarily proper.³³ In some instances a particular disclosure of information for a particular purpose may violate prevailing law or medical ethics. A disclosure of health information to an employer without the consent

28. AMERICAN MEDICAL RECORD ASSOCIATION, CONFIDENTIALITY OF PATIENT HEALTH INFORMATION: A POSITION STATEMENT OF THE AMERICAN MEDICAL RECORD ASSOCIATION 5-6 (1977), reprinted in *House Medical Privacy Hearings*, *supra* note 4, at 326-27.

29. *Id.* at 4, reprinted in *House Medical Privacy Hearings*, *supra* note 4, at 325.

30. In considering medical privacy legislation during the 96th Congress, committees of the House and Senate included provisions permitting disclosure of medical information to the Secret Service and to agencies engaged in foreign intelligence and counterintelligence activities. For the Senate version, see S. 503, 96th Cong., 1st Sess. (1979); S. REP. NO. 96-935, 96th Cong., 2d Sess. 22-23 (1980) [hereinafter cited as SENATE REPORT]. For the House version, see H.R. 5935, 96th Cong., 1st Sess. (1979); HOUSE REPORT, *supra* note 1, at 63-65; H.R. REP. NO. 832 pt. 2, 96th Cong., 2d Sess. 36-37 (1980).

The Senate never took up S. 503. The House, however, in a post-election session, did consider and reject H.R. 5935. The opposition of the Chairman of the House Select Committee on Intelligence, who stated his view that the bill would encourage refusals to provide mental health information to government agencies "when there is a clear national interest in requesting it," was a factor in the defeat. See 126 CONG. REC. H11,370 (daily ed. Dec. 1, 1980) (statement of Rep. Boland).

The Watergate scandal brought the acquisition of medical records for "national security" investigations to the public's attention. During an investigation of Daniel Ellsberg, after the publication of the Pentagon Papers in 1971, the FBI approached Ellsberg's psychiatrist, but the psychiatrist refused to acknowledge that Ellsberg was a patient. Under the direction of Howard Hunt and Gordon Liddy, with the assistance of the Central Intelligence Agency, the psychiatrist's office was later broken into in 1973. The federal district court judge cited the burglary of the psychiatrist's office to explain dismissing criminal charges against Ellsberg relating to the Pentagon Papers. For a complete account of these events, see P. SCHRAG, TEST OF LOYALTY 109-15, 352-56 (1974).

31. See, e.g., *Medical Reports Supplied by This Year's Presidential Candidates*, 17 MEDICAL WORLD NEWS 57 (1976).

32. See *supra* note 30.

33. AMERICAN MEDICAL RECORDS ASSOCIATION, CONFIDENTIALITY OF PATIENT HEALTH INFORMATION: A POSITION STATEMENT OF THE AMERICAN MEDICAL RECORD ASSOCIATION 6 (1977), reprinted in *House Medical Privacy Hearings*, *supra* note 4, at 327.

of the patient is an example of a disclosure that is improper under most circumstances. The basic list does not distinguish between consensual and non-consensual disclosures.

Fourth, not all medical records are needed for each use, and some of the uses account for many more disclosures than others. For example, disclosures to credit agencies for determination of credit eligibility may be rare, but disclosures pursuant to judicial process, for use in civil and criminal trials, are more routine.

The length of this list of social users of medical information is more striking than any particular entry. The list demonstrates that supposedly confidential medical information has a large number of users outside of the treatment and payment process. Medical information is a valuable resource to many elements of society, and many users could not operate in the same fashion without the data.

No attempt is made here to evaluate the legitimacy of the needs of the social users. Many users can make strong arguments in favor of the social utility of their activities. This is why Professor Alan Westin concluded that these secondary uses of medical information raise "the sharpest clash between society's interest in protecting medical confidentiality and its interest in a wide variety of other functions."³⁴

Another, perhaps more perverse, measure of the value of medical information comes from evidence that there is considerable surreptitious trafficking in medical information. While no broad study of the illicit acquisition of medical information has ever been conducted in this country, a grand jury investigation in Denver, Colorado, and an exhaustive investigation conducted in Ontario, Canada, support the conclusion that medical information is regularly obtained for some purposes by improper means. The evidence was sufficient to permit a congressional committee that considered medical privacy legislation to conclude that surreptitious trafficking in medical records is "common" and "nationwide."³⁵

In Denver, a grand jury found that for over twenty-five years a private investigative reporting company engaged in a nationwide business of obtaining medical information without the patient's consent.³⁶ In June 1976 the

34. A. WESTIN, *supra* note 2, at 85.

35. HOUSE REPORT, *supra* note 1, at 25.

36. Dale Tooley, the District Attorney who led the investigation, told a Senate committee how the company operated:

There was an instruction book the company had whereby it trained its investigators to pose as doctors on the telephone. File cards were maintained on hospitals in virtually every State in the country, on military hospitals and doctors' offices. I can recall one note in a card file on a Chicago hospital which said: Call after midnight, talk with a black accent and you can get whatever records you need. It was that precise in detail.

Sometimes sources were paid: Interns, nurses who worked in these hospitals. Occasionally mail was used under false pretenses. But the telephone was the main method. As this testimony points out, the firm was 99 percent successful in being able to pierce the medical records protection system of these health care providers.

We located literally hundreds of copies of broad based solicitations sent out to insurance companies which said, "We can secure medical records without authorization

Denver grand jury issued a special report to the Privacy Protection Study Commission that said in part: "From the evidence, it is clear that the problem with respect to the privacy of medical records in this jurisdiction exists in many cities and jurisdictions across the nation."³⁷

Corroborating evidence for this conclusion can be found in the three volume report of the Royal Commission of Inquiry into the Confidentiality of Health Information in Ontario, Canada.³⁸ After an investigation that included testimony from over 500 witnesses, the Royal Commission found that the same conduct uncovered by the Denver grand jury was routine in Ontario during 1976 and 1977. As with the Denver firm, those seeking the information were mainly insurance companies and lawyers.³⁹ The Royal Commission was even able to elicit a general admission from the Insurance Bureau of Canada that its members had gathered medical information through sources without the authorization of the patients.⁴⁰

Mr. Justice Horace Krever, the Commissioner of the Royal Commission, testified before a House subcommittee that he suspected that the practices uncovered during the inquiry occurred not only in Ontario, but throughout all of North America. Some of the insurance companies and investigative agencies exposed during the investigation were subsidiaries of American companies.⁴¹

Despite uncertainty about the exact scope of medical information trafficking in America, the existence of a company, and perhaps even an industry, that obtains such information surreptitiously suggests that there is a significant demand for the data that goes well beyond the needs of identified "social users."

Physicians and patients have always recognized the patient's interest in preventing information from being disclosed to friends or neighbors. There now exists a large class of additional persons who may have a desire to obtain that same information. Thus, not only is there more personal information maintained in medical records, but there are more persons from whom the information may need to be protected. The value of medical information for

from the patient." Yet, to our knowledge, not a single insurance company or lawyer reported any of those solicitations to any law enforcement agency, nor to any regulatory agency.

Senate Medical Privacy Hearings, supra note 13, at 197 (statement of Dale Tooley, District Atty., Denver, Colo.). See also *HOUSE REPORT, supra* note 1, at 25; *PRIVACY COMMISSION REPORT, supra* note 1, at 174, 285-86, 336-37.

37. *PRIVACY COMMISSION REPORT, supra* note 1, at 285.

38. H. KREVER, *REPORT OF THE ROYAL COMMISSION OF INQUIRY INTO THE CONFIDENTIALITY OF HEALTH INFORMATION* (Toronto, Ontario, Canada) (1980).

39. *Id.* at 514-31. See also *House Medical Privacy Hearings, supra* note 4, at 510-11, 537-40 (statement of Mr. Justice Horace Krever, Commissioner, Royal Commission of Inquiry into the Confidentiality of Health Records, Toronto, Ontario).

40. H. KREVER, *supra* note 38, *passim*; *House Medical Privacy Hearings, supra* note 4, at 509-10 (statement of Harvey Strosberg, counsel, Royal Commission on Inquiry into the Confidentiality of Health Records, Toronto, Ontario). See *Senate Medical Privacy Hearings, supra* note 13, at 132 (statement of Dale Tooley, District Atty., Denver, Colo.).

41. *House Medical Privacy Hearings, supra* note 4, at 508 (statement of Mr. Justice Horace Krever, Commissioner, Royal Commission of Inquiry into the Confidentiality of Health Records, Toronto, Ontario).

so many different uses, both licit and illicit, is a major reason why confidentiality is, and should be, an issue of greater concern today than ever before.

II. ETHICAL AND LEGISLATIVE GUIDANCE

For guidance in resolving questions about the propriety of disclosing patient information, physicians can look to the ethical principles that guide the medical profession or to state or federal law. Three basic criteria can be applied in evaluating the adequacy of these principles or laws. The first measures the policy judgments reflected therein. Is the resolution of conflicts between confidentiality and other important social goals fair? Will the possibility of disclosure of patient information unduly disrupt the physician-patient relationship? Will the inability of third parties to obtain patient information interfere with important social functions such as medical research, law enforcement, or fiscal control? While these questions are ultimately crucial and far more complex, the gaps in current confidentiality guidance make them secondary at this time.

A second criterion is clarity: will the rules be understood by the physicians who will have to apply them? It would not be difficult to develop a complex set of confidentiality rules and procedures that would, as a result of their complexity, probably be ignored, misunderstood, or misapplied by physicians. Although confidentiality issues have developed strong legal overtones, it is crucial to recognize that basic decisions about disclosure are made by physicians. Thus, rules should be understandable without undue need to rely on lawyers or the courts for interpretation.⁴² Legal principles that can only be divined through the distillation of judicial decisions are of little value. As with the first criterion, the clarity of confidentiality guidance is secondary at this time.

A third criterion for evaluating confidentiality principles is comprehensiveness: can a physician find an answer to any disclosure question with which he is faced? Comprehensive confidentiality rules are not difficult to devise. For example, a rule that prohibits all disclosures is comprehensive. Of course, the results achieved by such a rule may be undesirable or inconsistent with law. A more realistic example of comprehensive rules might provide that some disclosures are mandatory, that others are discretionary under specified standards or procedures, and that some disclosures are prohibited. All that is required to make the rules comprehensive is that all possible disclosures fall into one category or the other.

The review of relevant law and ethics that follows demonstrates that the available confidentiality guidance generally fails to satisfy the comprehensiveness test. With only a few exceptions,⁴³ existing guidance does not meaningfully address all disclosure questions that can arise in the modern practice of

42. See *infra* note 111 and accompanying text.

43. See *infra* notes 99-109 and accompanying text.

medicine. As a result, physicians generally are left to resolve complex confidentiality problems on their own.

A. *Ethical Guidance*

Since the fourth century B.C., the Hippocratic Oath has called on physicians to maintain the confidentiality of patient communications.⁴⁴ The clause of the Oath concerning confidentiality provides: "And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secret."⁴⁵ The Hippocratic Oath does not forbid all disclosures of medical information, but requires only that physicians keep in confidence that "which should not be published abroad." Thus, even at its origins, medical confidentiality was not an absolute principle. The Oath does not define under what circumstances physicians may reveal information. Whether it was generally understood in ancient Greece what should or should not be "published abroad," or whether it was intended that each physician should make the determination on his own is not apparent from the Oath. In any event, the Hippocratic Oath, although still in use today, provides no clear guidance for modern physicians faced with disclosure decisions.

Later ethical codes have different formulations of the confidentiality obligation for physicians. Thomas Percival published an influential⁴⁶ code of medical ethics in 1803 that included the following: "Secrecy and delicacy, when required by peculiar circumstances, should be strictly observed. And the familiar and confidential intercourse, to which the faculty are admitted in their professional visits, should be used with discretion and with the most scrupulous regard to fidelity and honour."⁴⁷ Percival's formulation of the confidentiality obligation appears to be less strict than that of the Hippocratic Oath. Secrecy was to be strictly observed only when required by "peculiar circumstances." Other information obtained in the course of professional visits, whether or not confidential, was to be used with discretion and with regard to fidelity and honor. This seems to be a more limited view of the importance of confidentiality than the "holy secrets" approach of the Hippocratic Oath.

The first Code of Ethics of the American Medical Association, adopted in

44. Medical confidentiality originated prior to the Oath, since the Oath "merely acknowledged a principle already rooted in the ethos of ancient Greece." PRIVACY COMMISSION REPORT, *supra* note 1, at 283.

45. 1 HIPPOCRATES 164-65 (W. Jones trans. 1923), *reprinted in* ETHICS IN MEDICINE 5 (S. Reiser, A. Dyck & W. Curran eds. 1977).

46. A brief history of medical ethics by the AMA's Judicial Council described Percival's code as "the most significant contribution to ethical history subsequent to Hippocrates." AMERICAN MEDICAL ASSOCIATION, CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION vii (1981).

47. T. PERCIVAL, MEDICAL ETHICS (1803), *reprinted in* PERCIVAL'S MEDICAL ETHICS 61, 90 (1975).

1847, was based on Percival's Code.⁴⁸ The Code's provisions on confidentiality repeated the language from Percival's Code without substantive change, and continued:

The obligation of secrecy extends beyond the period of professional services; —none of the privacies of personal and domestic life, no infirmity of disposition or flaw of character observed during professional attendance, should ever be divulged by [the physician] except when he is imperatively required to do so. The force and necessity of this obligation are indeed so great, that professional men have, under certain circumstances, been protected in their observance of secrecy by courts of justice.⁴⁹

The AMA's addition to Percival's ethics seems to be a strong affirmation of the importance of confidentiality. The physician could only breach his obligation of secrecy when "imperatively required to do so." Although this appears to be at least as strong as the Hippocratic Oath, the 1847 Code still failed to provide any specific guidance to the types of disclosure that qualified as "imperative."

In 1903 the AMA replaced its Code of Ethics with "Principles of Medical Ethics."⁵⁰ The language on secrecy that appeared in the Code was retained with some small changes. For example, the 1903 Principles continued to provide that "secrecy and delicacy should be strictly observed," but no longer limited this required observance to the "peculiar circumstances" of the Code.⁵¹ The 1903 Principles also clarified when the secrecy obligation may be breached. Exceptions were to be made only when "imperatively required by the laws of the state."⁵²

These principles provided physicians, apparently for the first time, with a clear, specific, and comprehensive statement of when confidentiality must be sacrificed to a higher duty. If a proposed disclosure was not required by law, then the disclosure would be an unethical breach of patient confidentiality.

The 1903 Principles were comprehensive, but a price was paid for the comprehensiveness. A directive to rely on state law for disclosure authorizations is inflexible, and this was even more true at the turn of the century than it is today. Only some of the most modern state laws address complex disclosure questions, such as those that arise in emergency situations or at other times when it is not possible to obtain the consent of the patient.⁵³ It also follows that under the 1903 Principles disclosures for public health or medical research were prohibited unless a state law made the disclosure mandatory.

48. CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION, *supra* note 46, at vii.

49. AMERICAN MEDICAL ASSOCIATION, CODE OF ETHICS OF THE AMERICAN MEDICAL ASSOCIATION I-I-2 (1847), *reprinted in* PERCIVAL'S MEDICAL ETHICS 218, 220 (1975).

50. AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION (1903), *reprinted in* PERCIVAL'S MEDICAL ETHICS 240, 241 (1975).

51. *Id.* at I-I-2, *reprinted in* PERCIVAL'S MEDICAL ETHICS at 241.

52. *Id.* at I-I-3, *reprinted in* PERCIVAL'S MEDICAL ETHICS at 241-42.

53. *See, e.g.*, R.I. GEN. LAWS § 5-37.3-4(b) (Supp. 1982).

Whether the AMA actually intended that disclosures to public health authorities be limited to those affirmatively required by law is problematical.

The certainty of the 1903 Principles may have been helpful, at least in theory, to the physician confronting a disclosure question. Because the use of medical information outside the treatment process was more uncommon at the turn of the century, the guidance might have been more adequate in its day than it now appears. Changes made in 1912, however, suggest that the inflexibility of the guidance was recognized shortly after the 1903 revisions.

The 1912 AMA Principles retained the "imperatively required by the laws of the state" exception. Included, however, were the following:

There are occasions, however, when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected because the physician has knowledge, obtained through the confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case, the physician should act as he would desire another to act toward one of his own family under the circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.⁵⁴

The introduction of a communicable disease disclosure exception was accompanied by a new concept of a general duty to society that is of a higher order than the duty to protect a patient's privacy. While this approach is more flexible than the state law exception, it is also more vague and more subjective; the exception is specifically cast in terms of how the physician would desire another to act toward his own family. While this rule may be more realistic, it loses the certainty and comprehensiveness of its predecessor. The new exception also fails to address disclosure issues, such as those surrounding emergency situations or medical research.

The next revision of the AMA Principles came in 1957.⁵⁵ In this version, ethical principles were reduced to ten fundamental concepts. This version was only one-seventh as long as the 1912 version. The ninth principle addresses the confidentiality obligation:

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 of the community.⁵⁶

The legal requirement exception that originated in 1903 was retained, and the concept of a general duty to society was expanded. Disclosures may be made when necessary to protect the welfare of the individual or of the commu-

54. AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION I-2 (1912), *reprinted in* PERCIVAL'S MEDICAL ETHICS 259, 259-60 (1975).

55. AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION I-2 (1957), *reprinted in* PERCIVAL'S MEDICAL ETHICS 278, 279 (1975).

56. *Id.*

nity. While this appears to be a more objective standard than the 1912 version, the words "necessary," "protect," "welfare," or "community" are not defined. As a result, the 1957 Principles—issued at a time when interest in the use of medical information for other purposes was already on the rise—still left much to be defined by the individual physician.

The Principles were again revised in 1980⁵⁷ and were reduced to eight fundamental concepts. Confidentiality is covered in the fourth principle: "A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law."⁵⁸

The need to obey laws requiring disclosure continued to be recognized, but the references in the previous version to community welfare were dropped. What remained was a simple affirmation of the obligation to preserve patient confidentiality without any specific guidance on how to respond to requests for information from researchers, police, federal agencies, or other potential users of information. What constitutes a "patient confidence" that is subject to safeguarding is not clear.

All of these codes or statements of principles, from the Hippocratic Oath to the current AMA version, state that protection of confidentiality is an important obligation of physicians. None of the codes, however, indicates the complexity of this obligation. In fact, the current AMA statement—which was drafted when concern about medical confidentiality was high—is quite general and contains little to guide physicians.

The vagueness of these ethical codes can be illustrated more clearly by considering how they apply in the case of a particular disclosure. A good example is disclosure for use in medical research. Medical research is an important aspect of modern medicine and is well supported by the medical establishment and the federal government.⁵⁹ Identifiable medical records are essential in the conduct of many types of medical research.⁶⁰

It is not surprising that ethical codes predating modern medical research techniques did not consider the possibility of disclosure for research purposes. The two most recent AMA statements not only fail to address disclosure to medical researchers, but also seem to preclude such disclosures. The 1957 statement permitted disclosures required by law or necessary to protect the welfare of the individual or the community. Disclosures for research would be consistent with this statement only if the research were determined to be necessary to protect the community. The necessity of each individual research pro-

57. AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION (1980), reprinted in CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION, *supra* note 46, at ix.

58. *Id.*

59. Federal government outlays for health research for fiscal year 1983 were estimated to be \$3.9 billion. This is approximately two-thirds of total health research funding. See U.S. OFFICE OF MANAGEMENT AND BUDGET, THE UNITED STATES BUDGET IN BRIEF 58 (1982).

60. See Gordis & Gold, *Privacy, Confidentiality, and the Use of Medical Records in Research*, 207 SCIENCE 153 (1980). See also HOUSE REPORT, *supra* note 1, at 47-54.

ject would be difficult to demonstrate. The latest AMA restatement seems more clearly to deny the use of medical information for medical research. It requires the safeguarding of patient confidences within the constraints of the law. Since disclosures for research are not legally required, it is difficult to find justification for such disclosures in the current AMA Principles.

The point here is not that the use of patient information in medical research is forbidden by medical ethics. The AMA supports use of patient records in medical research.⁶¹ The point is that the basic statements of ethical principles are inadequate because they do not appear to permit disclosures of identifiable medical information for uses that are generally accepted by the medical establishment and perhaps even by the general public. The courts, nevertheless, have turned to these codes on occasion for guidance on disclosure questions, and several courts have quoted the Hippocratic Oath in support of their decisions.⁶² There do not appear to be alternative sources of comprehensive guidance from the medical establishment.⁶³

With all of the attention focused on privacy in recent years,⁶⁴ it is astounding that the medical establishment has not made a greater effort to clarify its ethical rules or to offer meaningful guidance to physicians on modern confidentiality problems. It seems certain that current ethical codes are widely ignored by physicians.

B. Legal Guidance

Several aspects of physician-patient confidentiality have been addressed by state legislatures or by Congress. The physician-patient testimonial privilege provides some protection from disclosure during litigation for confidential communications. State reporting laws define when the disclosure of patient information is required as a matter of law. A federal law protects the confidentiality of medical records used in drug and alcohol treatment programs. There are also state laws that regulate the privacy of medical records.

A review of these laws demonstrates that a physician's legislatively defined responsibilities are generally clearer than his or her ethical obligations.

61. Section 4(b)(4) of the AMA model state health care confidentiality law permits disclosure of patient information for use in health research. CONFIDENTIALITY OF HEALTH CARE INFORMATION ACT § 4(b)(4), reprinted in *House Medical Privacy Hearings*, *supra* note 4, at 1143.

62. See, e.g., *Hammonds v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793, 801 (N.D. Ohio 1965) ("Almost every member of the public is aware of the promise of discretion contained in the Hippocratic Oath, and every patient has a right to rely upon this warranty of silence."); *Horne v. Patton*, 291 Ala. 701, 708, 287 So. 2d 824, 829 (1973) ("When the wording of Alabama's state licensing statute is considered alongside the accepted precepts of the medical profession itself, it would seem to establish clearly that public policy in Alabama requires that information obtained by a physician in the course of a doctor-patient relationship be maintained in confidence, unless public interest or the private interest of the patient demands otherwise.").

63. The Judicial Council of the American Medical Association has issued opinions on confidentiality. Current opinions deal with press relations (5.03), public disclosures (5.04), attorney-physician disclosures (5.05), computers and confidentiality (5.06), disclosures to insurance company representatives (5.07), and employment related disclosures (5.08). See CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION, *supra* note 46.

64. See *supra* note 2.

Existing laws are far from comprehensive, however, and only occasionally provide meaningful guidance.

1. Physician-Patient Privilege

Existing law in most states recognizes a physician-patient testimonial privilege.⁶⁵ When it applies, this privilege generally provides that the physician cannot testify about confidential communications with his patient, made in the course of treatment, unless the patient waives the privilege. The physician-patient privilege is similar to privileges recognized for confidential communications between attorney and client and between husband and wife. Unlike these privileges, however, the physician-patient privilege was not recognized at common law. It was first created by a New York State statute in 1828.⁶⁶

Because the privilege belongs to the patient and cannot be asserted by the physician,⁶⁷ the physician is not forced to decide when he may testify or what he may testify about. As a result, the privilege is a useful device for resolving some confidentiality problems that may be faced by physicians. Nevertheless, a physician may be required to testify notwithstanding the desire of the patient for confidentiality or the desire of the physician to preserve that confidentiality. The reasons why the privilege is of such limited utility derive from the nature and scope of the privilege.

First, the privilege is a testimonial privilege. It only applies when the physician is testifying in court or in related proceedings. This represents only a small fraction of the disclosure demands that may confront a physician. For most disclosure decisions, the privilege is irrelevant: "The most important thing to remember about the testimonial privilege is that it has virtually nothing to do with normal, everyday use and disclosure of records maintained by a medical-care provider. The discretion to disclose or not to disclose, in most circumstances, resides solely with the provider."⁶⁸

Second, the privilege is much narrower than it seems. Statutory exemptions and judicial restrictions have so limited the privilege in many states that the protections are only rarely available. In California, for example, the privilege does not apply in cases in which the patient puts his condition in issue, criminal proceedings, will contests, malpractice cases, disciplinary proceedings, or several other types of cases.⁶⁹ The California statute is not exceptional. In recommending against including a physician-patient privilege in the Federal Rules of Evidence, the Judicial Conference Committee found that exceptions to the privilege in many states are "so numerous as to leave little if any basis for the privilege."⁷⁰

65. See generally J. WIGMORE, EVIDENCE §§ 2380-91 (McNaughton rev. ed. 1961).

66. *Id.* at § 2380.

67. *Id.* at § 2386.

68. PRIVACY COMMISSION REPORT, *supra* note 1, at 285.

69. CAL. EVID. CODE §§ 996-1007 (West 1966 & Supp. 1983).

70. FED. R. EVID. 504, Advisory Committee's Note (proposed rule), reprinted in S.

Third, the privilege does not exist in all states. According to the 1977 report of the Privacy Protection Study Commission, forty-three states have some form of the testimonial privilege.⁷¹ In some of these states, however, the privilege is applicable only to psychiatrists and not to other physicians.⁷² The privilege is not recognized in federal criminal trials⁷³ or in nondiversity cases in federal court.⁷⁴

Finally, legal commentators have been hostile toward the privilege. Professor Wigmore disputes the premises upon which the privilege rests. He questions whether physician-patient communications are in fact confidential; whether patients are less communicative in the absence of a privilege; and whether the injury to the physician-patient relationship as a result of the disclosure of confidential communications is greater than the expected benefit to justice by the disclosure of the communications when relevant in court.⁷⁵ Wigmore's objections to the privilege arise from his observation that it tends to be used in those cases—primarily personal injury and life and health insurance—in which the patient voluntarily comes to court.⁷⁶ This hostility has probably discouraged the courts from attempting to turn the privilege into a more significant protection.

The psychotherapist-patient privilege is more highly regarded than the physician-patient privilege. The Advisory Committee on the Federal Rules of Evidence, for example, recommended adoption of a psychotherapist-patient privilege but recommended against adoption of a physician-patient privilege.⁷⁷ The more favorable reaction toward the psychotherapist privilege appears to be based on a recognition that confidentiality is of special importance in the psychiatric relationship.

Furthermore, the physician-patient privilege is of limited utility to a physician confronted with a disclosure question. The privilege is available only when the disclosure issue arises in a courtroom. If the privilege is successfully invoked, the physician cannot testify. Otherwise, his testimony will be re-

SALTZBURG & K. REDDEN, FEDERAL RULES OF EVIDENCE MANUAL 757 (2d ed. 1977). The Committee noted the following exclusions from the privilege: Communications not made for the purposes of diagnosis and treatment; commitment and restoration proceedings; issues about wills or otherwise between parties claiming by succession from the patient; actions on insurance policies; required reports (venereal diseases, gunshot wounds, child abuse); communications in furtherance of crime or fraud; mental or physical condition put in issue by patient (personal injury cases); malpractice actions; and some or all criminal prosecutions.

The proposals of the Advisory Committee on testimonial privileges were not accepted by the Congress.

71. PRIVACY COMMISSION REPORT, *supra* note 1, at 284.

72. The State of Florida, for example, is one of a dozen states that recognizes a psychotherapist-patient privilege but not a general physician-patient privilege. FLA. STAT. § 90.503 (1979). Other states are listed in Note, *Privacy in Personal Medical Information: A Diagnosis*, 33 U. FLA. L. REV. 394, 395-96 n.9 (1981).

73. *United States v. Meagher*, 531 F.2d 752 (5th Cir.), *cert. denied*, 429 U.S. 853 (1976).

74. *See United States v. Kansas City Lutheran Home & Hosp. Assoc.*, 297 F. Supp. 239 (W.D. Mo. 1981).

75. J. WIGMORE, *supra* note 65, at §§ 2380a, 2285.

76. J. WIGMORE, *supra* note 65, at § 2380a.

77. Advisory Committee's Note, *supra* note 70, reprinted in S. SALTZBURG & K. REDDEN, FEDERAL RULES OF EVIDENCE MANUAL at 757-58.

quired. The privilege provides no help to a physician who has to decide on the propriety of a disclosure outside of the courtroom.

2. Reporting Statutes

Every state requires health care providers to report selected identifiable patient information to state agencies. Reportable information may include communicable diseases, violent injuries (*e.g.*, gunshot wounds), occupational diseases or injuries, epilepsy, congenital defects, and injuries from child abuse or neglect.⁷⁸ In addition, an increasing number of states require the reporting of information relating to abortions, certain prescription drugs, cancer, and battered adults. The number of reportable medical conditions has increased in recent years.⁷⁹

Each statute reflects a state legislature's judgment that a patient's interest in the confidentiality of his medical condition is outweighed by another societal interest. The interest that is served by the disclosure depends on the nature of the information and the agency that receives it. For example, communicable disease information may be used by public health agencies to institute control measures to interrupt the transmission of disease. The reporting of gunshot wounds to police agencies assists in the identification of crimes and criminals. Cancer data may be collected for use in medical research.

Like the physician-patient privilege, state reporting laws resolve selected confidentiality problems. Whatever the physician's obligations to protect a patient's confidential communications, he or she clearly must obey the law of the state. When state reporting requirements apply, physicians do not have to decide on a case-by-case basis—as called for in the 1912 AMA Principles—whether an undefined “duty to society”⁸⁰ requires that patient information be disclosed.

The growing number of reporting laws also raises a related issue. Does the legal requirement to disclose otherwise confidential patient information create an obligation on the part of the physician to inform the patient that the disclosure will be made? The physician who informs a patient suspected of having a communicable disease that the state will be notified may find that the patient will refuse treatment, will accept treatment only on condition that the physician not report the disease, or will not seek treatment in the future. Avoidance of these undesirable consequences is a primary reason why confidentiality is important in the treatment process.

A physician can resolve the question of informing the patient of the reporting requirement in several ways without directly informing the patient that his disease will be reported to the state. First, since neither state law nor medical ethics require that the patient be told of the disclosure, a physician might conclude that there is no obligation to tell the patient. Second, relying

78. See generally NATIONAL COMMISSION ON CONFIDENTIALITY OF HEALTH RECORDS, *supra* note 2.

79. *Id.* at 2-3.

80. See *supra* text accompanying note 54.

on the assumption that everyone has notice of the law,⁸¹ a physician might deny that there is a problem by reasoning that the patient already knows that the disclosure will be made. Third, a physician might define his confidentiality obligation so that it only applies in the absence of state law. In other words, a physician's obligations only begin after required disclosures have been considered. None of these resolutions is satisfactory. The patient who is not informed of the disclosure and who is later contacted by a public health agency or learns of the disclosure in some other way may feel betrayed by his physician. This could significantly impair, or even end, the physician-patient relationship. Thus, whether or not a physician informs his patient of the reporting law, there is some risk of interfering with the medical treatment process, disrupting the physician-patient relationship, or both. So while state reporting laws do resolve at least some confidentiality problems for physicians, these laws create other problems.

By being forced to be an agent⁸² of the state for the purpose of protecting the public health, enforcing criminal laws, or for other reasons, the physician is faced with conflicting goals that have only been partially resolved by legislation. Both patients and physicians seem to accept the need for reporting some communicable diseases. As reporting expands to include abortion information, drug prescriptions, cancer, and "dangerous" patients, however, the conflicts that physicians confront will increase.⁸³

3. Federal Alcohol and Drug Abuse Confidentiality Rules

There is little general federal law on the confidentiality of medical records.⁸⁴ Federal Medicare regulations provide that hospital records are con-

81. The Privacy Protection Study Commission recommended that patients be given notice by the health care provider of all disclosures of medical information that might be made without the consent of the patient. PRIVACY COMMISSION REPORT, *supra* note 1, at 313-14. See also S. 503, 96th Cong., 1st Sess. § 3 (1979); H.R. 5935, 96th Cong., 1st Sess. § 113 (1979).

82. Dr. John F. Burnum cites treatment of venereal disease as one of many instances in which the physician "may be forced to wear two hats and to be thrown into mild ethical conflict." Dr. Burnum uses the term "double agent" to describe the role of the physician in such instances. Burnum, *The Physician as a Double Agent*, 297 NEW ENG. J. OF MEDICINE 278 (1977).

83. The collection of information on patients afflicted with acquired immune deficiency syndrome (AIDS) provides a current example of the conflict between the privacy of patients and the ability of government epidemiologists to study the spread of the disease. Since many of the identified victims of AIDS are homosexual, patients are especially concerned about what information is collected, how much of it is identifiable, and how it might be redisclosed. See Barton Gellman, *Tracing AIDS Cases Raises Privacy Issue*, Wash. Post, July 18, 1983, at A1, col. 3.

84. The Privacy Act of 1974, 5 U.S.C. § 552a (1982), provides rules for the disclosure of medical records maintained by federal agencies as part of a general scheme of regulation of federal record keeping practices. The Privacy Act applies to federal executive departments, military departments, government corporations, government controlled corporations, other establishments in the executive branch of government, and independent regulatory agencies. *Id.* at §§ 552a (a)(1), 552(e), 551(1).

When an agency provides by contract for a system of records containing information about individuals to be operated on behalf of the agency, the contractor must comply with the Privacy Act's requirements. *Id.* § 552a(m). Thus, it is possible for a nonfederal entity to be required to comply with the Privacy Act for records maintained in connection with federal contracts.

fidential and prohibits disclosure without the written consent of the patient.⁸⁵ It seems doubtful that this strict rule is followed,⁸⁶ and one court that considered it did not find "any intention on the part of Congress to make patient medical records any less available than they would normally be."⁸⁷

The only federal statutes that provide any detailed confidentiality rules for medical records are the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act⁸⁸ and the Drug Abuse Office and Treatment Act of 1972.⁸⁹ These laws, which are substantially identical and have a common set of regulations,⁹⁰ apply to medical records maintained in connection with the performance of any alcohol abuse or drug abuse prevention function conducted, funded, authorized, or assisted by the federal government. Assistance includes allowing income tax deductions for contributions or granting tax-exempt status.⁹¹

For covered alcohol and drug abuse records, the laws recognize three categories of disclosures that may be made without the consent of the patient. The first is to medical personnel to the extent necessary to meet a bona fide medical emergency.⁹² The second is to qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation. Such personnel, however, are expressly prohibited from identifying, either directly or indirectly, individual patients in any manner whatsoever.⁹³ The third category of permissible disclosure consists of the disclosures that may be made only if authorized by an appropriate order of a court after an application showing good cause. The law directs the court, in assessing good cause, to weigh the public interest and the need for disclosure

85. A medical record is maintained for every patient admitted for care in the hospital. Such records are kept confidential. The factors explaining the standard are as follows:

(1) Only authorized personnel have access to the record.

(2) Written consent of the patient is presented as authority for release of medical information.

(3) Medical records generally are not removed from the hospital environment except upon subpoena.

42 C.F.R. § 405.1026(a) (1982).

86. Nathan Hershey, Professor of Health Law, Graduate School of Public Health, University of Pittsburgh, asked the Health Care Financing Administration (HCFA) of the Department of Health and Human Services whether this regulation would permit the disclosure of identifiable medical records to epidemiological researchers. The HCFA responded that the regulations were not intended to preclude a hospital from participating in appropriate epidemiological research, if necessary precautions were taken to ensure the confidentiality of records. A hospital would not violate the regulations as long as appropriate measures were taken to ensure that records were not misused, that the study was valid, and that the patient's privacy was protected. In commenting on the response, Professor Hershey wisely noted that a court interpreting the regulation might reach a different result in a private legal action brought by a patient whose records were made available to researchers without his or her consent. See Hershey, *Using Patient Records for Research: The Response from Federal Agencies and the State of Pennsylvania*, 4 IRB 7 (1981). See also *infra* note 111.

87. *United States v. Providence Hosp.*, 507 F. Supp. 519, 520 (E.D. Mich. 1981).

88. 42 U.S.C. § 4582 (1976).

89. 21 U.S.C. § 1175 (1976).

90. See 42 C.F.R. §2.1 to .67-1 (1982).

91. *Id.* at § 2.12 (a)(4).

92. 21 U.S.C. § 1175(b)(2)(A) (1976); 42 U.S.C. § 4582(b)(2)(A) (1976).

93. 21 U.S.C. § 1175(b)(2)(B) (1976); 42 U.S.C. § 4582(b)(2)(B) (1976).

against the injury to the patient, to the physician-patient relationship, and to the treatment services. The court is specifically directed to impose appropriate safeguards against unauthorized disclosure.⁹⁴

Although they apply to only a very selected set of medical records, the alcohol and drug abuse confidentiality rules meet the minimum criteria established earlier for comprehensive guidance.⁹⁵ Certain categories of disclosures are permitted under the law, and all others are prohibited unless approved by a court. For all disclosure questions that arise, a physician has some direction. When the statute uses an undefined phrase such as "qualified personnel," more detailed guidance is provided in the regulations issued by the Public Health Service.⁹⁶

The need for separate confidentiality rules for a class of medical records considered to be especially sensitive supports two main points of this Article. First, the existence of these rules suggests that the rules for ordinary medical records either are not well defined or are too weak to satisfy a class of patients who can reasonably be expected to be concerned about confidentiality. The establishment of special "strict" confidentiality rules for some records may also suggest legislative agreement that weaker rules for ordinary records are appropriate. Second, the drug and alcohol rules illustrate the intense pressure to make medical records available for other purposes. Despite specific legislative recognition of the critical importance of confidentiality to the operation of drug and alcohol treatment programs, the law still allows disclosures without the consent or knowledge of the patient in a surprisingly wide range of circumstances.⁹⁷

94. 21 U.S.C. § 1175(b)(2)(C) (1976); 42 U.S.C. § 4582(b)(2)(C) (1976). In one case in which the IRS had issued a subpoena for patient records, a hospital argued that the subpoena might cover records of patients that were covered by 21 U.S.C. § 1175. Although the court found no indication that any records covered by the subpoena might be subject to the confidentiality provisions, it found that, given the narrow scope of the inquiry, the public interest in collecting taxes outweighed the potential injury of a disclosure to a drug-abuse treatment patient. No safeguards against unauthorized disclosure were imposed. *See United States v. Providence Hosp.*, 507 F. Supp. 519 (E.D. Mich. 1981). *See also infra* note 153 and accompanying text. This decision illustrates that the confidentiality protections afforded by court review depend on how individual judges interpret "good cause."

95. *See supra* text accompanying notes 42 & 43.

96. 42 C.F.R. § 2.52(a) (1982).

97. Although the drug and alcohol laws may provide comprehensive guidance to physicians, they should not necessarily serve as a model for other types of medical records. On the contrary, there are significant deficiencies in the law and inconsistencies in the regulations. For example, the law only permits nonconsensual disclosure of information in the event of medical emergencies to medical personnel. *See supra* note 92 and accompanying text. Disclosure to relatives appears to be prohibited. This is a potentially serious defect, since there may be times when it is necessary or appropriate to discuss a patient's treatment with his family and it is not possible or practical to obtain written consent. Notwithstanding the clear language of the statute, the regulations solve this problem by authorizing disclosure in the event of medical emergencies to family members or other persons with whom the patient is known to have a responsible personal relationship. 42 C.F.R. § 2.51(d) (1982). Although the result may be appropriate, the length to which the regulation drafters have had to twist the statute in order to reach the proper result illustrates some of the shortcomings of the law.

4. State Confidentiality Laws

There is tremendous variation in the number and quality of state laws on medical confidentiality. A 1979 review by the National Commission on Confidentiality of Health Records (NCCHR) of laws on the maintenance, use, and disclosure of personally identified patient information found that Vermont had seven such laws, but that Hawaii had thirty-nine.⁹⁸ In order to illustrate the disparity among state medical privacy laws, one of the more comprehensive and recent state medical confidentiality laws (Rhode Island) will be compared with one of the less sophisticated approaches (Minnesota). State medical confidentiality laws tend to be similar to either the Rhode Island or Minnesota models.

In 1978 Rhode Island passed a confidentiality of health care information act based on the American Medical Association model state legislation.⁹⁹ The law applies to any persons licensed by the state to provide health care services,¹⁰⁰ including physicians and hospitals, and restricts disclosures of "confidential health care information." This restriction includes "all information relating to a patient's health care history, diagnosis, condition, treatment, or evaluation."¹⁰¹

The Rhode Island law prohibits disclosure of confidential health care information without the written consent of the patient, except in fourteen specified situations¹⁰² such as medical emergencies, adjudication of health insurance claims by third party insurers, public health functions, and peer review. Disclosures to law enforcement personnel are permitted under narrowly defined circumstances, and disclosure to researchers and auditors are allowed, provided that the personnel receiving the records are "qualified." The law places limitations upon the maintenance, transfer, and use of health care information by third party recipients.¹⁰³

The law also provides that confidential health care information shall not be subject to compulsory legal process in any civil, criminal, legislative, or administrative proceeding except for court ordered psychiatric examinations, civil or criminal commitment proceedings, cases in which an individual introduces his physical or mental condition, cases in which a court has determined that an individual's mental or physical condition is of an imminent and serious danger to another, or in policy actions brought by an individual against his insurance carrier.¹⁰⁴

For a physician, the Rhode Island law provides nearly complete guidance

98. NATIONAL COMMISSION ON CONFIDENTIALITY OF HEALTH RECORDS, *supra* note 2, at 17-19, 54. North Carolina was between the extremes with twenty-one laws. The wide variation in number of state laws on confidentiality is reflective in part of the organization of law in each state code. See HOUSE REPORT, *supra* note 1, at 29.

99. R.I. GEN. LAWS § 5-37.3-1 (Supp. 1982).

100. *Id.* at § 5-37.3-3(a).

101. *Id.* at § 5-37.3-3(c).

102. *Id.* at § 5-37.3-4(b).

103. *Id.* at § 5-37.3-4(c).

104. *Id.* at § 5-37.3-6.

for the disclosure of patient information. It tells the physician to whom and under what circumstances information can be disclosed. This is not to say that the policy choices made in the law are necessarily consistent, complete, or sufficiently protective of the interests of the patient, the physician, or other users of health care information. The law is not totally comprehensive, because a state cannot intrude on the power of the federal government to compel disclosure of information needed in connection with federal programs.¹⁰⁵ This is an inherent limitation on state authority, and, given the broad authority of federal agencies to acquire identifiable patient information,¹⁰⁶ it is a significant limitation.

The Rhode Island law is similar to laws recently passed in California¹⁰⁷ and Montana.¹⁰⁸ Other states have enacted very limited confidentiality laws. A representative example is Minnesota. The only general health care information confidentiality provision in Minnesota law is found in the patient's bill of rights for hospitals and nursing homes. The law provides: "Every patient and resident shall be assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except as otherwise provided by law or a third party payment contract."¹⁰⁹ This simple provision provides little guidance for physicians and probably little protection for patients. Although the Minnesota bill of rights is a relatively new enactment, its confidentiality approach is representative of older, general confidentiality laws. Similar laws can be found in Massachusetts¹¹⁰ and Pennsylvania.¹¹¹

A 1979 review of state laws concerning health records confidentiality by the National Commission on Confidentiality of Health Records (NCCHR) concluded that the great majority of states had not adopted comprehensive statutes to regulate the record keeping practices of health care providers.¹¹²

105. See HOUSE REPORT, *supra* note 1, at 30.

106. See *infra* notes 143-57 and accompanying text.

107. CAL. CIV. CODE § 56 (West 1982).

108. MONT. CODE ANN. § 50-16-301 (1981).

109. MINN. STAT. ANN. § 144.651(15) (West Supp. 1982).

110. MASS. GEN. LAWS ANN. ch. 111, § 70E (West Supp. 1981).

111. 28 PA. ADMIN. CODE § 103.22(4) (1981). The Pennsylvania patient bill of rights is part of the state Administrative Code. The Pennsylvania Hospital Rules and Regulations also contain a confidentiality rule. It provides in part: "All records shall be treated as confidential. Only authorized personnel shall have access to the records." *Id.* § 115.27.

When the Pennsylvania Department of Health was asked by Professor Nathan Hershey whether either confidentiality regulation would preclude disclosure of identifiable patient records to epidemiological researchers, the Department stated that a researcher could become an "authorized person" within the meaning of the regulations after review and approval of the request by the medical staff and chief executive officer of a hospital. Professor Hershey points out that other state laws or regulations might be interpreted differently by state officials or by the courts. See Hershey, *supra* note 86.

The need for a strained interpretation of the Pennsylvania regulations by the State Department of Health in order to justify a socially desirable use of medical records illustrates the shortcomings of simple confidentiality rules, as well as the problems both physicians and patients may encounter in relying on these rules.

112. NATIONAL COMMISSION ON CONFIDENTIALITY OF HEALTH RECORDS, *supra* note 2, at 1-2.

The NCCHR found that the broadly-framed statutes were not likely to be aggressively enforced,¹¹³ and George J. Annas, Associate Professor of Law and Medicine at the Boston University Schools of Medicine and Public Health, has concluded that health professionals seldom know the law of their own states.¹¹⁴ The NCCHR also found that record keeping laws for mental health records tended to contain more detailed confidentiality standards.¹¹⁵

Although a number of states, such as Rhode Island, have passed modern, general health records confidentiality laws since the NCCHR survey, there are some inherent limitations of legislation passed at the state level. The difficulty of limiting federal government access to records has already been mentioned.¹¹⁶ Another problem with state-by-state regulation of record keeping practices is caused by the frequency of the interstate movement of records, patients, and physicians. The issues that arise from interstate movement can be illustrated by a brief example. A patient who lives in Maryland and is treated by a physician who has offices in both Maryland and the District of Columbia is referred to a physician who practices in Virginia. As records and patient information are passed back and forth between physicians, it can become more and more difficult for the physicians and the patient to determine which jurisdiction's law applies at what time.

Although this determination is likely to be irrelevant for routine treatment purposes, if each state has different rules and procedures governing the disclosure of the records, the legal problems could be complex. Similar issues are presented by the movement of physicians and their records from one state to another. These problems are largely unexplored.

Overall, it is difficult to generalize about the adequacy of state medical records confidentiality laws. A House committee that considered a federal medical privacy bill concluded in 1980 that "most States do not have well defined, modern laws on the confidentiality of medical records."¹¹⁷ Obviously, some states have more comprehensive laws than others. The newer laws have not been sufficiently tested in practice, or in the courts, to determine how well they will work. Current state laws will only sometimes provide guidance for physicians faced with disclosure decisions.

III. PHYSICIANS AND CONFIDENTIALITY: ISSUES TO CONSIDER WHEN RECORDS ARE SOUGHT

Many of the disclosures of identifiable medical information that occur routinely today are made with the consent of the patient. Disclosures to third party payors account for the majority of all disclosures,¹¹⁸ and health insurers

113. *Id.* at 6.

114. *Id.* at iv.

115. *Id.* at 5. Confidentiality laws exclusively devoted to the protection of mental health records were recently enacted in the District of Columbia. *See* D.C. CODE ANN. § 6-2001 to -2076 (1981). *See also* ILL. ANN. STAT. ch. 91½, § 801 (Smith-Hurd 1982-83).

116. *See* HOUSE REPORT, *supra* note 1, at 30.

117. HOUSE REPORT, *supra* note 1, at 29.

118. *See supra* notes 15-17, 28 and accompanying text.

normally obtain consent from the claimant as a prerequisite to payment.¹¹⁹ A physician who makes a disclosure to a health insurer with a patient's written consent faces fewer legal and ethical confidentiality questions.¹²⁰

A growing number of requests for disclosure of patient information are not accompanied by the patient's written consent. Many of these requests have already been mentioned.¹²¹ Some are for health-related purposes, such as peer review, fraud and abuse investigations, management and utilization controls, and medical research. Other requests, unrelated to health care, may come from law enforcement or intelligence agencies, the Secret Service, schools, and others.

These disclosures present the most difficult problems for conscientious physicians. Some requesters simply will ask the physician for his cooperation in making patient records available. For purposes of this Article, these will be categorized as disclosures within the discretion of the physician.¹²² Others seeking patient information will have the power to compel production of patient records. These will be categorized as compulsory disclosures. Each type of request presents a different and potentially complex confidentiality issue.

A. Discretionary Disclosures

1. Making the Decision

When a patient has not requested that medical information be disclosed and disclosure is not required by law, any disclosure is at the discretion of the physician. A physician who denies all requests for the exercise of that discretion will minimize problems with confidentiality issues.

Physicians may not find it easy to refuse automatically all discretionary disclosures. For example, one type of request that some physicians may find more compelling than most is a request for information to be used in medical research. Identifiable patient information is frequently crucial to medical research, and it is not always possible or practical to obtain patient consent.¹²³ In fact, the results of some research may be biased if information is unavailable because access was denied by either the physician or the patient.¹²⁴ Public

119. See *House Medical Privacy Hearings*, *supra* note 4, at 554 (statement of Marshall R. Crawford, Senior Director, Blue Cross and Blue Shield Association).

120. This is not to suggest that there are no legal or ethical questions attached to consensual disclosures. The ease with which patients sign away their confidentiality rights is sufficiently troubling that some restrictions may eventually be determined to be appropriate. Because, however, there are so many unresolved difficulties over non-consensual disclosures, consideration of the issues surrounding consensual disclosures must be left to the future.

121. See *supra* text accompanying note 28.

122. The concept of a discretionary disclosure is not intended to suggest that a physician is completely unrestricted in making a disclosure decision. Legal or ethical principles may influence or direct the result, although it has already been demonstrated that physicians will find little help in the law or in medical ethics. See *supra* text accompanying notes 44-117. The term "discretionary" was selected primarily to identify disclosures that are not required by legal process.

123. Gordis & Gold, *supra* note 60, at 154 ("Much population-based research would be very difficult to carry out if prior patient consent were required in order for the investigator to have access to medical records."). See also House Report, *supra* note 1, at 47-54.

124. *House Medical Privacy Hearings*, *supra* note 4, at 464 (statement of Dr. Leon Gordis,

health officials, who may need patient information to assist in the identification of specific health problems and to institute control measures to interrupt the transmission of disease, can make an even more compelling case for disclosure of records.

The cautious physician who chooses to make information available to researchers or others should consider placing restrictions on the maintenance and use of the information.¹²⁵ Generally, the most important issues are how identifiable patient information will be used, stored, and destroyed; and under what circumstances identifiable data may be redisclosed.¹²⁶ Deciding on the conditions that apply when patient information is to be disclosed can be complicated, and it is likely that most physicians simply rely on the professionalism of the recipient to safeguard the data.

The physician who fails to impose conditions on the use of patient information disclosed to researchers faces the possibility of being sued if the data is misused. Fear of liability for disclosure of patient information has already

Society for Epidemiological Research and Association of American Medical Colleges); HOUSE REPORT, *supra* note 1, at 50-51.

125. When the Department of Health and Human Services makes individually identifiable records available to researchers, the Department meets its obligations under the Privacy Act of 1974, 5 U.S.C. § 552a (1982), through a series of procedural and substantive prerequisites to disclosure. The prerequisites that apply to the system of records containing the research subjects data record maintained by Saint Elizabeth's Hospital, which is operated by the Department, are representative:

A record may be disclosed for a research purpose, when the Department:

(A) has determined that the use or disclosure does not violate legal or policy limitations under which the record was provided, collected, or obtained;

(B) has determined that the research purpose (1) cannot be reasonably accomplished unless the record is provided in individually identifiable form, and (2) warrants the risk to the privacy of the individual that additional exposure of the record might bring;

(C) has required the recipient to—(1) establish reasonable administrative, technical, and physical safeguards to prevent unauthorized use or disclosure of the record, and (2) remove or destroy the information that identifies the individual at the earliest time at which removal or destruction can be accomplished consistent with the purpose of the research project, unless the recipient has presented adequate justification of a research or health nature for retaining such information, and (3) make no further use or disclosure of the record except—(a) in emergency circumstances affecting the health or safety of any individual, (b) for use in another research project, under these same conditions, and with written authorization of the Department, (c) for disclosure to a properly identified person for the purpose of an audit related to the research project, if information that would enable research subjects to be identified is removed or destroyed at the earliest opportunity consistent with the purpose of the audit, or (d) when required by law;

(D) has secured a written statement attesting to the recipient's understanding of, and willingness to abide by these provisions.

Saint Elizabeth's Hospital Research Subjects Data Record System of Records, Routine Use 4, *reprinted in* I OFFICE OF THE FEDERAL REGISTER, PRIVACY ACT ISSUANCES, 1981 Compilation 347-48 (1981) (System number 09-30-0005).

126. For research involving human subjects conducted or funded by the Department of Health and Human Services, an institutional review board, established in accordance with federal regulations, must approve the research and must, among other things, determine that there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data. 45 C.F.R. § 46.111(a)(7) (1981). *See generally* 45 C.F.R. §§ 46.101-306 (1982). The review might include an examination of the conditions under which identifiable data is maintained. Nevertheless, a physician who discloses information for use in research that has been approved by an institutional review board under these regulations could be liable for the disclosure of the data notwithstanding that approval.

made some hospitals reluctant to provide data to researchers.¹²⁷ In the absence of a statute or other direction, perhaps from a professional society, a physician who discloses patient information must accept a real, although small, risk of legal liability to his patient.¹²⁸

Sympathy with the intended use of information is not the only reason a physician might consider in making a disclosure. In some instances, a physician may be liable for failing to disclose patient information. This was the holding in *Tarasoff v. Regents of the University of California*.¹²⁹ In that controversial decision, the California Supreme Court held that a psychiatrist could be liable to a third party for failing to warn the third party that a patient was dangerous. The court found that a psychiatrist had a duty to exercise reasonable care to protect an individual who might be harmed by a patient.¹³⁰

Psychiatrists argue strongly that confidentiality of patient communications is essential to their practice.¹³¹ *Tarasoff* raises the possibility that a psychiatrist or other physician might be liable not only for disclosing confidential information, but also for failing to disclose confidential information. This pos-

127. Dr. Leon Gordis, Chairman of the Department of Epidemiology at Johns Hopkins University, indicated that concern over possible liability as a result of nonconsensual disclosures of patient information is frequently the basis of refusals to provide information to health researchers. In one instance, a hospital asked the researcher and his sponsor to agree to indemnify the hospital against any claims made by any patient as a result of the release of patient information. See Letter from Dr. Leon Gordis to Rep. Richardson Preyer (June 6, 1979), reprinted in *House Medical Privacy Hearings*, *supra* note 4, at 471-72. See also HOUSE REPORT, *supra* note 1, at 78.

128. In the past, attempts by third parties to obtain records maintained by researchers were rare or unknown. As a result, the possibility of physician liability for disclosure to a researcher was remote. More recently, however, several lawsuits have been filed seeking access to researcher records. Two cases were reported in the press in the last several years. In one case, the Justice Department sued the New York State Health Department to compel disclosure of confidential studies of people living near the Love Canal area of New York. N.Y. Times, June 6, 1980, at B1, col. 4. In a second case, Proctor and Gamble sued the Center for Disease Control to obtain the names of women who were telephoned in studies of toxic shock syndrome. Wall St. J., Nov. 5, 1982, at 18, col. 1. Perhaps the most interesting aspect of these cases is that the United States is the plaintiff in one action and the defendant in the other.

The Carter Administration was concerned enough about the confidentiality of research records to propose legislation. See H.R. 3409, 96th Cong., 1st Sess. (1979). The Carter proposal was based on the recommendations of the Privacy Protection Study Commission. See PRIVACY COMMISSION REPORT, *supra* note 1, at 567-604. The legislation never received a hearing.

129. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

130. One of the most disputed aspects of *Tarasoff* was the court's acceptance of the proposition that psychiatrists are sometimes able to accurately predict whether a patient will resort to violence. Based on its determination that psychiatrists had such an ability—at least under the peculiar facts of the case—the court decided that a duty to warn also existed. Psychiatrists argue strongly that accurate predictions cannot be made. The California Supreme Court noted that the American Psychiatric Association and other professional societies contended that therapists are unable to predict violent acts reliably. The court acknowledged the difficulty but found it irrelevant to the case because the psychiatrist had, in fact, accurately predicted that the patient presented a serious threat of violence. *Id.* at 437-38, 551 P.2d at 344-45, 131 Cal. Rptr. at 24-25. The court stated the general rule that "[w]ithin the broad range of reasonable practice and treatment in which professional opinion and judgment may differ, the therapist is free to exercise his or her own best judgment without liability; proof, aided by hindsight, that he or she judged wrongly is insufficient to establish negligence." *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25. On the general question of predictions of dangerousness by psychiatrists, see, e.g., Coccozza & Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084 (1976); Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693 (1974).

131. See *supra* text accompanying notes 13-14.

sibility dramatically illustrates one of the uncertainties physicians face with respect to the protection of patient confidentiality. The clash between two important social interests—confidentiality on the one hand and the protection of life and limb on the other—is left to the physician to resolve, and the physician may be held responsible for his resolution.

2. Disclosure Dilemma

The dilemma that is presented by requests for disclosure can be illustrated by considering the use of medical information by the United States Secret Service in connection with the protection of public officials.¹³² The Secret Service routinely uses medical information to assess individuals who may pose a threat to the security of the President, other high public officials, candidates for public office, and their relatives.¹³³ The Secret Service contends that medical information is necessary to carry out this function,¹³⁴ and there is some congressional agreement.¹³⁵ In support of its use of medical information, the Secret Service cites the fact that more than 90 percent of those considered to be dangerous have a known history of mental problems.¹³⁶ Typically, the Service will ask a psychiatrist to evaluate a specific individual's propensity for violence. The majority of psychiatrists approached by the Secret Service seem to agree that there is a legitimate need for the information, and there appears to be a high degree of cooperation with requests for patient information.¹³⁷ Patient consent for the disclosure is only occasionally possible.

A psychiatrist or other physician who is approached by a Secret Service agent seeking patient information is under no statutory obligation to cooperate. In fact, some state laws may prohibit or restrict psychiatrists in state mental hospitals or elsewhere from disclosing some or all patient information to the Secret Service.¹³⁸ For most psychiatrists, however, as for most physi-

132. The Secret Service's protective functions are set out in 18 U.S.C. § 3056 (1976).

133. On the general issue of use of medical information by the Secret Service, see generally *House Medical Privacy Hearings*, *supra* note 4, at 732-35 (statement of H. Stuart Knight, Director, United States Secret Service).

134. *Id.* at 733.

135. All congressional committees that considered medical privacy legislation during the 96th Congress recommended that disclosure of medical information to the Secret Service be permitted. See HOUSE REPORT, *supra* note 1, at 63-65; SENATE REPORT, *supra* note 30, at 22-23; H.R. REP. NO. 832 pt. 2, 96th Cong., 2d Sess. 36-37 (1980).

136. *House Medical Privacy Hearings*, *supra* note 4, at 729 (statement of Bette B. Anderson, Under Secretary of the Treasury).

137. HOUSE REPORT, *supra* note 1, at 63.

138. The Director of the Secret Service testified that the cooperation varies from state to state. He indicated that Texas and Massachusetts have basically the same law, but that as a result of local interpretations, Texas officials are cooperative, whereas in Massachusetts, the Secret Service does not receive information. *House Medical Privacy Hearings*, *supra* note 4, at 739 (statement of H. Stuart Knight, Director, United States Secret Service).

In 1978 Illinois passed the Mental Health and Developmental Disabilities Confidentiality Act which included a restriction on disclosure of information to the Secret Service. The only information that could be disclosed by the State Department of Mental Health and Developmental Disabilities was the patient's name, address, age, and date of admission to, or discharge from, a Department facility. Ill. Laws P.A. 80-1508, § 12(a) (1979).

In 1981 the provision was amended to permit disclosure of "any information which would

cians facing similar questions, there is little guidance, and the decision is a personal one.

Is the disclosure of patient information to the Secret Service a violation of medical confidentiality principles? If the patient is, in fact, reasonably judged to be a danger, then a physician may feel justified in making the disclosure.¹³⁹ This is consistent with the holding in *Tarasoff* and with the current practice of psychiatrists. Confidentiality gives way to an overriding public interest in the protection of public officials.

While this is a reasonable, balanced solution to the question of disclosing information about a patient judged to be a danger, is the same result appropriate if the patient is not dangerous? What should a psychiatrist reveal when the Secret Service inquires about a patient who, in the opinion of the psychiatrist, is not a danger? If the disclosure of any confidential information is justified only by an overriding public interest, then it is difficult to justify disclosure of any information about a patient in the absence of such an interest.

If requests by the Secret Service for patient information were always general (for example, "Are any of your patients threats to the President?"), then concern over disclosing information by a negative answer would be minimized. No patients would be identified by a negative answer. The Secret Service, however, frequently asks for information about specific patients. Can a psychiatrist agree to cooperate with the Secret Service only in those instances in which a patient is a danger, and refuse to disclose information when the patient is not? If the terms of cooperation are clearly understood by all, then the answer is no. If a psychiatrist responds positively when asked if a particular patient is a threat but answers "no comment" otherwise, then that refusal to discuss a specific patient's propensity for violence is the equivalent of saying that the patient is not violent. In other words, it is difficult to limit disclosures about specific patients to those circumstances in which patients are a threat to others.

While we may be willing to overlook the confidentiality interests of the dangerous patient because of the greater public interest, it is not as easy to reach the same result in the case of nondangerous patients. Certainly many patients would object to disclosure of the basic fact that they are undergoing psychiatric treatment.¹⁴⁰ For a psychiatrist to share his judgments about a

indicate whether or not the [patient] has a history of violence or presents a danger of violence" to a person under Secret Service protection. The amended law restricts use of the information to investigative purposes and prohibits its public dissemination. ILL. ANN. STAT. ch. 91½, § 812 (Smith-Hurd Supp. 1983).

The additional information permitted to be disclosed by the 1981 amendment is consistent with the type of information that the Secret Service stated that it needed. See *House Medical Privacy Hearings*, *supra* note 4, at 727-31 (statement of Bette B. Anderson, Under Secretary of the Treasury), 732-35 (statement of H. Stuart Knight, Director, United States Secret Service).

139. It is hardly clear that patients would agree with the reasonableness of the disclosure, and a psychiatrist who told his patients that he cooperated with the Secret Service might well lose patients as a result.

140. See *supra* note 14.

patient's behavior or mental condition (for example, "John Smith is not a threat to the President") would be even more objectionable.

This disclosure dilemma arises because the Secret Service is actively seeking information. In *Tarasoff* the issue was whether the psychiatrist had a duty to make a self-initiated disclosure. Failure to make a self-initiated disclosure reveals nothing about a patient because nothing is disclosed. When information is actively sought from a physician by a third party, however, the potential exists for an ethical dilemma. Once a physician has agreed to disclose patient information under defined conditions, no matter how justifiable that disclosure may be, the physician may find that a denial of a request to disclose information on other patients will nevertheless reveal at least some information about those patients.

The number of requests made by the Secret Service each year is relatively small.¹⁴¹ The same problem can result when requests for information are made by other law enforcement agencies, however. The slippery slope in this area is particularly steep. Once cooperation begins, it is hard to find a place to stop. If confidentiality can be breached to prevent a murder, can it be breached to apprehend a murderer? Can confidentiality be breached to prevent a crime of lesser magnitude or to locate the criminal? Can confidentiality be breached to collect information on people who are suspicious or who have criminal records or tendencies? While physicians might have no difficulty in refusing such requests for information, not all of the circumstances are readily distinguishable from *Tarasoff* or from the Secret Service requests. Without firm guidelines, there is a danger that law enforcement agencies could have more access to patient information than either patients or physicians ever thought possible or desirable.¹⁴²

These questions are among the most complex discretionary disclosure issues confronting physicians. None of the alternatives is consistent with all principles. For the average physician, they may arise only rarely. They can be ignored by the physician who refuses to make any discretionary disclosures. It seems unlikely, however, that all physicians would be so resolute. If psychiatrists—who are generally very protective of patient confidences—cooperate in large numbers with the Secret Service, then it is likely that other physicians would be equally cooperative.

Regardless of the decision of a physician on any particular disclosure request—whether the requester is the Secret Service, a fraud investigator, a medical researcher, an intelligence agency, or someone else—the physician generally faces the decision without any meaningful guidance. Basic princi-

141. In 1979 the Director of the Secret Service testified that the Service conducted less than 4000 investigations a year. *House Medical Privacy Hearings*, *supra* note 4, at 736-37.

142. Disclosures of confidential medical information can be controlled by placing restrictions on the activities of the record keepers. This is a traditional strategy. Another approach that may be suitable in some instances is limiting the ability of law enforcement or other agencies to request medical information. This approach was incorporated in § 131 of H.R. 5935, 96th Cong., 2d Sess. (1980). In order to request medical information, the legislation would have required law enforcement agencies to certify in writing that the information was being sought for one of five purposes specifically permitted under the bill. *See also* HOUSE REPORT, *supra* note 1, at 67-69.

ples of medical ethics are silent on these issues, and the law is filled with uncertainties about the potential liabilities of physicians who must decide whether to disclose patient information.

B. Compulsory Disclosures

Given the complex issues presented by requests for discretionary disclosure of patient information, it appears that receipt by a physician of a summons, subpoena, or search warrant would simplify disclosure problems for the physician. But the physician who complies with such a request may be doing a disservice to his patients and ignoring his responsibility to protect the confidentiality of his records.

1. Who Can Compel Disclosure of Medical Records?

Traditionally, compulsory process has been used to obtain medical records in private litigation to which the patient is usually a party. When the patient is a party to the litigation, he is able to defend his own interest in confidentiality, and the physician may have no special responsibility.

The possibility that compulsory process will be used to obtain medical records can no longer be dismissed as limited to private litigation. The growth of government involvement in health matters has resulted in an expansion of the power of government agencies to compel the production of records. For example, the Secretary of Health and Human Services has general subpoena authority under the Social Security Act in connection with the Federal Old-Age, Survivors, and Disability Program¹⁴³ and the Medicare Program.¹⁴⁴ The Inspector General of Health and Human Services also has general subpoena power¹⁴⁵ in connection with his responsibility to promote economy and efficiency in Department programs and to prevent and detect fraud and abuse.¹⁴⁶ The Food and Drug Administration also has a legal right to records maintained in connection with new drug applications.¹⁴⁷ While there is no formal subpoena power under the law, the Secretary can enforce his right to records by suspending an application for failure to make records available.¹⁴⁸

The Attorney General has the power to subpoena records under the Com-

143. 42 U.S.C. § 405(d) (1976).

144. 42 U.S.C. § 1395ii (1976) (extending the authority of 42 U.S.C. § 405(d) to the Medicare program).

145. 42 U.S.C. § 3525 (1976). Other agency Inspectors General have similar subpoena authority, but it is less likely that agencies other than the Department of Health and Human Services would need medical records. *See* 5 U.S.C. app. I § 6(a) (Supp. V 1981).

146. 42 U.S.C. § 3523(a)(2) (1976).

147. 21 U.S.C. § 355(j) (1976). The law requires that rules and regulations must "have due regard for the professional ethics of the medical profession and the interests of patients." The regulation do provide that information that would identify patients is not available for public disclosure. The regulations are silent on possible sharing of identifiable data with other agencies or with other components of the Department of Health and Human Services. *See* 21 C.F.R. § 314.14(e)(2)(i)(a) (1982).

148. 21 U.S.C. § 355(e) (1976).

prehensive Drug Abuse Prevention and Control Act of 1970¹⁴⁹ and to issue administrative inspection warrants.¹⁵⁰ Similar authority with respect to workplaces and employment records, including medical records, is granted to the Secretary of Labor under the Occupational Health and Safety Act of 1970,¹⁵¹ and to the Secretary of Health and Human Services, as an element of the public health research features of the Act.¹⁵² The general subpoena authority of the Internal Revenue Service can be used to obtain health records of physicians and hospitals targeted for tax investigations.¹⁵³

Disclosure of medical records can also be compelled by contract. For example, federal law requires that Medicare contracts with health maintenance organizations (HMOs) provide the Secretary of Health and Human Services with a right of access to all pertinent HMO records.¹⁵⁴ Federal Medicaid law requires that states with Medicaid programs obtain an agreement from all providers of services that they will furnish the state or the Secretary any requested information.¹⁵⁵ Also, the 1978 Medicare-Medicaid Anti-Fraud and Abuse Amendments encouraged states to establish Medicaid fraud control units by providing significant federal funding,¹⁵⁶ and this has led to the passage of state laws granting these units subpoena and warrant authority.¹⁵⁷

The breadth of the compulsory process powers that have been granted to government agencies is illustrated by one of these state Medicaid fraud control laws. In 1978 the State of Hawaii accepted the invitation in the Medicare-Medicaid Anti-Fraud and Abuse Amendments and established a Medicaid Fraud Unit to investigate and prosecute Medicaid fraud.¹⁵⁸ A companion law authorized the issuance of administrative warrants to inspect, copy, and maintain records required to be kept by providers of health care services.¹⁵⁹ For purposes of such a warrant, probable cause was legislatively determined to exist "upon showing a valid public interest in the effective enforcement" of the

149. 21 U.S.C. § 876 (1976).

150. 21 U.S.C. § 880 (1976). See *United States v. Montrom*, 345 F. Supp 1337 (E.D. Pa. 1972), *aff'd*, 480 F.2d 919 (3d Cir. 1973) (upholding inspection warrant of Bureau of Narcotics and Dangerous Drugs for records and stocks of osteopath).

151. 29 U.S.C. § 657(a), (b) (1976).

152. 29 U.S.C. §§ 669(b), 671 (1976 & Supp. V 1981).

153. 26 U.S.C. § 7602 (1976). See *United States v. Providence Hosp.*, 507 F. Supp. 519 (E.D. Mich. 1981) (upholding IRS subpoena for patient-identifiable hospital records notwithstanding medicare regulation governing confidentiality of medical records); *Gretsky v. Basso*, 136 F. Supp. 640 (D. Mass. 1955) (upholding IRS subpoena for patient-identifiable hospital records).

154. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 114, 96 Stat. 349 (1982) (amending § 1876 of the Social Security Act, to be codified at 42 U.S.C. § 1395mm(i)(3)(A)(ii)).

155. 42 U.S.C. § 1396a(a)(27) (1976 & Supp. V 1981).

156. 42 U.S.C. §§ 1396b(a)(6), 1396b(q) (Supp. V 1983). State Medicaid plans are required to "provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan." 42 U.S.C. § 1396a(a)(7) (1976).

157. See, e.g., FLA. STAT. § 409.2664 (Supp. 1982); PA. STAT. ANN. tit. 62, §§ 1401-1411 (Purdon Supp. 1983-84); VA. CODE § 32.1-310 to -321 (Supp. 1983).

158. HAWAII REV. STAT. § 28-91 (Supp. 1982).

159. *Id.* at § 346-42.

Medicaid fraud law.¹⁶⁰

In 1978 this law was relied upon to obtain a warrant authorizing the seizure of a psychologist's records of Medicaid beneficiaries, including therapeutic notes, patient history forms, medical records and reports, and diagnoses.¹⁶¹ The warrant was obtained without a showing of "any particularized need" to inspect the records, and without asking for voluntary production of the records.¹⁶²

The psychologist, together with the Hawaii Psychiatric Society, brought suit in federal district court to enjoin enforcement of the administrative warrant authority. Among other things, the judge found that the law's probable cause standard did not satisfy fourth amendment requirements and that there was substantial probability that it violated the right to privacy.¹⁶³ The judge issued a preliminary injunction.

What is of particular significance here is not the ruling of the court or even the willingness of the psychologist and others to challenge the statute, but the statutory authority itself and the way that it was used. Upon a minimal showing, a state agency was authorized by the legislature to seize medical records without "even a suspicion" of fraud.¹⁶⁴ The agency given the authority proceeded to seize sensitive records of mental health treatment even though the same information could have been obtained by other means. One can expect that government fraud investigators may use their powers of compulsory process increasingly in the future.¹⁶⁵ Whether other physicians or patients will be willing or able to resist compulsory process, as was done in Hawaii, remains to be seen.

2. *United States v. Miller* and the Right to Privacy

In considering the use of compulsory process to obtain personal records maintained by third party record keepers, the Supreme Court's 1976 decision in *United States v. Miller*¹⁶⁶ is particularly relevant. In *Miller* a United States Attorney subpoenaed a bank for the financial records of one of its customers, who was a suspect in a criminal investigation. The subpoena was challenged by the customer at trial, but the challenge was ultimately denied by the Supreme Court. After finding that the bank records were not owned by the customer and were not in his possession, the Court held that the customer did not have any interest in the records and was not entitled to notice of the sub-

160. *Id.* at § 346-42(a)(1).

161. *Hawaii Psychiatric Soc'y v. Ariyoshi*, 481 F. Supp. 1028, 1034 (D. Hawaii 1979).

162. *Id.* at 1034-35.

163. *Id.* at 1046.

164. *Id.* at 1041.

165. *Cf. Advocates for Children of New York, Inc. v. Blum*, 529 F. Supp. 422 (S.D.N.Y.1982) (Nonprofit and charitable agencies under contract with City of New York to provide preventive services to children and families obtained a preliminary injunction prohibiting city and state officials from compelling the agencies to turn over uniform case records of clients, including intimate personal and family information collected in confidence with some reasonable expectation of privacy.).

166. 425 U.S. 435 (1976).

poena or an opportunity to challenge it in court. In other words, the law does not recognize that a bank customer has any interest protectable from the government in the records of his bank account. The Court reached this result notwithstanding the personal nature of checking account information and the customer's expectation that documents transmitted to the bank would remain private.¹⁶⁷

Miller is a seminal case on the privacy of third party records. The Privacy Protection Study Commission described the case as "starkly underscor[ing] an individual's present defenselessness with respect to records maintained about him."¹⁶⁸ Much of the work of that Commission, including its recommendations on the privacy of medical records, reflects its view that *Miller* should be overturned by statute and that an individual must be given a legally enforceable interest in records about himself maintained by third parties.¹⁶⁹

Does the holding in *Miller* apply to medical records in a physician's possession? Does an individual have a protectable legal interest in those medical records? These questions can be debated at great length, but the short answer is that it is uncertain. These issues have not been addressed authoritatively by the Supreme Court or by lower courts. There are sufficient similarities between bank records and medical records, however, to make the possibility of a comparable result real.¹⁷⁰

The general significance of *Miller* for a third party record keeper is that if the subject of a record has no legal, protectable interest in those records, the record keeper must take steps to protect the interest of the subject of the records or those interests will go unprotected. As a practical matter, in the absence of a statute or a definitive court decision,¹⁷¹ the *Miller* decision is

167. *Id.* at 447 (Brennan, J., dissenting) (citing *Burrows v. Superior Court*, 13 Cal. 3d 238, 529 P.2d 590, 118 Cal. Rptr. 166 (1974)).

168. PRIVACY COMMISSION REPORT, *supra* note 1, at 7.

169. PRIVACY COMMISSION REPORT, *supra* note 1, at 19-21.

170. Federal legislation has diminished the likelihood that *Miller* will be applied again to bank records. The Right to Financial Privacy Act of 1978, 12 U.S.C. § 3401-3422 (Supp. V 1981), generally provides that a federal agency seeking bank records, either by compulsory process or by request, must notify the customer. The customer may fight the agency by going to court to protect his privacy interests. The Act illustrates how an individual can be permitted to protect his own interests in records maintained by third parties.

The Act should not be considered as a model for the protection of an individual's interest in records maintained by third parties. In fact, the law falls considerably short of the recommendations made by the Privacy Protection Study Commission. See PRIVACY COMMISSION REPORT, *supra* note 1, at 345-91. The Act has been criticized, *inter alia*, for its numerous exemptions, and for its formal request procedure (12 U.S.C. § 3408 (Supp. V 1981)) which permits all federal agencies to seek voluntary disclosure of customer records from banks, and for customer challenge procedures that place "a significant, and possibly unfair, burden on the customer." Trubow & Hudson, *The Right to Financial Privacy Act of 1978: New Protection From Federal Intrusion*, 12 J. MAR. J. PRAC. & PROC. 487, 499 (1979). See also Note, *The Right to Financial Privacy Act of 1978*, 28 DE PAUL L. REV. 1059 (1979).

171. A few state supreme courts have rejected *Miller* and reached different results based on state constitutional protections against unreasonable searches and seizures. See, e.g., *Charnes v. DiGiacomo*, 200 Colo. 94, 612 P.2d 1117 (1980); *Commonwealth v. DeJohn*, 486 Pa. 32, 403 A.2d 1283 (1979), *cert. denied*, 444 U.S. 1032 (1980). Most states that have considered the issue, however, have followed *Miller*. See Note, *A Right to Privacy in Bank Records: The Colorado Supreme Court Rejects United States v. Miller*, 52 U. COLO. L. REV. 529, 533-34 n.24 (1981).

effectively being applied when medical records are subpoenaed. Government agencies with powers of compulsory process and courts are not required to notify patients. Whether a patient has standing to contest a subpoena is uncertain. In the absence of timely notice, however, a patient is not in a position to assert and defend his own privacy interest in his medical records. Since those who seek medical records by subpoena take no steps to protect the patient's privacy interest or to notify the patient of the subpoena, the patient's interest will go unprotected unless the physician takes action.

3. Litigation

Recent litigation over demands by the National Institute for Occupational Safety and Health (NIOSH) for access to medical records maintained by employers illustrates some of the options confronting physicians who are subpoenaed.¹⁷² In a typical case, NIOSH issues a subpoena for occupational medical records in connection with a health hazard investigation conducted under the Occupational Safety and Health Act of 1970,¹⁷³ the company resists the subpoena in whole or in part, and the agency goes to court against the company to enforce its subpoena.

An initial issue in the NIOSH cases is whether the company has legal standing to defend the right of privacy of its employees. Although the relationship between the employer and employee may not be as intimate as the relationship between physician and patient, courts have found that the company has sufficient interest to assert the privacy claim. One court noted: "As a practical matter, the absence of any notice to the employees of the subpoena means that no person other than Westinghouse would be likely to raise the privacy claim. Indeed, this claim may be effectively lost if we do not hear it now."¹⁷⁴ It is probable that, if a physician attempted to raise privacy on behalf of his patients he would be found to have standing.

A second issue in the NIOSH cases is whether the employee/patient should be notified of the subpoena. Companies and courts have taken different approaches. In one case, General Motors notified 704 workers, seeking their consent for the disclosure.¹⁷⁵ Almost 500 of these workers did not consent to the release of their records.¹⁷⁶ In another case, although Westinghouse did not initially notify its employees, notice was later required by the court in

172. See, e.g., *General Motors Corp. v. Director of Nat'l Inst. for Occupational Health & Safety*, 636 F.2d 163 (6th Cir. 1980), *cert. denied*, 454 U.S. 877 (1981); *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570 (3d Cir. 1980); *United States v. Lasco Indus.*, 531 F. Supp. 256 (N.D. Tex. 1981); *United States v. Allis-Chalmers Corp.*, 498 F. Supp. 1027 (E.D. Wis. 1980); *E.I. du Pont de Nemours & Co. v. Finklea*, 442 F. Supp. 821 (S.D. W. Va. 1977).

173. 29 U.S.C. §§ 669(b), 671 (1976 & Supp. V 1981).

174. *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570, 574 (6th Cir. 1980); *accord* *United States v. Allis-Chalmers Corp.*, 498 F. Supp. 1027, 1029 (E.D. Wis. 1980); *United States v. Lasco Indus.*, 531 F. Supp. 256, 263 (N.D. Tex. 1981).

175. *General Motors Corp. v. Director of Nat'l Inst. for Occupational Health & Safety*, 636 F.2d 163, 164 (6th Cir. 1980), *cert. denied*, 454 U.S. 877 (1981).

176. *Id.*

order to permit employees to raise personal claims of privacy.¹⁷⁷

A third issue in the NIOSH cases involves restrictions on maintenance and reuse of the medical records by the issuer of the subpoena. Protection of data was an issue in both *General Motors* and *Westinghouse*, and both courts reviewed the security arrangements.¹⁷⁸ Since NIOSH regulations generally prohibited redisclosure, that was not an issue, although it might be in a different case.¹⁷⁹

What are the obligations of a physician who receives a summons, subpoena, or search warrant? If the physician neither notifies his patients nor resists the process, no privacy claim will be raised and it may be lost entirely. If the physician resists turning over the records, a complex and expensive lawsuit may result. It may not be coincidental that reported cases involving resistance of subpoenas frequently involve large corporations that are capable of financing the litigation costs.

An alternative for the physician is to notify his patients that the records are being sought. This too involves an expense to physicians, although it would likely be considerably less than the cost of litigation. Notifying patients could have significant detrimental consequences for the relationship between physician and his patients. For example, if patients are notified that their records have been subpoenaed in a fraud investigation of the physician, the patients might be confused by the fact of the investigation. Some patients might automatically assume that the physician was guilty of a crime. Failure to provide an explanation would probably result in some patients believing that they were the targets of the investigation.¹⁸⁰

The physician who receives a subpoena, summons, or search warrant for medical records has no simple, convenient, or inexpensive way to respond to the process and protect his patient's privacy interest at the same time. Each alternative has distinct financial, medical, or other disadvantages. Existing legal and ethical principles provide no guidance to physicians.

IV. CONCLUSION

Existing legal and ethical principles that guide physicians with respect to their obligations to protect the confidentiality of medical records are generally

177. *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570, 581-82 (6th Cir. 1980); *accord United States v. Lasco Indus.*, 531 F. Supp. 256, 265-66 (N.D. Tex. 1981). *But see United States v. Allis-Chalmers Corp.*, 498 F. Supp. 1027 (E.D. Wis. 1980) (notice to employees not provided or required).

178. *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570, 579-80 (6th Cir. 1980); *General Motors Corp. v. Director of Nat'l Inst. for Occupational Health & Safety*, 636 F.2d 163, 166 (6th Cir. 1980).

179. Legislation considered during the 96th Congress included specific restrictions on redisclosure of patient information tailored to each different type of disclosure permitted. *See HOUSE REPORT*, *supra* note 1; *Senate Medical Privacy Hearings*, *supra* note 13, at 455.

180. Section 133 of H.R. 5935, 96th Cong., 1st Sess. (1979) provided that notice to the patient was not required in circumstances when the disclosure was for research, public health, audit, or selected other purposes for which the bill would have permitted disclosure without the consent of the patient. Notice was required when the patient was likely to be the target of an investigation. *See HOUSE REPORT*, *supra* note 1, at 70.

out of date and are not comprehensive. Physicians faced with requests or demands for patient information will find little in law or ethics to define their responsibilities with any precision. Yet the physician frequently is the only one who is in a position to take action to protect the confidentiality of his records and the privacy of his patients.

This problem has always existed, but was not as serious in the past because medical records were only occasionally used outside the medical treatment process. Confidentiality increasingly is taking second place to a growing list of competing interests, however, and the expanded use of medical records for nontreatment purposes is exacerbating the shortcomings in existing confidentiality principles.

There are several major consequences of these developments. First, as demand for medical records increases, the physician is being called upon to play a more central role in the protection of confidentiality. But the role that a physician should play is undefined because the physician's responsibilities are unclear. The result may be increased litigation over medical confidentiality issues and the obligations of physicians.

Second, the widespread dissemination and use of medical records ultimately may give rise to the general belief that information provided "in confidence" to a physician is no longer confidential.¹⁸¹ If this occurs, the consequences for the practice of medicine are uncertain. If confidentiality is important to the practice of medicine, it may become necessary to require physicians to protect patient confidentiality or to permit patients to protect their own interests in confidentiality.

Third, because of the magnitude and complexity of privacy issues today, the courts cannot be expected to develop appropriate solutions in a timely fashion. Some issues, such as disclosure of medical records to intelligence agencies or to the Secret Service, are not likely to arise in litigation. When an issue such as the right of public health officials to have access to medical records arises, it is likely to be in the midst of a public health emergency when the need for a fast resolution may prevent a carefully considered decision. Other balances, such as weighing the rights of patients against the interest of the government in maintaining proper fiscal controls on health programs, require factual, fiscal, and policy determinations most suited for resolution by legislatures.

A further shortcoming of judicial decisionmaking on medical privacy questions is the likelihood that any rules promulgated by the courts will fail to satisfy all of the criteria for confidentiality guidance discussed above.¹⁸² While the policy judgments made by the courts may well be appropriate, and

181. Disclosures made during treatment also can give rise to the belief that patient records are not confidential. A physician who told his patient that at least seventy-five health professionals had access to the patient's medical record during a hospital stay received this reaction from his distressed patient: "I always believed that medical confidentiality was part of a doctor's code of ethics. Perhaps you should tell me just what you people mean by 'confidentiality!'" Siegler, *Confidentiality in Medicine—A Decrepit Concept*, 307 *NEW ENG. J. OF MED.* 1518, 1519 (1982).

182. See *supra* text accompanying notes 42 & 43.

while it is not inconceivable that a judicial decision could be understood by the medical community, the piecemeal nature of litigation makes it unlikely that any rules will meet the foregoing standards for comprehensiveness. It could take decades before a complete set of rules evolved from judicial decisions. Therefore, the only practical way to develop suitable guidance defining the responsibilities of physicians, the right of patients, and the proper protection for medical information is through legislation.