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Health Governance and Mental Health Privacy Laws: Restoring the Balance Between Individual Privacy and Public Safety Following the 2007 Virginia Tech Shooting

by Isabel Chang

INTRODUCTION

On April 16, 2007, Seung Hui Cho, a deeply troubled student at Virginia Tech University, committed the deadliest shooting in U.S. history.¹ The gunman killed thirty-two people and injured seventeen others before finally killing himself.² Although this was one of the more recent shootings to have rocked the nation, it was not the first.³ The 1999 Columbine High School shooting in Little Rock, Colorado, was one of the earliest school shootings of its kind, which triggered a series of “copycat” attacks thereafter.⁴

Given the numerous times Cho was recommended for professional help, some commentators speculate that the shooting could have been prevented. They believe that had the government clarified the two privacy rules governing student health records – (1) the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and (2) the Family Educational Rights and Privacy Act (FERPA) – Cho’s high school and college officials would have released his health information for both treatment and law enforcement purposes.

This common reluctance of federally-funded institutions, such as Virginia Tech, to disclose student information stems partly from the fear that they will lose funding if they violate the rules. Thus, they err on the safe side by refusing to release information even in situations that warrant disclosure. Following the 2007 shooting, however, it has become evident that both state and federal governments should re-examine their privacy regulations and promote the disclosure,

¹ The Washington Post, *Deadliest U.S. Shootings*, July 20, 2012, available at <http://www.washingtonpost.com/wp-srv/special/nation/deadliest-us-shootings/>.

² The Washington Post, *supra* note 1.

³ The Washington Post, *supra* note 1.

⁴ Tammerlin Drummond, *Battling the Columbine Copycats*, May 10, 1999, available at <http://www.time.com/time/magazine/article/0,9171,990949,00.html>.

rather than the withholding, of student health information when the student poses a real risk to his own, or to the general public's, safety.

Part I of this paper will examine the definition of “privacy” and the historical development of this concept over time. Part II will discuss the importance of privacy laws to the individual and to the public. Part III will identify the problems underlying current health information privacy laws, using the 2007 Virginia Tech shooting as a case study. Lastly, Part IV will propose changes to current privacy laws to achieve a better balance between individual privacy and public safety interests.

I. DEFINITION AND HISTORY OF “PRIVACY”

Privacy is a concept that is difficult to define yet deeply felt by most individuals regardless of their gender, race, or creed.⁵ It has long been recognized as a basic human right and is referenced in the Quran, the Bible, and Jewish law.⁶ The concept was also prevalent in ancient Greece, where society drew a distinction between the private domain and the public sphere.⁷ This understanding is illustrated in the English word “privacy,” which is derived from the Latin term “privatus,” meaning a person who is not a public official or a member of the military.⁸

While there exists a substantial amount of literature on modern definitions of privacy, there is no single, universal definition.⁹ However, scholars have consistently included the following components in their privacy models: solitude, seclusion, anonymity, and secrecy or

⁵ William Lowrance, Ph.D., *Privacy and Health Research: A Report to the U.S. Secretary of Health and Human Services*, (1997), available at <http://aspe.hhs.gov/admsimp/PHR1.htm>.

⁶ Privacy Rights and the Law, THE OPEN UNIVERSITY, <http://openlearn.open.ac.uk/mod/oucontent/view.php?id=398256&direct=1> (last visited Oct. 12, 2012).

⁷ Joy Pritts, J.D., *The Importance and Value of Protecting the Privacy of Health Information:*

The Roles of the HIPAA Privacy Rule and the Common Rule in Health

Research, THE NATIONAL ACADEMY OF SCIENCES (2008), available at

<http://www.iom.edu/~media/Files/Activity%2520Files/Research/HIPAAandResearch/PrittsPrivacyFinalDraftweb.ashx>.

⁸ Pritts, *supra* note 7, at 2.

⁹ Pritts, *supra* note 7, at 2.

reserve.¹⁰ These components suggest that privacy involves “being in one’s own space.”¹¹ Others have described privacy as being in a state or a sphere in which outsiders do not have access to that person, his information, or his identity. Still others believe that privacy is grounded in an individual’s ability to control such factors as who, when, how, and to what extent others may enter that sphere.¹² This ability also encompasses an individual’s right to control the quality of personal information that they share with others.¹³

A. Privacy in the United States

Today, the word “privacy” does not appear anywhere in the U.S. Constitution.¹⁴ Although there is no express right, the Bill of Rights reflects the drafters’ concern in protecting this interest.¹⁵ This is evidenced in the First Amendment (privacy of beliefs), the Third Amendment (privacy of the home), the Fourth Amendment (privacy of the person and possessions), the Ninth Amendment (more general protection of privacy not specifically guaranteed by the first eight amendments), and the Fourteenth Amendment (liberty clause).¹⁶ Hence, the right to privacy is deemed a fundamental right by implication.¹⁷

It is widely believed that Samuel Warren and Louis Brandeis’s 1890 *Harvard Law Review* article, “The Right of Privacy,” initiated the public debate on the right of privacy.¹⁸ The article is also believed to have led to the establishment of privacy law itself.¹⁹ In the article, the authors opined that the media’s intrusion into the private affairs of citizens was extremely

¹⁰ Pritts, *supra* note 7, at 2.

¹¹ Pritts, *supra* note 7, at 2.

¹² Pritts, *supra* note 7, at 3.

¹³ Pritts, *supra* note 7, at 3.

¹⁴ Doug Linder, *The Right of Privacy*, EXPLORING CONSTITUTIONAL LAW (2012), available at <http://law2.umkc.edu/faculty/projects/ftrials/conlaw/rightofprivacy.html>.

¹⁵ Linder, *supra* note 14.

¹⁶ Linder, *supra* note 14.

¹⁷ *Griswold v. Connecticut*, 381 U.S. 479, 484 (U.S. 1965).

¹⁸ Harry Kalven, Jr., *Privacy in Tort Law—Were Warren and Brandeis Wrong?*, 31 LAW & CONTEMP. PROBS. 326, 327 (1966).

¹⁹ Kalven, Jr., *supra* note 18, at 327.

harmful.²⁰ In response, Warren and Brandeis advocated the creation of a tort remedy for such privacy violations.²¹

Justice Brandeis's subsequent dissent in the United States Supreme Court's *Olmstead v. United States* decision is also considered influential in the development of modern privacy law. There, he pointed out that the drafters of the Constitution "conferred, as against the government, the right to be let alone—[is] the most comprehensive of rights and the right most valued by civilized men," affirming his article's conceptualization of privacy.²² His dissent "led not only to the 'reasonable expectation of privacy' test that governs Fourth Amendment law, but also shaped the constitutional right to privacy recognized in *Griswold v. Connecticut* and *Roe v. Wade*."²³ Following *Olmstead*, privacy law expanded from the realm of the individual to the "general right to be let alone."²⁴ Even though the right continued to expand over the years, the Supreme Court never defined its limits.²⁵

Given the strong desire to protect one's privacy, it is unsurprising that individuals especially wish to safeguard their medical records, which can contain very sensitive details about one's life.²⁶ Possible details include a patient's physical and mental health, social behaviors, personal relationships, and financial status.²⁷ In 1999, the California HealthCare Foundation (CHCF) conducted a survey revealing that nearly three out of four Americans were concerned about the privacy of their medical records.²⁸ In 2005, following the enactment of the Health Insurance Portability and Accountability Act (HIPAA), two out of three Americans expressed

²⁰ Carole M. Cleaver, *Privacy Rights in Medical Records*, FORDHAM URB. L.J. 165, 172 (1984).

²¹ Cleaver, *supra* note 20, at 172.

²² *Olmstead v. United States*, 277 U.S. 438, 478 (U.S. 1928).

²³ Neil M. Richards, *The Puzzle of Brandeis, Privacy, and Speech*, VAND. L. REV. 1295, 1296 (2010).

²⁴ Cleaver, *supra* note 20, at 173.

²⁵ Cleaver, *supra* note 20, at 173.

²⁶ Sharyl J. Nass, Laura A. Levit, and Lawrence O. Gostin, *The Value and Importance of Health Information Privacy*, NATIONAL ACADEMY OF SCIENCES (2009), available at <http://www.ncbi.nlm.nih.gov/books/NBK9579/#a20016f79rrr00101>.

²⁷ Pritts, *supra* note 7, at 5.

²⁸ National Consumer Health Privacy Survey 2005, FORRESTER RESEARCH FOR THE CALIFORNIA HEALTHCARE FOUNDATION, (2005), available at <http://www.chcf.org/publications/2005/11/national-consumer-health-privacy-survey-2005>.

concern over their health information despite the federal protections granted under the act. Even though public respect for patient privacy dates back to at least 5th century B.C., when the Hippocratic Oath is presumed to have been written and instituted in medical practice, the proliferation of federal privacy statutes is a relatively recent phenomenon that only gained traction in the late 20th century.

B. Health Information Privacy Takes Shape

Indeed, the first of these privacy statutes was passed in 1966, when the federal government enacted the Freedom of Information Act (FOIA), 5 U.S.C. § 552, which provides the least amount of privacy relative to subsequent acts, regulations, and Supreme Court rulings.²⁹ The FOIA gives any person the right to access federal agency records unless they contain information protected under one of the nine exemptions, such as matters relating to national security, personnel, or medical files.³⁰ The act was premised on the belief that the public has the right to know what is going on in their government, because a fully informed citizenry allows for more robust participation.³¹ Thus, the FOIA was one of the first federal laws to encourage disclosure rather than secrecy of information.³²

However, the FOIA grants less privacy than one might expect from the law because its exemptions are not absolute. To determine whether disclosure of any exempted material is permitted, one must resort to alternative sources of law including statutes, regulations, common law, and general principles of equity.³³ However, “these statutory exemptions must be narrowly construed in order to effectuate the legislative intent.”³⁴ In particular, when determining whether

²⁹ Cleaver, *supra* note 20, at 181.

³⁰ What is FOIA?, UNITED STATES DEPARTMENT OF JUSTICE, available at <http://www.foia.gov/about.html> (last visited October 28, 2012).

³¹ Cleaver, *supra* note 20, at 181-182.

³² Cleaver, *supra* note 20, at 182.

³³ Cleaver, *supra* note 20, at 182.

³⁴ Cleaver, *supra* note 20, at 182.

or not to grant a FOIA request for medical files, a two-part analysis must be conducted: (1) whether the information constitutes a medical file, which is covered by the medical records exception, and (2) if so, whether disclosure would amount to an unjustifiable invasion of individual privacy.³⁵

In 1974, Congress enacted the Privacy Information Act, which specifically prohibits the unauthorized disclosure of certain federal government records regarding individuals.³⁶ This act was intended to promote formal, governmental respect for the privacy of citizens. Despite its seemingly contradictory nature, this Act was devised to complement and work in tandem with the FOIA when dealing with medical records.³⁷ Under the FOIA's two-part analysis described above, if it is determined that a disclosure would result in an unwarranted invasion of privacy, then the governmental agency is not obligated to disclose the information in question, and the Privacy Information Act takes effect.³⁸ In other words, the Privacy Information Act is triggered only when an FOIA analysis warrants non-disclosure.³⁹ This result differs markedly from the prior common law protection afforded to medical records, which were considered to be owned, and thus controlled, solely by private health care providers.⁴⁰

In the mid-1970s, the Supreme Court twice addressed the privacy right in the context of medical records.⁴¹ The first case, *Planned Parenthood of Central Missouri v. Danforth*, was decided in 1976.⁴² This involved the constitutionality of Missouri's abortion statute

³⁵ Cleaver, *supra* note 20, at 182 (citing *Washington Post v. Dep't of Health and Human Servs.*, 690 F.2d 252, 260 (D.C. Cir. 1980)).

³⁶ Privacy Act of 1974, as amended, FEDERAL TRADE COMMISSION, *available at* www.ftc.gov/foia/privacy_act.shtm (last visited October 24, 2012).

³⁷ Cleaver, *supra* note 20, at 181.

³⁸ Cleaver, *supra* note 20, at 184.

³⁹ Cleaver, *supra* note 20, at 184.

⁴⁰ Cleaver, *supra* note 20, at 184-185.

⁴¹ Cleaver, *supra* note 20, at 173.

⁴² *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (U.S. 1976).

recordkeeping and reporting requirements, which were intended to promote maternal health.⁴³ Given the statute's objective and that the statute was reasonably designed to preserve patient confidentiality, the Court held the statute constitutional.⁴⁴ It was inferred from this ruling that privacy interests may sometimes be forfeited in exchange for important state interests, such as the preservation of maternal health.⁴⁵

One year later, in *Whalen v. Roe*, physicians and patients brought suit against the Commissioner of Health of New York, arguing that a New York statute requiring the recordation of names and addresses of every person who obtained prescription medication for certain drugs was unconstitutional.⁴⁶ The appellees argued that the statute impermissibly invades a "zone of privacy" accorded by the Constitution to doctor-patient relationships.⁴⁷ The Court disagreed, reversing the District Court's finding that the statute was unconstitutional. The Court based its decision on the fact that the two interests involved – "the individual interest in avoiding disclosure of personal matters" and "the interest in independence in making certain kinds of important decisions" – were insufficiently impaired to constitute a violation.⁴⁸ Furthermore, it believed that the statute provided adequate protection against the disclosure of patients' names, that the disclosures mandated by the Department of Health closely resembled other disclosures required for public health purposes, that the argument that the statute would prevent lawful uses of drugs was unsound, and that the statute did not strip patients of their ability to decide on their own whether to use covered medications.⁴⁹

⁴³ Danforth, *supra* note 42, at 76.

⁴⁴ Danforth, *supra* note 42, at 54.

⁴⁵ Cleaver, *supra* note 20, at 174-175.

⁴⁶ *Whalen v. Roe*, 429 U.S. 589 (U.S. 1977).

⁴⁷ *Whalen*, *supra* note 46, at 598.

⁴⁸ *Whalen*, *supra* note 46, at 599-600.

⁴⁹ Cleaver, *supra* note 20, at 174.

Two decades later, the U.S. Department of Health & Human Services set forth national standards governing the protection of individuals' health information by issuing the Privacy Rule (45 C.F.R. § 164.502(b)) in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.⁵⁰ The Privacy Rule covers health plans, health care clearinghouses, and “any health care provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA.”⁵¹ It protects individually identifiable health information that is either held or transmitted by a covered entity in any form or media.⁵² This information is referred to as “protected health information (PHI).”⁵³

II. THE IMPORTANCE OF PRIVACY LAWS TO THE INDIVIDUAL AND TO THE PUBLIC

It is widely accepted that individuals desire privacy over their personal details, and this is especially true with respect to their medical information. Survey evidence reveals that a majority of respondents strongly wish to restrict access to this information and are only willing to disclose it for extremely limited purposes, such as medical research studies conducted by the government or by academia.⁵⁴ Otherwise, the respondents exhibited a near-absolute reluctance to grant third parties access to their records (*e.g.*, private hospitals offering preventative care programs).⁵⁵

A 2005 California HealthCare Foundation survey found that one out of eight respondents was so concerned with the privacy of his health information that he took steps to protect the information himself, potentially placing his health at risk or imposing financial hardships onto

⁵⁰ Summary of the HIPAA Privacy Rule, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, *available at* <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html> (last visited October 28, 2012).

⁵¹ Summary of the HIPAA Privacy Rule, *supra* note 50.

⁵² Summary of the HIPAA Privacy Rule, *supra* note 50.

⁵³ Summary of the HIPAA Privacy Rule, *supra* note 50.

⁵⁴ Medical Privacy and Confidentiality Survey Summary and Overview, CALIFORNIA HEALTHCARE FOUNDATION, *available at* <http://www.chcf.org/publications/1999/01/medical-privacy-and-confidentiality-survey> (last visited October 28, 2012).

⁵⁵ National Consumer Health Privacy Survey 2005, *supra* note 28.

himself in the process.⁵⁶ These behaviors included seeking out new doctors, requesting that his health information not be recorded or that a diagnosis be falsified, forgoing insurance coverage so that a claim would not have to be filed, or completely evading medical care. The Privacy Rule was designed to reduce such behavior, since the perceived strength of confidentiality protections bears directly upon an individual's decision to seek treatment, especially in mental health and substance abuse cases.⁵⁷

Recognizing the public's attitudes toward maintaining the confidentiality of their personal information, the drafters anchored the Privacy Rule in the "minimum necessary" use and disclosure principle.⁵⁸ Covered entities must now make reasonable efforts to use, disclose, and request the minimum amount of PHI necessary for the intended purpose.⁵⁹ To attain this goal, they must design and implement their own policies and procedures to limit uses and disclosures to the minimum necessary.⁶⁰ When the minimum necessary standard governs a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for any given purpose, unless it can justify its need for the whole record as reasonably necessary for the purpose.⁶¹

A. HIPAA Privacy Rule Enacted to Protect Individuals' Health Information

If the individual does choose to seek therapy despite his or her privacy concerns, its efficacy may be impeded, because a person's willingness to make self-disclosures needed for medical treatment may decrease as the perceived negative consequences of a privacy breach increase.⁶² Similarly, the United States Supreme Court observed in 1996 that "psychotherapy . . .

⁵⁶ National Consumer Health Privacy Survey 2005, *supra* note 28.

⁵⁷ Pritts, *supra* note 7, at 6.

⁵⁸ Summary of the HIPAA Privacy Rule, *supra* note 50.

⁵⁹ Summary of the HIPAA Privacy Rule, *supra* note 50.

⁶⁰ Summary of the HIPAA Privacy Rule, *supra* note 50.

⁶¹ Summary of the HIPAA Privacy Rule, *supra* note 50.

⁶² Pritts, *supra* note 7, at 6.

depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears.”⁶³ The Privacy Rule fosters this kind of atmosphere by making patients feel safe in revealing their personal thoughts to their doctors, no matter how embarrassing or shameful the disclosure may be, knowing that the latter will be subjected to severe penalties if they fail to safeguard this information.⁶⁴

Since the rule promotes such full and frank communication between doctors and patients, it also plays a vital role in ensuring that patients receive optimal medical care. Owing to the exception for treatment purposes, the Privacy Rule authorizes personal information to be released during the provision of health care and related services, including consultation between providers regarding a patient.⁶⁵ In fact, one of the primary goals of the Privacy Rule is to facilitate the flow of health information needed to “provide and promote high quality health care and to protect the public’s health and well being.”⁶⁶

The Privacy Rule is also necessary in enabling patient autonomy, which is the patient’s ability to control the course of his or her own medical treatment and to participate in the treatment decision-making process. By conferring upon individuals a privacy right over their medical records, the rule frees patients from any restraints that may prevent them from acting out of their own volition. This is because patients can feel confident attending therapy sessions, knowing that their most intimate thoughts and feelings will never be exposed to the public for reasons unrelated to treatment or necessity. Under this paradigm, patients retain control over their own affairs by maintaining control over the use and disclosure of their private information.

⁶³ Jaffee v. Redmond, 518 U.S. 1, 10 (U.S. 1996).

⁶⁴ Summary of the HIPAA Privacy Rule, *supra* note 50 (citing civil penalties ranging from \$100 to \$50,000 or more per violation and criminal penalties of up to \$50,000 and one-year imprisonment, or more, depending on the nature of the violation).

⁶⁵ Summary of the HIPAA Privacy Rule, *supra* note 50.

⁶⁶ Summary of the HIPAA Privacy Rule, *supra* note 50.

The Rule also facilitates individual autonomy in several aspects of a patient's life. First and foremost, patients are able to maintain their dignity by keeping aspects of their lives or certain behaviors that they deem humiliating from the public sphere.⁶⁷ This way, individuals have control over who has access to private information about them and why.⁶⁸ Second, the Rule makes it possible for individuals to maintain and control a variety of social relationships.⁶⁹ Thus, an individual is able to adapt his behavior to interactions with different people in different environments, such as his boss at work or his psychologist during a therapy session.⁷⁰ This allows the individual to remain in charge of his personal affairs, rather than feeling constrained by the threat of public disclosure of his private information.⁷¹ Third, guaranteed privacy allows a person to make independent decisions without coercion bearing down on his decision-making.⁷² Individuals are thus encouraged to be themselves and to perhaps behave in ways that are socially deviant now that the Privacy Rule has provided a safe environment for them to do so.⁷³

Privacy also benefits society as a whole, because it makes possible a free society.⁷⁴ Large-scale surveillance measures, such as national databases and CCTV cameras, threaten not just the individual's fundamental value of personhood but also the nature of our society.⁷⁵ Preserving the individual's private sphere furthers the goal of maintaining a free society, because such a society cannot be had if individuals have no personal space to which they can retreat from governmental intrusion when they wish to do so.⁷⁶

⁶⁷ Pritts, *supra* note 7, at 4.

⁶⁸ Pritts, *supra* note 7, at 4.

⁶⁹ Pritts, *supra* note 7, at 4.

⁷⁰ Pritts, *supra* note 7, at 4.

⁷¹ Pritts, *supra* note 7, at 4.

⁷² Pritts, *supra* note 7, at 4.

⁷³ Pritts, *supra* note 7, at 4.

⁷⁴ Pritts, *supra* note 7, at 5.

⁷⁵ Pritts, *supra* note 7, at 5.

⁷⁶ Pritts, *supra* note 7, at 5.

While privacy over PHI often comes up in health care provider contexts, the concern extends to various other aspects of the individuals' lives, especially to situations in which the individuals are concerned about the potential misuse of this information. For example, approximately six out of ten respondents indicated that they would not grant potential employers access to their medical records out of fear of employment discrimination. Other reasons for individuals' reluctance include the potential consequences of "social stigma, insurance discrimination, . . . and, for addictions, possible criminal prosecution, job termination, forfeiture of legal protections such as protection under the Americans with Disabilities Act, or the right to receive disability benefits."⁷⁷ Clearly, the respondents had good reason to think twice before disclosing their information, because there are significant consequences at stake. Lastly, respondents were least willing to share their PHI with pharmaceutical companies to be used in the marketing of new drugs and other related products, possibly because they believed that these for-profit companies possessed little interest in the protection of their information.⁷⁸

Taking into consideration the fact that privacy is not an absolute right and that this interest can sometimes yield to public safety interests, the Privacy Rule attempts to alleviate the tension between these two competing interests by drawing a distinction between "permitted" and "authorized" uses and disclosures of PHI depending on the nature and the intended use of the information.⁷⁹ "Permitted" uses and disclosures are those that are permitted, but not required, without an individual's authorization for the following six purposes:

- (1) To the Individual (unless required for access or accounting of disclosures);
 - (2) Treatment, Payment, and Health Care Operations;
 - (3) Opportunity to Agree or Object;
 - (4) Incident to an otherwise permitted use and disclosure;
 - (5) Public Interest and Benefit Activities; and
 - (6) Limited Data Set for the purposes of research, public health or health care operations.¹⁸
- Covered entities may rely on

⁷⁷ National Consumer Health Privacy Survey 2005, *supra* note 28, at 2.

⁷⁸ National Consumer Health Privacy Survey 2005, *supra* note 28.

⁷⁹ National Consumer Health Privacy Survey 2005, *supra* note 28.

professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.⁸⁰

On the other hand, “authorized” uses and disclosures are those that require the individual’s written authorization for purposes other than treatment, payment, or health care operations or for reasons that are otherwise permitted or required under the rule.⁸¹

B. Separate “Psychotherapy Notes” Provision Offers Increased Privacy

While the distinction between “permitted” and “authorized” uses and disclosures of PHI noted above pertains to medical records, HIPAA established an entirely separate category for psychotherapy notes. This is due to the greater degree of privacy warranted by the especially sensitive contents of such documents.⁸² To receive this increased protection, psychotherapy notes must be kept physically separate from a patient’s medical records, or else they will be treated like ordinary medical records.⁸³

By definition, psychotherapy notes are “detailed notes that are recorded in any medium (paper or electronic) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session.”⁸⁴ These are sometimes referred to as “process notes” within the profession, because they are the doctor’s personal impression notes regarding a patient during a therapy session.⁸⁵ It is worth noting that the definition explicitly excludes the following: clinical test results, the modality and frequency of furnished treatments, the length of counseling sessions, and

⁸⁰ Cleaver, *supra* note 20.

⁸¹ Cleaver, *supra* note 20.

⁸² Psychotherapy Notes, TMA Privacy Office Guidance, *available at* <http://www.tricare.mil/tma/privacy> (last visited October 28, 2012).

⁸³ California HealthCare Foundation, *supra* note 49.

⁸⁴ California HealthCare Foundation, *supra* note 49.

⁸⁵ American Psychological Association, More Protections for Patients and Psychologists Under HIPAA, *available at* <http://www.apa.org/monitor/feb03/hipaa.aspx>.

summaries of the diagnosis, functional status, treatment plan, symptoms, prognosis, or progress to date.⁸⁶ Except when psychotherapy notes are used by their originators to provide treatment, or by entities covered under HIPAA for certain health care operations, uses and disclosures of psychotherapy notes for treatment, payment, and health care operations require the individual's written authorization.⁸⁷

A positive implication of the psychotherapy notes provision is that such information is given notably increased protection, especially against third-party payors, than it was in the past.⁸⁸ Unlike before, disclosure of psychotherapy notes now require specific permission from the patient, rather than just generalized consent.⁸⁹ The authorization must also be for psychotherapy notes only, meaning that the notes may not include any other PHI.⁹⁰ In addition, insurance companies can no longer request entire patient records to determine insurance eligibility or coverage.⁹¹ Therefore, health plans cannot refuse to reimburse patients for medical expenses if they decline to release information covered under the psychotherapy notes provision.⁹²

III. PROBLEMS UNDERLYING CURRENT HEALTH INFORMATION PRIVACY LAWS

HIPAA and the Family Education Rights and Privacy Act of 1974 (FERPA) are the two federal laws governing how postsecondary institutions must handle their students' mental health records.⁹³ Unfortunately, the two acts do not mesh very well and have engendered confusion

⁸⁶ California HealthCare Foundation, *supra* note 49.

⁸⁷ U.S. Department of Health & Human Services, *Uses and Disclosures for Treatment, Payment, and Health Care Operations*, available at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>.

⁸⁸ California HealthCare Foundation, *supra* note 49.

⁸⁹ California HealthCare Foundation, *supra* note 49.

⁹⁰ Yale University HIPAA Privacy Office, Clinician's Guide to HIPAA Privacy, available at <http://hipaa.yale.edu/resources/docs/HIPAA-Clinician-inside.pdf>.

⁹¹ Psychotherapy Notes, *supra* note 82.

⁹² Psychotherapy Notes, *supra* note 82.

⁹³ Sandra Barboza, Susan Epps, Randy Byington, Shane Keene, *HIPAA Goes to School: Clarifying Privacy Laws in the Education Environment*, The Internet Journal of Law, Healthcare, and Ethics (2010).

about when each act applies and to what extent.⁹⁴ To begin with, HIPAA establishes the “floor” on privacy rights, which allows states to adopt more stringent medical privacy laws if they so desire.⁹⁵ It is quite possible that a state has adopted laws that give individuals greater privacy rights than those granted under HIPAA.⁹⁶ However, states cannot pass any law that takes away any of the individual’s HIPAA rights due to the preemption provisions contained in the act.⁹⁷

Confusion is further compounded when additional state regulations and common law rules apply. “Due to the complexity and ambiguity of federal regulations, and the vast amount of State privacy law which must be analyzed . . . the HIPAA preemption analysis is considered to be one of if not the most challenging aspects of HIPAA implementation.”⁹⁸ Furthermore, these conflict of laws analyses can change, as state laws can be revised and new laws can be promulgated, which will necessitate new analyses.⁹⁹ This is also true of HIPAA, which has been amended twice since the Privacy Rule was issued in December 2000, with the most recent modification having taken place in August of 2002.¹⁰⁰

A. The Interplay of HIPAA and FERPA

The interplay of HIPAA and FERPA seems especially relevant to mental health counselors and school officials who do not have sufficient legal knowledge to conduct a proper analysis. In fact, having examined various universities’ memoranda to faculty and staff explaining the school’s policy on the use and disclosure of psychotherapy notes, it was found that they merely reprint the law without adding any original comments, such as

⁹⁴ Lesley McBain, *Balancing Student Privacy, Campus Security, and Public Safety: Issues for Campus Leaders*, American Association of State Colleges and Universities (2008).

⁹⁵ Stephen A. Stuart, California Office of HIPAA Implementation, *HIPAA State/State Law Preemption Fact Sheet* (2003).

⁹⁶ Stuart, *supra* note 96, at 1.

⁹⁷ Stuart, *supra* note 96, at 1.

⁹⁸ Stuart, *supra* note 91, at 1.

⁹⁹ Stuart, *supra* note 91, at 1.

¹⁰⁰ Stuart, *supra* note 91, at 1.

recommendations as to how that particular school can achieve compliance.¹⁰¹ Common components of such memoranda included very basic information such as the definitions of key HIPAA vocabulary terms, a brief overview of the act's purpose, and general protocols copied verbatim from the act.¹⁰²

Nevertheless, it is still important to determine how HIPAA and FERPA work together to ensure the proper withholding, as well as the proper disclosure, of protected information. In general, HIPAA is viewed as applicable to health care settings, while FERPA is geared towards school settings.¹⁰³ Specifically, FERPA was created to give parents the right to review their children's education records.¹⁰⁴ When a student turns eighteen years old or attains any education beyond high school, the parental rights transfer to that student.¹⁰⁵

While FERPA does not explicitly address health records, any record that is created and maintained for school-related purposes is considered to be part of the student's education record.¹⁰⁶ Like HIPAA, FERPA imposes strict requirements on the use and disclosure of information contained in such education records.¹⁰⁷ Although many people appreciate these corresponding privacy provisions, they fail to realize that the latter discourages school officials from releasing information even in emergent situations.¹⁰⁸

This problem has been exacerbated by school officials' uncertainty as to which privacy regulation to apply to the disclosure of student health records, which may fall under the Privacy Rule's definition of "medical records" but also under FERPA's definition of "education

¹⁰¹ University of Washington, *Psychotherapy Notes Management*; California State University, Northridge, *Use and Disclosure of Psychotherapy Notes*; University of Arkansas, *Psychotherapy Notes Policy*; Columbia University, *Confidentiality of Psychotherapy and Personal Notes*.

¹⁰² Stuart, *supra* note 91.

¹⁰³ Stuart, *supra* note 91.

¹⁰⁴ Summary of the HIPAA Privacy Rule, *supra* note 50.

¹⁰⁵ Celina Muñoz, *Privacy at the Cost of Public Safety: Reevaluating Mental Health Laws in the Wake of the Virginia Tech Shootings*, S. CAL. INTERDISC. L.J. 161, 184 (2008).

¹⁰⁶ Stuart, *supra* note 91.

¹⁰⁷ Stuart, *supra* note 91.

¹⁰⁸ Stuart, *supra* note 91.

records.”¹⁰⁹ Some commentators believe that this very confusion contributed to the 2007 Virginia Tech shootings, which they argue could have been avoided had the university been given clear guidance on how to comply with these two rules.¹¹⁰

B. The 2007 Virginia Tech Shooting: Limitations of Current Privacy Laws

The shooter, Seung Hui Cho, had a long history of engaging in antisocial behavior dating back to early childhood, which concerned his teachers and peers to the point that they feared being in the same room as him.¹¹¹ Before starting seventh grade, Cho was ordered to receive counseling and was diagnosed with social anxiety disorder.¹¹² During eighth grade, following the Columbine High School shooting, Cho revealed that he wanted to repeat those attacks.¹¹³ By the end of that school year, it was documented that Cho had suicidal and homicidal tendencies.¹¹⁴ Following additional therapy sessions, Cho was diagnosed with selective mutism and was prescribed antidepressants, which his doctor discontinued after a year, believing that Cho’s condition had sufficiently improved.¹¹⁵

In high school, Cho was placed in a special education program to help him overcome his disorder and performed well, earning A’s and B’s in his classes.¹¹⁶ Although his parents, teachers, and mental health counselors provided continued support for Cho, he refused to receive additional treatment by his junior year, declaring that nothing was wrong with him.¹¹⁷ When it

¹⁰⁹ Stuart, *supra* note 91.

¹¹⁰ Stuart, *supra* note 91.

¹¹¹ Muñoz, *supra* note 105, at 164.

¹¹² Muñoz, *supra* note 105, at 164.

¹¹³ Muñoz, *supra* note 105, at 164.

¹¹⁴ Muñoz, *supra* note 105, at 164.

¹¹⁵ Muñoz, *supra* note 105, at 164.

¹¹⁶ Muñoz, *supra* note 105, at 164.

¹¹⁷ Muñoz, *supra* note 105, at 164.

came time for Cho to attend college, a school guidance counselor recommended that he choose a local college close to home, but he was determined to attend Virginia Tech.¹¹⁸

Cho's freshman and sophomore years in college were uneventful, but his problems resurfaced during the fall of his junior year, possibly because he no longer had the special support system that was present during high school.¹¹⁹ Due to the privacy laws governing students' mental health histories, Virginia Tech administrators and professors were never informed about Cho's condition. In fact, the only way in which they could have acquired this information is if Cho's parents voluntarily provided them with it.¹²⁰

From that point onward, Cho proved to be a distraction to his English class by wearing reflective sunglasses, hats, and scarves to lectures and penning extremely violent papers that made his classmates uncomfortable in class.¹²¹ His conduct was reported to the Dean, the Judicial Affairs Director, and the University's Care Team, but they chose not to take any forceful action.¹²² The head of the English Department, Dr. Lucinda Roy, also met with Cho to discuss the possibility of private tutoring, during which she observed that Cho "seemed depressed, lonely, and very troubled."¹²³

Life at the dorms fared no better. After multiple attempts, his roommates gave up on trying to befriend him after he stabbed a carpet in a girl's room.¹²⁴ In November and December of 2005, female residents complained of Cho's annoying instant messages, emails, and phone calls.¹²⁵ After campus police told Cho to stop contacting one particular female student, he told

¹¹⁸ Associated Press, *Portrait of a Killer*, available at <http://www.guardian.co.uk/world/2007/aug/30/internationaleducationnews.highereducation>.

¹¹⁹ Associated Press, *supra* note 116.

¹²⁰ Muñoz, *supra* note 105, at 165.

¹²¹ Associated Press, *supra* note 116.

¹²² Muñoz, *supra* note 105, at 166.

¹²³ Muñoz, *supra* note 105, at 166.

¹²⁴ Associated Press, *supra* note 116.

¹²⁵ Associated Press, *supra* note 116.

his roommates, "I might as well kill myself now."¹²⁶ The statement prompted a psychiatric evaluation by a clinical social worker, who found that Cho was "mentally ill, was an imminent danger to self or others, and was not willing to be treated voluntarily." He was then admitted into a hospital, where he was discharged the next day.¹²⁷ Three days later, Cho affirmatively called the university's counseling center for the first time and scheduled an appointment but failed to show up.¹²⁸ Although Cho called the center a second time, he did not make an appointment.¹²⁹ During the next months, Cho continued to write violent stories, one of which bore a striking resemblance to the actual shootings that would take place.¹³⁰

Many people believe that given the numerous warning signs of Cho's mental instability, school authorities had more than enough opportunities to intervene and possibly prevent the shootings. However, the school's failure to act was probably due to its ignorance of the interplay of HIPPA, FERPA, and Virginia state laws. The school was also overzealous in complying with the privacy rules, erring on the safe side of protecting Cho's mental health records even when he posed a threat to others.¹³¹

Additionally, during Cho's transition from his special education program in high school to Virginia Tech – where he lacked a designated support system – there was no continuity in the communication or care regarding his mental health condition. This was evidenced in his sudden decline in performance in classes and the fact that he grew increasingly lonely and depressed over his years there. Due to the stringent privacy laws in place and the possible consequences

¹²⁶ Associated Press, *supra* note 116.

¹²⁷ Muñoz, *supra* note 105, at 167.

¹²⁸ Muñoz, *supra* note 105, at 166.

¹²⁹ Muñoz, *supra* note 105, at 166.

¹³⁰ Muñoz, *supra* note 105, at 167-168.

¹³¹ Associated Press, *supra* note 116.

for violating them, the university was never given, nor did it ever receive, any information regarding Cho's mental state.¹³²

Health care providers at schools have long questioned which of the various privacy laws apply to student health information.¹³³ At postsecondary institutions, a student's mental health treatment records are excluded from the definition of education records if they are used only in connection with the treatment and disclosed only to those providing the treatment.¹³⁴ Education records contain information ranging from a student's date and place of birth, parent and emergency contact information, grades, test scores, special education records, disciplinary records, medical records that the school creates itself or collects from other entities, documentation of attendance, schools attended, and courses taken, to personal information such as the student's social security number.¹³⁵ FERPA provisions only apply when education records are released to such individuals as the student, the student's parents, professors, or any health care provider outside of the school.¹³⁶

For the most part, schools are under no obligation to release student medical records created by campus officials unless certain requirements are met, at which point they are usually required to obtain the student's written, dated consent.¹³⁷ There are limited exceptions as to when a student's authorization is not mandated before disclosure, such as when campus officials seek those records to further "legitimate educational interests" or during emergency situations when the health or safety of that student or other persons are at risk.¹³⁸ FERPA is not so extensive as to cover officials' personal observations or conversations with students, which

¹³² Muñoz, *supra* note 105, at 169.

¹³³ Psychotherapy Notes, *supra* note 83.

¹³⁴ Psychotherapy Notes, *supra* note 83.

¹³⁵ Psychotherapy Notes, *supra* note 83.

¹³⁶ Muñoz, *supra* note 105, at 174.

¹³⁷ Muñoz, *supra* note 105, at 174-175.

¹³⁸ Muñoz, *supra* note 105, at 175.

means that officials are free to report any unusual behavior to the proper authorities.¹³⁹ Despite this allowance, the disclosure must also be consistent with applicable law and standards of ethical conduct, which imposes yet another hurdle for school officials to clear despite their lack of expertise in these laws.¹⁴⁰

One last, but very significant, reason as to why federally-funded schools, which fall within the ambit of FERPA, are so reluctant to release students' medical records is the fear of having their funding revoked if they fail to comply with the rule.¹⁴¹ To minimize the chances of this happening, schools play it safe by granting very few, if any, disclosures. As a result, school officials and the parents of troubled children are much less likely to be informed of a child's mental health condition unless it is egregiously bad. This, in turn, makes it less likely for schools and parents to detect problems and intervene to protect the child's or the public's safety.

IV. PROPOSALS FOR CHANGE

While privacy is considered to be a fundamental right owed to individuals, this interest can conflict with societal interests, such as the health and safety of the general public. For instance, modern privacy laws have led to a blanket adherence to withhold health information even when it is not required, such as when substantial public interests are at stake. As such, the government's increasing emphasis on privacy has resulted in harmful threats to society's various other interests. Since the individual's right to privacy and society's right to safety cannot co-exist equally, legislators must pay special attention to how providing for one interest will affect the other.

¹³⁹ Muñoz, *supra* note 105, at 175.

¹⁴⁰ Rhonda Williams, *HIPAA or FERPA or Not*, available at http://www.ascaschoolcounselor.org/article_content.asp?edition=91§ion=140&article=1159.

¹⁴¹ Muñoz, *supra* note 105, at 175.

To eliminate confusion as to which federal act controls in a given scenario, Congress should explicitly state what falls within the scope, as well as what falls outside of the scope, of each of the two rules. It should modify HIPAA to read that FERPA alone covers “educational records,” rather than merely leaving them out of the definition of PHI.¹⁴² Similarly, Congress should amend FERPA to read that this act has exclusive authority over said educational records.

In addition, the two FERPA exceptions that deal with the student privacy/public safety dichotomy should be clarified. The exceptions for non-disclosure are (1) when there is a “legitimate educational interest” and (2) in emergency situations, if it is “necessary to protect the health or safety of the student or other persons.”¹⁴³ The first exception covering legitimate educational interests should be demonstrated with examples, as they are ill-defined in the act. As a result, the exception may be subject to abuse, thereby decreasing students’ confidence in the rule’s ability to protect their privacy interests.

The second exception regarding health and safety should delineate what kinds of situations constitute emergencies. Clarification is especially important, because officials must be able to quickly assess a given situation and respond decisively. Promoting such certainty would maximize officials’ chances of successfully handling emergencies.

Another way to overcome school officials’ reluctance to disclose student health records is to mandate the Department of Education, or compensate private law firms, to draft online guides as to how the various federal and state privacy rules interact in their geographic region. If drafted by private firms, these guides should be reviewed by the Department of Education for accuracy and thoroughness before being published. The firms could be further incentivized to gather questions from the local public and to answer the most frequently asked ones on a regular

¹⁴² Muñoz, *supra* note 105, at 183.

¹⁴³ Muñoz, *supra* note 105, at 183.

basis (e.g., bi-annually). The Department of Education should also consider hosting its own, or supporting private companies', webinars explaining the rules in depth, subsidizing the costs for participants or granting financial aid to the hosts. This in turn will lower the admission price for attendees or offset the costs that the hosts incur.

To encourage disclosure, mental health providers should also be given a safe harbor for doing so.¹⁴⁴ The safe harbor would shield providers who release information on a good faith basis from being charged or penalized for the disclosure. However, due to the overlap between HIPAA and FERPA, it should be made clear how the two impact one another before a safe harbor is implemented. Although HIPAA omits educational records from its definition of protected health information, it should be revised so that it specifies which regulations (i.e., FERPA) do cover this class of items. This change will eliminate uncertainties about which regulations permit which disclosures, encouraging health care providers to disclose private information when appropriate. In fact, while the U.S. Department of Education and the U.S. Department of Health and Human Services published the "Joint Guidance on the Application of the Family Education Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Students' Health Records" in the aftermath of the 2007 Virginia Tech shooting, many questions still remain as to the scope of each of these acts.

Alternatively, because public safety is of paramount importance to society, the federal government should consider encouraging disclosure over privacy interests in certain limited circumstances. Although privacy has historically been highly valued, there are analogous situations in which disclosure is required. This is true in domestic violence situations, where school teachers and administrators are required to report such incidents to the authorities, even

¹⁴⁴ Psychotherapy Notes, *supra* note 83.

though this would intrude upon the individual and the family's sphere of privacy.¹⁴⁵ This can be achieved by imposing an affirmative duty to disclose upon schools to ensure a greater likelihood of identifying and treating students who pose a threat to himself or to others before it is too late for intervention. This duty can be conditioned on the school official's good faith belief that the student poses such a threat.

The federal government could take this a step further by making it easier for school officials to decide whether or not to disclose a student's information, increasing their likelihood of doing so. Instead of requiring officials to decide whether or not to report a student because he is potentially dangerous to others, they should be required to report all incidents of aberrant behavior. This would reduce guesswork and would not be as heavily dependent upon the official's discretion, which is subject to variation. The reports could then be relayed to the university's centralized "threat assessment group," which would consist of officials of various capacities across the university who have interacted with the student in question.¹⁴⁶ Such members would include student services personnel, faculty, campus law enforcement, off-campus law enforcement, mental health services providers, and any other personnel as deemed necessary.¹⁴⁷ Collectively, they could devise a much more comprehensive plan for the student based on their combined insights than they could alone. During these threat assessment group meetings, the members would also be informed about the student's latest condition. The members would thus become alerted to what signs they should watch for in the student, as well as what they should do in the event of an emergency. The group as a whole would then become obligated to act upon any emergency reports to protect the campus community.¹⁴⁸

¹⁴⁵ Child Welfare Information Gateway, *Mandatory Reporters of Child Abuse and Neglect: Summary of State Laws*, available at http://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm (2008).

¹⁴⁶ McBain, *supra* note 95, at 9.

¹⁴⁷ McBain, *supra* note 95, at 17.

¹⁴⁸ McBain, *supra* note 95, at 9.

As witnessed from the Virginia Tech tragedy, fragmented communication across different divisions of the university prevented any one individual from consolidating the numerous incidents of Cho's aberrant behavior into a "coherent whole."¹⁴⁹ Centralizing the process of evaluating unusual student behavior via threat assessment groups will allow different sources to contribute their input and enable extensive communications across the university level. This will amount to a proactive and effective treatment system, rather than one that lets students like Cho slip through the cracks.¹⁵⁰

In step with the current Privacy Rule, any disclosure should still be limited only to those individuals who are involved in the student's treatment¹⁵¹ or hold administrative positions at the student's school. Whoever makes the disclosure should also substantiate his reasons for the disclosure. Several factors that should guide an individual's decision as to whether or not to disclose protected information include, but are not limited to, the severity of the student's condition or mental health status, the duration of such condition or status, and whether or not there exists an imminent harm to any person.

CONCLUSION

In any given society, privacy rights will continue to be of prime importance to individuals, but there are certain limited situations in which it should yield to the greater interest of public safety. Although the interplay of various federal and state privacy regulations can be daunting, it is important to use these laws for the benefit of protecting the safety of the student, his peers, and the general public. School officials should be encouraged to disclose a student's health information when there is a reasonable, good faith belief that the student poses an immediate threat to himself or to others, and they should be guided by the Department of

¹⁴⁹ McBain, *supra* note 95, at 17.

¹⁵⁰ McBain, *supra* note 95, at 17.

¹⁵¹ Psychotherapy Notes, *supra* note 83.

Education on how to do so. Imposing a restriction as to who can use and disclose a student's information to those individuals necessary for treatment should obviate invasion of privacy concerns, because it would limit such use to legitimate purposes. By fostering an environment in which these officials no longer hide behind complex regulations to avoid making difficult decisions, the federal government will be better able to preserve the individual's privacy interest while simultaneously protecting the safety of the general public.