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Legal Protection for the Confidentiality of Health Care Information in Pennsylvania: Patient and Client Recovery for Unauthorized Extra-Legal Disclosure

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LEGAL PROTECTION FOR THE CONFIDENTIALITY OF HEALTH CARE INFORMATION IN PENNSYLVANIA: PATIENT AND CLIENT ACCESS; TESTIMONIAL PRIVILEGES; DAMAGE RECOVERY FOR UNAUTHORIZED EXTRA-LEGAL DISCLOSURE

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This article is the result of research on privacy and confidentiality over a much too long period of time. It would not have been possible to complete a project of this dimension without the tireless work of student research assistants. I wish especially to express my appreciation to Robert Erickson and Fran McElhill. Several of my colleagues were helpful in identifying problems with portions of the draft. Gerry Abraham supplied me with valuable insights on confidentiality law and problems in Pennsylvania, and Leonard Packer's suggestions on the evidentiary aspects of the testimonial privilege section were especially helpful. The article would not have been possible if Arnold Cohen, Director of Villanova's Continuing Legal Education Program had not encouraged me to concretize my views on the Law of Confidentiality by holding a program at Villanova. Doris Brogan was helpful in reading portions of the text for clarity. Dan Taube's comments on the draft were also useful. I have gained much from discussions with health lawyers over the years, but special appreciation is extended to Joe Sebastianelli. My thanks are especially extended to the Villanova Law Review for tireless efforts in source checking and correcting citation errors or omissions. Sharon Sugarman, Articles Editor of the Law Review, deserves to be singled out for heroic efforts and patience in integrating the many changes that the manuscript went through.

None of the above share any of the responsibilities for the wrongheaded thinking and errors of substance that may be contained in the article; this is the responsibility of the author alone.

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I. INTRODUCTION

HOSPITAL administrators and health care providers are faced with increasing demands for access to health care information. This is the result of several factors. Perhaps the foremost is the increased monitoring of private and government reimbursement programs.¹ The maturing of computer technology and the

1. Federal programs under the Social Security Act have provided for partially or exclusively supported federal health insurance for the elderly (Medicare) and the indigent (Medicaid). See Health Insurance for the Aged Act, Pub. L. No. 89-97, 79 Stat. 290 (1965). These programs originally provided for reimbursement for inpatient and outpatient care, physician services and other medical services. The coverage depended upon which of the two programs was utilized. In the last few years federal legislation and regulations have severely

availability of means for the inexpensive communication and storage of information as well as the increasing costs and growth in the health care industry have also been factors which contributed to the burgeoning demand for access to health care information.² At the same time, unprecedented laws have been enacted protecting the confidentiality of such information.³ The result is a myr-

restricted and tightly regulated reimbursement under Medicare and Medicaid. The most significant of these laws are: The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, 96 Stat. 324 (1982); Social Security Act Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65 (1983) (establishing Prospective Payment System (PPS)); and the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and 1986, Pub. L. No. 99-272, 100 Stat. 151 (1985); Pub. L. No. 99-509, 100 Stat. 1874 (1986). These amendments contain restrictive payment measures, including fee freezes for physicians who do not sign a participation agreement, a mandatory second surgical opinion program for elective surgery with denial of reimbursement if the patient did not seek a second opinion and ceilings on clinical laboratory fees and other services. The Health Care Quality Improvement Act of 1986 requires hospitals to report malpractice claims and disciplinary actions against physicians to a central federal agency. Pub. L. No. 99-660, 100 Stat. 3743 (1986). An analysis of the substance of these changes in the federal insurance and reimbursement system under Medicare and Medicaid is beyond the scope of this article. The impact of these changes have been significant, resulting in massive restructuring of the delivery of health care services as well as producing unprecedented demands on the information systems of health care institutions. One nationally recognized health care information management professional has suggested that the stricter scrutiny of health service charges and the reduced reimbursement of health care services constitutes the most serious threat to confidentiality. This is because the focus of information management has shifted more dramatically than before from confidentiality to providing information for reimbursement. Beyond that, the restructuring of reimbursement has resulted in more outpatient services and more health care services being farmed out from institutions to partnerships and smaller business entities of allied professions. This has also placed additional strains on confidentiality because of the increased sharing of health care information and the computerization of health records.

2. See PRIVACY PROTECTION STUDY COMM'N, THE REPORT OF THE PRIVACY PROTECTION STUDY COMM'N: PERSONAL PRIVACY IN AN INFORMATION SOCIETY 277 (1977) [hereinafter PRIVACY PROTECTION STUDY REPORT]; A. WESTIN, COMPUTERS, HEALTH RECORDS, AND CITIZEN RIGHTS (1976); Boyer, *Computerized Medical Records and the Right to Privacy: The Emerging Federal Response*, 25 BUFFALO L. REV. 37 (1975).

3. The important federal and state legislation and regulations protecting confidentiality have been enacted within the last two decades. The federal legislation and regulations protecting the confidentiality of drug and alcohol treatment records derive from three statutes. These are the Drug Abuse Office and Treatment Act of 1972, § 408 of Pub. L. No. 92-255, 21 U.S.C. § 1175, as amended by § 303 of Pub. L. No. 93-282, 88 Stat. 137, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, 42 U.S.C. § 4582, as amended by § 122(a) of Pub. L. No. 93-282, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974, 88 Stat. 131. The relevant section pertaining to confidentiality of patient records was originally codified at 42 U.S.C. § 4582 but has been transferred to 42 U.S.C. § 290dd-3 (Supp. III 1985), where it was codified as part of the Public Health Service Act. In Pennsylvania, a state law was enacted in 1972. See Pennsylvania Drug and Alcohol Abuse Control Act,

iad of federal and state statutory and regulatory provisions that leave the health care industry in Pennsylvania uncertain as to some of the most basic duties and responsibilities regarding confidentiality. The legal morass in which practitioners, health care providers and citizens find themselves regarding health care information in Pennsylvania is the impetus for this article.

This article will analyze the protection provided by law in Pennsylvania for the confidentiality of health care information in respect to three areas. First, it will explore the extent to which patients or clients have access to health care information in health records. Next, it will explore the extent to which there is legal protection against the disclosure of health care information in health legal proceedings. Finally, the article will analyze the extent to which protection is available against the disclosure of such information outside of legal proceedings (extra-legally).

A. *Some Foundation Concepts and Perspectives Regarding Health Care Information and Confidential Information*

All of the information that is acquired about a patient or client in the course of treatment is properly referred to as health care information.⁴ This includes information in the health records of institutions and professionals as well as other patient-identifiable information generated in the course of providing health care to the patient or client. "Health care information," as employed in this article, is a descriptive term that indicates all that

PA. STAT. ANN. tit. 71, § 1690.101 (Purdon 1972). Confidentiality regulations enacted pursuant thereto may be found at 4 PA. CODE §§ 255.4, 255.5; 28 PA. CODE §§ 157.23, 709.28 (1986). Regulations governing the confidentiality of records of patients in licensed hospitals were also promulgated in 1972. See 28 PA. CODE §§ 103.21, 115.27 (1972). In 1976, Pennsylvania enacted comprehensive legislation governing the confidentiality of records of patients or clients in mental health facilities. See Mental Health Procedure Act, PA. STAT. ANN. tit. 50 (Purdon 1976). Current regulations concerning confidentiality of such records were promulgated in 1979. 55 PA. CODE § 5100 (Purdon 1979). In addition to the federal legislation above, Congress enacted the Freedom of Information Act (FOIA) in 1966. 5 U.S.C. § 552 (1966). FOIA specifically exempts "medical files" from the general public access rights granted in respect to information in federal agency records. *Id.* § 552(b)(6).

The above statutes and regulations will be referred to in the body of this article where the confidentiality provisions contained therein impact on the activities of the health care practitioner in this state.

4. See generally ADVISORY PANEL ON PRIVACY AND CONFIDENTIALITY OF HOSPITAL RECORDS, AM. HOSP. ASS'N, GUIDELINES ON INSTITUTIONAL POLICIES FOR DISCLOSURE OF MEDICAL RECORD INFORMATION (1979); J.A. BRUCE, PRIVACY AND CONFIDENTIALITY OF HEALTH CARE INFORMATION (1984).

information which the health care industry acquires about a patient or client.

In contrast, the notion of "confidential information" is normative. To say that information is "confidential" is to say something about whether that information should be made public. The law of confidentiality in Pennsylvania regarding health care information consists of the court decisions, legislative enactments and administrative regulations that provide legal protection to patients and clients concerning disclosure of that information. In the course of treatment of patients and clients by physicians, psychologists, social workers and other health care practitioners, much of the health information acquired is viewed as confidential.⁵ By this I mean that those who are involved in the sharing and acquiring of information as part of the activity of treatment do not intend, expect or desire that their communications, testing or diagnosis be made public. If the health care practitioner is licensed, this most basic notion of confidentiality is reflected in licensing regulation proscriptions against the betrayal of secrets.⁶

5. A recent publication of the Pennsylvania Medical Records Association reflects the view of health care practitioners as to the extent to which health care information is viewed as confidential. It defines "confidential information" in this way:

Confidential information is a term used to classify that information contained in the medical record that is based on examination, treatment, observation, or conversation with the patient. It includes medical histories, reports of actions and findings, summaries, diagnoses and prognoses, records of treatment, medications ordered and administered, notes, entries, x-rays, and other written or graphic data prepared, maintained, or preserved in health care facilities pertaining to patients receiving inpatient, outpatient, or emergency care. The term "confidential information" also applies to that class of information contained in reports, records, evaluations, proceedings, notes, interviews, statements, memoranda, or other data of a hospital or hospital-organized medical staff committee or extended care facility consisting of medical or nursing audits, departmental evaluations, research studies, or corrective action investigations. Department of Health (DOH) hospital regulations mandate that all medical records be treated as confidential with access limited to authorized personnel. It is recommended that hospitals provide orientation and continuing education to hospital personnel regarding the confidentiality of patient treatment and records.

PENNSYLVANIA MEDICAL RECORD ASS'N AND THE HOSPITAL ASS'N OF PENNSYLVANIA ON UTILIZATION AND QUALITY ASSURANCE, GUIDELINES FOR THE RELEASE OF INFORMATION FROM THE MEDICAL RECORD 3 (1982) (citations omitted) [hereinafter GUIDELINES]; see also AMERICAN HOSPITAL ASS'N, HOSPITAL MEDICAL RECORDS 5 (1972).

6. A physician's duty of confidentiality has from time immemorial been embodied in the Hippocratic Oath. Each physician is required to take the oath upon entering the profession. The Oath reads in pertinent part:

Whatever in connection with my professional practice, or not in con-

The ethical standards of the profession of all health care practitioners, whether licensed or not, explicitly limit the circumstances

nection with it, I see or hear, in the life of men, which ought not be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.

The Principles of Medical Ethics reaffirms the duty of confidentiality embodied in the Hippocratic Oath:

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.

AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS § 9 (1957).

The principle of confidentiality contained in the licensing standards for psychologists in Pennsylvania reads:

Safeguarding information about an individual that has been obtained by the psychologist in the course of his teaching, practice, or investigation is a primary obligation of the psychologist. A person licensed as a psychologist under the provisions of the act, cannot, without the written consent of his client, be examined in a civil or criminal action as to any information acquired in the course of his professional service on behalf of the client. Information may be revealed with the consent of the clients affected only after a full disclosure to them and authorization by the client or clients. A psychologist shall exercise reasonable care to prevent his employees, associates and others whose services are utilized by him from disclosure or using the information of the client.

A psychologist may reveal the following information of a client when communicated to him.

(1) Information received in confidence is revealed only after most careful deliberation and when there is clear and imminent danger to an individual or to society, and then only to appropriate professional workers or public authorities.

(2) Information obtained in clinical or consulting relationships, or evaluative data concerning children, students, employees, and others are discussed only for professional purposes and only with persons clearly concerned with the case. Written and oral reports should present data germane to the purposes of the evaluation, every effort should be made to avoid undue invasion of privacy.

(3) Clinical and other materials are used in classroom teaching and writing only when the identity of the persons involved is adequately disguised.

(4) Confidentiality of professional communications about individuals is maintained. Only when the originator and other persons involved give their express written permission is a confidential professional communication shown to the individual concerned. The psychologist is responsible for informing the client of the limits of the confidentiality.

(5) Only after explicit permission has been granted is the identity of research subjects published. When data have been published without permission for identification, the psychologist assumes responsibility for adequately disguising their sources.

(6) The psychologist makes provisions for the maintenance of confidentiality in the preservation and ultimate disposition of confidential records.

49 PA. CODE § 41.61 (1978).

under which health care information may be disclosed and, thereby are reflections of the professions view that such information should be nonpublic (confidential).⁷

B. *Principles and Policies Supporting Confidentiality Requirements*

The concern by patients, clients and health care practitioners that health care information remain confidential is a reflection of two distinct yet interrelated notions: the integrity of the professional-client/patient relationship and the right to privacy. The former is a classic policy justification for confidentiality; the latter is a principle justification for confidentiality.

1. *The Instrumentalist Utilitarian Justification for Confidentiality*

The distinction between an argument of policy and an argument of principle is one that Professor Ronald Dworkin has developed in much of his work. Basically, policy arguments are those that identify a goal and assess the extent to which particular action does or does not promote that goal. They are arguments determining the extent to which actions are efficient in accomplishing something in society. Arguments of principle are those that support a particular position by invoking a proposition that is

7. An example of ethical standards of confidentiality defined in standards of the profession is Principle 5 of the Revised Ethical Principles of Psychologists which reads:

Confidentiality. Psychologists have a primary obligation to respect the confidentiality of information obtained from persons in the course of their work as psychologists. They reveal such information to others only with the consent of the person or the person's legal representative, except in those unusual circumstances in which not to do so would result in clear danger to the person or to others. Where appropriate, psychologists inform their clients of the legal limits of confidentiality.

(a) Information obtained in clinical or consulting relationships, or evaluative data concerning children, students, employees, and others, is discussed only for professional purposes and only with persons clearly concerned with the case. Written and oral reports present only data germane to the purposes of the evaluation, and every effort is made to avoid undue invasion of privacy.

(b) Psychologists who present personal information obtained during the course of professional work in writings, lectures, or other public forums either obtain adequate prior consent to do so or adequately disguise all identifying information.

(c) Psychologists make provisions for maintaining confidentiality in the storage and disposal of records.

(d) When working with minors or other persons who are unable to give voluntary, informed consent, psychologists take special care to protect the persons' best interests.

Ethical Principles of Psychologists, 36 AMERICAN PSYCHOLOGIST 635-38 (June 1981).

grounded in society's sense of justice and morality.⁸

The policy justification is that confidentiality of information acquired is necessary for effective treatment or therapy. Confidentiality encourages the unfettered exchange of information between the patient or client and the professional. Such uninhibited discourse is essential to effective treatment or therapy. Under this view of confidentiality, the immunity arising from non-public disclosure of health care information protects the integrity of the relationship by promoting trust between the patient or client and the professional.

This focus on the integrity of the relationship is instrumental. When this policy focus comes into play, the essential question is to what extent the public disclosure of the information would impair the trust between the professional and the patient or client. The approach is utilitarian; i.e. a goal is recognized (preserving the integrity of the relationship); then the extent to which particular government or private action efficiently does or does not promote this goal is evaluated.

2. *The Right to Privacy Justification for Confidentiality*

Another perspective on the underlying justification for confidentiality is embraced by various laws. Confidentiality is also sought for health care information in order to protect the patient's or client's right to privacy.

Since recognition of a legal right to privacy was initially and forcefully advocated by Brandeis and Warren in a 1890 Harvard Law Review article, the right has proliferated in our legal system. The right to privacy is employed by courts in a variety of senses, and to protect a bundle of interests. The multifaceted aspect of the right makes attempts at unitary definitions not especially use-

8. See R. DWORKIN, *TAKING RIGHTS SERIOUSLY* 1, 22-28 (1978). Professor Dworkin takes the position that when policy concerns directly collide with principle concerns in fundamental rights cases, the principle should be given primacy. *Id.*

This article adopts the distinction between policy and principle espoused by Professor Dworkin to the extent that it is useful to distinguish between the two kinds of arguments that are used to support confidentiality and to sort out the arguments that are in tension when access to health care information is before Pennsylvania courts. It does not, however, completely embrace Professor Dworkin's view of the primacy of principle.

The distinction between principle and policy developed by Professor Dworkin has been extensively commented upon and is not accepted by many scholars. See, e.g., *Jurisprudence Symposium*, 11 GA. L. REV. 969 (1977). One of the most significant of Dworkin's detractors is Professor Greenwalt. See Greenwalt, *Policy, Rights, and Judicial Decision*, 11 GA. L. REV. 991 (1977).

ful. Some of the most often invoked definitions of the right to privacy are: (1) the right to be let alone;⁹ (2) the condition of human life in which acquaintance with affairs of one's personal life is limited;¹⁰ (3) control over information;¹¹ and (4) the right of a person to be free of unwanted publicity.¹² As these definitions suggest a central branch of the right to privacy is the right of persons to decide for themselves whether others will have access to personal or intimate information about them. It is this informational privacy right that is generally invoked in support of confidentiality for health care information.¹³

A patient's or client's need for privacy with respect to health care information is not derived primarily from that person's concern about the integrity of the relationship between himself or herself and the professional. Rather, the need for the condition of privacy is a reflection of the patient's or client's most basic

9. Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890). The right has been employed by courts to protect interests in limiting acquaintance with personal affairs or informational privacy interests, by the use of constitutional law, torts and breach of implied warranty or contract theories. See, e.g., *York v. Story*, 324 F.2d 450 (9th Cir. 1963); *Knight v. Penobscot Bay Medical Center*, 420 A.2d 915 (Me. 1980); *Nader v. General Motors Corp.*, 25 N.Y.2d 560, 255 N.E.2d 765, 307 N.Y.S.2d 647 (1970). In addition, courts have employed the right to privacy to protect interests in (1) physical exclusiveness, *Stanley v. Georgia*, 394 U.S. 557 (1969) and (2) mental repose, *Kovacs v. Cooper*, 336 U.S. 557 (1969). Next to informational privacy, probably the most extensive and certainly the most controversial use of the right to privacy is to protect independence of personal decisionmaking or personal autonomy. See *Moore v. City of East Cleveland*, 431 U.S. 494 (1977); *Roe v. Wade*, 410 U.S. 113 (1973); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *State v. Pilcher*, 242 N.W.2d 348 (Iowa 1976). The Supreme Court has formally recognized that the Constitutional Right of Privacy has both an informational and personal autonomy branch. See *Whalen v. Roe*, 429 U.S. 589, 598-99 (1977). This term, "right to be let alone," was probably first used by Judge Cooley. See T. COOLEY, A TREATISE ON THE LAW OF TORTS OR THE WRONGS WHICH ARISE INDEPENDENT OF CONTRACT 29 (1st ed. 1880). In the Warren and Brandeis article, the "right to be let alone" was introduced to generally discuss the right to privacy, and because of the significance of that article, the term has since been used as a general statement of the right. See, e.g., *Kerby v. Hal Roach Studios*, 53 Cal. App. 2d 207, 210, 127 P.2d 577, 579 (Cal. Dist. Ct. App. 1942).

10. Gross, *The Concept of Privacy*, 42 N.Y.U. L. REV. 34, 35-36 (1967).

11. C. FRIED, AN ANATOMY OF VALUES 140 (1970); see also *United States v. Westinghouse Elec. Co.*, 638 F.2d 570 (3d Cir. 1980) (privacy includes control over knowledge about oneself, including both quantity and quality of that information); *Welsh v. Pritchard*, 125 Mont. 517, 241 P.2d 816 (1952) (right of privacy includes protection in exclusive use and enjoyment of that which is one's own).

12. *Gill v. Snow*, 644 S.W.2d 222 (Tex. Ct. App. 1982) (right of privacy is right to be free from any unwarranted publicity).

13. See A. WESTIN, PRIVACY AND FREEDOM 7 (1967); Shils, *Privacy: Its Constitution and Vicissitudes*, 31 LAW & CONTEMP. PROBS. 281, 282 (1966); RESTATEMENT OF TORTS § 867 (1939).

sense of security and morality. When the condition of privacy is lost in respect to intimate or personal information, one clearly senses that loss, because the condition of privacy in respect to such information immunizes a person from access to him or her as a person; such immunity is central to one's sense of security.

The right to privacy in respect to health care information is tied to human dignity, the principle of equal respect of persons and the notion of personhood itself.¹⁴ Privacy is a core justification for the non-publicness of health care information, because it is ultimately grounded in society's notions of fairness and justice that are reflected in everyday discourse and long-standing traditional values of Anglo-American society.¹⁵

As will be discussed throughout this article, there is considerable legal significance in the distinction between a policy and principle justification for maintaining confidentiality in respect to health care information.¹⁶ As a general matter, though, it will suf-

14. For a useful evaluation of the evolution of the theoretical expoundment of the human dignity personhood model of privacy, see P. SCHOEMAN, *PHILOSOPHICAL DIMENSIONS OF PRIVACY: AN ANTHOLOGY* (1984). The human dignity personhood model of privacy was first intimated by Warren and Brandeis in their famous article, *The Right to Privacy*. Warren & Brandeis, *supra* note 9. In the article, the authors refer to privacy as part of a more general right. The more general right was said to be the "right to immunity of person," the "right to one's own personality." Dean Bloustein later further developed these views. See Bloustein, *Privacy as an Aspect of Human Dignity: An Answer to Dean Prosser*, 39 N.Y.U. L. REV. 962 (1964).

15. See M. PERRY, *THE CONSTITUTION, THE COURTS AND HUMAN RIGHTS* (1982); D. RICHARDS, *THE MORAL CRITICISM OF LAW* (1977); Wellington, *Common Law Rules and Constitutional Double Standards: Some Notes on Adjudication*, 83 YALE L.J. 221, 249-51 (1973); see also *Pavesich v. New England Life Ins. Co.*, 122 Ga. 190, 50 S.E. 68 (1905) (using classic natural law justification for right to privacy).

16. A few practical differences between the principle and policy reasons ought to be noted as they are relevant to the discussion in the text that follows. First, the strategies used for countering an argument based on policy are different than those used to attack arguments based on principle. For instance, when attacking a policy argument, there are three basic options. One is to question the importance of the social goal that is being promoted. The second option is to question the efficiency of a particular action as a means for accomplishing the goal. This is what occurs, for example, in many testimonial privilege decisions in Pennsylvania where courts restrict the kind of information that is privileged by concluding that the information is not essential to the integrity of the professional and client or patient relationship. See, e.g., *Cohen v. Jenkintown Cab Co.*, 238 Pa. Super. 456, 357 A.2d 689 (1976) (attorney-client privilege not bar to attorney's testimony which would reveal substance of confidential communication where client's interests or rights cannot be adversely affected by disclosure). Finally, one might point to other important goals that would be frustrated by the particular action in question. This occurs in testimonial privilege decisions where the privilege is restricted because of the important countervailing policy of truth-seeking. See, e.g., *In re Pittsburgh Action Against Rape*, 494 Pa. 15, 428 A.2d 126 (1981) (denying privilege asserted by director of rape crisis center because of society's interest in truth-seeking function of criminal justice system).

face to say at this point that arguments of principle have a force in legal arguments that ranged from sometimes "trumping" arguments of policies to at least requiring that privacy be given some weight in the decisionmaking process. As a result, when the privacy-oriented basis for maintaining confidentiality is embraced in legislation or judicial opinions, patients or clients are given greater legal rights to decide whether there will be nonconsensual access to health care information than when an integrity-of-relationship policy is the central basis for legal protection of the confidentiality of health care information.¹⁷

C. *The Limited Role of "Privileges" in Protecting Confidentiality and the Importance in Distinguishing Between Legal and Extra-Legal Disclosure*

In analyzing the extent to which patients and clients have legal rights in the confidentiality of health information about them, it is both useful and essential that a distinction be made between instances when health care information is disclosed as part of a formally-initiated legal proceeding and instances when such information is disclosed to persons or business entities outside of legal proceedings. A considerable amount of confusion by both the bar and health professions about legal protection for confidentiality is traceable to the failure to recognize this difference. An example of this confusion may be found in the extent to which both lawyers and health care professionals tend to over-

The strategy for attacking an argument of principle, on the other hand, is different. Arguments of principle have essential roles in litigation involving fundamental rights. Rights often "trump" governmental action that promotes societal goals. See R. DWORKIN, *supra* note 8, at 22-28. For example, a person's assertion that government action violated the fourth amendment right to privacy may prevail even though the government may correctly argue that the government action effectively promotes an important societal goal. This would be the case if there was a warrantless search of homes in a residential area for evidence of a crime. If the evidence was found, it would promote the societal goal of crime control, but the action would be unconstitutional because of failure to meet the probable cause and warrant requirements of the Constitution. Partially because of these features of rights arguments founded on principle, much of the argument strategy in constitutional litigation evolves around "characterizing" the interest or right involved. As will be demonstrated in this article, the above distinction is important in the evaluation and scope of the newly emerging constitutional testimonial privilege and in determining the extent of tort liability for extra-legal disclosure of health care information and patient and client access to health care information.

17. For a discussion of the constitutionally based testimonial privilege in Pennsylvania, see *infra* notes 271-308 and accompanying text. For a discussion of legal remedies for extra-legal disclosure, see *infra* notes 361-436 and accompanying text.

emphasize the role of the professional-client "privilege" in protecting confidentiality. In Pennsylvania and elsewhere, a limited number of professional-client relationships have been designated by the legislature as sufficiently important to provide the patient or client with the limited right to prevent the professional from testifying in legal proceedings about information that was provided to the professional by the client.¹⁸ This is the major, if not exclusive, role of the "privilege." Testimonial privileges are granted in legal proceedings with respect to certain health care information. Such testimonial privileges are important because they provide some protection for confidentiality by preventing health care information from becoming fully public as part of the records of formally initiated judicial proceedings.¹⁹ However, lawyers, patients and health care practitioners also have concerns about the extent to which there are legal rights to access to health care information and about the extent to which there is legal protection against disclosure of health care information in social and business situations that are not a part of formally-initiated legal proceedings. Professional-client privileges play at most a subsidiary and subordinate role in the determination of the right of the patient or client to access and to prevent extra-legal disclosures.²⁰

When the confidentiality of health care information has been lost by public disclosure outside of legal proceedings, the patient or client may have a right to recover damages in a civil action. The right to damages in such a case depends on the scope and viability of tort and contract theories for invasion of privacy or breach of confidentiality.²¹ The factors that influence rights and remedies for extra-legal disclosures are different than those involved in determining whether a testimonial privilege applies to evidence sought from a health care professional in a legal proceeding.²²

18. See, e.g., 42 PA. CONS. STAT. ANN. § 5928 (Purdon 1982) (defining attorney-client testimonial privilege); *id.* § 5929 (defining physician-patient testimonial privilege).

19. For a discussion of the health care practitioner testimonial privilege in legal proceedings, see *infra* notes 101-270 and accompanying text.

20. For a discussion of legal remedies for unauthorized extra-legal disclosure, see *infra*, notes 361-436 and accompanying text.

21. Court records are generally open to the public without the benefit of statutory rights to access. Agency records are accessible under FOIA. 5 U.S.C. § 552(a) (1966). Many states have tracked FOIA and provide for the right to access to agency records. See, e.g., ILL. ANN. STAT. ch. 116, para. 201 (Smith-Hurd Supp. 1986).

22. The tort remedy that would apply to disclosure of health care informa-

D. *Countervailing Factors: Increasing Societal Needs and Access to Health Care Information*

The concern for privacy and the integrity of the professional-client relationship that is reflected in the notion of confidentiality of health care information is at odds and in constant stress with the practical everyday informational needs of the health care industry and society. In today's computerized third-party payor, highly regulated system of delivering health care services, a complex information-gathering system is triggered whenever a person interfaces with the health care industry for treatment. In the initial stage and throughout the course of treatment, personal and intimate information is acquired and stored, and becomes part of the health care practitioner's business and patient records. The testing of the patient or client as part of diagnosis or treatment in many instances involves the storing of information that has been acquired from business entities and professionals other than those on the staff of the private practitioner or hospital or affiliated institutional health care provider. The laboratory that tests and provides information for diagnosis and evaluation in turn generates new information about the patient which is then stored in its business records. Where medication is prescribed, the information is further acquired and stored as part of the business

tion that was on judicial record would be the public disclosure tort. The *Restatement (Second) of Torts* defines this tort:

One who gives publicity to a matter concerning the private life of another is subject to liability to the other for invasion of his privacy, if the matter publicized is of a kind that

- (a) would be highly offensive to a reasonable person, and
- (b) is not of legitimate concern to the public.

RESTATEMENT (SECOND) OF TORTS § 652D (1976). The legitimate public concern concept noted in section 652D(b) of the *Restatement (Second)* exempts from liability information which the public has an interest in knowing about. This includes information in records which are part of judicial proceedings. See *Rawlins v. Hutchinson Publishing Co.*, 218 Kan. 295, 543 P.2d 988 (1975) (no invasion of privacy occurred when newspaper reprinted story about alleged misconduct of police officer ten years ago since facts were matter of public interest); *Landmark Communications, Inc. v. Virginia*, 435 U.S. 829 (1978) (state statute imposing criminal sanctions on any person who publishes confidential information pertaining to special judicial proceedings held unconstitutional). In addition, publication of judicial records has been found to be protected from tort liability by the first amendment. See *Landmark Communications*, 435 U.S. at 829; *Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469 (1975). Some courts have not granted an absolute first amendment right to publish information on judicial records. See, e.g., *Roshto v. Hebert*, 413 So. 2d 927 (La. Ct. App. 1982). However, this has had little impact on disclosure of health care information. See *Gilbert v. Medical Economics Co.*, 665 F.2d 305 (10th Cir. 1981) (holding publication of facts about physician's psychiatric history is newsworthy in story about alleged malpractice).

records. When reimbursement is sought for health care services from third-party payors, these private and governmental entities in turn acquire virtually all of the information that has been generated in respect to that service and store that information in their computers and business records.²³

In addition to the need for information as part of the everyday delivery of health care services, health care information is sought outside of the health care industry itself for powerful reasons. Researchers involved in important studies are making increasing demands for access to health care information.²⁴ Beyond research, courts, administrative agencies and legislative bodies demand access to health care information as part of their policy-making and adjudicatory functions. The computerization of most health care records has made this information more accessible.²⁵

In a general sense, the law of confidentiality in Pennsylvania consists of judicial, legislative and agency decisions, where the privacy interests of the patient or client and the integrity of the

23. For a discussion of the stress on confidentiality of health care information created by new federal policies on reimbursement under Medicare and Medicaid, see *supra* note 1.

One of the reasons for increasing demands for access to health care information is the explosion of medical knowledge. Professionals now seek more information about clients as part of diagnosis and treatment. Detailed information on lifestyle from diet to sexual activities is sought as part of medical background. The extent to which new information is being acquired is noted in AUSTEN & KINNEY, *THE CONTENT OF UNDERGRADUATE MEDICAL EDUCATION IN THE FUTURE OF MEDICAL EDUCATION* 71, 73 (J. Graves ed. 1973).

For a discussion of the increasing demands upon health care information, see generally A. WESTIN, *supra* note 2, at 44; PRIVACY PROTECTION STUDY REPORT, *supra* note 2; Boyer, *supra* note 2. It has also been suggested that fear of malpractice suits has resulted in the need for more tests and information in treatment as part of defensive medicine. UNITED STATES DEP'T OF HEALTH, EDUC. AND WELFARE, *MEDICAL MALPRACTICE: SECRETARY'S COMM'N ON MEDICAL MALPRACTICE*, 38 app. (1973) [hereinafter APPENDIX TO REPORT]; see also J.A. BRUCE, *supra* note 4.

24. See Adams, *Medical Research and Personal Privacy*, 30 VILL. L. REV. 1077 (1985). Professor Adams has noted the importance of the role that patient medical records play in scientific research that leads to advances in medical knowledge. *Id.* at 1079. However, since medical records contain a vast amount of sensitive information about patients whose identity cannot be disguised adequately, release of this information carries with it the risk of public disclosure, resulting in serious harm and embarrassment to the patient. *Id.* at 1079-80. In his article, Professor Adams attempts to set forth a mechanism for the distribution and use of medical records that protects a patient's personal privacy, but that also accommodates the needs of medical researchers who must have access to this information. *Id.* at 1080.

25. See PRIVACY PROTECTION STUDY REPORT, *supra* note 2; Lincoln & Korpman, *Computers, Health Care, and Medical Information*, 210 SCI. 257 (Oct. 1980).

health care practitioner-client relationship are balanced against the needs of government, business entities and private persons for access to health care information.

II. PATIENT OR CLIENT ACCESS: THE FIRST OF THREE PHASES OF CONCERN OVER THE NON-PUBLICNESS OF HEALTH CARE INFORMATION

a. Introduction

Patient or client access to health care information is a proper starting point for discussion of legal protection for the confidentiality of health care information for several reasons. First, access by patients or clients to health care information does involve the question of the publicness of this information to some extent. Second, access to health care information is a necessary feature of meaningful exercise of the patient's right to decide whether others shall have access to this information and access is, therefore, inextricably bound up with the patient's right to privacy in health care information. Third, confidentiality concerns from the internal perspective of lawyers and health professionals focuses on access as one of three phases of non-publicness. The other two phases are disclosure in legal proceedings and extra-legal disclosure.

Patient and client access and damage recovery for unauthorized extra-legal disclosure of health care information are unified by a common theory. The theory is that the professional-patient relationship creates fiduciary duties running to the patient or client. These include the duty to disclose health care information to the client and the duty not to disclose such information to strangers.

Patient access does, however, bring into issue policies and arguments that are somewhat different than those that play important roles in the two other phases of legal protection of the confidentiality of health care information. The confidentiality or non-publicness of health care information is asserted by health care professionals against the patient as necessary to protect the property interest these professionals have in these records and necessary to maintain the autonomy of the profession. Health care practitioners also contend that disclosure of some health care information may be harmful to the patient and invade the right to privacy of other persons whose comments or history may be included in the patient's record.

The dearth of reported decisions on the right of access of patients to their records suggests that denial of access to the patients or clients seldom results in legal action. Yet recently enacted legislation regulating both records in the possession of government agencies generally and health records specifically have addressed the question of access. These laws view a right to access as an essential aspect of the subject's right to privacy. Before someone may knowingly decide whether another party should have access to information in these records, that person needs to know what is in the record. Beyond that, access has been provided to ensure the accuracy of the records by providing the subject with an opportunity to correct or amend information that may have adverse consequences if disclosed.²⁶ Access is a problem which the health care practitioner deals with on a regular basis and one on which the health care profession has expressed strong views. These views have until very recently generally been against the right of patients or clients to access to health care information.²⁷

Access only presents a problem, of course, when the health care practitioner or custodian of records chooses not to provide access. Such denial reflects a tension within the health care practitioner-client relationship that is generally not present in other areas of concerns of confidentiality. In this context, it is not the patient or client who seeks to protect the confidentiality of the records; the patient or client wants access.²⁸ In other contexts,

26. See, e.g., CAL. HEALTH & SAFETY CODE §§ 25250-25259 (West Supp. 1987); COLO. REV. STAT. §§ 25-1-801, 25-1-802 (1973 & Supp. 1986); OR. REV. STAT. § 192.525 (1977); WISC. STAT. ANN. § 146.83 (West Supp. 1986).

27. See generally Kennedy & Jacobs, *Literature Review of Legal Aspects of Medical Records*, TOPICS IN HEALTH REC. MGMT. 19, 21-22 (June 1981). The American Medical Association softened its position on access and now supports a limited right to access with considerable discretion available to the health care provider to withhold portions of the health records if disclosure would be injurious to the patients mental or physical health. See *Privacy of Medical Records: Hearings on H.R. 2979 and H.R. 3444 Before the Subcomm. of the House Comm. on Gov't Operations*, 96th Cong., 1st Sess. 1134-36 (1980) [hereinafter *Privacy Hearings*]. The medical care providers are apparently in agreement that patients or clients should have access to health records and be able to procure a copy of the record. See PRIVACY PROTECTION STUDY REPORT, *supra* note 2, at 295.

28. In the typical situation, confidentiality protects the interests of the patient or client. Patients and clients seek to have health information confidential on behalf of their right to privacy in respect to that information, and because of their view that they have a right to decide who shall have access to personal and intimate information about them. When patients seek access to their own records, they may do so to protect the same interests. Patients and clients may wish to know the contents of the record in order to be able to intelligently consent to others having access or in order to determine whether there is erroneous

the patient or client, in conjunction with the health care practitioner, claims confidentiality because it complements the patient's concern about privacy and the practitioner's concern about the integrity of the practitioner-patient relationship. Until very recently, the right of health care professionals to deny the patient or client access to their records was clearly established where access was sought by the patient or client under the common law.

A patient or client may seek access to health care information for a variety of reasons. When the patient or client has incurred a physical injury or has been subjected to an unauthorized medical procedure, health records may be sought because they are pertinent to a negligence or battery action that has been brought against the health care practitioner. In such instances, access is granted as a matter of right under state and federal discovery laws.²⁹ In a whole range of other situations where health care information is sought by patients and clients, it is by no means certain that there is a legal right to access to this information.

Examples of circumstances when there may be no right of access are: (1) when the record is sought prior to initiation of litigation to determine whether a malpractice action should be brought; (2) when the patient or client seeks access in order to knowingly decide whether to consent to the release of the information; (3) when access is sought to determine the basis for adverse action against the patient or client by government agencies or business entities; (4) when the information is sought by the patient to know what health care information has been gathered about him or her and whether the health care information is accurate and complete; and (5) when the information is sought for the patient's personal record for future use in medical treatment.

b. Common Law Theories Supporting and Denying a Right to Access to Health Records

As late as 1973, the overwhelming number of states did not provide for patient or client access to health records.³⁰ Access

information in the record, again so that they can meaningfully exercise their right to decide what information about them will be disseminated.

29. Information in the health record would generally be relevant to the malpractice action and, since the patient or client has waived any testimonial privilege, there are no difficulties with obtaining the records in discovery where malpractice actions have been initiated by the patient or client. *See Dixon v. Cappellini*, 88 F.R.D. 1 (M.D. Pa. 1980); *Burda v. Warmkessel*, 63 Sch. L. R. 121 (1967).

30. *See APPENDIX TO REPORT, supra* note 23, at 181.

was generally available only through discovery after the client initiated a malpractice action. A state appellate court did not recognize a common-law right to access until 1959,³¹ and by 1965 only six states had enacted legislation providing for patient or client access.³²

The primary rationale for the denial of a right to access is the view that medical records are the exclusive property of the health care practitioner.³³ This rationale was buttressed by the further arguments that, since some information in the health record was technical and involved personal information about other individuals, direct access would be detrimental to the patient and/or invade the privacy of third parties.³⁴

The clear recent trend has been to grant a common-law right of access.³⁵ Those courts that have interpreted the common law

31. *Wallace v. University Hosps.* 164 N.E.2d 917 (Ohio C.P. 1959), *modified*, 170 N.E.2d 261 (Ohio Ct. App. 1960), *appeal dismissed*, 171 Ohio St. 487, 172 N.E.2d 459 (1961). On appeal the court limited the patient's right to access to inspection under the defendant hospital's supervision. The plaintiff was only permitted to make "copies of such parts of such records, as in the discretion of defendant, is proper under the circumstances of the case," bearing in mind the beneficial interest of the patient. 170 N.E.2d at 261.

32. APPENDIX TO REPORT, *supra* note 23, at 181.

33. *See In re Culbertson's Will*, 57 Misc. 2d 391, 292 N.Y.S.2d 806 (1968) (holding that records are exclusively property of physician). *Culbertson* was subsequently altered by the New York courts. *See In re Striegel*, 92 Misc. 2d 113, 399 N.Y.S.2d 584 (1977) (holding that treating doctor has primary custodial rights to patient records, but not exclusive ownership rights).

34. APPENDIX TO REPORT, *supra* note 23, at 181; *see also* Comment, *Toward a Uniform Right to Medical Records: A Proposal for a Model Patient Access and Information Practices Statute*, 30 UCLA L. REV. 1349, 1371 (1983).

35. This right was first recognized in an Ohio case. *Wallace v. University Hosps.*, 164 N.E.2d 917 (Ohio C.P. 1959) (granting patient right to access, based on patient's property interest in hospital records), *modified*, 170 N.E.2d 261 (Ohio Ct. App. 1960), *appeal dismissed*, 171 Ohio St. 487, 172 N.E.2d 459 (1961). A few courts have since recognized the patient's right of access to his medical records. *Pyramid Life Ins. Co. v. Masonic Hosp. Ass'n*, 191 F. Supp. 51 (W.D. Okla. 1961); *In re Striegel*, 92 Misc. 2d 113, 399 N.Y.S.2d 584 (1977); *Hutchins v. Texas Rehabilitation Comm'n*, 544 S.W.2d 802 (Tex. Ct. App. 1976). A patient's right to access has also been based on the fiduciary relationship between the physician and patient. *Emmett v. Eastern Dispensary & Casualty Hosp.*, 396 F.2d 931 (D.C. Cir. 1967) (fiduciary relationship between physician and patient imposes duty on physician to disclose information patient requests); *Cannell v. Medical & Surgical Clinic*, 21 Ill. App. 3d 383, 315 N.E.2d 278 (1974) (adopting *Emmett* as law in Illinois).

Courts have also held that a doctor's failure to disclose information is fraudulent concealment and tolls the statute of limitations in a negligence action. *See Sheets v. Burman*, 322 F.2d 277, 279 (5th Cir. 1963); *Hudson v. Moore*, 239 Ala. 130, 133, 194 So. 147, 149 (1940); *Guy v. Schuldt*, 236 Ind. 101, 109, 138 N.E.2d 891, 895 (1956); *Perrin v. Rodriguez*, 153 So. 555, 556-57 (La. Ct. App. 1934); *Schmucking v. Mayo*, 183 Minn. 37, 235 N.W. 633 (1931); *Thompson v. Barnard*, 142 S.W.2d 238, 241 (Tex. Ct. App. 1940), *aff'd*, 138 Tex. 277, 158

to provide for patient access have done so by utilizing three theories. The most idiosyncratic and least influential of these is the "public records" theory. Under this view, medical records are treated as part of those more general records which, because they are required to be kept under statute or regulations, are accessible to the public. This analogy, however, is quite strained. Core examples of records that are public under this concept are those that are required to be kept by public officers and papers required to be filed as part of the duties of public office. Health care information is quite unlike such public information because of the privacy and confidentiality principles and policies that attach to information acquired as part of a professional-client/patient relationship. Yet state courts interpreting Texas law³⁶ and a federal court interpreting Oklahoma law³⁷ have characterized medical records as "quasi-public" and subject to patient access under the public records doctrine on the basis that the records are legally required to be maintained. Interestingly, these courts have limited access to those patients or their representatives for purposes of determining whether there is a basis for a malpractice action against the health care practitioner. At most, the judicial application of the public records doctrine to health care information is a reflection of the current receptiveness on the part of some courts to the right of patient access.

Two additional theories have been utilized by courts to provide for a common-law right to access. These interpretations of the common law have gained a greater following than the "quasi-public records" theory and are part of the evolving jurisprudence in the law of confidentiality for health care information. Initially, courts recognized a right to access by bifurcating the property interests that are involved. The custodian was found to have an exclusive property interest in the record; while the patient or client was determined to have a property interest in the information in the record that was sufficient to give the patient or client a right of access to the record provided that the patient or client paid for the cost of reproducing the information. As with the public records cases, most of the early litigation involved patients or clients who were seeking access to health care information to determine whether there was a basis for a malpractice action against

S.W.2d 486 (1942); *cf.* *Alden v. Providence Hosp.*, 382 F.2d 163 (D.C. Cir. 1967); *Garfield Memorial Hosp. v. Marshall*, 204 F.2d 721 (D.C. Cir. 1953).

36. *See, e.g., Morris v. Hoerster*, 377 S.W.2d 841 (Tex. Ct. App. 1964).

37. *See Pyramid Life Ins. Co. v. Masonic Hosp. Ass'n of Payne County*, 191 F. Supp. 51 (W.D. Okla. 1961).

the health care practitioner.³⁸

The bifurcated property theory evolved into a more pervasive theory of access that is part of the emerging jurisprudence of confidentiality and privacy law. In 1974 an Illinois appellate court in *Cannell v. Medical and Surgical Clinic*,³⁹ found that the “fiduciary” nature of the physician-patient relationship imposed a duty upon the physician to disclose information in the health record to the patient. Interpreting the professional patient or client relationship as a “fiduciary” relationship is part of the contemporary judicial attitude that is reflected in many of the cases where confidentiality of health care information is an issue. As a later part of this article demonstrates, judicial characterization of the health care physician-client or patient relationship as a “fiduciary” one has been the central plank of the development of a bundle of rights that flow to the patient. These rights include tort damages for unauthorized disclosure of health care information and the right to recover in negligence against a physician’s failure to fully disclose the risks involved in a medical procedure, as well as a right to access.⁴⁰

Two policy reasons have spun out of these recent decisions supporting a right to access. These are that providing patient access will reduce the number of unwarranted malpractice actions, and that access is an essential condition for the patient to be able

38. See, e.g., *Gerkin v. Werner*, 106 Misc. 2d 643, 434 N.Y.S.2d 607 (1980); *In re Striegel*, 92 Misc. 2d 113, 399 N.Y.S.2d 584 (1977); *Wallace v. University Hosps.*, 164 N.E.2d 917 (Ohio C.P. 1959), *modified*, 170 N.E.2d 261 (Ohio Ct. App. 1960), *appeal dismissed*, 171 Ohio St. 487, 172 N.E.2d 459 (1961); see also *People v. Cohen*, 98 Misc. 2d 874, 414 N.Y.S.2d 642 (1979) (records of dentist accused of sexually abusing patients held by him as custodian and must be produced).

39. 21 Ill. App. 3d 383, 315 N.E.2d 278, 280 (1974). *Cannell* built upon an earlier case, *Emmett v. Eastern Dispensary and Casualty Hosp.*, 396 F.2d 931 (D.C. Cir. 1967). Illinois has further limited access under the fiduciary relationship theory to health care information in the possession of a health care practitioner employed by the patient himself. See *Cook v. Optimum/Ideal Managers Inc.*, 130 Ill. App. 3d 180, 473 N.E.2d 334 (1984).

40. For a discussion of damage remedies for unauthorized disclosure under what is sometimes referred to as the “breach of confidentiality” tort, see *infra* text following note 402. The kinship of these two lines of cases is expressly recognized in *Emmett*, where the court cited three leading unauthorized disclosure cases: *Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920); *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958); and *Smith v. Driscoll*, 94 Wash. 441, 162 P. 572 (1917). *Emmett v. Eastern Dispensary and Casualty Hosp.*, 396 F.2d 931, 936 n.20 (D.C. Cir. 1967). The connection was also made in *Cannell*, which cited a leading case imposing a duty upon a physician to fully disclose to a patient the risks attendant to an operation; *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). *Cannell*, 21 Ill. App. 3d at 385, 315 N.E.2d at 280.

to exercise the right to consent to the release of health records or to decide whether to have additional treatment.⁴¹

These policy reasons have moved jurisdictions that adopt the bifurcated property or fiduciary relationship theory to provide for a general right to access that is not limited to patients who are seeking access to health care information to determine whether it would be appropriate to initiate a legal action, although most of the decisions have factually involved such requests. The right to access, however, is clearly not unlimited and is subject to discretionary withholding of information by the health care practitioner where disclosure would not be in the "best interests" of the patient or client.

Although there has been little discussion by courts regarding the "best interests" limitation on the right to access, it is clear that the self-interest of the health care practitioner is not sufficient to deny access. Courts have interpreted the "best interests" standard liberally and have found bald paternalistic reasons for non-disclosure insufficient. The smattering of cases restricting patient access where a common-law right of some dimension has been recognized have involved patients of psychiatrists, a situation in which courts and legislatures have been receptive to the view that disclosure of information may be damaging to the patient.⁴² Upon such demonstration it would seem that under common-law access principles, the withholding of health care information would be permissible.

Litigation involving common-law rights to patient or client access has been sparse. In Pennsylvania there appear to be no appellate court opinions dealing with the issue. However, in Pennsylvania and elsewhere there has been a phenomenal amount of legislative and agency action that has provided for a right to access.⁴³ The right to access in Pennsylvania as expounded in recent legislation and regulations is structured around the type of health care record and the place where the health care record is maintained.

41. *In re Striegel*, 92 Misc. 2d 113, 399 N.Y.S.2d 584 (1977).

42. *See, e.g.*, *Cynthia B. v. New Rochelle Hosp. Medical Center*, 60 N.Y.2d 452, 458 N.E.2d 363, 470 N.Y.S.2d 122 (1983); *Gotkin v. Miller*, 379 F. Supp. 859, 866 (E.D.N.Y.), *aff'd*, 514 F.2d 125 (2d Cir. 1975); *Project Release v. Prevost*, 722 F.2d 960, 976 n.16 (2d Cir. 1983).

43. *See generally* Comment, *supra* note 34; Comment, *Patient Access to Medical Records in Washington*, 57 WASH. L. REV. 697 (1982).

A. *Statutory Right to Access to Health Care Records in Pennsylvania*

Until very recently a limited right to access was granted to some clients and patients in Pennsylvania under state and federal legislative enactments and agency regulations. Access rights to the records of those receiving treatment in mental health treatment facilities were governed by regulations promulgated in 1979 pursuant to authority in the Mental Health Procedure Act.⁴⁴ Records of patients and clients receiving treatment for drug and alcohol abuse were governed by regulations promulgated under the 1972 Alcohol and Drug Abuse Control Act⁴⁵ and under the Federal Drug and Alcohol Abuse Statutes.⁴⁶ Individuals receiving

44. See 55 PA. CODE § 5100.33(b)-(d), (g)-(j) (1986). Access refers to "physical examination" of records, but does not imply "physical possession" of the records or copies thereof. *Id.* § 5100.33(b). A person receiving treatment may request access to such records, which shall be denied to limited portions of the record only if disclosure will be a substantial detriment to treatment or when disclosure will reveal the identity of persons or breach the trusts of such persons contrary to an agreement to maintain confidentiality. *Id.* § 5100.33(a). Third parties who are granted access to such records may discuss the information therein only to the extent necessary to represent the patient in a legal proceeding. *Id.* § 5100.33(d); see also 55 PA. CODE § 5100(f) (1986) (records of person receiving mental health services are property of hospital).

45. For the author's observations involving the scope of the implementing regulations under the 1972 Act, see *infra* note 62 and accompanying text. The regulations were initially codified in 4 PA. CODE §§ 255.1-.2 (1980) and 4 PA. CODE §§ 255.3-261.6 (1986). These regulations have been recodified in 28 PA. CODE § 157.23 (relating to patient records and incorporates §§ 255.4 and 255.5 of 4 PA. CODE); § 709.28 (relating to confidentiality); § 709.30(3) (relating to patient access). The prior patient access regulation, 4 PA. CODE § 262-2(h)(3), has been changed substantively in its new version, 28 PA. CODE § 709.30(3). On other questions of confidentiality the recodification essentially tracked the previous regulations.

46. Statutory authority for the federal regulations on confidentiality discussed below and in the text of the article comes from two statutes. These are the Drug Abuse Office and Treatment Act of 1972, 408 Pub. L. No. 92-255, 21 U.S.C. § 1175 as amended by § 303 of Pub. L. No. 93-282, 88 Stat. 137, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, 42 U.S.C. § 4582, as amended by § 122(a) of Pub. L. No. 93-282, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974, 88 Stat. 131. Regulations promulgated under the Federal Acts apply to veterans hospitals and health records that are in the custody of programs that are federally funded, including those that are subsidized by Medicare or federally funded programs. Regulations governing the confidentiality of health records subject to both Acts begin at 42 C.F.R. § 2.1. The most recent variation of these regulations reflect a more liberal approach to consensual release of record information. See generally *id.* § 2.36-1. Federal regulations do not specifically provide for access to records by a patient or client. However, such access is implicitly recognized in the permissive access rights provided to a patient's attorney and the patient's family, providing the patient has consented to access within the meaning of the regulations. See *id.* §§ 2.35-1, 2-36. As discussed in note 54, *infra*, since the state regulations under the Pennsylvania statute specifically address the question of patient access

treatment in licensed hospitals were provided a limited right to access in regulations adopted by the state Department of Health.⁴⁷

B. *The Impact of the 1987 Medical Records Evidence Act*

Legislation that became effective on January 1, 1987 substantially expands patient or client access rights in Pennsylvania.⁴⁸ The Medical Records Evidence Act primarily provides for the use of certified copies of the medical charts or the records of health care facilities in legal proceedings and defines the scope of liability for directors of these facilities. The Act also expressly provides that a patient "shall have the right of access to all of his medical charts and records and to photocopy the same for his own use." This unambiguous and unqualified right to access expands the existing law in two major respects. Access rights are provided for patients of all health care facilities as defined in department of health regulations and no limitation is placed on the information that is accessible by the patient from the health care record. Health care facilities within the meaning of the Act include, hospitals, skilled nursing, intermediate care and ambulatory surgical facilities, and birth centers. Specifically excluded from the definition of health care facilities are, facilities caring exclusively for the mentally ill, many programs treating persons for drug and alcohol dependency, and the offices of licensed private practitioners involved with the practice of medicine, osteopathy, optometry, chiropractic, pediatry or dentistry.⁴⁹

and are more pervasive in the scope of patient access, those regulations would likely govern patient or client access to all records of drug and alcohol treatment.

47. See 28 PA. CODE § 103.22(b)(15) (1982) ("The hospital shall provide the patient . . . access to all information contained in his medical records, unless access is specifically restricted by the attending physician for medical reasons.").

48. 42 PA. CONS. STAT. ANN. § 151 (Purdon Supp. 1987).

49. This name is one given to the Act by the author because of the emphasis on use of certified copies of records in legal proceedings. The legislation is part of Title 42 which deals with the judiciary and judicial procedures including the evidentiary privilege statutes. The Act applies to the medical charts or records of any health care facility licensed by the Department of Health. The licensing regulations for the Department of Health define, "Health Care Facility" as:

"Health Care Facility." A general, tuberculosis, chronic disease or other type of hospital, a skilled nursing facility, a home health care agency, an intermediate care facility, an ambulatory surgical facility, birth center regardless of whether such health care facility is operated for profit, nonprofit or by an agency of the Commonwealth or local government. The term health care facility shall not include an office used primarily for the private practice of medicine, osteopathy, optom-

The Act is inconsistent with pre-existing regulations applicable to licensed hospitals. Under applicable principles of statutory construction in Pennsylvania, the Act would implicitly repeal those regulations. This is the result of the Act taking effect subsequent in time to the regulations and in the fact that the Act specifically addresses the areas of inconsistency.⁵⁰ Under regulations existing prior to the Act a hospital patient's right to access may be restricted by the "attending physician for medical reasons."⁵¹

etry, chiropractic, podiatry or dentistry, nor a program which renders treatment or care for drug or alcohol abuse or dependence unless located within a health facility, nor a facility providing treatment solely on the basis of prayer or spiritual means. A mental retardation facility is not a health care facility except to the extent that it provides skilled nursing care. The term health care facility shall not apply to a facility which is conducted by a religious organization for the purpose of providing health care services exclusively to clergymen or other persons in a religious profession who are members of a religious denomination.

35 PA. CONS. STAT. ANN. § 448.802(a) (Purdon Supp. 1987).

"Hospitals" under the regulations are defined as:

"Hospital." An institution having an organized medical staff which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the care of injured, disabled, pregnant, diseased or sick or mentally ill persons, or rehabilitation services for the rehabilitation of injured, disabled, pregnant, diseased or sick or mentally ill persons. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific medical specialties, but not facilities caring exclusively for the mentally ill.

Id.

It appears, therefore, that mental health treatment facilities and outpatient psychiatric treatment facilities are not health care facilities for purposes of the access rights under the Act. Such facilities would be licensed by the Department of Welfare and subject to access regulations enacted under the authority granted under 50 PA. CONS. STAT. ANN. §§ 7105, 7112 (Purdon Supp. 1987). For a further discussion, see *infra* note 59 and accompanying text.

50. Statutory construction decisions in Pennsylvania, as elsewhere, consist of a series of rules and principles that conflict, and if applied to a particular statute would result in conflicting interpretations. Therefore, generalizing about proper standards for interpreting statutes is a hazardous endeavor. Since 1937, Pennsylvania has been guided by a statutory construction act, and numerous cases have been decided with this statute as a guide to interpreting other statutes. See PA. STAT. ANN. tit. 46, § 551 (Purdon 1969) (repealed 1972), *superseded by* 1 PA. CONS. STAT. ANN. § 1921 (Purdon Supp. 1987). The text of the Construction Act specifically gives preference to the "plain meaning rule," at least where the language is in fact unambiguous. The Act states that, "When the words of a law are clear and free from all ambiguity, the letter of it is not to be disregarded under the pretext of pursuing its spirit." PA. STAT. ANN. tit. 46, § 551 (Purdon 1969). In addition, the access policies applicable to hospital records are administrative regulations. Where the legislature clearly and unambiguously states a policy that is inconsistent with existing agency regulations, as in the case of the 1987 Medical Records Evidence Act, the conclusion that the regulations are repealed by implication is compelling.

51. 28 PA. CODE § 103.22(b)(15).

The Act provides for access to "all of the medical charts and records" and plainly does not provide for discretionary withholding of information by the physician or health care facility. This newly enacted legislation then provides for a more general and pervasive right to access than any of the existing statutes or regulations in Pennsylvania. The Act, however, specifically does not cover facilities that provide exclusively for the treatment of the mentally ill, or for the records of most patients being treated for drug or alcohol treatment. Access rights for the health care records of these patients or clients are defined by other statutes and regulations.

C. *Patient or Client Access to Mental Health Records and Records of Drug and Alcohol Treatment*

Patient access to health records involving treatment for mental health problems and drug and alcohol abuse involve issues that may not be present when access to other health records is sought. The professional's interpretation of mannerism, statements, overt actions, dreams and fantasies may be misunderstood or, if known by the client, disrupt therapy or otherwise cause detriment to the patient. Because the nature of psychotherapeutic treatment may involve statements and other information by family members or intimate associates of the patient, disclosure of mental health records to the patient may adversely affect these relationships. The same is true with respect to treatment for drug and alcohol abuse. Beyond that, information concerning drug and alcohol abuse, if disclosed, may cause the patient adverse consequences in such things as opportunities for employment and insurance.

Disclosure may also place the person or persons who disclosed information to the therapist in physical danger, and access by the patient may invade their privacy. In addition, disclosure may prevent the health care practitioner from obtaining information from nonpatients.⁵² For these reasons, in many legislative acts that grant the right to access for health records regarding treatment for mental conditions or drug and alcohol abuse, the health care professional is given discretion to withhold information, especially during treatment, upon demonstration that the disclosure will be harmful or in other ways detrimental to the patient or other third parties.⁵³

52. See Comment, *supra* note 34; Comment, *supra* note 43.

53. See APPENDIX TO REPORT, *supra* note 23, at 181.

1. *Health Records Subject to Patient or Client Access Under the Mental Health Procedure Act*

In determining the scope of patient access to records involving treatment for mental health problems in Pennsylvania, it is important to distinguish between (1) records that are in the possession of a mental health treatment facility, (2) records that contain health care information regarding treatment for drug and alcohol problems, (3) records that are in the possession of a licensed health care facility and (4) records in possession of a health care practitioner that do not involve information about treatment for drug and alcohol problems. All records of treatment for drug and alcohol abuse or dependence, even if they are in the custody of a mental health facility or private health care practitioner, are governed by state and federal alcohol and drug abuse acts and regulations. Rights of patient or client access to such records are primarily governed by regulations under the 1972 Pennsylvania Drug and Alcohol Abuse Control Act.⁵⁴

Records of treatment for mental health problems that do not

54. The federal and state laws regulating the confidentiality of health information regarding drug and alcohol treatment are typical of the "cooperative" federalism that governs the arrangement between the federal and state governments in areas of privacy. The federal statutes and regulations do not preempt the states from regulating in these areas; state laws, however, must provide at least the same protection as the federal act for confidentiality where health records are subject to both laws. See 42 C.F.R. §§ 2-23, 2-23-1 (specifically addressing relationship of federal regulations to state law). A state may, however, provide for more strict confidentiality requirements than the federal regulations do. The regulations promulgated under the Pennsylvania Drug and Alcohol Abuse Act of 1972 are broader in protecting confidentiality in several ways, the most important being the greater number of records that are covered and more limited circumstances for authorized disclosure. Pennsylvania regulations would likely govern patient access because the federal regulations do not specifically address access. See *supra* note 46. Access to clients is specifically provided for in § 709.30(3)-(b) of the Pennsylvania regulations:

(3) A client has the right to inspect his own records. The project director may temporarily remove portions of the records prior to the inspection by the client if the director determines that the information may be detrimental if presented to the client. Reasons for removing sections shall be documented and kept on file.

(4) The client has the right to appeal a decision limiting access to his records to the project director.

(5) The client has the right to request the correction of inaccurate, irrelevant, outdated or incomplete information from his records.

(6) The client has the right to submit rebuttal data or memoranda to his own records.

28 PA. CODE § 709.30(3)-(6) (1986). The prior regulation provided that a patient may request "removal" of "inaccurate, irrelevant, outdated, or incomplete information." See 4 PA. CODE § 262-2(h)(3) *replaced by* 28 PA. CODE § 709.30(3)-(6) (1986). The "removal" language has been superseded.

involve treatment for drug and alcohol abuse or dependence are governed by the state Mental Health Procedure Act and regulations promulgated by the Department of Welfare pursuant to the Act.⁵⁵ These regulations provide for a limited right to patient or client access. However, there is some confusion about the records that come within the jurisdiction of the Act and promulgated regulations. Rights provided for under the Mental Health Procedure Act apply only to the records of facilities that have been approved by the Secretary of Welfare or County Administrator as eligible to receive earmarked state funds for treatment.⁵⁶ The Act and regulations clearly apply to the records of all patients treated at approved facilities on an involuntary basis and to those receiving inpatient treatment on a voluntary basis.

Language defining the scope of the Act and regulations plainly state that coverage is limited to all involuntary treatment and to voluntary "inpatient treatment."⁵⁷ Despite language that seems clearly to exclude voluntary outpatient treatment in mental health treatment facilities from the mandatory requirements of the Act, some health care practitioners and health care lawyers have suggested that the Act is ambiguous and argue that the rights and procedures under the Act and regulations apply to all approved mental health treatment facilities and to the records of patients that are treated on a purely voluntary outpatient basis. This interpretation focuses on the fact that the Act defines "inpatient treatment" as treatment where residence is required on a part or full time basis in a "facility." "Facility" is then defined in the Act to include health care establishments that provide for the care of mentally ill persons "whether as outpatients or inpa-

55. See PA. STAT. ANN. tit. 50, § 7112 (Purdon 1969 & Supp. 1986) (providing that department shall adopt rules to effectuate provisions of Act); see also *id.* § 7111 (providing documents concerning treatment shall be kept confidential). For a discussion of the pertinent provisions of relevant regulations promulgated under the Mental Health Procedure Act, see *supra* note 44 and accompanying text.

56. PA. STAT. ANN. tit. 50, § 7105 (Purdon 1969 & Supp. 1986).

57. See *id.* § 7103. The provision is as follows:

This act establishes rights and procedures for all involuntary treatment of mentally ill persons whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons. "Inpatient treatment" shall include all treatment that requires full or part-time residence in a facility. For the purpose of this act, a "facility" means any mental health establishment, hospital, clinic, institution, center, day care center, base service unit, community mental health center, or part thereof, that provides for the diagnosis, treatment, care or rehabilitation of mentally ill persons, whether as outpatients or inpatients.

Id.

tients.”⁵⁸ This broad language defining “facility” in the Act and regulations is read to mean that they are applicable to the health records of all patients that are being treated in approved mental health treatment facilities, even when treatment is solely on a voluntary outpatient basis.

This interpretation would ignore the plain meaning of the Act and regulations and is clearly unwarranted. The broad definition of “facility” is a reflection of the fact that the Act is limited in its potential coverage to establishments that have been “approved” and are thus eligible to receive monies from state funds. The Act identifies such approved establishments as “treatment facilities” for purposes of the outer limits of coverage. Looked at in this way the provisions defining the scope of the Act are not ambiguous but mean what they plainly say: the mandatory rights and procedures under the Act are applicable to all persons involuntarily treated at an “approved treatment facility” and patients treated on a voluntary basis where residence is required on a part or full time basis, again in an “approved treatment facility.”

If the overall thrust of the Act is considered it makes perfect sense for the drafters not to have intended that the mandatory requirements of the Act apply to voluntary outpatient treatment, even if the treatment occurred at a facility that had been approved and was eligible for state monies. As the title of the Mental Health Procedure Act suggests, much of the focus of the Act is on the procedural rights patients have while being treated in a treatment facility on an inpatient basis, part or full time. Many of the procedural and treatment rights have little applicability to voluntary outpatient treatment.

Confidentiality policies of the Act would seem more appropriately to be applicable to the health records of all approved facilities. The Act, however, does not require that these policies, including patients’ right to access to records, govern the health records of patients in voluntary outpatient facilities that are eligible to receive state funds. In respect to confidentiality policies, the question of the mandatory applicability of the Act to the records of patients treated on a voluntary outpatient basis has become academic.

The licensing function of the Department of Welfare operates independently of the Mental Health Procedure Act. Adherence to the confidentiality policies of the Act could therefore be

58. *Id.*

imposed as a condition of the licensing or funding approval of the facility. This would be a consequence of the discretionary action by the licensing or funding agency and not by compulsion under the Act. This in fact has occurred. Regulations establishing standards for the licensing of outpatient psychiatric clinics specifically require that the records of such outpatient facilities comply with the confidentiality requirements of the Mental Health Procedure Act.⁵⁹ This would, of course, include policies regarding the right to patient access. Therefore, health care administrators and practitioners treating patients or clients on a voluntary outpatient basis at approved treatment facilities are well advised to view the access policies of regulations under the Mental Health Procedure Act as the controlling law.

Health records of the patient receiving treatment for mental illness from the "purely private practitioner" or from a psychotherapist practicing in an establishment that is not a licensed or approved facility would quite clearly not be subject to access rights under Mental Health Procedure Act regulations.⁶⁰

2. *Access to Health Records for Alcohol and Drug Abuse and Dependency*

In contrast, the rights to access under regulations promulgated pursuant to the Pennsylvania Drug and Alcohol Abuse Control Act arguably apply to all records involving treatment for drug

59. Jurisdiction for the licensing of health care facilities is granted to the Department of Health. The Department of Health has authority to license all health care facilities as defined in the enabling statute. This explicitly excludes facilities that are involved exclusively with treatment for those with mental illness or the mentally retarded. Health care facilities include more than hospitals, however. Skilled nursing, home health care agencies, ambulatory surgical and birth center facilities also come within the licensing authority of the Department of Health. See 35 PA. CONS. STAT. ANN. § 448.802a (Purdon Supp. 1987). The licensing of facilities that treat persons that have been determined to have a mental illness or are mentally retarded is within the jurisdiction of the Department of Welfare. See 50 PA. CONS. STAT. ANN. §§ 4201(2), 7105 & 7112 (Purdon Supp. 1987); 62 PA. CONS. STAT. ANN. § 1021 (Purdon Supp. 1987).

The licensing standards of the Department of Welfare for psychiatric outpatient clinics specifically require that such clinics comply with the confidentiality policies of the regulations enacted under the Mental Health Procedure Act. 55 PA. CODE § 5200.41(c) (1984).

60. Department of Health laws and regulations and the Mental Health Procedure Act specifically exempt the purely private practitioner from their coverage. See 35 PA. CONS. STAT. ANN. § 448.802a (Purdon Supp. 1987) (definition of health care facility excludes an "office used primarily for the private practice of medicine, osteopathy, chiropractic, podiatry or dentistry."); 55 PA. CODE § 5200.2(b) (1986) (chapter does not apply to "group practice arrangement of private practitioners"); see also 50 PA. CONS. STAT. ANN. §§ 7103, 7105 (Purdon Supp. 1987).

and alcohol abuse. The Act specifically applies to all patient records prepared or obtained pursuant to the Act, and in addition applies to all patient records related to drug or alcohol abuse or drug or alcohol dependence prepared or obtained by the "private practitioner, hospital, clinic, drug rehabilitation or drug treatment center."⁶¹ The confidentiality policies, including the right to access, therefore, are broader in scope under the Pennsylvania Drug and Alcohol Abuse Control Act because they apply to the purely private practitioner who is treating a person for drug or alcohol abuse or dependence.

3. *Scope of Statutory Right to Access*

A general right of access to records is granted to patients at licensed hospitals and other health care facilities, all patients treated at approved and licensed mental health facilities and all patients involved with treatment for drug and alcohol abuse or dependence. In respect to minor patients, the regulations provide for an independent right of access in some circumstances; parental or guardian consent is generally required.⁶² The right

61. PA. STAT. ANN. tit. 71, § 1690.108(c) (Purdon 1972). The definitions in the current Department of Health regulations that grant a right of access suggest that the regulations apply to clients who are receiving drug or alcohol services as part of a project that is sanctioned by a county agent. For a discussion of these regulations, see *supra* note 54. See also 28 PA. CODE § 701.1 (1986) (definitions). Because the confidentiality policies in the enabling legislation apply to information relating to drug and alcohol abuse dependency of records prepared or obtained by the "private practitioner, hospital, clinic, drug rehabilitation or drug treatment center" the access policies of the above implementing regulations arguably apply to all of these records as well. See PA. STAT. ANN. tit. 71, § 1690.108(c) (Purdon 1972).

62. For a discussion of rights relating to patients in a mental health facility, see generally 55 PA. CODE § 5100.33(b)-(d), (g)-(j) (1986). For a discussion of the highlights of these regulations, see *supra* note 44. For the rights of patients in licensed hospitals and other health care facilities, see 42 PA. CONS. STAT. ANN. § 151 (Purdon Supp. 1987) (hospital to provide unrestricted access to information contained in medical records). For the rights of patients receiving treatment for drug and alcohol abuse, see 28 PA. CODE § 709.30(3)-(6) (1986). The full scope of a minors right to access to health care information and consent to waive other rights in respect to disclosure of health care information is beyond the scope of this article. The matter is especially complicated because there is a constitutional dimension to consent in areas where the state is regulating the decision of a minor to have an abortion or access to contraceptives. Some of the important state laws on a minors right to access to health records follow. Pennsylvania statute provides that any person "who is eighteen years of age or older, or has graduated from high school, or has married, or has been pregnant, may give effective consent to medical, dental and health services." PA. STAT. ANN. tit. 35, § 10101 (Purdon 1977). The Mental Health Procedure Act regulations provide that minors, fourteen years of age or older shall control release of their records provided they understand the nature of the records and purposes of their release. For patients under fourteen or those minors that have been adju-

with respect to records in mental health facilities is specifically limited to inspection.⁶³ No right to possession of the record or to a copy is provided for in the relevant regulations. By implication, only inspection rights are provided for when access to drug and alcohol treatment records is sought.⁶⁴ Patients or clients at hospitals or other health care facilities are granted a right to photocopy the health care record.⁶⁵

As previously discussed, the recently enacted Medical Records Evidence Act, provides for unlimited access by patients to their health records in custody of hospitals and other health care facilities. All of the other regulations providing for access grant the health care professional discretion to deny disclosure to portions of the record where such disclosure would be in some sense harmful to the patient or third parties. Regulations under the Mental Health Procedure Act are the most intricate as far as allowing discretion to withhold information. Limited portions of the record may be denied to the patient when an appropriate health care practitioner has documented that disclosure would constitute a "substantial detriment" to the patient's treatment or when disclosure would reveal the identity of persons or breach the confidentiality of persons who have provided information under a confidentiality agreement.⁶⁶ Pre-sentence reports that

indicated incompetent control or release of records are to be exercised by the parent or guardian of the patient. For patients over fourteen that lack understanding, the regulations curiously provide that a person chosen by the patient may exercise the right if found by the director of the facility to be acting in the patients best interests. 55 PA. CODE § 5100.33(a) (1986). The federal regulations involving drug and alcohol treatment records provide for the consent of both the parent or guardian for minors under the age of eighteen unless state law provides for the independent right of a minor to consent, in which case state law is to govern, 42 C.F.R. §§ 215 (a)-(f) (1986). Regulations promulgated under the Pennsylvania Drug and Alcohol Abuse Act of 1972 do not specifically address the question of a minor patient's right to access. Presumably, the federal regulations cited above would govern a minor patient's access to these records.

63. The regulation provides: "The term "access" when used in this section refers to physical examination of the record, but does not include nor imply physical possession of the records themselves or a copy thereof except as provided in this chapter." 55 PA. CODE § 5100.33(b) (1986).

64. For summary of relevant access regulations promulgated under the Pennsylvania Drug and Alcohol Abuse Act of 1972, see *supra* note 54. This note also contains the author's analysis as to why the state law regulations govern patient's access to drugs and alcohol treatment records.

65. 42 PA. CONS. STAT. ANN. § 151 (Purdon Supp. 1987).

66. The regulation provides:

A person who has received or is receiving treatment may request access to his record, and shall be denied such access to limited portions of the record only:

are part of the record may only be released to the patient upon order of the sentencing judge.⁶⁷ Where patients have been denied access to portions of their records pursuant to the above exceptions to access, procedures under the Mental Health Procedure Act provide that the basis for denial must be noted in the record.⁶⁸

The Medical Records Evidence Act has left the scope of some patient or client access to records involving drug and alcohol treatment unclear. This is because the definition of health care facility in the Act includes programs involving drug and alcohol treatment that are located within a health care facility.⁶⁹ Thus, it appears, for example, that a drug and alcohol treatment program located within a hospital would be subject to the access rights of the Act. This may result in a situation where a patient has somewhat greater access to records of drug or alcohol treatment if he or she is involved in a program which is part of a hospital than if the patient is being treated for drug and alcohol abuse by a private practitioner or at a mental health treatment facility. The difference would be that where the Act governs, discretionary withholding of information from the patient by the health care practitioner would not be allowed. When access rights are governed by regulations under the state and federal statutes, information could be withheld upon a determination by the health care practitioner that disclosure would be harmful to the patient.

Regulations promulgated pursuant to authority under the state Alcohol and Drug Abuse Control Act provide that information in records may be withheld prior to inspection where disclosure would be "detrimental to the client."⁷⁰ Access rights under the 1987 Act do not provide for limiting disclosure. As indicated earlier, the access rights under the 1987 Act would implicitly repeal conflicting sections of the earlier state drug and alcohol reg-

(1) Upon documentation by the treatment team leader, it is determined by the director that disclosure of specific information concerning treatment will constitute a substantial detriment to the patient's treatment.

(2) When disclosure of specific information will reveal the identity of persons or breach the trust or confidentiality of persons who have provided information upon an agreement to maintain their confidentiality.

55 PA. CODE § 5100.33(c) (1986).

67. *Id.* § 5100.33(h).

68. *Id.* § 5100.33(i).

69. *See* 35 PA. CONS. STAT. ANN. § 448.802(a) (Purdon Supp. 1987).

70. *See* 28 PA. CODE § 709.30(3) (1986) (project director may deny patient access to records if determined that access will be detrimental to treatment).

ulations. The result might be different when records were subject to both the 1987 state Act and regulations promulgated under the federal drug and alcohol abuse statutes although the better view would be that the full access rights of the 1987 state Act would control.⁷¹

4. *Access to Health Care Records in the Custody of the Private Practitioner*

As the previous discussion has indicated, legislation and regulations apply to many health records, but quite conspicuously do not apply to the records of a patient or client who is being treated by a private practitioner, unless that purely private practitioner is involved with drug or alcohol treatment of that patient. The result is a huge gap in the right to access under legislation and regulations in Pennsylvania for patients and clients dealing with a health care practitioner who is not treating someone in a mental health treatment facility, or a licensed health care facility or is not involved with drug or alcohol dependency treatment. Most conspicuously absent from coverage are the records of physicians, dentists, psychotherapists and other professionals that are involved with the delivery of health care services in a private practice. Patient or client access to these records would be governed by the Pennsylvania common law. There is no common-law jurisprudence on rights of patients or clients to access health records. Whether a right of access to records in the custody of the private practitioner would be recognized in Pennsylvania is, therefore, a matter of considerable speculation. Given the strong public poli-

71. Language in the federal regulations rather clearly states that state law may not "authorize or compel any disclosure prohibited" by the regulations. 42 C.F.R. § 2.23 (1986). The federal regulations do not specifically speak to whether the patient has a right to access to drug and alcohol treatment records. Access is provided to the attorney of a patient and to the family of a patient when the patient has given written consent. *Id.* § 2.35. The clear implication of the regulations would be that the patient has a right to access since the patient may consent to access by the attorney, family or other third parties. Consensual access to the patient's family is limited if disclosure would be harmful to the patient. *Id.* § 2.36-1. One might plausibly argue that the overall regulatory scheme implies that a similar limitation is placed upon patient access under the federal regulations. This is reaching to find prohibitions on disclosure which if clearly intended ought to have been specifically indicated in the language of the regulations. Moreover, the regulations suggest that the prohibition on redisclosure by the attorney is to protect against disclosure to third parties. In my view the better reading of the regulations is that they would not prohibit full disclosure of records to a patient and that the federal regulations would not override the full disclosure rights provided to patients under the 1987 Act in Pennsylvania where the patient is part of a treatment program in a health care facility.

cies in Pennsylvania providing for access, combined with the current trend in common-law adjudication nationally to provide for a right to access and the activist posture of Pennsylvania courts in respect to privacy, it is likely that a common-law right to access would be recognized in Pennsylvania.

5. *Patient or Client Access to Health Care Information in the Possession of Parties Other than Health Care Providers*

a. Access to Health Care Information in the Custody of State or Federal Agencies and in the Possession of Business Entities

Federal and state laws authorize agencies to have access to health care information without the consent of the patient or client in many instances. For example, employers are required to disclose medical records of employees that are in their possession to the Occupational Safety and Health Agency (OSHA).⁷² Health care practitioners are required to disclose health care information regarding epilepsy and child abuse to state agencies in Pennsylvania.⁷³ Moreover, under limited circumstances a business entity may be able to acquire health care information about someone without the individual's consent.⁷⁴

The common-law right to access that has previously been discussed has not been extended by courts to health records that are not in the possession of health care practitioners or health care facilities. Indeed, one writer has suggested that there are no reported cases where access to records in the possession of such third parties has been recognized under common-law principles.⁷⁵ This is because the *sine qua non* of the right to access under common-law principles is the health care practitioner-client rela-

72. See 29 U.S.C. § 657 (1982) (provision authorizing secretary to enter workplaces and inspect place, equipment, etc. and also requiring employers to make, keep, preserve and make available records which secretary may require regarding cause and prevention of occupational accidents and illnesses).

73. See Child Abuse Prevention and Treatment Act, 42 U.S.C. § 5101-15 (1982) (Act authorizing Secretary through National Center on Child Abuse and Neglect to: research child abuse; publish research on child abuse; develop and maintain information clearing house on all programs for prevention of child abuse; publish training materials for personnel involved in treatment or prevention of child abuse; provide technical assistance to agencies concerned with prevention and treatment of child abuse; and together with federal agencies prepare comprehensive plan for prevention of child abuse).

74. See PRIVACY PROTECTION STUDY REPORT, *supra* note 2, at 279-82; *Privacy Hearings*, *supra* note 27, at 341-42.

75. See Comment, *supra* note 34, at 1364-65.

tionship and the rights and duties that flow from that relationship. Where the health record is in the custody of agencies or business entities other than health care practitioners or health care institutions, the basic professional-client relationship does not provide a repository for rights and duties.

b. Federal Statutes Providing for Access to Government and Business Records

Therefore, patient or client access is primarily governed by federal and state statutes and regulations. At the federal agency level the controlling statutes are the Freedom of Information,⁷⁶ Privacy⁷⁷ and Fair Credit Reporting Acts.⁷⁸ In respect to health records in the custody of state agencies, the "Right to Know" Act⁷⁹ in Pennsylvania and specialized access statutes such as that which provides employees with a right of access to their personnel records⁸⁰ may provide certain patients a right of access to their health records when they are in the custody of state agencies and business entities.

Both the federal Freedom of Information (FOIA)⁸¹ and Privacy Acts⁸² provide for access to records in the possession of federal agencies. As such, they provide potential legal vehicles for patient or client access to health care information that has been acquired by agencies of the federal government. Records that come within the jurisdictional reach of each of the statutes vary to some extent. FOIA applies to all records that are in the custody of agencies of the executive branch of government,⁸³ while the Privacy Act is limited to records that are part of a "system of

76. 5 U.S.C. § 552 (1982).

77. *Id.* § 552a.

78. 15 U.S.C. § 1681-81t (1982) (Act requiring that consumer reporting agencies adopt reasonable procedures for meeting needs of commerce in providing information, which is also fair and equitable to consumer).

79. *See generally* PA. STAT. ANN. tit. 65, §§ 66.1-4 (Purdon 1969 & Supp. 1986) (pertaining to inspection PA. STAT. ANN. and copying of public records).

80. *See generally id.* tit. 43, § 1321 (upon request of employee, employer must permit inspection of employee personnel file kept to determine qualifications for employment, promotion, compensation, termination and other disciplinary action).

81. *See* 5 U.S.C. § 552 (1982).

82. *See id.* § 552a.

83. Although FOIA is quite pervasive with respect to the records that come within its reach, where the records are in the possession of a private organization, the existence of federal funding is not sufficient for the records to be agency records under the statute. *See Forsham v. Harris*, 445 U.S. 169 (1980). In order for data generated by private institutions supported by federal funding to be an "agency record," it must be demonstrated that the agency possesses

records”⁸⁴ within the meaning of the Act. This distinction has very little practical significance because most health records in the possession of federal agencies are retrievable by a patient identification number such as the social security number and would, therefore, be part of a “system of records.”

The confidentiality of health care information when access is sought by third parties is protected by the Freedom of Information Act by the specific exemption for medical records in the statute.⁸⁵ Since standing to access records under the Privacy Act is limited to the person who is the subject of the record, health care information is protected against third-party access under the Privacy Act as well.⁸⁶ According to some commentators, the exception for medical records disclosure under FOIA was read by some agencies to apply to the subject of the record as well as third parties. This view seems to be clearly erroneous.⁸⁷ However, since

such data, but that the data was subject to substantial government control. *See* Ciba-Geigy Corp. v. Mathews, 428 F. Supp. 523 (S.D.N.Y. 1977).

84. *See* 5 U.S.C. § 552a(d)(1) (1977); *see generally* J. FRANKLIN & R. BOUCHARD, *GUIDEBOOK TO THE FREEDOM OF INFORMATION AND PRIVACY ACTS* § 2.08 (1986) [hereinafter *GUIDEBOOK*].

85. *See* 5 U.S.C. § 552(b)(6) (1977), which reads:

(b) This section does not apply to matters that are:

...

(6) personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Id.

86. *See id.* § 552a(d)(1), which provides:

(1) upon request by any individual to gain access to his record or to any information pertaining to him which is contained in the system, permit him and upon his request, a person of his own choosing to accompany him, to review the record and have a copy made of all or any portion thereof in a form comprehensible to him, except that the agency may require the individual to furnish a written statement authorizing discussion of that individual's record in the accompanying person's presence

Id.; *see generally* *GUIDEBOOK*, *supra* note 84, at § 2.08. The rights of access to personal records under the Privacy Act apply to any “individual,” which is defined as “a citizen of the United States or an alien lawfully admitted for permanent residence.” 5 U.S.C. § 552a(a)(2) (1982). This language is generally viewed as excluding business entities from rights under the Act. *See generally* *GUIDEBOOK*, *supra*, at § 2.04. FOIA, on the other hand, has an exceptionally broad standing provision and is available to “any person” including non-citizens and business entities. *See* Florida Medical Ass'n, Inc. v. Department of Health, Educ. & Welfare, 479 F. Supp. 1291, 1307 (M.D. Fla. 1979).

87. *See* *PRIVACY PROTECTION STUDY REPORT*, *supra* note 2, at 508. The exception from disclosure for medical files, contained in section (b)(6) of FOIA, has consistently been interpreted by the Supreme Court and others to be included to protect the privacy of the person who is the subject of the file. A request for access to one's own medical file would not in any meaningful sense constitute an invasion of privacy of the person who waived that concern by re-

the Privacy Act specifically provides for access to medical records by a patient or client, the question of whether FOIA would also be available is of little significance.⁸⁸

Access to health care information under the Privacy Act is limited in several important respects. Each agency is required under the Act to promulgate rules of access to records and "special procedures," if necessary for the disclosure of medical records. Guidelines established by the Office of Management and Budget for implementing the access requirement of the Act provide that an agency is to develop procedures for disclosure to agents for the patient where in the view of the agency direct disclosure would have an adverse effect on the patient.⁸⁹ The result is that a variety of procedures for access have been developed that have to be gleaned by researching the Federal Register in respect to the specific agency that has custody of the record. These access procedures range in liberality of access from the Department of Health, Education and Welfare,⁹⁰ where a designated "responsible" person, that need not be a medical professional, may receive the medical record, to the Veterans Administration, that restricts release to a physician of the patient's choice.⁹¹

Perhaps the most significant limitation under the Privacy Act access provisions is the failure to require notification to the patient that the agency is acquiring health care information about him or her when the agency collects the information from the health care provider or parties other than the patient. Without such notification, the right of the patient to access to the medical

questing access to his own medical records. The privacy of other persons who may be identified in the file would adequately be protected by the commonplace FOIA practice of deleting reference to them from the medical record. This is quite a different matter than exempting the file per se from access by the patient as some have suggested is the rule in FOIA actions.

88. See 5 U.S.C. § 552a(f)(3) (1982), which provides:

(f) Agency rules.—In order to carry out the provisions of this section, each agency that maintains a system of records shall promulgate rules, in accordance with the requirements (including general notice) of section 553 of this title, which shall—

...
(3) establish procedures for the disclosure to an individual upon his request of his record or information pertaining to him, including special procedure, if deemed necessary, for the disclosure to an individual of medical records, including psychological records, pertaining to him.

Id.

89. See generally PRIVACY PROTECTION STUDY REPORT, *supra* note 2, at 296-98; 5 U.S.C. § 552a(f)(3) (1982).

90. See PRIVACY PROTECTION STUDY REPORT, *supra* note 2, at 297.

91. *Id.*

record under the Act is illusory.⁹² The Privacy Act right to access is important in Pennsylvania where medical records are in the custody of the Veterans Hospital, which is expressly exempted from the access provisions of the state Mental Health Procedure Act.⁹³ Where the Privacy Act provisions are available to a patient to access his or her medical record, the patient also has the right to delete or amend erroneous or irrelevant information in the record.⁹⁴ This right is generally not available under other medical record access statutes in Pennsylvania or elsewhere. Liquidated damages and attorneys' fees, as well as actual damages, are recoverable against individuals who willfully deny a patient access to medical records in violation of the Privacy Act.⁹⁵

92. *Id.* at 514; Comment, *supra* note 34, at 1359; *see also* 5 U.S.C. § 552a(e)(3) (1982), which provides that the agency must:

(3) inform each individual whom it asks to supply information, on the form which it uses to collect the information or on a separate form that can be retained by the individual—

(A) the authority (whether granted by statute, or by executive order of the President) which authorizes the solicitation of the information and whether disclosure of such information is mandatory or voluntary;

(B) the principal purpose or purposes for which the information is intended to be used;

(C) the routine uses which may be made of the information, as published pursuant to paragraph (4)(D) of this subsection; and

(D) the effects on him, if any, of not providing all or any part of the requested information.

5 U.S.C. § 552a(e)(3) (1982).

93. PA. STAT. ANN. tit. 50 § 7105 (Purdon 1969 & Supp. 1986) (“[m]ental health facilities operated under the direct control of the Veterans Administration or other Federal agency are exempt from obtaining state approval”).

94. *See* GUIDEBOOK, *supra* note 84, § 3.04(2)(h).

95. *See* 5 U.S.C. § 552a(g)(1)(D) (1982), which provides that when the agency:

(D) fails to comply with any other provision of this section, or any rule promulgated thereunder, in such a way as to have an adverse effect on an individual, the individual may bring a civil action against the agency, and the district courts of the United States shall have jurisdiction in the matters under the provisions of this subsection.

Id.; *see also id.* § 552a(g)(4), which provides:

(4) In any suit brought under the provisions of subsection (g)(1)(C) or (D) of this section in which the court determines that the agency acted in a manner which was intentional or willful, the United States shall be liable to the individual in an amount equal to the sum of—

(A) actual damages sustained by the individual as a result of the refusal or failure, but in no case shall a person entitled to recovery receive less than the sum of \$1,000; and

(B) the costs of the action together with reasonable attorney fees as determined by the court.

Id. There is a split in the circuit courts on whether “actual damages” under the Privacy Act includes damages for mental and physical pain and suffering or is limited to economic loss. *Compare Parks v. IRS*, 618 F.2d 677 (10th Cir. 1980)

c. The State "Right-To-Know" Act

Rights to access under FOIA and the Privacy Act are limited to federal agencies; therefore, in Pennsylvania, access by patients or clients to medical records that are in the possession of state agencies other than health care facilities would be governed by the state "Right-To-Know" Act.⁹⁶ The Act provides for general access to the "public records" of state and local agencies. However, medical records seem clearly not to be "public records" within the meaning of the "Right-To-Know" Act.⁹⁷

The opportunity for business entities to acquire health care information about individuals without their consent has increased dramatically.⁹⁸ Rights of patients or clients to access health information in the possession of private entities in Pennsylvania under existing statutory law do not, to any meaningful extent, exist. Access rights available to those whose credit history is in the records of credit reporting agencies do not include access to medical records under the Fair Credit Reporting Act.⁹⁹ The statute pro-

(holding physical and emotional pain and suffering sufficient) *with* Fitzpatrick v. IRS, 665 F.2d 327 (11th Cir. 1982) (economic damages required).

96. *See generally* PA. STAT. ANN. tit. 65, §§ 66.1-4 (Purdon 1969 & Supp. 1986).

97. *See id.* § 66.1(2) The definition of "public record" provides:

"Public Record." Any account, voucher or contract dealing with the receipt or disbursement of funds by an agency or its acquisition, use or disposal of services or of supplies, materials, equipment or other property and any minute, order or decision by an agency fixing the personal or property rights, privileges, immunities, duties or obligations of any person or group of persons: Provided, That the term "public records" shall not mean any report, communication or other paper, the publication of which would disclose the institution, progress or result of an investigation undertaken by an agency in the performance of its official duties, except those reports filed by agencies pertaining to safety and health in industrial plants; it shall not include any record, document, material, exhibit, pleading, report, memorandum or other paper, access to or the publication of which is prohibited, restricted or forbidden by statute law or order or decree of court, or which would operate to the prejudice or impairment of a person's reputation or personal security, or which would result in the loss by the Commonwealth or any of its political subdivisions or commissions or State or municipal authorities of Federal funds, excepting therefrom however the record of any conviction for any criminal act.

Id.; *see also* Patients of Philadelphia State Hosp. v. Commonwealth, 53 Pa. Commw. 126, 132, 417 A.2d 805, 808 (1980) (evaluation report on state psychiatric hospital by commission on accreditation of hospitals was public record within meaning of "Right-To-Know" Act).

98. *See generally* PRIVACY PROTECTION STUDY REPORT, *supra* note 2, at 277; *Privacy Hearings*, *supra* note 27, at 341-42.

99. *See generally* 15 U.S.C. § 1681-81t (1982). Of specific import is 15 U.S.C. § 1681g (1982), which provides:

(a) Every consumer reporting agency shall, upon request and proper

viding for a general right of employees to the files of their employers specifically exempts medical records from the definition of "personnel file."¹⁰⁰

d. The Need in Pennsylvania for Legislation that Provides for a Uniform Right to Patient or Client Access to Health Care Records

Recent legislation in Pennsylvania recognizes the importance of providing patients and clients with access to health care infor-

identification of any consumer, clearly and accurately disclose to the consumer:

(1) The nature and substance of all information (except medical information) in its files on the consumer at the time of the request.

(2) The sources of the information; except that the sources of information acquired solely for use in preparing an investigative consumer report and actually used for no other purpose need not be disclosed: *Provided*, That in the event an action is brought under this subchapter, such sources shall be available to the plaintiff under appropriate discovery procedures in the court in which the action is brought.

(3) The recipients of any consumer report on the consumer which it has furnished—

(A) for employment purposes within the two-year period preceding the request, and

(B) for any other purpose within the six-month period preceding the request.

(b) The requirements of subsection (a) of this section respecting the disclosure of sources of information and the recipients of consumer reports do not apply to information received or consumer reports furnished prior to the effective date of this subchapter except to the extent that the matter involved is contained in the files of the consumer reporting agency on that date.

Id.; see also *Retail Credit Co. v. Dade County, Fla.*, 393 F. Supp. 577 (S.D. Fla. 1975).

100. See PA. STAT. ANN. tit. 43, § 1322 (Purdon 1969 & Supp. 1986), which provides:

An employer shall, at reasonable times, upon request of an employee permit that employee to inspect his or her own personnel files used to determine his or her own qualifications for employment, promotion, additional compensation, termination or disciplinary action. The employer shall make these records available during the regular business hours of the office where these records are usually and ordinarily maintained, when sufficient time is available during the course of a regular business day, to inspect the personnel files in question. The employer may require the requesting employee to inspect such records on the free time of the employee. At the employer's discretion, the employee may be required to file a written form to request access to the personnel file. This form is solely for the purpose of identifying the requesting individual to avoid disclosure to ineligible individuals. To assist the employer in providing the correct records to meet the employees need, the employee shall indicate in his written request, either the purpose for which the inspection is requested, or the particular parts of his personnel record which he wishes to inspect.

Id.

mation. However, glaring gaps in coverage have left health care practitioners and patients uncertain as to their duties and rights. Most conspicuously, current legislation does not reach the health records of most private practitioners. Distinctions in Pennsylvania law do not appear to be supported in logic or policy. Generally, the right to access turns upon where the information is stored and not upon the nature of the health care information or of the professional-patient or client relationship. Patients have full access to health records in the custody of licensed hospitals and other licensed health care facilities where they are being treated regardless of the nature of the treatment. Yet those same patients do not have a clearly stated right of access to the records of the family physician who may have recommended that they be hospitalized or to the records of a physician who is treating them in post-hospital recuperative treatment. Patients who are being treated for a mental illness in a licensed mental health treatment facility have a right to access, but numerous other patients or clients receiving psychotherapy from psychiatrists or psychologists in a private practice may not. Yet all patients who are being treated for drug or alcohol abuse or dependency probably are provided with a limited right of access to their records.

Arguments that have traditionally been raised by health care professionals against patient and client access have been found wanting in several forums and in much scholarship. The profession has been unable to demonstrate with hard evidence that disclosure would be harmful to patients or clients in most cases. Legislators have accommodated these concerns. Much legislation that has provided for a right to access provides for non-disclosure upon a demonstration of detriment to the patient or provides for dissemination to third parties on behalf of the patient or client. The assertion that disclosure to the patient will result in increased malpractice suits has been persuasively refuted with countervailing claims that access to the health record prior to formal adjudication will likely reduce unwarranted lawsuits against the profession. The Federal Privacy Commission concluded in its 1977 report that access would likely produce a reduction of unwarranted lawsuits against health care practitioners. If this is the case, then a general right to patient or client access is consistent with the concerns of the profession about the excessive transactional costs in malpractice actions and the availability of reasonable malpractice insurance.

It is especially anomalous to deny patient or client access in

Pennsylvania and in our legal system generally when there has been general recognition that the professional-patient relationship involves a cluster of rights and duties including the duty to disclose all of the material risks that are attendant to the particular medical procedure. Recognition of patients and clients' rights to privacy implies that health care information ought not be released without the consent of the patient or client. But consent is a hollow gesture if the patient or client does not know what information exists in the health record.

The laws in Pennsylvania that provide for a right to access have generally been moderate and have accommodated the interests of the profession by providing for discretionary withholding of information when there are bona fide therapeutic, as contrasted to paternalistic, reasons for doing so. By providing for a right to access, the Pennsylvania legislature has recognized the compelling arguments in support of access for patients in licensed hospitals, health care facilities, mental health treatment facilities and for patients with drug and alcohol problems. These arguments would seem to apply to other patients and clients as well.

III. TESTIMONIAL AND EVIDENTIARY PRIVILEGES FOR THE HEALTH CARE PRACTITIONER: A CALL FOR REFORM

In this part of the article, I will discuss the extent to which a testimonial privilege is provided to professionals and patients or clients when health care information is sought as part of formally initiated legal proceedings. One of the ways that the confidentiality of health care information is protected legally is through testimonial privileges. These privileges attach at the pre-trial discovery stage and preclude the disclosure of information in legal proceedings in appropriate circumstances.

Testimonial privileges perform an especially important role in protecting confidentiality in view of the scope of public access to the records of legal proceedings. Once health care information is admitted into legal proceedings, it becomes part of the records that are made accessible to the general public and media. The right of access to information in the records of courts or administrative agencies has been clearly established under state and federal freedom of information acts and "sunshine laws."¹⁰¹

101. Court records are generally open to the public under common-law access principles without the benefit of statutory rights to access. Agency records are accessible under the Freedom of Information Act. 5 U.S.C. § 552(a) (1982).

State and federal court decisions have granted access to the media on the basis of rights granted in the common law and Constitution as well. Publication by the media of health care information that is contained in judicial records is protected by the first amendment.¹⁰² Therefore, the general publication of personal or intimate information in public records is essentially immunized from the reach of tort law and without remedy in our legal system. The prominence that courts have given to media access and publication of health care information that is part of the official records of formally initiated legal proceedings leaves the testimonial privilege as the basic legal vehicle for protecting the confidentiality of much health care information.

*A. General Themes and Trends in the Evidence Law
on Testimonial Privileges*

In the sections that follow I will examine the special features of Pennsylvania law with respect to testimonial privileges for health care practitioners. First, however, I think it will be useful to review evidence law generally in respect to basic features of the employment and construction of testimonial privileges by courts. This general background will facilitate the projection of that which is distinguishable and noteworthy about the law of Pennsylvania.

When courts or agencies seek the testimony of a health care practitioner about communications with a client or patient, they do so for important reasons. The information sought is thought to be pertinent and relevant to the proper determination of facts and the resolution of issues in proceedings before the legal tribunal. Providing formal decision-makers with the evidence and testimony necessary in order to maximize correct fact-finding and issue resolution is a central policy of both federal and state constitutions. Centuries of tradition in Anglo-American law have resulted in the lofty status of truth finding as a policy, especially in criminal proceedings. The primacy of this policy is reflected in constitutional protections in criminal prosecutions and civil adjudicatory proceedings.¹⁰³ For example, President Richard Nixon's

102. See *Landmark Communications, Inc. v. Virginia*, 435 U.S. 829 (1978); *Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469 (1975); *Gilbert v. Medical Economics Co.*, 665 F.2d 305 (10th Cir. 1981).

103. Former Chief Justice Burger stated the tradition of truth-seeking that is embraced by the judiciary aptly:

We have elected to employ an adversary system of criminal justice in which the parties contest all issues before a court of law. The need to

claims of executive privilege gave way to the need for integrity in fact-finding.¹⁰⁴ In other contexts, when constitutional guarantees embodied in the sixth amendment right to confrontation are implicated,¹⁰⁵ other important interests in confidentiality have given way as well. In the law of evidence generally the oft-repeated maxim, "the public has a right to every man's evidence," is an embodiment of the primacy of truth-finding as a policy.¹⁰⁶ The

develop all relevant facts in the adversary system is both fundamental and comprehensive. The ends of criminal justice would be defeated if judgments were to be founded on a partial or speculative presentation of the facts. The very integrity of the judicial system and public confidence in the system depend on full disclosure of all facts, within the framework of the rules of evidence. To ensure that justice is done, it is imperative to the function of courts that compulsory process be available for the production of evidence needed either by the prosecution or by the defense.

United States v. Nixon, 418 U.S. 683, 709 (1974); *see also* Williams v. Florida, 399 U.S. 78 (1970); Dennis v. United States, 384 U.S. 855, 870 (1966); Walder v. United States, 347 U.S. 62 (1954); Lewis v. Court of Common Pleas, 436 Pa. 296, 304 n.4, 260 A.2d 184, 189 n.4 (1969).

In civil adjudication, where important property or liberty interests are implicated, the Supreme Court has found that individuals have a right to confrontation which includes cross-examination and access to evidence that is to be used in agency termination of these interests. *See* Goldberg v. Kelly, 397 U.S. 254 (1970). *Compare* Stanley v. Illinois, 405 U.S. 645 (1972) (father is entitled hearing as to his fitness as parent before his children can be declared wards of state); Bell v. Burson, 402 U.S. 535 (1971) (before state can revoke drivers license and vehicle registration, it must provide forum for determination of whether possibility exists of licensee being found at fault); Willner v. Committee on Character and Fitness, 373 U.S. 96 (1963) (due process violated when applicant for admission to bar not given opportunity to ascertain and contest reason for rejection) *with* Bishop v. Wood, 426 U.S. 341 (1976) (city ordinance did not grant employee property interest and employee's discharge did not violate due process); Matthews v. Eldridge, 424 U.S. 319 (1976) (evidentiary hearing not required prior to termination of Social Security benefits because administrative procedures comport with due process).

104. United States v. Nixon, 418 U.S. 683 (1974).

105. U.S. CONST. amend. VI. The sixth amendment provides in pertinent part: "In all criminal prosecutions, the accused shall enjoy the right . . . to be confronted with the witness against him . . ." *Id.* The sixth amendment right to confrontation is a primary basis for providing access to information in criminal proceedings even in the face of powerful confidentiality arguments. *See* Davis v. Alaska, 415 U.S. 308 (1974) (holding Alaskan statute which privileged juvenile records violated sixth amendment right to confrontation where statute operated to deny defendant confrontation rights in cross-examining witness whose testimony implicated him in crime); Smith v. Illinois, 390 U.S. 129 (1968) (accused was denied his sixth amendment right to confrontation when he was denied right to ask witness his name or address); *see also* Branzburg v. Hayes, 408 U.S. 665 (1972) (grand jury's interest in investigating crime overrides claims of journalist that sources are privileged).

106. *See* Branzburg v. United States, 408 U.S. 665, 668 (1973) (citizens have duty to testify when properly summoned); United States v. Bryan, 339 U.S. 323, 331 (1950) (every person within jurisdiction of government must testify when summoned as witness); Balckmer v. United States, 284 U.S. 421, 438 (1932)

result has been to view testimonial privileges as exceptions to the general duty to provide testimony and to interpret these exceptions narrowly.¹⁰⁷

B. *Standing to Assert Testimonial Privileges*

Few matters in the evidence law on testimonial privileges are as settled as the rules of standing concerning who may assert a testimonial privilege. It is generally held that the client is the holder of the privilege, i.e., the privilege is the client's to assert or waive.¹⁰⁸ This personal standing rule functions to mean that the professional has no independent right to protect the confidentiality of health care information by claiming a testimonial privilege in a legal proceeding if the client has expressly or impliedly waived the privilege.¹⁰⁹ Viewing the right not to disclose communications in legal proceedings as a personal right of the client complements the official position that the essential policy behind testimonial privileges is the protection of free and unfettered communications between the client and professional. Providing that the right is a personal one residing with the communicator most clearly furthers this policy. The personal standing rule is

(one of duties of every citizen is to support administration of justice by giving testimony when properly summoned). The statement probably most often cited for this proposition is that of the late Professor Wigmore:

For more than three centuries it has now been recognized as a fundamental maxim that the public (in the words sanctioned by Lord Hardwicke) has a right to every man's evidence. When we come to examine the various claims of exemption, we start with the primary assumption that there is a general duty to give what testimony one is capable of giving and that any exemptions which may exist are distinctly exceptional. . . .

8 J. WIGMORE, *EVIDENCE* § 2192 (McNaughton rev. ed. 1961).

107. *See, e.g.*, *Trammel v. United States*, 445 U.S. 40 (1980) (discarding federal privilege against adverse spousal testimony); *Herbert v. Lando*, 441 U.S. 153 (1979) (rejecting first amendment privilege which would bar plaintiff in defamation from inquiring into editorial processes of defendant where inquiry will produce evidence material to proof of critical element of action); *Kansas Comm'n on Civil Rights v. Sears, Roebuck & Co.*, 216 Kan. 306, 532 P.2d 1263 (1975) (disclosure of customer credit ratings justified to protect state interest in investigating claim of race discrimination in granting credit).

108. *See generally* C. McCORMICK, *EVIDENCE* (3d ed. 1984); 8 J. WIGMORE, *supra* note 106, § 2196. Leading and often cited Pennsylvania cases in support of this general proposition are: *Romanowicz v. Romanowicz*, 213 Pa. Super. 382, 248 A.2d 238 (1968); *Commonwealth v. McKenna*, 206 Pa. Super. 317, 213 A.2d 223 (1965); *see also* L. PACKEL & A. POULIN, *PENNSYLVANIA EVIDENCE* §§ 501-522 (West 1987).

109. *See Romanowicz v. Romanowicz*, 213 Pa. Super. 382, 385, 248 A.2d 238, 240 (1968) (patient consented to and actually sought introduction of testimony; therefore, physician has no right to bar testimony); *see also* 8 J. WIGMORE, *supra* note 106, § 2386 at 851.

also a feature of the privacy-based justification for testimonial privileges since the right of privacy is that of the patient to decide whether personal or intimate information will be accessible by others.

Although the health care practitioner has no personal standing to claim the privilege over the patient's objection, a legal duty is imposed in Pennsylvania upon the health care professional to take steps to protect the privilege. This duty may require that the privilege be asserted by the health care practitioner on behalf of the client.¹¹⁰ At a minimum, if a health professional or custodian of health records is requested to disclose communications in legal proceedings, that person must notify the client of that request so that the client has an opportunity to assert or waive the privilege.¹¹¹ Since the privilege survives the death of a client in some instances, the privilege may be asserted by the representative of the client's estate.¹¹² If the client is deceased, notification of the request to the family and personal administrator of the deceased is required.¹¹³

The scope of a health care provider's duty in such instances was thoroughly evaluated by the Pennsylvania Supreme Court in *In re June 1979 Allegheny County Investigating Grand Jury*.¹¹⁴ The Allegheny Hospital was asked to disclose information in hospital records involving tests given to patients by businesses that were under investigation for fraud.¹¹⁵ In that or similar situations, the court clearly found that there was a legal duty imposed upon the

110. See *In re June 1979 Allegheny County Investigating Grand Jury*, 490 Pa. 143, 148, 415 A.2d 73, 76 (1980) (hospital owes duty to limit access to patients' records to authorized personnel); *In re Action Mental Health, Inc.*, 32 Pa. D. & C.3d 612, 615 (1983) (institution holding patient records may assert physician-patient privilege).

111. See *In re June 1979 Allegheny County Investigating Grand Jury*, 490 Pa. 143, 415 A.2d 73 (1980); *In re Action Mental Health, Inc.*, 32 Pa. D. & C.3d 612 (1983).

112. See, e.g., *In re Selser*, 27 N.J. Super. 257, 99 A.2d 313 (1953); *Wilcox v. Coons*, 359 Mo. 52, 220 S.W.2d 15 (1949); *Cohen v. Jenkintown Cab Co.*, 238 Pa. Super. 456, 357 A.2d 689 (1976); see also *Michaels v. Metropolitan Life Ins. Co.*, 26 Luz. 79 (C.P. Pa. 1930) (assuming that privilege not applicable).

113. See, e.g., *In re Selser*, 27 N.J. Super. 257, 99 A.2d 313 (1953); *Wilcox v. Coons*, 359 Mo. 52, 220 S.W.2d 15 (1949); *Cohen v. Jenkintown Cab Co.*, 238 Pa. Super. 456, 357 A.2d 689 (1976); see also *Michaels v. Metropolitan Life Ins. Co.*, 26 Luz. 79 (C.P. Pa. 1930) (assuming that privilege not applicable).

114. 490 Pa. 143, 415 A.2d 73 (1980). In this case, the supreme court assumed as a basis of its decision that the patients would not have standing to challenge the grand jury investigation. *Id.* at 149 n.5, 415 A.2d 76 n.5. This view of the patients' standing was vigorously challenged by Justice Nix. *Id.* at 153, 415 A.2d at 79 (Nix, J., concurring).

115. *Id.* at 146, 415 A.2d at 75.

health care provider or professional to assert any testimonial privilege that may be available to the patient or client.¹¹⁶ When such requests are made of custodians of health records, the court reasoned that the finding of a legal duty to assert the privilege was necessary to protect the privacy of the patient or other persons about whom the record contained personal, highly intimate information.¹¹⁷ Two recent decisions where the custodian of health care records successfully asserted privileges on behalf of patients demonstrate the importance of the *Allegheny County* decision to protection of the confidentiality of health care information.¹¹⁸

C. Waiver: Express or Implied from Litigation or Publication

As a personal right, the testimonial privilege may be waived by the patient or client. A waiver, to be effective, must be knowingly, intelligently and voluntarily made.¹¹⁹ The waiver may be

116. *Id.* at 148, 415 A.2d at 76. On the general question of the duty to take steps to protect confidentiality and privacy, the court, speaking through Justice Eagen, stated:

Although the patient's medical records are the property of the hospital, the personal nature of the information they contain results in an obligation on the part of the hospital to maintain the confidentiality of the records. Unless otherwise provided by law, the hospital must limit access to the records to authorized personnel in the absence of consent by the patient.

Id., 415 A.2d at 76 (citation omitted).

117. *Id.* In the context of *Allegheny County*, the general obligation to protect confidentiality included the duty to assert the privilege on behalf of the client in respect to the subpoena, since the hospital was the custodian of the records, and the patients were not the subject of the grand jury investigation. Where requests are made to health care practitioners or to custodians of records for information about patients or clients where they are the focus of the inquiry, the obligation would at least include notifying the client and giving him an opportunity to exercise his right not to disclose. The duty to notify the patient or client would clearly be part of the health care practitioner's responsibilities where patient consent was required before disclosure.

118. See *In re Action Mental Health, Inc.*, 32 Pa. D. & C.3d 612 (1983). Action Mental Health Inc. provided mental health, marital, drug and alcohol counseling. *Id.* at 613. The district attorney's office, pursuant to a search warrant, seized files which contained information concerning patient treatment and claims submitted to Blue Cross/Blue Shield. *Id.* at 614. Action sought to enjoin the examination of the files claiming constitutionally based psychotherapist-patient privilege prohibited the district attorney from examining the files. *Id.* at 613. The court held that Action had the right to assert the privilege. *Id.* at 615. Similarly in *Marcelli v. Commonwealth*, the court held that the psychiatric records of a defendant in a civil action were not discoverable because of the patient's constitutional right of privacy and that Haverford State Hospital, the custodian of the records, had standing to assert the patient's constitutionally based privilege. 23 Pa. D. & C.3d 600 (1982).

119. This is the standard applicable to waiver of any significant right. See *In re Pebsworth*, 704 F.2d 261, 262 (7th Cir. 1983) (express waiver is intentional,

expressly communicated, either orally or in writing. Most commonly, express waivers are made part of applications for individual or group insurance. Such waivers are generally quite extensive, providing the insurer with a right of access to health care information for determining eligibility for insurance, investigating claims for reimbursement and for use in any subsequent litigation between the insured and insurer.¹²⁰

A waiver may be inferred from a broad range of actions by the patient or client. The two general situations where such implied waiver of the privilege has been found by the courts are:

1) where the patient or client initiates litigation involving his or her physical or mental condition; and

2) where communications are uttered to the health care professional in the presence of other persons or under circumstances where the communication to other persons is intended or clearly foreseeable to the patient or client. The former is sometimes described as the "litigant exception" to the testimonial privilege;¹²¹ the latter is often spoken of as the requirement of "confidentiality."¹²² The litigant exception and confidentiality doctrines are actually legal concepts that are part of the broader notion that the patient's or client's actions in these circumstances constitute an implied waiver of the testimonial privilege.

The extent to which a waiver of testimonial privilege occurs as a result of voluntary action by the patient or client in initiating or conducting litigation differs from state to state. If the patient

voluntary relinquishment of known right); see generally Waltz, *Informed Consent to Therapy*, 64 Nw. U.L. REV. 628 (1970).

120. These waivers are generally found to be valid. See C. McCORMICK, *supra* note 108, § 103 at 254. In Michigan, waivers in insurance policies have been found to be invalid because they violate public policy. *Gilchrist v. Mystic Workers of the World*, 196 Mich. 247, 163 N.W. 10 (1917). In *Gilchrist*, the court determined that the language of the applicable statute expressed a legislative intent to prohibit anticipatory waivers which become operative after the death of the patient. *Id.* at 251-52, 163 N.W. at 11.

121. See *Commonwealth v. El*, 273 Pa. Super. 1, 416 A.2d 1058 (1979). In *El*, the superior court allowed the prosecutor to cross-examine the custodian of records at a drug treatment center, despite a Pennsylvania statute which states that drug and alcohol treatment records may not "be used to initiate or substantiate criminal charges against a defendant under any circumstances." *Id.* at 12-13, 416 A.2d at 1064. This was permitted because the defendant had brought the records into the courtroom and had questioned the head of a methadone clinic. *Id.* at 13, 416 A.2d at 1064. The court stated: "It would not be proper to disallow the district attorney to cross-examine [the custodian] and to review the other records which he had with him at that time." *Id.*

122. See *Commonwealth v. Goldblum*, 498 Pa. 455, 447 A.2d 234 (1982) (communications between witness and his psychologist were not privileged because they were made by witness for future disclosure at witness' own trial).

initiates a malpractice action against the health care professional, the privilege is automatically waived. In cases where the patient initiates a personal injury action against someone other than the professional some courts strictly limit the waiver to instances where the information is pertinent to specific emotional distress or physical injury claims, or where the health care professional is utilized by the plaintiff as a witness.¹²³ Other jurisdictions view the waiver more broadly.¹²⁴

1. *Implied Waiver as a Consequence of Publication by the Patient or Client to a Non-Professional: The Confidentiality Requirement*

In interpreting the scope of testimonial privileges regarding communications between the health care professional and client, many courts have found that the privilege attaches only to communications that were "confidential" in the circumstances in which they were uttered.¹²⁵ Two basic tenets defining the parameters of confidentiality have evolved. The first is that communications uttered in the presence of certain persons other than the health care practitioner are not confidential.¹²⁶ The second is that communications made to the health care professional where the patient has a reasonable expectation that they will be commu-

123. See *Roberts v. Superior Court*, 508 P.2d 309, 107 Cal. Rptr. 309 (1973) (where no specific mental condition of patient is at issue and discovery of privileged communication is sought, those communications are privileged); *State v. Olsen*, 271 Or. 369, 532 P.2d 230 (1975) (when patient calls upon doctor to testify, he must intend to waive privilege). For a summary of some of the distinctions made by courts when waiver of records for psychotherapy is asserted as a result of participation in a lawsuit, see S. KNAPP & L. VANDECREEK, *PRIVELEGED COMMUNICATIONS IN THE MENTAL HEALTH PROFESSIONS* 66-69 (Van Nostrand Reinhold Co. 1987).

124. See *Phillips v. Powell*, 210 Cal. 39, 42, 290 P. 441, 443 (1930) (bringing action to recover for personal injuries constitutes waiver of privilege of confidential information acquired by physician, provided testimony is material). In Pennsylvania, the physician-patient testimonial privilege statute contains an explicit exception to the privilege for civil actions brought by the patient for personal injuries. See, e.g., *Miller v. Colonial Refrigerated Transp. Inc.*, 81 F.R.D. 741 (M.D. Pa. 1979) (holding statute applies to psychiatric records of patient); see also *Dennie v. University of Pittsburgh School of Medicine*, 638 F. Supp. 1005 (W.D. Pa. 1986) (implied waiver of privilege from personal injury action complete defense to subsequent breach of confidentiality action).

125. This has been the case in construction of the attorney-client privilege even when the statute does not specifically refer to the term "confidential." See C. McCORMICK, *supra* note 108, § 101 at 249. Courts have carried over this view and applied the confidentiality requirement to physician-patient privilege statutes. See *id.*; 8 J. WIGMORE, *supra* note 106, § 2381.

126. See *Horowitz v. Sacks*, 89 Cal. App. 336, 344, 265 P. 281, 285 (1928) (communications between physician and patient in presence of third party are not privileged); *Gilham v. Gilham*, 177 Pa. Super. 328, 330, 110 A.2d 915, 916 (1955) (third persons may testify to communications overheard by them).

nicated or otherwise made available by the professional to third parties are not confidential.¹²⁷ The divergence in judicial attitudes regarding application of the above notions tracks, to a large extent, the differences that have been noted earlier. Courts that take a very restrictive view of testimonial privileges are inclined to treat information as non-confidential if it is uttered in the presence of someone other than the professional even if that person is a member of the treatment staff.¹²⁸ Other jurisdictions that are more generous in the construction of the privilege treat statements made in the presence of agents of the practitioner, such as nurses or other individuals, that are present as part of treatment as confidential.¹²⁹ A few courts do not follow a strict agency approach, but rather treat the communication as confidential if the person has some functional role in treatment.¹³⁰

It is important to note that when courts employ the confidentiality requirement to limit testimonial privileges, they utilize a notion of confidentiality that many times is at odds with the ethical notion of confidentiality that is embraced by the health care profession. Health care professionals view much of the information that is acquired in the course of treatment as confidential in the sense that it ought not be made public by the health care professional. The concept of confidentiality that is utilized by courts in limiting testimonial privileges is narrower in scope and a reflection of the view that if the patient has exposed information be-

127. See *Commonwealth v. Goldblum*, 498 Pa. 455, 464, 447 A.2d 234, 239 (1982) (privilege between doctor and client does not exist as to communications which are to be publicly disclosed pursuant to direction of client); *Commonwealth v. Edwards*, 318 Pa. 1, 6, 178 A. 20, 22 (1935) (confidential relationship between jail physician and accused murderer did not exist in such manner as to make communication privileged).

128. See *Weis v. Weis*, 147 Ohio St. 416, 429, 72 N.E.2d 245, 252 (1947) (statements to nurse are not privileged communications); C. McCORMICK, *supra* note 108, § 101 at 249. For a discussion of privileged communications made to a nurse or attendant, see Annotation, *Evidence: Privilege of Communication by or to Nurse or Attendant*, 47 A.L.R.2d 742 (1956).

129. See *Ostrowski v. Mochridge*, 242 Minn. 265, 272, 65 N.W.2d 185, 190 (1954) (statements made to doctor in presence of nurse who is acting as agent of doctor are privileged); *Gilham v. Gilham*, 177 Pa. Super. 328, 330, 110 A.2d 915, 916 (1955) (communications in presence of nurse are privileged since she was in attendance in her professional capacity).

130. See *Franklin Life Ins. Co. v. William J. Champion & Co.*, 350 F.2d 115, 130 (6th Cir.) (communications to intern upon entrance to hospital are privileged), *reh'g denied*, 353 F.2d 919 (1965), *cert. denied*, 384 U.S. 928 (1966); *Blue Cross v. Superior Court*, 61 Cal. App. 3d 798, 801, 132 Cal. Rptr. 635, 636 (1976) (claims filed with health insurer are reasonably necessary to obtain treatment and therefore are privileged); C. McCORMICK, *supra* note 108, § 101, at 250.

yond the confines of the direct professional-client or -patient relationship, the information ought not be privileged. As will be discussed in a later portion of the article, the professional and judicial views of confidential information for purposes of testimonial privileges are at considerable odds in respect to communications that arise in group or intra-family treatment sessions with psychotherapists.

D. *Pennsylvania Law*

In Pennsylvania, a testimonial or evidentiary privilege in respect to health care information may be based on any of three legal grounds. The privilege may be based on the relationship between the professional and client or patient (relationship-based testimonial privilege); the privilege may be based on the kind of record in which the health care information is stored (record-based testimonial privilege); or the privilege may be based on the state and federal constitutional right to privacy (constitutionally based testimonial privilege).

Pennsylvania law on testimonial privileges for health care information is also the law that is applicable to diversity cases brought in federal courts sitting in Pennsylvania when the claim or defense before the court is based upon Pennsylvania substantive law. This is by virtue of Rule 501 of the Federal Rules of Evidence specifically providing that the state law of privilege will apply to such cases.¹³¹

1. *Relationship-Based Testimonial Privileges*

The importance of the truth-finding policy in Anglo-American law is reflected in part by the general requirement that health care professionals be required to testify about communications within their professional relations if the communications are relevant to a matter before a court or administrative agency. This was clearly the case for health care practitioners at early common law where neither the legislature nor courts provided a privilege from requiring testimony about communications between the patient and physician. The only two relationships given a testimonial privilege at common law were the attorney-client relationship and

131. See FED. R. EVID. 501; S. SALTZBURG & K. REDDEN, FEDERAL RULES OF EVIDENCE MANUAL 331 (1986); see also *Miller v. Colonial Refrigerated Transp., Inc.*, 81 F.R.D. 741 (M.D. Pa. 1979) (applying Pennsylvania privilege law in diversity case). For a further discussion of testimonial privileges for health care practitioners, see *infra* notes 134-229 and accompanying text.

the husband-wife relationship.¹³² Today virtually every state legislature has privileged some communications between the physician and patient. Other health care professional relationships have also been viewed as privileged through legislative enactment.¹³³

a. Health Care Practitioners Covered

There has been virtually universal resistance by the courts to the judicial creation of testimonial privileges that are grounded exclusively on the health care professional-client relationship.¹³⁴ In Pennsylvania, at least, it appears quite certain that before a relationship may enjoy the protections of a testimonial privilege, the testimonial privilege must be specifically created by the legislature. The leading decision is *In re Pittsburgh Action Against Rape*,¹³⁵ where a majority of the supreme court rejected the invitation to expand by judicial decision the testimonial privilege to the rape counselor-client relationship. In a thoughtful, well-reasoned dissent, Justice Larsen argued for a testimonial privilege for communications between the sexually abused client and counselor. Drawing extensively on studies and law review articles, he pointed to the functional similarities between counseling sexual abuse victims and psychotherapy, and the essential role of the confidentiality of communications to the relationship as well as to law enforcement interests.¹³⁶ Justice Roberts, speaking for a majority

132. See generally 8 J. WIGMORE, *supra* note 106, § 81. Wigmore traces the attorney-client privilege to the 16th Century. *Id.* The precise date of the origin of the husband-wife privilege is apparently obscure. Wigmore indicates that it was in place by the late 16th century. *Id.* §§ 2332-2334.

133. See generally R. SLOVENKO, *PSYCHOTHERAPY, CONFIDENTIALITY AND PRIVILEGED COMMUNICATION* 47 (1966); Schuman & Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C.L. REV. 893, 907 (1982) (all but two states have enacted either physician-patient, psychologist-patient or psychotherapist-patient privilege); Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175 (1960) (33 states with physician-patient privilege). For a current compilation of all of the states, testimonial privilege statutes applicable to health care practitioners, and a general overview of the important issues testimonial privilege law raises for psychotherapists, see the interesting and useful book by S. KNAPP & L. VANDECREEK, *supra* note 123.

134. McCormick suggests that the shift from the courts to the legislature in the creation of new testimonial privileges may be a reflection of several factors. These are: (1) the preoccupation of courts with truthfinding as a policy; (2) cynicism about whether privilege protects communications in relationships and the difficulty of demonstrating this with empirical studies. See C. MCCORMICK, *supra* note 108, § 76.

135. 494 Pa. 15, 428 A.2d 126 (1981).

136. *Id.* at 34-63, 428 A.2d at 133-50 (Larsen, J., dissenting). The nature of the relationship between a rape victim and crisis counselor is the functional equivalent of the psychotherapeutic relationship. *Id.* at 55, 428 A.2d at 146

of the court, however, found that the goal of truth seeking and the defendant's right to confrontation in the rape prosecution from which the appeal arose, as well as the "difficulty in drawing a line" on testimonial privileges overrode the need for confidentiality.¹³⁷ Justice Roberts' opinion in *Pittsburgh Action Against Rape* concerning the judicial expansion of testimonial privileges has not been seriously questioned in subsequent appellate court decisions. The unmistakable trend nationally is to limit testimonial privileges, as the Pennsylvania Supreme Court did, to those relationships that the legislature specifically identifies in the statute creating the privilege.

The legislative-created testimonial privileges in Pennsylvania now cover the following health care relationships: (1) physician/psychiatrist and patient/client; (2) psychologist and client; (3) sexual assault counselor and client; (4) school personnel and students; and (5) marriage counselor and client.

(1) The Physician/Psychiatrist and Patient/Client Testimonial Privilege

In Pennsylvania, there is no specific statutory testimonial privilege for psychiatrists. Such testimonial privileges are granted to licensed psychologists¹³⁸ and physicians.¹³⁹ Since psychiatrists

(Larsen, J., dissenting). The information revealed in both relationships is of an extremely sensitive nature. *Id.* The need for confidentiality is critical to the existence of the relationship. *Id.* Furthermore, for a great number of women, a rape crisis counselor is their only available psychotherapeutic assistance. *Id.* at 57, 428 A.2d at 147 (Larsen, J., dissenting). Rape crisis centers are vital to a community and have been industriously encouraged. *Id.* at 58, 428 A.2d at 148 (Larsen, J., dissenting). Nowhere does there exist a more pressing need for privacy than in the rape victim-crisis counselor relationship. *Id.* at 60, 428 A.2d 149 (Larsen, J., dissenting).

137. *Id.* at 24-27, 428 A.2d at 130-32. Our system of criminal justice is a search for the truth. *Id.* at 24, 428 A.2d at 130. The truth finding function precludes the creation of an absolute privilege for rape victims and their crisis counselors. *Id.* at 25, 428 A.2d at 131. Also at stake is the basic consideration of fairness to the accused seeking to defend himself against criminal charges. *Id.* at 27, 428 A.2d at 131. It would be unfair to deny the accused the opportunity to ascertain what his accuser previously said. *Id.*

For a rare example of judicial expansion of testimonial privileges under the common law, see *Allred v. State*, 554 P.2d 411 (Alaska 1976) (recognition of common law testimonial privilege to a social worker).

138. The current statutory testimonial privilege for psychologists reads: Confidential communications to licensed psychologists

No person who has been licensed under the act of March 23, 1972 (P.L. 136, No. 52), to practice psychology shall be, without the written consent of his client, examined in any civil or criminal matter as to any information acquired in the course of his professional services in behalf of such client. The confidential relations and communications between

are licensed medical doctors, the privilege granted by the legislature to physicians also applies to psychiatrists who are engaged in the practice of psychotherapy. The anomaly of determining the scope of the privilege available to a patient in psychotherapy on the basis of whether the therapist is a medical doctor or psychologist caused Justice Roberts in *In re "B"*¹⁴⁰ to suggest that the psychologist privilege statute would also apply to psychiatrists. However, this view has not been adopted by the courts. It is now clearly settled in Pennsylvania that any testimonial privilege given psychiatrists by statute is exclusively that provided for in the physician-patient privilege statute.¹⁴¹

The physician-patient testimonial privilege in Pennsylvania is unusual both in the literal content of the statutory language and in the judicial interpretation of the privilege by Pennsylvania courts. The statute specifically limits the testimonial privilege to

a psychologist and his client shall be on the same basis as those provided or prescribed by law between an attorney and client.

42 PA. CONS. STAT. ANN. § 5944 (Purdon 1982). For a discussion of testimonial privileges generally in Pennsylvania, see L. PACKEL & A. POULIN, *supra* note 108, at §§ 501-522.

139. The current physician-patient statutory testimonial privilege reads:
Physician not to disclose information

No physician shall be allowed, in any civil matter, to disclose any information which he acquired in attending the patient in a professional capacity, and which was necessary to enable him to act in that capacity, which shall tend to blacken the character of the patient, without consent of said patient, except in civil matters brought by such patient, for damages on account of personal injuries.

42 PA. CONS. STAT. ANN. § 5929 (Purdon 1982).

140. 482 Pa. 471, 394 A.2d 419 (1978) (Roberts, J., concurring). In his opinion, Justice Roberts stated:

Although this statute does not expressly apply to medical doctors engaged in the practice of psychotherapy, but rather only to those with graduate degrees in psychology, . . . it would be arbitrary to believe that the Legislature intended the scope of a patient's privilege to depend on whether the attending therapist is a medical doctor or a psychologist.

Id. at 489, 394 A.2d at 428 (Roberts, J., concurring) (citation omitted).

Justice Roberts' view is not supported by the plain language of section 5944, which refers to persons who have been licensed to practice psychology. Section 5944 became effective in 1978 and is a recodification of the psychologist privilege statute enacted in 1972. The 1972 statute provided that persons licensed to practice any of the healing arts would be exempt from the provisions of the act. In recodifying the statute the legislature specifically referred to the 1972 statute and therefore the legislative history of section 5944 does not support Justice Roberts' construction of that section as applying to psychotherapists other than psychologists.

141. See *Miller v. Colonial Refrigeration Transp. Inc.*, 81 F.R.D. 741, 744 (M.D. Pa. 1979) (psychologist-patient privilege is not applicable to psychiatrist); *Commonwealth v. Petrino*, 332 Pa. Super. 13, 32-33, 480 A.2d 1160, 1170 (1984) (psychiatrists claim their privilege under physician-patient statute), *cert. denied*, 471 U.S. 1069 (1985).

civil matters, and case law has been faithful to the literal language of the statute.¹⁴² Beyond that, the statute specifically applies only to “information” acquired by the physician which is “necessary” to “attending the patient in a professional capacity” and which tends to “blacken the character of the patient.” Both of these limitations have been interpreted by the courts to severely restrict the physician testimonial privilege.

(a) The Communication Limitation

Although the text of the physician-patient testimonial privilege statute has referred to “information” since its enactment in 1907, court construction since the beginning has limited application of the statute solely to utterances by the patient to the physician. Two early Pennsylvania Supreme Court decisions established this limitation. In *Skruch v. Metropolitan Life Insurance Co.*,¹⁴³ the court found that testimony by a physician that his patient had suffered from convulsions was not privileged because such testimony did not concern “communications” by the patient.¹⁴⁴ The testimony was allowed even though the convulsions were symptoms of a loathsome disease.¹⁴⁵ In dicta, the court suggested that the statute would, however, reach testimony that referred to the disease or the fact that the convulsions were symptoms of the disease.¹⁴⁶ Two years later, in *In re Phillips Estate*,¹⁴⁷ the court repudiated this dicta and fully elaborated a construction of the statutory privilege that has been controlling ever since. In *Phillips*, where the validity of a will was contested, physicians testified that their patient, the deceased testator, was suffer-

142. Only two early decisions have dealt with the issue, and both have limited the testimonial privilege to civil proceedings. One is a Pennsylvania Supreme Court case. In *Commonwealth v. Edwards*, 318 Pa. 1, 178 A. 20 (1935), the supreme court, in an opinion by Chief Justice Frazer, affirmed the lower court's determination that a confession of murder made to a physician employed by the county while the defendant was in jail was not privileged because it was a criminal proceeding. *Id.* at 7, 179 A. at 22; see also *Commonwealth v. Townsley*, 30 Pa. D. & C. 209, 211 (1937) (testimony of physician that wife suffered miscarriage not privileged in prosecution for support and maintenance partly because proceeding was criminal).

143. 284 Pa. 299, 131 A. 186 (1925).

144. *Id.* at 300, 131 A. at 186.

145. *Id.* at 301, 131 A. at 186. A person can have convulsions without the fact blackening his character in any way. *Id.* at 302, 131 A. at 186.

146. *Id.* If follow-up questions would have shown that the deceased had suffered from a loathsome disease, the doctor's response would have been privileged. *Id.*

147. 295 Pa. 349, 145 A. 437 (1929).

ing from paresis.¹⁴⁸ On cross-examination they further testified that, in their opinion, paresis can result only from syphilis.¹⁴⁹ The lower court decision to exclude the testimony on the basis that it would tend to blacken the character of the patient within the meaning of the testimonial privilege statute was reversed by the supreme court with only Justice Frazer dissenting.¹⁵⁰ The *Phillips* court held that only "communications" from the patient to the physician were privileged under the statute.¹⁵¹ In doing so, the court *ipso facto* excluded from the reach of the testimonial privilege statute all observations and diagnoses by the physician and all other health care information acquired about the patient as part of treatment except the utterances of the patient to the physician.

Recent decisions by the Pennsylvania Supreme Court have developed a rationale for limiting the statute to communications by the patient that was not found in the *Skruch* and *Phillips* opinions. The court has indicated that the scope of privileged health care information is to be determined by an evaluation of whether disclosure of the information for which the privilege is sought would offend the rationale of the statute.¹⁵² In this determination, the statutory privilege has been characterized as enacted solely to promote the policy of encouraging patient disclosure to the physician of all possible information bearing on his or her illness for the rendering of effective treatment.¹⁵³ Applying a strict utilitarian analysis, the court has concluded that only patient communications or information that would expose such communications is, as a preliminary matter, included in the statutory

148. *Id.* at 352, 145 A. at 438. Three of the decedent's attending physicians testified that the decedent was not competent to make a will. *Id.*

149. *Id.* The physicians did not say whether the disease was inherited or arose because of the decedent's personal actions. *Id.*

150. *Id.* at 355, 145 A. at 439. The court stated that the statute only excludes communications made to the physician by the patient. *Id.* Facts which the physician ascertained by examining the patient do not fall into this category. *Id.*

151. *Id.* The court stated that it was clear that the physician's testimony was not a communication within the meaning of the statute. *Id.* at 356, 145 A. at 439.

152. *Allegheny County*, 490 Pa. at 149, 415 A.2d at 77 (purpose of privilege is to create confidential atmosphere); see *In re "B,"* 482 Pa. at 478, 394 A.2d at 422 (purpose of statute is to create confidential atmosphere between patient and physician).

153. *Allegheny County*, 490 Pa. at 143, 415 A.2d at 77 (privilege encourages full disclosure to physician); see *In re "B,"* 482 Pa. at 478, 394 A.2d at 422 (statute encourages patients to disclose all information bearing on illness so physician may render effective treatment).

privilege.¹⁵⁴ As a result of this view the privilege has not been extended to: (1) dental records;¹⁵⁵ (2) all testimony by physicians of their diagnoses or examinations of patients even in respect to venereal disease;¹⁵⁶ (3) names and addresses of patients and other identifying data;¹⁵⁷ (4) reports and tests;¹⁵⁸ and (5) x-rays.¹⁵⁹

As previously noted, it has been suggested in dicta that information that would "tend to expose" patient communications also comes within the statutory privilege. However, very little information beyond direct patient communications has been found privileged by Pennsylvania courts. As a practical matter, with the very limited exceptions noted above, the physician/psychiatrist-patient testimonial privilege is applicable only to those communications by the patient to the physician/psychiatrist.

Limiting the testimonial privileges for physicians and psychiatrists to communications is not compelled by the language of the statute,¹⁶⁰ which refers to "information" and not "communica-

154. See *Allegheny County*, 490 Pa. at 148, 415 A.2d at 77 (statute limited to information directly related to patient's communications); *In re "B,"* 482 Pa. at 480, 394 A.2d at 423 (patient records that do not contain communications by patient to physician are not privileged). For a discussion of *Allegheny County*, see Annotation, *Allegheny County*, 10 A.L.R. 4th 542 (1981).

155. See *Pennsylvania Dental Ass'n v. Commonwealth*, 75 Pa. Commw. 7, 13, 461 A.2d 329, 332 (1983) (statutory privilege against disclosure does not apply to dental records).

156. See *Michaels v. Metropolitan Life Ins. Co.*, 26 Luz. 79, 80 (C.P. Pa. 1930) (physician may testify regarding facts ascertained by examining patients).

157. See *Woods v. National Life and Accident Ins. Co.*, 347 F.2d 760, 764 (3d Cir. 1965) (name, address and other identifying data given by patient is not privileged); *Robinson v. Magovern*, 83 F.R.D. 79, 89-90 (W.D. Pa. 1979) (address of patient, procedure performed, name of operating physician not privileged); *Sweeney v. Green*, 116 Pa. Super. 190, 191-92, 176 A. 849, 850 (1935) (names of patients doctor attended are not privileged).

158. See *Allegheny County*, 490 Pa. at 150, 415 A.2d at 77 (tissue reports contain no privileged communications); *Romanowicz v. Romanowicz*, 213 Pa. Super. 382, 387, 248 A.2d 238, 241 (1968) (psychiatric reports should be considered because parties agreed reports were proper evidence).

159. *Massich v. Keystone Coal and Coke Co.*, 137 Pa. Super. 541, 544, 10 A.2d 98, 100 (1939) (medical opinion derived from examination of x-rays is not privileged).

160. *But see In re Phillips Estate*, 295 Pa. 349, 145 A. 437 (1929). In *Phillips*, the Pennsylvania Supreme Court construed the Act of June 7, 1907, P.L. 462, Pa. Stat. 1920, § 21860 [reenacted at 42 PA. CONS. STAT. ANN. § 5929] to encompass only "communications made to [the physicians and surgeons] by their patients." *Id.* at 353, 145 A. at 439 (emphasis in original). The court based its construction upon the rule that the constitutional scope of a statute was to be construed by viewing the policy as strictly limited to the clear expression in the statute and not by implication. *Id.* at 353, 145 A. at 438-39. Therefore, the court found that the phrase, "[a]n Act to prevent physicians and surgeons from testifying . . . to communications made to them by their patients," in the title of

tion." The construction of the statute with respect to the communication limitation is at odds with the basic realities of health care, especially where psychiatrists and clients are involved in psychotherapy. The Pennsylvania Supreme Court has clearly sorted out and exempted from the statutory privilege all diagnoses and examinations by psychiatrists even where a diagnosis was based upon a communication.¹⁶¹ Diagnosis and treatment are linked inseparably to information shared and acquired from the patient or client including his or her verbal statements to the health care practitioner. This is especially true in the case of psychotherapy. Much of the information acquired by the psychotherapist is from client communications.¹⁶² While conversations between other physicians and their patients may be incidental to treatment, in the context of psychotherapy, the talk is the treatment.¹⁶³

In *Allegheny County*, a majority of the Pennsylvania Supreme Court limited the scope of the physician/psychiatrist privilege to "information directly related to the patient's communication and thus tending to expose it."¹⁶⁴ The court made it clear that the privilege is not triggered by a demonstration that the information relates "back in some way to [a] . . . communication by a patient."¹⁶⁵ It appears then that only testimony by the psychiatrist about the precise statement made by the client or testimony that would reveal the precise statements made by the client come within the privilege.

Given the essential inseparability of communications by a cli-

the Act restricted the phrase "any information" in the body of the statute to mean only communications. *Id.* at 352, 145 A at 438. In restricting the construction of the word, "information," the court held in error the common pleas decision in *Reid v. Reid*, which had broadly construed "information" to include "not only statements, but also knowledge arising from observation and examination of the patient." *Id.* at 353, 145 A. at 438 (quoting *Reid v. Reid*, 50 Pa. C. 601, 604 (1920) (purpose of act would be defeated if "information" were to be construed narrowly)).

161. See *In Re "B,"* 482 Pa. at 471, 394 A.2d at 419 (patient's psychiatric records not within statutory privilege).

162. See generally R. SLOVENKO, *supra* note 133. Professor Slovenko states the crucial role of communications in psychotherapy as follows:

In psychotherapy, however, every statement is a link in the chain. Thus all statements are relevant to treatment, and require confidentiality. All physicians may discuss matters with their patients which have no relevance to the illness, but in psychotherapy, almost all, if not all, statements are pertinent to and essential for treatment.

Id. at 44.

163. *Id.*

164. 490 Pa. at 150, 415 A.2d at 77. For additional discussion of *Allegheny County* see *supra* notes 114-17 and accompanying text.

165. 490 Pa. at 149, 415 A.2d at 77.

ent and diagnosis and examination in psychotherapy, the “communications” limitation of the psychiatrist-client privilege as construed by Pennsylvania courts leaves the core of the psychotherapeutic relationship exposed and without statutory protection when health care information is sought in legal proceedings. The primacy of the role of communications in psychotherapy is also at odds with the employment of the utilitarian rationale by the courts in Pennsylvania to limit the privilege to communications. The Pennsylvania Supreme Court suggests that the scope of information that is initially to come within the statute is to be determined on the basis of whether the information is essential to creating a confidential atmosphere where the patient will “be encouraged to disclose all possible information bearing on his or her illness.”¹⁶⁶ In this determination the court has separated “communications” from diagnoses and examinations because confidentiality “is not required for the doctor to observe and examine.”¹⁶⁷ This distinction may have some merit in the case of medical treatment for a purely physical illness, but collapses where a patient is engaged in talk therapy with a psychiatrist. A physician may diagnose an illness based upon physical symptoms without any verbal communications from the patient. Where, however, data for diagnosis is primarily derived from conversations between the psychiatrist and the client, no clear distinction between communications and diagnosis and examination may be made.

(b) The “Blacken the Character of the Patient” Limitation

The most exceptional and restrictive feature of the physician/psychiatrist testimonial privilege in Pennsylvania is the provision in the statute which specifically limits the privilege to communications which “tend to blacken the character of the patient.”¹⁶⁸ The legislative history of the physician-patient privilege does not provide any guidance as to the type of communication covered by or the purpose behind the inclusion of the “blacken the character” language in the statute. The language suggests that only communications that would be damaging to the plaintiff’s reputation if disclosed come within the statutory coverage. Some of the earlier decisions were able to avoid this construction

166. *Id.*; see also *In re “B,”* 482 Pa. at 478, 394 A.2d at 422 (patient will be encouraged to disclose all possible information).

167. *In re “B,”* 482 Pa. at 478, 394 A.2d at 422.

168. PA. CONS. STAT. ANN. § 5929 (Purdon 1982).

question because the testimony was found admissible notwithstanding the fact that it was damaging to the plaintiff's reputation on the basis that the physician's testimony did not concern "communications."¹⁶⁹

In interpreting this unusual statutory language, Pennsylvania courts have been restrictive. The two earliest supreme court decisions interpreting the statute, *Skruch*,¹⁷⁰ and *Phillips*,¹⁷¹ indicated without discussion that the privilege was limited to communications by the patient about a "loathsome" disease.¹⁷² Subsequent decisions have implied that only venereal diseases are sufficiently loathsome to "tend to blacken the character" within the meaning of the statute.¹⁷³ In addition, statements by the patient about illegal or immoral activity such as having an illegal abortion or extra-marital sexual relations are apparently covered by the statutory language.¹⁷⁴ This is not the case with communications concerning chronic alcoholism¹⁷⁵ and mental illness.¹⁷⁶ Appellate court decisions in Pennsylvania have now clearly established that alco-

169. See, e.g., *Bonner v. Diller*, 60 Pa. L.J. 585, 585 (1911) (testimony by hospital staff physician as to observation and treatment of alleged lunatic is admissible without discussion as to extent such testimony would have on person's character).

170. 284 Pa. at 299, 131 A. at 186. For a discussion of *Skruch*, see *supra* notes 143-46 and accompanying text.

171. 295 Pa. at 351, 145 A. at 439. For a discussion of *Phillips*, see *supra* notes 147-51 and accompanying text.

172. Two recent Pennsylvania Supreme Court cases are in accord. *Allegheny County*, 490 Pa. at 150, 415 A.2d at 77 (communication must blacken one's character to be within statute); *In re "B,"* 482 Pa. at 480, 394 A.2d at 423 (Act's prohibition applies only to loathsome diseases).

173. See *Gilham v. Gilham*, 177 Pa. Super. 328, 330-31, 110 A.2d 915, 916 (1955) (patient's communication to doctor that she feared she had contracted venereal disease concerned sufficiently loathsome disease to render communication privileged); *Michaels v. Metropolitan Life Ins. Co.*, 26 Luz. 79, 80-81 (C.P. Pa. 1930) (physician would not be permitted to testify as to patient's communications regarding her suspected venereal disease) (dicta).

174. See *Gilham v. Gilham*, 177 Pa. Super. 328, 330-31, 110 A.2d 915, 916 (1955) (patient's communication of her extra-marital affair to her doctor is privileged); *Berman v. Duggan*, 119 P.L.J. 242, 242-43 (1971) (hospital records and information disclosed by patients to doctors concerning therapeutic abortions are privileged); *Peters v. Peters*, 4 Pa. D. & C. 287, 287-88 (1923) (patient's admission to doctor that she had expelled fetus from womb is privileged communication); *Reid v. Reid*, 50 Pa. C. 601, 602-03 (1920) (doctor's opinion after examining patient that she had several miscarriages and was pregnant is privileged in action for divorce based on alleged adultery by woman).

It is likely that the cases treating abortion as coming within the statute would not be followed in view of *Roe v. Wade*, which recognized a woman's constitutional right to an abortion. See 410 U.S. 113 (1973). For a discussion of cases that have found mental illness and alcoholism not to be within the statutory provision, see *infra* notes 175-77 and accompanying text.

175. *Soltaniuk v. Metropolitan Life Ins. Co.*, 133 Pa. Super. 139, 144, 2

holism and mental illness are not loathsome diseases for purposes of the testimonial privilege statute. The rationale for this view is that contemporary society is enlightened enough not to view mental illness or alcoholism or alcohol-related diseases as loathsome or tending to blacken the character of the patient or client if disclosed.¹⁷⁷

In tandem, the “communications” and “blacken the character” limitations on the relationship-based statutory testimonial privilege for physicians and psychiatrists as they have been employed by the Pennsylvania courts almost totally eviscerate the privilege. In view of judicial construction of the statutory privilege, it is appropriate to ask what, if any, health care information acquired in a physician-psychiatric patient or client relationship comes within the statute. The answer appears to be very little beyond communications about clearly immoral conduct, criminal conduct or venereal disease.

(2) The Psychologist-Client Testimonial Privilege

Curiously, in Pennsylvania, the relationship-based testimonial privilege for those who are receiving treatment as patients of licensed psychologists is broader than the privilege provided for patients of psychiatrists. This is because the statute defining the scope of the privilege for licensed psychologists does not contain the “blacken the character” limitation that is found in the physi-

A.2d 501, 503 (1938) (information regarding patient's alcoholism and delirium tremens did not sufficiently blacken patient's character to render it privileged).

176. *In re “B,”* 482 Pa. at 493-94, 394 A.2d at 423. For a discussion of *In re “B,”* see *infra* notes 284-91 and accompanying text.

177. There is little elaboration of the rationale for excluding mental illness and alcohol-related diseases from the statute in Pennsylvania Supreme Court opinions. Justice Manderino in *In re “B”* suggests that greater awareness and understanding of mental illness is the basis for non-coverage: “Of course, what may have been defined as a ‘loathsome disease’ in 1925, when *Skruch* was decided, may not remain so today. Whatever the meaning of ‘loathsome disease,’ psychiatric treatment does not evidence the existence of such a condition.” *In re “B,”* 482 Pa. at 480, 394 A.2d at 423. Judge Waller developed the rationale more fully: “In this age of enlightenment regarding mental disorders, it is generally understood that incompetency due to organic and physical causes is something over which no mortal so afflicted has control. Thus, the court sees no stigma here.” *In re Kohr's Estate*, 71 Pa. D. & C.2d 48, 51 (1976).

Justice Roberts, concurring in *In re “B,”* would find psychological disorders to be within the statutory provision because of the importance of confidentiality in therapy. 482 Pa. at 489, 394 A.2d at 430 (Robert, J., concurring). He would also distinguish physical illnesses and find that they would not tend to blacken the character of the patient. *Id.* at 493, 394 A.2d at 430 (Roberts, J., concurring).

cian (psychiatrist) statute.¹⁷⁸ Moreover, the testimonial privilege extends to both criminal and civil proceedings while the statute defining the scope of privileges for physicians and psychiatrists is specifically limited to civil proceedings.¹⁷⁹

The psychologist-client privilege statute provides that no licensed psychologist shall be examined in any civil or criminal matter as to confidential communications acquired in the course of professional services rendered on behalf of the client. The statute also provides that the scope of the privilege shall be determined on the same basis as the attorney-client privilege.¹⁸⁰

Since the adoption of the psychologist-client privilege statute in 1976, there has been only a handful of appellate decisions interpreting the scope of the privilege.¹⁸¹ The statute refers to information acquired "on behalf" of a client in the course of rendering professional services. This language suggests that the privilege applies only to communications that are part of a formal psychologist-client relationship. Only one appellate court decision has been presented with a significant question on the application of the statute to communications by a person to a psychologist outside of a formal, professional client relationship. The superior court in *In re Adoption of Embick*,¹⁸² held that the statutory privilege was not applicable to communications between the natural parents and a psychologist where the parents were asked to see the psychologist by a state agency as part of proceedings brought to terminate their parental rights.¹⁸³ The statute did not apply to these communications because the Embicks were not seeing the psychologist for treatment or therapy, and therefore a

178. For the full text of the current statutory testimonial privilege for psychologists, see *supra* note 138. For the full text of the current statutory testimonial privilege for physicians (psychiatrists), see *supra* note 139.

179. Compare 42 PA. CONS. STAT. ANN. § 5944 (Purdon 1982) ("No [psychologist] . . . shall be . . . examined in any civil or criminal matter . . .") with *id.* § 5929 ("No physician [psychiatrist] shall be allowed, in any civil matter, to disclose any information . . .").

180. For the full text of the psychologist-client testimonial privilege statute, see *supra* note 138. For a discussion of the historical background of the statute in respect to whether the privilege applies to psychiatrists, see *supra* note 140 and accompanying text.

181. Only two appellate court cases have construed the scope of the statutory privilege directly: *Commonwealth v. Goldblum*, 498 Pa. 455, 464, 447 A.2d 234, 239 (1982) (privilege given to psychologist-client communications is coextensive with that granted to attorney-client communications); *In re Embick*, 351 Pa. Super. 491, 498-500, 506 A.2d 455, 458-60 (1986) (communications enjoy same support as privilege for attorney-client communications).

182. 351 Pa. Super. 491, 506 A.2d 455 (1986).

183. *Id.* at 500-01, 506 A.2d at 460-61.

psychologist-client relationship did not exist within the meaning of the privilege statute.¹⁸⁴ Under these and similar circumstances, a testimonial privilege does not generally apply to information that is acquired by the health care practitioner, because of the view that where the examination is undertaken as part of litigation, the patient or client should not expect that the information is confidential.¹⁸⁵ Therefore, on the precise facts of *Embick*, the result is consistent with general authority and Pennsylvania law.¹⁸⁶ However, *Embick* should not be read to limit the privilege to information acquired from a client who has contractually employed the psychologist for treatment. For the testimonial privilege to attach, the patient or client ordinarily must be interacting with the professional, "with a view to a curative treatment."¹⁸⁷ This standard may be met without a specific contractual relationship between the client and professional.¹⁸⁸ Furthermore, the professional psychologist's concept of a psychologist-client relationship extends beyond those instances where a client employs a psychologist for treatment. Finally, where health records are concerned, the notion of whether an individual is in a patient relationship with a health care institution is viewed broadly and has been applied to any person who interfaces with the institution.¹⁸⁹

A crucial focus in judicial interpretation of the statute will be in applying the law of the attorney-client privilege to information

184. *Id.* at 500, 506 A.2d at 460. The *Embick* court does not specifically hold that the psychologist was not in a professional-client relationship with the Embicks for all purposes. The court concludes only that: "under the facts of this case, the relationship between appellants and [the psychologist] was not the type of relationship contemplated by the statute which confers the privilege." *Id.* Compare *Commonwealth v. Edwards*, 178 A. 20, 318 Pa. 1 (1935) (physician employed by county not in physician-patient relationship with person in custody) (*dicta*).

185. See, e.g., *Romanowicz v. Romanowicz*, 213 Pa. Super. 382, 385, 248 A.2d 238, 240 (1968) (introduction of communication between psychiatrist and client by client herself renders communication no longer privileged). For a discussion of the confidentiality requirement and the litigant exception, see *supra* notes 123-24 and accompanying text.

186. See, e.g., *Commonwealth v. Goldblum*, 498 Pa. 455, 464, 447 A.2d 234, 239 (1982) (communications between patient and psychologist occurred for sole purpose of using communications at trial to prove patients competency and therefore enjoyed no privilege).

187. 8 J. WIGMORE, *supra* note 106, § 2382; see also C. McCORMICK, *supra* note 108, § 99, at 246 ("patient must have consulted the physician for treatment or for diagnosis looking for treatment").

188. C. McCORMICK, *supra* note 108, § 99, at 246 ("If consulted for treatment it is immaterial by whom the doctor is employed.").

189. *Id.* § 313, at 884 (privilege may extend to any information obtained by hospital personnel related to treatment); see *Head v. Colloton*, 331 N.W.2d 870 (Iowa 1983) (bone marrow bank donor found to be "patient").

acquired in the psychologist-client relationship. As previously noted, the statute specifically incorporates the law of attorney-client privilege. Courts will therefore properly and necessarily be engaged in analogical reasoning in determining the extent to which there is protection for confidentiality of health care information acquired as part of a psychologist-client relationship.

When the psychologist-client privilege is viewed in terms of the attorney-client privilege as required under Pennsylvania law, several significant limitations on the scope of testimonial privilege become apparent. The most significant of these are: a) the confidential communication limitation, and b) the adverse party limitation.

(a) The Confidential Communication Limitation

In case law interpreting the scope of testimonial privileges for communications between attorney and client, courts have required that for the privilege to attach, the client must demonstrate that the communication was "confidential" in the circumstances in which it was uttered. The Pennsylvania statutes for the attorney-client testimonial privilege are specifically limited to "confidential" communications.¹⁹⁰ The legal notion of confidentiality that has developed in cases involving the attorney-client privilege has been applied to the psychologist-client privilege.¹⁹¹ Two basic tenets defining the parameters of confidentiality have evolved. The first is that communications uttered in the presence of certain persons other than the lawyer or psychologist are not confidential.¹⁹² The second is that communications made to the

190. There are separate testimonial privileges on civil and criminal proceedings in Pennsylvania for communications between an attorney and client. See 42 PA. CONS. STAT. ANN. §§ 5916, 5928 (Purdon 1982). The language is identical except that § 5916 refers to a "criminal proceeding" and § 5928 to a "civil matter." *Id.* Section 5928 reads: "In a civil matter counsel shall not be competent or permitted to testify to confidential communications made to him by his client, nor shall the client be compelled to disclose the same, unless in either case this privilege is waived upon trial by the client." 42 PA. CONS. STAT. ANN. § 5928 (Purdon 1982).

191. See *Commonwealth v. Goldblum*, 498 Pa. 455, 464, 447 A.2d 234, 239 (1982) (quoting 42 PA. CONS. STAT. ANN. § 5944 (Purdon 1982) ("[T]he confidential relations and communication between a psychologist and his client are on the same basis as those provided by law between an attorney and client")).

192. See, e.g., *Loutzenhiser v. Doddo*, 436 Pa. 512, 518, 260 A.2d 745, 748 (1970) (communication by uncle to attorney in presence of niece and nephew not privileged); *In re Cridges Estate*, 289 Pa. 331, 336, 137 A. 455, 457 (1927) (statement of deceased to lawyer in presence of prospective buyer of real estate not privileged); *In re Fogg's Estate*, 249 Pa. 63, 65-66, 94 A. 453, 453-54 (1915)

attorney or psychologist under circumstances where the client has a reasonable expectation that they will be communicated or otherwise made available by the attorney or psychologist to third parties are not confidential.¹⁹³

Examples of communications that lose their privilege under the above two principles are numerous when the attorney-client privilege is asserted. Communications by a client to an attorney in the presence of relatives of the client including the client's spouse have been found to be nonconfidential.¹⁹⁴ Where the family lawyer is attempting to mediate a disagreement between family members by functioning as an intermediary, communications by the client are not confidential for purposes of the testimonial privilege.¹⁹⁵ Likewise, a statement to the client's lawyer in the presence of a prospective purchaser of the client's real estate is not a confidential communication.¹⁹⁶ Presumably, analogous limitations would apply to psychologist-client communications.

Statements by the client to the psychologist, which are expected to be repeated to third parties, would not be confidential. Moreover, when a client speaks to a psychologist in preparation for litigation, civil or criminal, the communications are not confidential. Two recent cases illustrate this. In *Commonwealth v. Goldblum*,¹⁹⁷ the testimonial privilege was lost because of the lack of confidentiality, where the client had previously disclosed communications regarding his mental competency to a psychologist as

(communications to family lawyer acting as intermediary in intra-family dispute between mother and daughter not privileged).

193. *See, e.g.*, *Commonwealth v. Goldblum*, 498 Pa. 455, 464, 447 A.2d 234, 239 (1982) (communications made by patient to psychologist for purpose of having psychologist testify at trial as to patient's competency are not confidential); *In re Fogg's Estate*, 249 Pa. 63, 65-66, 94 A. 453, 453-54 (1915) (statements made to family lawyer for the purpose of communicating among family members during intra-family dispute were made with expectation they would be repeated and were not confidential); *cf. Brennan v. Brennan*, 281 Pa. Super. 362, 367, 422 A.2d 510, 513-18 (1980) (client's specific instructions for counsel not to disclose whereabouts sufficient to render communication confidential and within statutory privilege).

194. *See, e.g.*, *Loutzenhiser v. Doddo*, 436 Pa. 512, 518, 260 A.2d 745, 748 (1970) (communication between attorney and client before client's niece not privileged); *In re Burr's Estate*, 381 Pa. 547, 550-51, 113 A.2d 712, 713-14 (1955) (communication between attorney and client before client's niece not privileged); *Tracy v. Tracy*, 377 Pa. 420, 424, 105 A.2d 122, 124-25 (1954) (communications between attorney and client at conference where client's spouse was present not privileged).

195. *In re Fogg's Estate*, 249 Pa. 63, 65-66, 94 A. 453, 453-54 (1915).

196. *In re Cridge's Estate*, 289 Pa. 331, 334, 137 A. 455, 457 (1927).

197. 498 Pa. 455, 447 A.2d 234 (1982).

part of a defense in another legal proceeding.¹⁹⁸ Similarly, communications to a psychologist who was examining a natural parent as part of a termination of parental rights proceedings were found not to be confidential in the legal sense employed by courts in determining the scope of the psychologist-client testimonial privilege.¹⁹⁹

One of the questions that is raised by the confidentiality restriction on a testimonial privilege is under what circumstances the presence of staff persons or students will cause communications by the client to be non-privileged because of lack of confidentiality. Absent definitive authority, one would presume that if the staff person's presence is in furtherance of the treatment and diagnosis of the client as an agent of the psychologist the statements would be privileged. This is the rule for health care practitioners generally. However, there is authority in Pennsylvania construing the attorney-client privilege that leaves that proposition in some doubt as applied to psychologists and clients. For example, the attorney-client privilege has not been applied to licensed attorneys where they functioned as secretaries or scribes.²⁰⁰ Moreover, while the privilege does apply to co-counsel and subordinates, it has not been applied to attorneys who act merely as agents to the client.²⁰¹ Furthermore, an insured motorist could not assert the privilege in respect to statements made to the attorney of the insurance company because of the absence of a specific attorney-client relationship with the attorney.²⁰²

The analogy between the attorney-client and psychologist-

198. *Id.* at 464, 447 A.2d at 239. In *Goldblum*, the defendant sought a new trial on the basis of his co-defendant's psychiatric examination which had been offered by the co-defendant at his separate trial. *Id.* at 463, 447 A.2d at 238. The examination had been requested by the co-defendant for the purpose of determining his competency and had been introduced at his trial. *Id.* The Commonwealth argued against the use by Goldblum of the examination on the ground that it was a confidential communication and therefore privileged. *Id.* at 463-64, 447 A.2d at 239. The Pennsylvania Supreme Court rejected the contention and held that a psychiatric examination prepared for the purpose of future disclosure was not confidential and therefore not privileged. *Id.*

199. *Embick*, 351 Pa. Super. at 500-01, 506 A.2d at 460. For a discussion of *Embick*, see *supra* notes 182-89 and accompanying text.

200. See, e.g., *Leahey v. O'Connor*, 281 Pa. 488, 493, 127 A. 65, 67-68 (1924) (communication between attorney and client not confidential because attorney was acting as client's private secretary at time).

201. See, e.g., *In re Seip's Estate*, 163 Pa. 423, 431-32, 30 A. 226, 227 (1894) (attorney who participated in settlement of intra-family dispute acted not as any party's attorney but as party's business agent and communications with him in that capacity were not privileged).

202. See *Gordon v. Robinson*, 210 F.2d 192, 198-99 (3d Cir. 1954) (attorney for motorist's liability insurance carrier was not in attorney-client relation-

client relationship is strained when the concept of confidentiality is applied to health care information that is communicated to the various professionals and agents that are typically involved in psychotherapy. Unlike the lawyer-client relationship, a psychotherapist's client may typically communicate to a range of persons other than the psychologist as part of treatment.²⁰³

As previously indicated, where the third person's presence is not in furtherance of treatment or diagnosis, statements by the client are not confidential. But what of students that are parties to the communication as part of their professional training or in the pursuit of research? There is no case law in Pennsylvania precisely resolving this question. One might suppose, however, that courts would view the presence of a research or resident trainee as sufficiently connected to the overall delivery of health care services in society to warrant treating statements by the client as confidential. This would be quite appropriate since the legal and psychological professions view such information as confidential in the ethical standards of their respective professions. However, in view of the restrictive construction given to testimonial privileges by Pennsylvania courts, there is, at the very least, serious doubt as to whether statements made by clients in the presence of persons who are there for their own purely educational or scholarly purposes would be privileged. This doubt is further justified by a Supreme Court of Pennsylvania holding that the attorney-client privilege is not applicable to a law student not admitted to the bar.²⁰⁴

(b) The Adverse Party Limitation

Where the psychologist is engaged in therapy with more than one client and statements are made in the presence of both clients, there is a serious question in Pennsylvania as to whether

ship with motorist and was permitted to testify at trial concerning all communications he had with motorist).

203. See *Slovenko*, *supra* note 133, at 190-92 (therapeutic process is often two-way to extent that other players in patient's life must be involved in order to effect best treatment).

204. *Dierstein v. Schubkagel*, 131 Pa. 46, 54, 18 A. 1059, 1060 (1890) (no privilege attached to communication between attorney's client and attorney's law clerk as law clerk is "on no higher plane than a blacksmith retained in a like service"); see also *Dabney v. Investment Corp. of Am.*, 82 F.R.D. 464 (E.D. Pa. 1979) (reaffirming *Dierstein* as Pennsylvania law as controlling precedent in Pennsylvania and holding privilege not applicable to law student that was not acting as agent of licensed attorney).

such communications are privileged.²⁰⁵ This problem also arises in a group therapy situation where statements are made to one or more psychologists in the presence of several clients. Although there are no cases dealing directly with such situations, decisions construing the attorney-client privilege cut against the view that statements to the psychologist in the presence of other patients would be confidential. Only information communicated to the attorney or his or her subordinates for the purpose of securing legal opinion and not made in the presence of strangers is confidential. Stranger in respect to the attorney-client privilege means any person other than the attorney or his or her subordinates.²⁰⁶ Group therapy perhaps presents the courts with the greatest strain in analogizing from the attorney-client privilege cases to the psychologist-client privilege cases. Although there is a psychologist-client relationship with all patients participating in group therapy, the patients are not "subordinates" of the professional and may be viewed as strangers for the purpose of determining whether the information is confidential. The consequence of this would be to exclude from the privilege all communications made to psychologists in group therapy where other clients are present.

One could persuasively argue that since, in group therapy sessions, the other clients' presence is essential to treatment, communications within the group should be privileged. However, the case law construing the attorney-client privilege is to the contrary. Communications to agents of the client, even if essential to a legal action, are not viewed as confidential.²⁰⁷ This is the case even if the communications are made to an attorney if the attorney is functioning as an agent and not solely receiving the information for the purpose of providing legal advice in a formal attorney-client relationship.²⁰⁸

205. See *Gilham v. Gilham*, 177 Pa. Super. 328, 330, 110 A.2d 915, 916 (1955) (third persons may testify to communications overheard by them).

206. *Dierstein v. Schubkagel*, 131 Pa. 46, 54, 18 A. 1059, 1060 (1890) (privilege extends only to communications made between attorneys and their necessary agents and assistants); see also *Dabney v. Investment Corp. of Am.*, 82 F.R.D. 464 (E.D. Pa. 1979) (interpreting *Dierstein* as controlling Pennsylvania authority).

207. See *In re Seip's Estate*, 163 Pa. 423, 431-32, 30 A. 226, 227 (1894) (attorney's communication to client's agent not confidential).

208. See *id.*; *Jeanes v. Fridenberg*, 3 Clark 199, 5 Pa. L.J. 6 (1845) (attorney-client privilege does not attach when attorney is party to legal action because of principal-agent theory); see also *In re Burr's Estate*, 381 Pa. 547, 550, 113 A.2d 712, 713-14 (1955) (communication between testator and attorney in presence of testator's daughter not confidential, and admissible in subsequent will contest); *In re Cridges Estate*, 289 Pa. 331, 336, 137 A. 455, 457 (1927) (communi-

The requirement of confidentiality as construed in attorney-client privilege cases may be inapposite to the psychologist-client group therapy situation. Lawyers and courts do not engage in the delivery of services to groups in the sense that psychologists do. If the stranger principle is applied to group therapy by analogy from the attorney-client privilege decisions, the result would be a restriction on the privilege that would be far more onerous to the psychologist than it is to the lawyer. Pennsylvania courts should recognize the difficulty in analogizing to the attorney-client privilege in group therapy situations and conclude that where the presence of the other client is part of the treatment or therapy, communications are privileged. This should also be the case where couples or family members are participating in therapy with a psychologist. Such an interpretation, however, is not clearly compelled by or implicit in case law interpreting the attorney-client privilege. In one attorney-client testimonial privilege area, Pennsylvania courts have treated communications by multiple clients that are represented by the same attorney as not privileged. This occurs when the clients are subsequently involved as adversaries in litigation. In that case, communications that are part of the common business of clients in that litigation lose their privileged status. For example, statements made by the client to an attorney representing family members were found not to be privileged when subsequent litigation over the validity of a gift of real estate to the family members by the client arose.²⁰⁹ Similarly, statements by married persons to a lawyer representing both the spouses lost their privileged character when divorce proceedings were subsequently initiated by one of the parties to the marriage.²¹⁰ These examples illustrate what evidence commentators refer to as the adverse party exception to the testimonial privilege for communications between an attorney and client.

Application of the adverse party rule to psychotherapy would seem to be of slight consequence outside the family counseling therapy setting since there are very few instances where clients participating in group therapy would subsequently be involved in litigation between themselves over matters that were discussed in the therapy sessions. Such litigation, however, would not be un-

cation between attorney and grantor made in presence of third party not confidential).

209. *In re Fogg's Estate*, 249 Pa. 63, 66, 94 A. 453, 453 (1915).

210. *Tracy v. Tracy*, 377 Pa. 420, 424, 105 A.2d 122, 124-25 (1954) (communications made by spouses to respective attorneys at property settlement conference not confidential).

common in family counseling therapy sessions which might later involve the family members in divorce or custody litigation.²¹¹

(3) Functional Testimonial Privileges for School, Marriage and Sexual Assault Counselors

The testimonial privileges previously analyzed are grounded on those limited professional-client relationships that have been designated by legislation. However, many licensed health care practitioners have not been provided a testimonial privilege by the legislature. Nurses employed privately by patients and social workers engaged in group or individual therapy do not enjoy a testimonial privilege in respect to communications by their clients in the course of delivery of health care services.²¹² Social workers especially illustrate the problems associated with the absence of a specific testimonial privilege since they perform important psychotherapeutic functions often involving clients having drug and alcohol problems.²¹³

Recently enacted legislation in Pennsylvania provides for testimonial privileges for health care practitioners when they are functioning as counselors to students,²¹⁴ married couples²¹⁵ and

211. See *Romanowicz v. Romanowicz*, 213 Pa. Super. 382, 386, 248 A.2d 238, 240 (1968) (testimony by psychiatrist who treated husband prior to custody battle between husband and wife for child inadmissible by wife at trial because of privileged nature).

212. See *In re Action Mental Health, Inc.*, 32 Pa. D. & C.3d 612, 617 (1983) ("the legislature has not chosen to extend [the confidential communications privilege] to the patient of an unlicensed counselor, however well qualified, who receives outpatient counseling on a voluntary basis"); *Farris v. Pennsbury School District*, 74 Pa. D. & C.2d 786, 787 (1975) (communications to nurses are confidential only where nurse has secured information in presence of physician for whom she was employed and whom she was assisting); see also Guernsey, *The Psychotherapist-Patient Privilege in Child Placement: A Relevancy Analysis*, 26 VILL. L. REV. 955, 963-64 (1981) ("Since all psychotherapists, psychiatrists as well as non-physicians, perform services which are essentially similar in nature . . . a statute which excludes one or more types of practitioners is inconsistent." (footnotes omitted)); cf. *In re ABC Juvenile*, 51 Pa. D. & C.2d 424, 427 (1971) (observations by nurse of patient's alleged inebriation not confidential).

213. A number of states privilege communications between social workers and their clients. See, e.g., CAL. EVID. CODE § 1010(c)-(e) (West Supp. 1981) (clinical social worker); N.Y. CIV. PRAC. L. & R. § 4508 (McKinney 1980 & Supp. 1981) (certified social worker).

214. The Pennsylvania testimonial privilege for school personnel reads:
Confidential Communications to School Personnel

a) *General Rule*—No guidance counselor, school nurse, school psychologist, or home and school visitor in the public schools or in private or parochial schools or other educational institutions providing elementary or secondary education, including any clerical worker of such school and institution who, while in the course of his professional or clerical duties for guidance counselor, home and school visitor, school

sexual assault victims.²¹⁶ The testimonial privileges granted in

nurse or school psychologist, has acquired information from a student in confidence shall be compelled or allowed:

(1) without the consent of the student, if the student is 18 years of age or over; or

(2) without the consent of his parent or guardian, if the student is under the age of 18 years;

to disclose such information in any legal proceeding, trial, or investigation before any government unit.

b) *Exemption*—Notwithstanding Subsection (a), no such person shall be excused or prevented from complying with the Act of November 26, 1975 (P.L. 438, No. 124), known as the "Child Protection Services Law."

42 PA. CONS. STAT. ANN. § 5945 (Purdon 1982); *see also In re Appeal of McClellan*, 82 Pa. Commw. 75, 79, 475 A.2d 867, 869-70 (1984) (citing 22 PA. CODE § 12.12(a) (1982)) (school counselor privilege encompasses only those situations where counselor is acting within his specific role and communication is expected to remain confidential). The regulations go beyond the statute in that they provide for school counselors to choose to disclose confidential information acquired in their counseling function where, in their view, such disclosure is necessary to protect the student or others from harm. 22 PA. CODE § 12.12(b) (1986). There has been no case law involving the question of whether the regulations exceed the authority granted to the state department of education. However, nothing in the legislative history of the section or in the plain language of section 5945 would warrant concluding that there was such a blanket exception made available to school counselors.

215. The testimonial privilege for marriage counselors reads: "Communications of a confidential character made by a spouse to an attorney, or a qualified professional, shall be privileged and inadmissible in evidence in any matrimonial cause unless the party concerned waives such immunity." PA. STAT. ANN. tit. 23, § 703 (Purdon 1986 Supp.). "Qualified professionals" is defined as "marriage counselors, psychologists, psychiatrists, social workers, ministers, priests, or rabbis, or other persons who, by virtue of their training and experience, are able to provide counseling." *Id.* § 104.

216. The testimonial privilege for counselors of sexual assault victims reads:

Confidential communications to sexual assault counselors

(a) *Definitions*.—As used in this section the following words and phrases shall have the meanings given to them in this subsection:

"Rape crisis center." Any office, institution or center offering assistance to victims of sexual assault and their families through crisis intervention, medical and legal accompaniment and follow-up counseling.

"Sexual assault counselor." A person who is engaged in any office, institution or center defined as a rape crisis center under this section, who has undergone 40 hours of training and is under the control of a direct services supervisor of a rape crisis center, whose primary purpose is the rendering of advice, counseling or assistance to victims of sexual assault.

"Victim." A person who consults a sexual assault counselor for the purpose of securing advice, counseling or assistance concerning a mental, physical or emotional condition caused by a sexual assault.

"Confidential communication." Information transmitted between a victim of sexual assault and a sexual assault counselor in the course of that relationship and in confidence by a means which, so far as the victim is aware, does not disclose the information to a third person other

these three instances are based upon the counseling function performed by the health care practitioner. They apply to all health care practitioners performing certain counseling functions regardless of whether that professional is protected under the previously discussed privileges.

(a) Health Care Professionals In Schools

The testimonial privilege granted school health professionals is remarkable in its scope. Guidance counselors, school nurses, school psychologists and home and school visitors in private and public schools that provide elementary or secondary education may not be compelled to testify in civil or criminal judicial proceedings or in agency investigation proceedings as to any information acquired in confidence while functioning as a guidance counselor. Language in the statute and judicial construction makes it clear that the privilege applies only to communications that are exchanged while the student is being counseled or cared for. Communications between a student and school principal, when the principal is not in a counseling relationship with the student, would not be privileged.²¹⁷

The statute specifically excludes from its confidentiality policies²¹⁸ those that are governed by the Child Protective Service Law of 1975.²¹⁹ Judicial construction and the language of the law leave little doubt that in Pennsylvania a duty is imposed on health care professionals to disclose information concerning child abuse.²²⁰ It is equally clear that disclosure pursuant to legal du-

than those who are present to further the interests of the victim in the consultation or those to whom disclosure is reasonably necessary for the transmission of the information or an accomplishment of the purposes for which the sexual assault counselor is consulted. The term includes all information received by the sexual assault counselor in the course of that relationship.

(b) Privilege.—A sexual assault counselor has a privilege not to be examined as a witness in any civil or criminal proceeding without the prior written consent of the victim being counseled by the counselor as to any confidential communication made by the victim to the counselor or as to any advice, report or working paper given or made in the course of the consultation.

42 PA. CONS. STAT. ANN. § 5945.1 (Purdon 1982).

217. See *In re Appeal of McClellan*, 82 Pa. Commw. 75, 79, 475 A.2d 867, 869-70 (1984).

218. 42 PA. CONS. STAT. ANN. § 5945(b) (Purdon 1982).

219. PA. STAT. ANN. tit. 11, §§ 2201-2224 (Purdon Supp. 1986).

220. The pertinent section of the Child Protective Service Law reads: Persons required to report suspected child abuse

(a) Any persons who, in the course of their employment, occupation, or practice of their profession come into contact with children

ties under the Child Protective Service Law are immune from civil or criminal responsibility.²²¹

(b) Counselors for Sexual Assault Victims and Married Couples

Testimonial privileges are specifically granted by statute in Pennsylvania to health care practitioners who are functioning as counselors to sexual assault victims and to married couples.²²² There have been no court decisions interpreting the recently en-

shall [file a report pursuant to (b)] when they have reason to believe . . . that a child coming before them in their professional . . . capacity is an abused child.

- (b) Persons required to report under subsection (a) include, but are not limited to, any licensed physician, medical examiner, coroner, dentist, osteopath, optometrist, chiropractor, podiatrist, intern, registered nurse, licensed practical nurse, hospital personnel engaged in the admission, examination, care or treatment of persons, a Christian Science practitioner, school administrator, school teacher, school nurse, social services worker, day care center workers or any other child care or foster care worker, mental health professional, peace officer, or law enforcement official.

Id. § 2204(a), (c).

221. *See id.* § 2211; *Roman v. Appleby*, 558 F. Supp. 449, 457-58 (E.D. Pa. 1983) (health care professionals immune from liability for good-faith disclosures of child abuse pursuant to supposed duties under Child Protection Service Law of 1975). Section 2212 imposes criminal penalties for willful failure to report child abuse. PA. CONS. STAT. ANN. tit. 11, § 2212 (1982). Section 2211, which correspondingly provides for immunity to those who report if they act in good faith, reads:

Any person, hospital, institution, school, facility or agency participating in good faith in the making of a report or testifying in any proceeding arising out of an instance of suspected child abuse, . . . shall have immunity from any liability, civil or criminal, that might otherwise result by reason of such actions. For the purpose of any proceeding, civil or criminal, the good faith of any person required to report cases of child abuse pursuant to section 4 shall be presumed.

Id. § 2211.

The *Roman* court found health care practitioners immune from liability under both state tort law and constitutional tort action under section 1983 of title 42 of the United States Code. 558 F. Supp. at 457. This was the case even if the health care practitioner was wrong in supposing that child abuse had occurred. *Id.* As the court noted, the strong policies of encouraging the reporting of child abuse, as reflected in the statutory language generally and in the presumption in the statute of "good faith" in reporting, provide immunity to the health care practitioner for civil or criminal responsibility except in cases of gross negligence or reckless disregard of rights. *Id.* at 459.

222. *See* 42 PA. CONS. STAT. ANN. § 5945 (Purdon 1982) (sexual assault counselors); PA. STAT. ANN. tit. 23, § 202, 703 (Purdon Supp. 1986) (mandatory counseling and testimonial privilege for marriage counselors). For the full text of the sexual assault victim privilege statute, see *supra* note 216. For the full text of the marriage counselor privilege statute, see *supra* note 215.

acted statutes granting these testimonial privileges. The testimonial privilege for sexual assault counselors applies to both communications between the victim and counselor and to advice, reports and working papers generated in the course of the consultation.²²³ Interestingly, this testimonial privilege adheres to individuals that do not have professional degrees and are not licensed, provided they have undergone forty hours of training and are counseling in a "rape crisis center" within the meaning of the statute.²²⁴

The testimonial privilege for "qualified professionals" functioning as marriage counselors was enacted as part of the Divorce Code in 1980. "Qualified professionals" is broadly defined in the statute to include "marriage counselors, psychologists, psychiatrists, social workers, ministers, priests, or rabbis, or other persons who, by virtue of their training and experience, are able to provide counseling."²²⁵ However, the significance of the privilege that is suggested by the range of counselors covered is offset by the statute specifically limiting the privilege to the admissibility of communications that are introduced as evidence in legal proceedings affecting the marriage relationship.²²⁶

Each of the functionally based testimonial privileges are limited by requirements that the communications be "confidential." Two features of the confidentiality limitation are worth noting. Unlike other testimonial privilege statutes in Pennsylvania, the sexual assault counseling privilege statute specifically defines "confidential communications." All information received in the course of the sexual assault victim-counselor relationship is viewed as confidential unless it is communicated by means that the victim knows will reach third persons unless those persons are

223. 42 PA. CONS. STAT. ANN. § 5945.1(a) (Purdon 1982). For the full text of § 5945.1(a), see *supra* note 216. The two appellate court cases interpreting the Sexual Assault Counselor privilege statute have suggested that the statute only established a testimonial privilege and that the statutory privilege is not applicable to the records themselves. Both were criminal cases. See *Commonwealth v. Samuels*, 354 Pa. Super. 1, 456 A.2d 1383 (1983); *Commonwealth v. Cacek*, 358 Pa. Super. 381, 517 A.2d 992 (1986). Although the statute does not explicitly mention that the records themselves are privileges, these interpretations of the statute seem clearly inconsistent with the purpose of the statute and if applied generally would practically eliminate the confidentiality protection for health care information between the counselor and client.

224. 42 PA. CONS. STAT. ANN. § 5945.1(a) (Purdon 1982). For the full text of § 5945.1(a), see *supra* note 216.

225. PA. STAT. ANN. tit. 23, § 703 (Purdon Supp. 1986). For the full text of § 703, see *supra* note 215.

226. 42 PA. CONS. STAT. ANN. § 5945.1(a) (Purdon 1982). For the full text of § 5945.1(a), see *supra* note 216.

present in counseling and their presence is essential.²²⁷ This statutory concept of confidential communications conforms more closely to the health care professionals' notion of confidentiality than the more restrictive, judicially developed view of confidential information that was discussed earlier in respect to the relationship-based testimonial privileges.²²⁸

The sexual assault counselor testimonial privilege statute has the virtue of specifically addressing the crucial question of whether the presence of third parties results in loss of the privilege because the utterance of the particular client is no longer a "confidential communication." By preserving the privilege in respect to communications uttered to those persons whose presence is essential to counseling, the statute reflects a more reasonable accommodation of the interests at stake than the restrictive notion of confidentiality developed by judicial construction of statutes that do not specifically address the question.

In contrast, the statute dealing with the testimonial privilege for school counselors and students does not define the statutory notion of confidential information, and the counselor is confronted with the same questions concerning the availability of the privilege in respect to communications to third persons, especially in group therapy, that confront other health care practitioners.²²⁹

2. *Record-Based Evidentiary and Testimonial Privileges*

The central collecting place for health care information is, of course, the records that are maintained by the health care practitioner or health care institution on the patient or client. Such records contain a range of information, some of which is not related to the patient's health. Records of health care, until recently, consisted of handwritten and typed entries by professional staff into a file that was maintained in the physical possession of the private practitioner or health care institution. Numerous factors in the contemporary delivery of health care have dramatically altered the system for establishing and maintaining records. Increased specialization, utilization of multi-discipline profession-

227. See 42 PA. CONS. STAT. ANN. § 5945.1(a) (Purdon 1982).

228. For a discussion of the issues concerning confidential communications in the presence of third parties and their effect on the privilege, see *supra* notes 190-211 and accompanying text.

229. For a discussion of the issues concerning confidential communication in the presence of third parties and their effect on the privilege, see *supra* notes 190-211 and accompanying text.

als, greater requirements of accountability by third-party payors and the computerization of health care information have placed greater stress on confidentiality and privacy.²³⁰ This has resulted in the development of new concepts that more accurately reflect on the information collection and storing system and in the enactment of federal and state legislation to protect the confidentiality of health care information.

a. Importance of Protecting the Confidentiality of Health Records

Modern society is characterized by information exchange relationships. As a condition for receiving forms of government largess, persons are required to provide the government agency with a considerable amount of information. This is also true with respect to the entire range of consumer purchase and credit transactions. Access to employment, insurance and education requires the exchange of highly personal information. In these business, governmental, and economic relationships, records of the information are maintained and today have become increasingly computerized. Today it is useful to speak of the information about a patient or client that is maintained in permanent form by the professional or health care institution as "health records."²³¹ Of all the records that are maintained from information exchange relationships, health records contain information that is the most personal and intimate and which raises the most concerns about privacy and confidentiality. Although the reasons for this are fairly obvious, they are worth restating. Information about one's physical condition embodies the most basic subject of privacy. Similarly, one's intimate personal and family relationships and sexual experiences, real or fantasized, are recognized as calling forth our most fundamental desires for privacy and secrecy. Publication of such information violates our sense of self-respect, human dignity and personhood.²³² Disclosure of this highly per-

230. See *Privacy Hearings*, *supra* note 27; PRIVACY PROTECTION STUDY REPORT, *supra* note 2; see also J.A. BRUCE, *supra* note 4, at 7-18; GUIDELINES, *supra* note 5; *Privacy Hearings*, *supra* note 27.

231. See J.A. BRUCE, *supra* note 4, at 2-3.

232. *Id.* Judge Hamely of the Ninth Circuit aptly noted this in an often quoted passage from a precedent setting privacy case, *York v. Story*: "We cannot conceive of a more basic subject of privacy than the naked body. The desire to shield one's unclothed figure from the view of strangers, and particularly strangers of the opposite sex, is compelled by elementary self-respect and personal dignity." 324 F.2d 450, 455 (9th Cir. 1963), *cert. denied*, 376 U.S. 939 (1964); see also H. ARENDT, *THE HUMAN CONDITION* 60 (1958).

sonal and intimate information may damage our reputation and so affect others' perceptions of us that it may cause financial ruin and destroy or permanently alter friendships and other associations.

Recognition of the particular concerns with information contained in health records with respect to privacy and confidentiality is in part reflected at the federal level by the privacy exemption in the Freedom of Information Act and statutes directed at the health records of those treated for drug and alcohol dependency at legally funded programs. The Freedom of Information Act specifically exempts from disclosure "medical files"²³³ and federal regulation of drug and alcohol treatment records provide for stringent protection of privacy and confidentiality.²³⁴ In Pennsylvania, during the last fifteen years, numerous statutes and regulations have been enacted to protect the confidentiality of health care information that is part of health records. The earliest and most protective of these is the Pennsylvania Drug and Alcohol Abuse Control Act of 1972.²³⁵ In 1976, another statute, the Mental Health Procedures Act, was enacted.²³⁶ Regulations promulgated under these statutes and by the licensing agency for hospitals²³⁷ are the major legal vehicles for protecting confidentiality of health records in Pennsylvania.

233. 5 U.S.C. § 552(b)(6) (1978). The federal Freedom of Information Act was enacted in 1966 and provides access to persons generally to information that is in federal government agency records. The Act adopts a presumption in favor of disclosure and places the burden on the agency to demonstrate that an exemption under the Act is applicable to information before it is non-disclosable. *Id.* § 552(a)(6)(A)(i). Exemption (b)(6) is the major vehicle for protecting privacy interests under the Act and the core notion of information that is to be protected because of the powerful privacy concerns involved is medical records. *Id.* Exemption (b)(6) reads:

(b) This section does not apply to matters that are:

(6) Personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Id.

234. *See supra* note 46.

235. PA. STAT. ANN. tit. 71, §§ 1690.101, 1690.108 (Purdon Supp. 1986); 4 PA. CODE §§ 255.4, 255.5 (1986); 28 PA. CODE § 157.23 (1986) (regulations providing for confidentiality of patients' records pursuant to statutory mandate in § 1690.108).

236. PA. STAT. ANN. tit. 50, §§ 7101, 7111 (Purdon Supp. 1986); 55 PA. CODE § 7100.111 (1986) (regulations concerning release of records under § 7111 of the Act).

237. *See* 28 PA. CODE § 103.22(a), (b)(4) (1983) (every hospital licensed under Pennsylvania law shall have Patients' Bill of Rights which, *inter alia*, shall afford patient right to have all his records treated as confidential except as otherwise provided by law).

b. Admissibility of Health Records Generally

Health records may be offered as evidence in legal proceedings for a variety of reasons. Documentary information concerning the medical history or professional diagnosis of the patient may be introduced to establish the truth of the asserted facts or statements that are in the health record. Information in the health record may also be used to impeach the credibility of witnesses as part of cross-examination. In addition, documents that are part of health records may be utilized to refresh the memory of a witness, or to rehabilitate a witness.

A major objection that is raised in opposition to admittance of information in a health record into evidence is that the information is hearsay. Nearly all of the information contained in a health record is hearsay and would thus be inadmissible.²³⁸ Some of the information placed in the health record is not within the personal knowledge of the entrant and the person who enters the information into the record is generally not before the court. Therefore, no witness is available to cross-examine in an effort to determine credibility. However, due to judicial construction of the business records exception to the proscription against the admissibility of hearsay,²³⁹ health records are generally admissible if the requirements of the business records exception are met.

The general business records exception is based upon the view that records compiled in the course of established business activities or practices are sufficiently reliable and trustworthy to overcome the problems that are presented by hearsay evidence generally. Thus, documents and information contained in health records are normally admissible in legal proceedings if the proper foundation is laid for the records, and the information is relevant to matters before the court or investigatory agency.

Traditionally, the authenticity of the records would have to be established by the testimony of the custodian of the records before the business records exception would be triggered.²⁴⁰ Re-

238. "Hearsay" is generally inadmissible. FED. R. EVID. 802. Hearsay is defined by the Federal Rules of Evidence as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted." FED. R. EVID. 801.

239. An exception to the inadmissibility of hearsay arises when the hearsay consists of some type of record, prepared by a person with knowledge of the activity the record reports, and that record is kept as the regular practice of the business. *See id.* 803(6); 42 PA. CONS. STAT. ANN. § 6108 (Purdon 1982).

240. *See generally* A. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 335 (1978).

cently, however, the requirements of demonstrating the authenticity of the records as part of a business practice have been loosened to permit copies of the records to be introduced and for affidavits by custodians as to authenticity to be accepted in lieu of the custodian's presence and testimony in court. Legislation providing for use of certified copies of health records in legal proceedings became effective in Pennsylvania in 1987. Under the Medical Records Evidence Act, licensed health care facilities may elect to respond to a subpoena duces tecum with a notarized sealed copy of a patient's record.²⁴¹

Pennsylvania has adopted the Uniform Business Records as Evidence Act.²⁴² Therefore, the business records exception to the hearsay rule is made a part of Pennsylvania evidence law as a matter of legislative policy. The Act has been construed to apply to medical records, but only in a limited way. In Pennsylvania, facts in a health care record are admissible under the business records exception to the hearsay rule, but opinions, such as the diagnosis of the patient, are not.²⁴³ Pennsylvania courts make the

241. As noted earlier this is the name given to this Act by the author, see *supra* note 49 and accompanying text. See also 42 PA. CONS. STAT. ANN. § 6151 (Purdon Supp. 1987). This statute describes the appropriate process for certification of the records, and provides that patients whose medical charts or records are copied and delivered under the law have standing to apply for a protective order limiting access to and use of the copies. Presumably, the testimonial privileges that are discussed at length in the balance of this article would be raised as part of the protective order. See *id.* at §§ 6152(a), (b), (c), (d). Section 6152(b) provides that the attorney causing the service of the subpoena shall notify "all other attorneys of record or other parties" of the election of the health care facility. Given the fiduciary relationship of the health care facility in respect to the records of the patients as well as the rights provided for under the legislation to patients whose records are requested, attorneys would be well advised to provide notice to patients whose records are subpoenaed at the election of the health care facility even if the patients are not parties to the litigation. The general access rights provided for in this legislation are discussed in an earlier portion of this article.

242. *Id.* § 6108. The Uniform Business Records as Evidence Act reads, in pertinent part:

A record of an act, condition or event shall, insofar as relevant, be competent evidence if the custodian or other qualified witness testifies to its identity and the mode of preparation, and if it was made in the regular course of business at or near the time of the act, condition or event, and if, in the opinion of the court, the sources of information, method and time of preparation were such as to justify its admission.

Id. § 6108(c). Pennsylvania makes no distinction as to whether the business is for profit. *Id.* § 6108(d).

243. *Commonwealth v. Garcia*, 478 Pa. 406, 427, 387 A.2d 46, 56 (1978) (hospital records admissible to show facts of hospitalization and treatment but not diagnosis); *Commonwealth v. DiGiacomo*, 463 Pa. 449, 455, 345 A.2d 605, 608 (1975) (hospital records admissible to show hospitalization, treatment prescribed, and symptoms given but inadmissible for expert testimony); *Common-*

distinction between fact and opinion in applying the business records exception and do not admit opinions into evidence because the health care professional with personal knowledge of the opinion is not before the court for cross-examination.²⁴⁴ The federal rules of evidence provide for a general business records exception that would provide for the admissibility of all of the contents of health care records, both factual information and opinion.²⁴⁵

Where the health care professional is not before the court to testify, the extent to which information in health records may be admissible in the face of hearsay objections in Pennsylvania may be illustrated by the following. Suppose in the course of treatment a physician is told by his patient that he "has had sexual relations with several men." The physician further examines the patient and states that he has "symptoms that lead me to believe that he has been exposed to the AIDS virus and has ARC." Suppose the statement and diagnosis were included in the patient's record. If a party sought to introduce these statements in federal or state court in Pennsylvania to establish the fact that the patient's AIDS was acquired through homosexual activities, their admissibility would be objected on the ground that the information was hearsay. Under the federal rules of evidence, the business records exception would apply to both the statement and the diagnosis and support admissibility. Pennsylvania's business records hearsay rule would only admit the statement by the client regarding his homosexual activities as it is a factual statement. The diagnosis would not be admissible because it is an opinion of the health care practitioner. The practical effect of limiting admissibility of health care records in Pennsylvania in respect to opinions in the record is that the record is not admissible to establish the truth of such information unless the health care professional who directly observed or diagnosed the patient in

wealth v. Mobley, 450 Pa. 431, 434, 301 A.2d 622, 624 (1973) (hospital records admissible to show treatment prescribed, hospitalization, and symptoms given); Morris v. Moss, 290 Pa. Super. 587, 435 A.2d 184 (1981) (notation within hospital record that plaintiff was conscious at time of examination in emergency room, opinion that did not fall into hearsay exception).

244. Commonwealth v. DiGiacomo, 463 Pa. 449, 455-56, 345 A.2d 605, 608 (1975) (medical opinion contained in records and proffered as expert testimony is not admissible where doctor is not available for cross-examination); *In re Involuntary Termination of Parental Rights*, 449 Pa. 543, 550, 297 A.2d 117, 121 (1972) (without evidence of sources of information and time and manner of preparation, business records exception does not apply).

245. See FED. R. EVID. 803(6).

respect to the information that is entered into the record is directly offering testimony concerning this information. Under these circumstances, it is the hearsay rule that limits disclosure of the information. The record does not provide an independent basis for a testimonial or evidentiary privilege.

If the health care professional were before the court, then health care information that the professional acquired in treatment would be admissible even if that information was also contained in a health record. The contrary is also true. Information that is privileged on some other basis continues to be privileged when it is stored in a health record. Information that is privileged because it is obtained in furtherance of the legislatively protected, professional-client relationship does not lose its privileged status because it has been reduced to permanent form in a health record.²⁴⁶ So, for example, the notation of the physician that the patient had said that he had sexual relations with numerous men would be unavailable in a civil proceeding to the same extent that testimony by the physician as to the communications itself would be. In Pennsylvania, the physician-patient relationship based testimonial privilege would exclude the statement by the patient because it is a communication that would "tend to blacken the reputation" of the patient or client. This generally accepted proposition seems to be a reflection of the basic view that hearsay evidence in a record ought not to be admissible when direct testimony of the professional would be privileged.²⁴⁷ The Pennsylvania relationship-based testimonial privilege would also operate to exclude the patient's statement in federal court diversity cases. As previously noted, under the federal rules of evidence, federal courts apply the evidentiary privilege law of the state where the federal court sits.²⁴⁸ In such instances, again, the fact that information is stored in health records does not by itself cloak that information with a testimonial or evidentiary privilege.

In respect to some health care information in Pennsylvania, however, strong policies of confidentiality as expressed in re-

246. The Pennsylvania Supreme Court has expressly supported this proposition. See *Allegheny County*, 490 Pa. at 148 n.4, 415 A.2d at 76 n.4. For a discussion of this case, see *supra* notes 110-18 and accompanying text.

247. *Allegheny County*, 490 Pa. at 148 n.4, 415 A.2d at 76 n.4.

248. See FED. R. EVID. 501; S. SALTZBURG & K. REDDEN, FEDERAL RULES OF EVIDENCE MANUAL 331 (1986). In federal question cases, testimonial privileges for health care practitioners are generally not recognized in federal courts. See, e.g., *United States v. Mancuso*, 444 F.2d 691 (5th Cir. 1971); *In re Verplank*, 329 F. Supp. 433 (C.D. Cal. 1971). For a further discussion, see *supra* note 131 and accompanying text.

cently enacted legislation and agency regulations have provided that certain health records are to play an independent and more expansive role in protecting confidentiality. For patients that are involved in treatment for drug or alcohol conditions or patients that are being treated in mental health facilities, both an evidentiary and a limited testimonial privilege is granted on the basis of the health record in which that information is stored. In these two instances, at least, concern for protecting the privacy and confidentiality of the health records provides an evidentiary and testimonial privilege that operates under certain circumstances as a basis for a testimonial privilege that is independent of the relationship-based testimonial privilege.

c. Hierarchy of Confidentiality Policies in Pennsylvania for Health Records

There are specific statutory and regulatory policies in Pennsylvania protecting the confidentiality of some health records.²⁴⁹ Placed on a spectrum of confidentiality protection, at the apex of the hierarchy would be all records that contain information regarding treatment for drug and alcohol abuse.²⁵⁰ Next on the spectrum would be the records of patients being treated for problems in mental health treatment facilities.²⁵¹ General hospital records fall below this, and at the bottom of the spectrum would be the records of the purely private, licensed health care practitioner whose records do not include information relating to treatment for drug or alcohol abuse. There are no statutory or regulatory confidentiality policies enacted in Pennsylvania regarding the purely private practitioner not involved in treatment for drug and alcohol abuse. Regulations expressing confidentiality policies for hospital records provide that the patient has the right to confidentiality of hospital records except as "otherwise provided by law."²⁵² This language and the overall regulations indicate clearly that no special consideration in respect to testimonial privileges was intended in respect to information in hospital records. Such a conclusion is also implicit in the status of these policies as agency regulations not embodied in legislative

249. For a discussion of these policies, see *supra* notes 43-71.

250. For a discussion of the protection for information regarding drug and alcohol abuse treatment, see *infra* notes 258-61 and accompanying text.

251. For a discussion of the protection afforded mental health records, see *infra* notes 254-57 and accompanying text.

252. 28 PA. CODE § 103.22(b)(4) (1983).

enactments.²⁵³

The language of the statutory policies regarding confidentiality for drug and alcohol treatment and records of patients in mental health treatment facilities strongly suggests that the legislature intended for these records to provide an evidentiary and testimonial privilege that may function to some extent independently of the relationship-based testimonial privilege. The Mental Health Procedure Act provides that all documents in records subject to the Act shall "not be released or their contents disclosed"²⁵⁴ except in specified instances.

One of the exceptions to non-disclosure that the statute specifically mentions is disclosure to "a court in the course of legal proceedings authorized by this Act."²⁵⁵ This reference to disclosure to courts when proceedings are brought under the Mental Health Procedure Act itself, is the only reference in the Act to the release of mental health records to courts in Pennsylvania. The Act provides for stricter confidentiality for "privileged communications"²⁵⁶ that are in mental health records by stating that, "in no event"²⁵⁷ shall privileged communications, whether written or oral, be disclosed to anyone without the patient or client's written consent. The language of the statute clearly reflects a policy of non-disclosure of documents or the contents of mental health

253. This is not to suggest that the regulations enacted by the Pennsylvania Hospital Agency are *ultra vires* and do not have the status of "law" in Pennsylvania. The Pennsylvania Supreme Court has officially recognized the legal validity and binding nature of the regulations and Patients' Bill of Rights. *Allegheny County*, 490 Pa. at 148, 414 A.2d at 76.

254. PA. STAT. ANN. tit. 50, § 7111 (Purdon Supp. 1986).

255. *Id.* The exceptions are:

- (1) those engaged in providing treatment for the person;
 - (2) the county administrator, pursuant to section 110;
 - (3) a court in the course of legal proceedings authorized by this act;
- and
- (4) pursuant to Federal rules, statutes and regulations governing disclosure of information where treatment is undertaken in a Federal agency.

Id.

256. This intriguing section reads:

In no event, however, shall privileged communications, whether written or oral, be disclosed to anyone without such written consent. This shall not restrict the collection and analysis of clinical or statistical data by the department, the county administrator or the facility so long as the use and dissemination of such data does not identify individual patients. Nothing herein shall be construed to conflict with Section 8 of the act of April 14, 1972 (P.L. 221, No. 63), known as the "Pennsylvania Drug and Alcohol Abuse Control Act."

Id.

257. *Id.*

records in any legal proceeding other than those initiated under the Mental Health Procedure Act itself.

The statutory policy of non-disclosure in respect to information of drug and alcohol treatment in Pennsylvania is even stricter than that involving mental health records.

Pennsylvania enacted the Drug and Alcohol Abuse Control Act in 1972.²⁵⁸ This statute expresses one of the most stringent policies of confidentiality in our legal system in respect to records of treatment for drug and alcohol abuse. The Act generally provides that patient records may be released for purposes unrelated to treatment only upon an order of a court of common pleas after a determination of "good cause."²⁵⁹ This right to a hearing to demonstrate "good cause" before records compiled under the Act are released provides for more protection than is generally the case in respect to health records. The Act's provisions regarding information relating to drug or alcohol dependence are even more stringent. Records and information concerning drug and alcohol dependence are to be released only to medical personnel for treatment or to individuals for the purpose of obtaining benefits.²⁶⁰ On its face, the Act clearly indicates a policy

258. PA. STAT. ANN. tit. 71, §§ 1690.102-1690.115 (Purdon Supp. 1986).

259. *Id.* § 1690.108(b). The section reads:

All patient records (including all records relating to any commitment proceeding) prepared or obtained pursuant to this act, an all information contained therein shall remain confidential, and may be disclosed only with the patient's consent and only (i) to medical personnel exclusively for purposes of diagnosis and treatment of the patient or (ii) to government or other officials exclusively for the purpose of obtaining benefits due the patient as a result of his drug or alcohol abuse or drug or alcohol dependence except that in emergency medical situations where the patient's life is in immediate jeopardy, patient records may be released without the patient's consent to proper medical authorities solely for the purpose of providing medical treatment to the patient. Disclosure may be made for purposes unrelated to such treatment or benefits only upon an order of court of common pleas after application showing good cause therefor. In determining whether there is good cause for disclosure, the court shall weigh the need for the information sought to be disclosed against the possible harm of disclosure to the person to whom such information pertains, the physician-patient relationship, and to treatment services, and may condition disclosure of the information upon any appropriate safeguards. No such records or information may be used to initiate or substantiate criminal charges against a patient under any circumstances.

Id.

260. The relevant portion of the statute reads:

(c) All patient records and all information contained therein relating to drug or alcohol abuse or drug or alcohol dependence prepared or obtained by a private practitioner, hospital, clinic, drug rehabilitation or drug treatment center shall remain confidential and may be dis-

of non-disclosure of information of drug or alcohol dependence even in legal proceedings and even when the patient or client has consented.²⁶¹ This policy of confidentiality in the Mental Health Procedure Act applies only to records of mental health treatment facilities as defined in the Act. Confidentiality policies under the Drug and Alcohol Abuse Control Act, on the other hand, apply to the records prepared by all private practitioners and drug rehabilitation and treatment centers, including hospitals and clinics.²⁶²

Both of these statutes plainly limit disclosure of documents or of certain information in records in legal proceedings. When the health care practitioner is not before the court, these statutes provide an evidentiary privilege that would exclude evidence that is not otherwise excludable either under the hearsay or testimonial privilege rules in Pennsylvania. This would be the case in respect to information in records subject to the Mental Health Procedure Act and all information concerning drug and alcohol dependency in health records. If, for example, the record involved in the hypothetical previously discussed was that of a patient receiving treatment by a psychiatrist in a mental health treatment facility, the evidentiary privilege under the Mental Health Act would operate to exclude all of the information in such records from being admitted. This greatly expands the excludability of some health care information in Pennsylvania both in federal and state courts beyond the scope of the hearsay rules

closed only with the patient's consent and only (i) to medical personnel exclusively for purposes of diagnosis and treatment of the patient or (ii) to government or other officials exclusively for the purpose of obtaining benefits due the patient as a result of his drug or alcohol abuse or drug or alcohol dependence except that in emergency medical situations where the patient's life is in immediate jeopardy, patient records may be released without the patient's consent to proper medical authorities solely for the purpose of providing medical treatment to the patient.

Id. § 1690.108(c).

261. *See id.* § 1690.108(b), (c). The regulations that have been enacted under this Act provide for release of data acquired under the Act to courts with or without the consent of the client in limited circumstances. 4 PA. CODE § 255.5 (1986). These provisions provide a practical solution to the highly restrictive policies of confidentiality in the Act. The legality of the sections providing for release of health information have not been adjudicated. In view of the plain language of the Drug and Alcohol Abuse Act, and the strong policies of confidentiality, there would appear to be serious questions concerning the validity of some sections of the regulations. *Compare* PA. STAT. ANN. tit. 71, § 1690.108(b), (c) (Purdon Supp. 1986) (disclosure allowed only in case of emergency or with consent of patient) *with* 4 PA. CODE § 255.5 (1986) (disclosure allowed with or without patients' consent to judges, attorneys or health care professionals in numerous situations).

262. *See* PA. STAT. ANN. tit. 71, § 1690.108(c) (Purdon Supp. 1986).

or relationship-based privileges. In federal courts hearsay rules would not limit the statement of the patient regarding homosexual activity nor the diagnosis of the doctor. Under Pennsylvania rules, hearsay would not exclude the diagnosis, but would exclude the statement of fact by the patient. The physician-patient privilege would exclude the communication by the patient of homosexual activity in both state and federal courts. The net result of exclusive operation of the hearsay rules and testimonial privilege would be that in federal court all of the information in the record except the disclosure of homosexuality would be admitted, if relevant, and in state court factual information other than that which would tend to "blacken the reputation of the patient" would be admitted.

Because of the evidentiary privilege for mental health records under the Mental Health Procedure Act, in both federal and state courts, all of the information would be excluded. Similarly, statements about drug and alcohol use and dependency contained in the health record of a private practitioner would enjoy an evidentiary privilege even if there was not a relationship-based testimonial privilege that covered the information. So, for example, statements by a patient who was receiving counseling and therapy from a social worker of drug and alcohol use are not discoverable or admissible even though social workers do not in Pennsylvania, as a general matter, have a testimonial privilege. The diagnosis and evaluation of alcohol or drug dependency by the social worker contained in the record would also be covered by the records evidentiary privilege under the 1972 Drug and Alcohol Abuse Control Act.

d. A Record Based Testimonial Privilege for Mental Health and Drug and Alcohol Treatment Records

The strong policies of confidentiality embodied in both the Mental Health Procedure and Alcohol Abuse Control Acts, raise questions beyond the evidentiary records privileges that seem rather clearly to apply to attempts to use records subject to the Act as evidence when the health care practitioner is not before the court. Do these strong policies of confidentiality provide a testimonial privilege that is independently based upon the records in which the information is stored when the health care practitioner is before the court?

Suppose, for example, that in a civil proceeding a psychiatrist is asked to testify as to information that he acquired from his pa-

tient about specific experiences of drinking or drug use. As previously noted, even in respect to communications, no relationship-based testimonial privilege would apply. In respect to information that the psychiatrist remembered independently, but that was in a record subject to the Drug and Alcohol Abuse Control Act, would the psychiatrist be able to assert a privilege not to testify on the basis of the language in the Act which prohibits disclosure of "records and information contained therein"? One possible answer would be that the information is not privileged because the Act only prohibits disclosure from the record in the sense of someone reciting from the health record in court proceedings.

Since the psychiatrist had independent recollection of the information, the fact that it is in a record should not preclude disclosure. This interpretation of the restrictive language of both statutes would make that statutory language superfluous, because as previously noted, under the business records exception to hearsay rules in Pennsylvania, information concerning diagnosis and treatment could not be introduced into evidence or read from such records into evidence in any event.²⁶³

It would be anomalous to suppose that the legislature selected the above-quoted language to merely express existing policy regarding the admissibility of information in health records generally. Indeed, the thrust of the two statutes seems clearly to be that drug and alcohol treatment and mental health records involve such sensitive information about the privacy of patients and clients that new and extraordinary rules regarding disclosure of such information are required. As previously discussed, the language in the statutes prohibiting disclosure of "records and information contained therein" is not superfluous but is a plain expression that an evidentiary privilege attaches to documents and to information in these records when admissibility is sought without the health care practitioner who is not before the court to testify. In addition, at least it would seem that where the health care professional does not independently recall the information contained in the drug and alcohol or mental health treatment records, the records ought not to be available to refresh the

263. For a discussion of this hearsay exception, see *supra* note 239 and accompanying text. This is also supported by the principle of statutory construction that specific provisions shall be given effect over general provisions. 1 PA. CONS. STAT. ANN. app. § 1933 (Purdon 1986); see also *Commonwealth ex rel. Platt v. Platt*, 266 Pa. Super. 276, 286-87, 404 A.2d 410, 415 (1979) (specific requirement in Mental Health Procedures Act for testimony of treating psychiatrist controls general provision of physician-patient confidentiality statute).

health care professional's recollection. If the records of mental health treatment and drug or alcohol treatment were used for such a purpose, the policies of confidentiality expressed in the plain language of the two statutes would be substantially frustrated. If courts were to interpret the two statutes to provide a record-based testimonial privilege, this would not, however, mean that the privilege would not give way when countervailing constitutional rights to access to such information were at stake.²⁶⁴ Such a record-based testimonial privilege would also be subject to the litigant or implied waiver doctrines to which all statutory testimonial privileges are subject to.²⁶⁵

e. Records Maintained Under the Peer Review Act

A substantial majority of the states have enacted statutes to protect the confidentiality of the records of organizations developed within the health care profession for peer review of the credentials and practices of physicians and other health care practitioners.²⁶⁶ Peer review is a form of self-regulation by health professionals that promotes important policies of protecting the public from unqualified or unfit health care practitioners and in reducing potential malpractice actions. State legislatures have recognized that considerable legal protection for the confidentiality of the activities of peer review organizations is necessary if peer review is to continue and be effective. Most states therefore provide for an evidentiary or testimonial privilege to the committee reports, records, proceedings and testimony of peer review organizations.²⁶⁷

Legislative protection for peer review activities was initially enacted in Pennsylvania in 1974. It provides that proceedings and records of review committees shall be held in confidence and not available as evidence in any "civil proceeding against a professional health care provider arising out of matters which are the subject of evaluation and review by such committee."²⁶⁸ Until

264. For a discussion of the tension between privileges and countervailing constitutional rights, see *infra* notes 310-30 and accompanying text.

265. For a discussion of the implied waiver doctrines, see *supra* notes 119-30 and accompanying text.

266. See generally Cuneo, *Disclosure v. Confidentiality of Hospital Peer Review Committee Reports*, MED. TRIAL TECH. Q. 172 (1985); Comment, *Medical Peer Review Protection in the Health Care Industry*, 52 TEMP. L.Q. 552 (1979); Note, *The Missouri Rule: Hospital Peer Review is Discoverable in Medical Malpractice Cases*, 50 Mo. L.R. 459, 475-76 (1985).

267. Note, *supra* note 266, at 475-76.

268. See generally P.L. 564, No. 193, as amended 1978, October 5, P.L. 1121,

recently the scope of the privilege provided by the Peer Review Act had not been construed by appellate courts in Pennsylvania, although other provisions in the Act had been.

In *Sanderson v. Bryan*,²⁶⁹ the superior court construed the Act in a way that strengthens confidentiality for peer review records. Peer review records involving treatment by the defendant physician of patients other than the plaintiff were sought in discovery. The trial court strictly construed the privilege in the Act to be limited to peer review of treatment of the plaintiff or to material reasonably association with plaintiff's cause of action and found the requested information to be discoverable.

The superior court reversed, holding that peer review records involving the physician were privileged. In dicta the court suggested that except when sought by the physician most of the information acquired as part of peer review activity would be privileged and not admissible in civil proceedings. *Sanderson* is a sound construction of the Peer Review Act.²⁷⁰ As the court observed, the strict construction of the Peer Review privilege suggested by the plaintiff would obliterate the confidentiality policies in the statute by making much information available through discovery. Such information would become public if it were part of the judicial record in a lawsuit. The court also noted that disclosure of peer review information would violate the privacy of other patients or clients. Without providing the broad confidentiality protection that was intended by the legislature, self-regulation by the health care profession through peer review is not likely as a practical matter to be seriously undertaken by health care professions.

3. Constitutionally Based Testimonial Privilege

As the previous discussion of testimonial privileges under

No. 262, PA. STAT. ANN. tit. 63 § 425.1 (Purdon Supp. 1986). The confidentiality provisions are found in section 425.2.

269. — Pa. Super. —, 522 A.2d 1138 (1987).

270. The court concluded that applying the strict construction of the Peer Review Act that was suggested by the plaintiff would produce unreasonable and impractical results. By providing that other plaintiffs could receive peer review information for litigation, the confidential nature of peer review would be obliterated and much information would become public as part of the records of judicial proceedings. The language of the Peer Review Act that refers to "civil proceedings against a professional health care provider" was found by the court to have been included so that a health care professional would have access to charges that were raised in peer review proceedings and eliminate a "star chamber" atmosphere.

statutes in Pennsylvania demonstrates, privileges for all of the health care practitioners covered, especially psychiatrists, are limited. Indeed, as has been noted, the physician and psychiatrist-patient privilege is perhaps the most restrictive in the legal system.²⁷¹ While the testimonial privilege for psychologists and the testimonial privilege for health care practitioners who function in rape, sexual assault and student counseling roles is broader, the construction of these privileges by the courts in Pennsylvania has also been quite restrictive.²⁷² One reason for this restrictive approach has been a myopic view of the statutory testimonial privileges as enacted solely for the purpose of protecting the integrity of the health care practitioner-patient relationship in respect to communications between patient and professional. When the Pennsylvania courts have viewed the privilege solely from this perspective and weighed the integrity of the relationship interest against the long-standing value of truth-seeking and the principle that every person must come forth with his evidence, the testimonial privilege has invariably come out on the short end of the balance.

There are two reasons why this view results in constriction of the privilege. The first is the existence of legitimate doubts about whether disclosure of confidential communications in legal proceedings does, in fact, impact upon the integrity of the professional client or patient relationship in any meaningful way. This skepticism has been expressed in judicial opinions outside Pennsylvania and by commentators.²⁷³ The basis for this cynicism is

271. For a discussion of this privilege, see *supra* notes 139-77 and accompanying text.

272. For a discussion of Pennsylvania courts' construction of these privileges, see *supra* notes 181-229 and accompanying text.

273. Manifestations of cynicism about the adverse impact of denial of testimonial privileges in judicial opinions have been spearheaded by the Supreme Court itself. *Trammel v. United States*, 445 U.S. 40, 50-53 (1980) (ancient foundations for sweeping privilege afforded to inter-spousal communications are unpersuasive in contemporary times); *United States v. Gillock*, 445 U.S. 360, 366-72 (1980) (state legislator enjoys no evidentiary privilege barring introduction of legislative acts of legislator); *Herbert v. Lando*, 441 U.S. 153, 169-75 (1979) (any absolute evidentiary privilege that would bar plaintiff in libel action from inquiring into editorial process of newsmaking would be substantial interference with plaintiff's ability to prove his case); *United States v. Nixon*, 418 U.S. 683, 705-07 (1974) (legitimate need of judiciary to enhance fact finding outweighs any proposed absolute executive privilege); *Branzburg v. Hayes*, 408 U.S. 665, 693-702 (1972) (no evidence exists to show that failure to grant testimonial privilege to newsman in order for him to shield his confidential sources will result in undermining of press and its inability to collect and disseminate news); *United States v. Tsinnijinnie*, 601 F.2d 1035, 1039 (9th Cir. 1979) (no privilege exists to excited utterance of spouse).

understandable. Only a small percentage of the clients or patients that are involved in relationships with health care practitioners ever interface with the legal system. Information that has been acquired in the health care-practitioner-client relationship is sought in legal proceedings even less frequently. It is also extremely difficult to determine in an empirical way whether disclosure of information in legal proceedings specifically or generally inhibits individuals from entering into or fully participating in the delivery of health care services.²⁷⁴ If the reason given in support of a testimonial privilege is solely the integrity of the relationship value, then for the foregoing reasons and others, the privilege is not likely to have much weight in the inevitable weighing of val-

274. See generally C. MCCORMICK, *supra* note 108, §§ 180, 181 (demonstrating causal relationship between denial of privilege in particular instance where testimony is sought in judicial proceedings and prospective communications between health care professionals and clients is difficult). In *Branzburg v. Hayes*, media reporters submitted affidavits attesting to the fact that a reporter's privilege was necessarily essential to information gathering. 408 U.S. at 679-81. This evidence had little effect on a majority of the Court in that case. *Id.* at 685. At least one commentator has suggested that social science methodology is capable of empirically validating the assumption that there is a causal relationship between privileges and communications in a professional-client relationship. See Rosenburg, *The New Looks in Law*, 52 MARQ. L. REV. 539, 543-46 (1969). For a successful example of use of empirical studies to evaluate the factual assumptions underlying a rule, and which resulted in change of the rule, see Blasi, *The Newsmen's Privilege: An Empirical Study*, 70 MICH. L. REV. 229, 284 (1971) (broad-based research into effect of subpoenas on reporter's confidential sources shows need for testimonial privilege for reporters). Knapp and VandeCreek point to several of the obstacles in the path of research examining the utilitarian justification for testimonial privileges. S. KNAPP & L. VANDECREEK, *supra* note 123, at 25-26. A major problem is the inability, because of ethical reasons, to utilize the response of those who are seeking or are already in psychotherapy, to breaches of confidentiality or changes in testimonial privileges. *Id.* As a result, the growing recent research is comprised of surveys of health professionals or their clients or analogue studies of other groups, mostly students. *Id.* Knapp and VandeCreek survey current studies and conclude that these studies add support for the view that confidentiality of information acquired in psychotherapy is expected and viewed as important to the kind of information disclosed in treatment. *Id.* at 30-33. They conclude, however, that the studies are not especially useful on the broader question of the relationship between the existence of a testimonial privilege and patient disclosures in psychotherapy. *Id.* at 32-33. Some of the studies point out that many patients or clients are not aware of the existence of that area of the law of evidence that provided for testimonial privileges to communications determined to be privileged. *Id.* at 31. Perhaps the best attempts to date to examine the relationship between privileges and communications in a professional-client relationship are found in Weinerand and Shuman, *Privilege, A Comprehensive Study*, J.L. & PSYCHOLOGY, Fall 1984; Shuman, *Privilege Study: An Empirical Examination of Psychotherapy Privilege*, 60 N.C.L. REV. 893 (1982). These studies support the view that the privilege has little impact on the relationship. However, the research methodology is arguably wanting, and the studies are not dispositive of the question.

ues that courts perform in determining the scope of statutory testimonial privileges.

The second reason courts are understandably inclined to give primacy to the truth-seeking policy in interpreting statutory testimonial privileges is the nature of the role of appellate courts in interpreting legislation. When appellate courts interpret statutes, they function as agents of the legislature. If they are wrong in their interpretation of the statute, their error may be corrected by the legislature with subsequent amendments to the statute. In view of this agency role and the truth-seeking value that has been developed by the judiciary independently and as part of long-standing traditions involving separation of power, it is not surprising that statutory testimonial privileges are often narrowly circumscribed. If the scope of testimonial privileges is cast as a matter of weighing the effect of disclosure on a patient's willingness to communicate against the judiciary's interest in truth-seeking, the resolution is loaded heavily against the privilege.²⁷⁵

If one views testimonial privileges as ensuring the confidentiality of health care information in order to protect a patient's or client's right to privacy, greater importance should be given to the privilege when it is weighed against truth-seeking values and policies. The right to privacy is given primacy over other important policies and values in the areas of torts²⁷⁶ and constitutional law²⁷⁷ and under state²⁷⁸ and federal statutes.²⁷⁹ In many in-

275. This result seems self-evident upon review of the Supreme Court's determination of the scope of executive privilege in regard to the judiciary's interest in fact-finding. *United States v. Nixon*, 418 U.S. 683, 707-13 (1974) (while governmental interest in effective executive is very high, it is outweighed by judiciary's interest in placing all relevant facts before it). *Nixon* also stands for the proposition that federal courts should construe all privileges narrowly. *Id.*; see also *United States v. Tsinnijinnie*, 601 F.2d 1035, 1038 (9th Cir. 1979) (marital privilege should be construed narrowly so as not to encompass excited utterances by spouses). Much commentary has generally supported restricting development of new privileges as well as restricting expansion of existing ones. See, e.g., C. McCORMICK, *supra* note 108, § 75.

276. There are numerous examples of judicial recognition that privacy outweighs truth-seeking interests in tort actions initiated under the tort right of privacy. See, e.g., *Briscoe v. Reader's Digest Ass'n*, 4 Cal. 3d 529, 541, 483 P.2d 34, 42, 93 Cal. Rptr. 866, 874 (1971) (rights guaranteed by first amendment do not require total abrogation of individual's right to privacy); *Roshto v. Hebert*, 413 So. 2d 927, 933 (La. Ct. App. 1982) (where published facts are injurious to person's reputation and are non-newsworthy, person's privacy rights outweigh press' first amendment rights).

277. See, e.g., *Burrows v. Superior Court*, 13 Cal. 3d 238, 245, 529 P.2d 590, 594-95, 118 Cal. Rptr. 166, 170-71 (1974) (California constitution guarantees individuals' right to privacy to detriment of judiciary's interest in truth-seeking); *Commonwealth v. Sell*, 504 Pa. 46, 63-65, 470 A.2d 457, 466 (1983) (Penn-

stances, the right to privacy has overridden strong truth-seeking policies. The paradigm, of course, would be in fourth amendment cases where pertinent and relevant evidence is not admitted into the criminal proceedings because it was acquired in violation of the fourth amendment rights to privacy.²⁸⁰ Three states, Pennsylvania, California²⁸¹ and Alaska have begun to look at testimo-

sylvania's protection of individuals' right to privacy as embodied in its constitution outweighs legitimate interest of state in gathering evidence).

278. A dramatic example of state statutory privacy policies overriding countervailing interests in access to information is *Head v. Colloton*, 331 N.W.2d 870, 873-74 (Iowa 1983) (bone marrow information about patient not available to person with terminal illness); *see also* *State v. Hunt*, 91 N.J. 338, 346-47, 450 A.2d 952, 955-56 (1982) (telephone company could not release toll billing records without customer's consent or appropriate judicial sanction).

279. The Freedom of Information Act specifically exempts information from disclosure if disclosure constitutes an unwarranted invasion of privacy. 5 U.S.C. § 552(b)(6) (1977); *see* *Wine Hobby USA Inc. v. IRS*, 502 F.2d 133, 135 (3d Cir. 1971) (IRS list of names of amateur winemakers enjoys same exemption as medical records under § 552(b)).

280. *See, e.g.,* *Katz v. United States*, 389 U.S. 347, 353 (1967) (plurality) (extending constitutional right of informational privacy under fourth amendment to telephone conversations). Perhaps the most illuminating discussion of how the warrant and probable cause reasonableness requirements of the fourth amendment emphasize privacy over truth-seeking interests in some instances is contained in Justice Harlan's dissenting opinion in *United States v. White*. 401 U.S. 745, 789-95 (1971) (Harlan, J., dissenting). Justice Harlan suggests that under these fourth amendment requirements, the risk of loss of privacy is limited to those persons that a court has determined are likely to be involved in criminal activities. *Id.* at 790 (Harlan, J., dissenting). The fourth amendment tradition in our constitutional system is a reaction to the early English tradition of issuing general search warrants and authorizing invasions of privacy whenever the government sought to acquire evidence in enforcing the criminal law. *See* H. PACKER, *THE LIMITS OF THE CRIMINAL SANCTION* 151 (1968) (criminal procedure rights are "obstacle courses" to truth-seeking and crime control interests). A more philosophical statement of the role of rights in overriding countervailing policy considerations including truth-seeking is found in R. DWORKIN, *supra* note 8, at 22-28. Dworkin metaphorically speaks of this special feature of rights such as privacy as "trumping" government action that promotes the common good. *Id.* at 28.

281. *See* *Falcon v. Alaska Pub. Office Comm'n*, 570 P.2d 469 (Alaska 1977); *In re Lifschutz*, 2 Cal. 3d 415, 431-35, 467 P.2d 557, 567-70, 85 Cal. Rptr. 829, 839-42 (1970) (constitutional right to privacy is broad enough to encompass and underpin psychotherapist-patient privilege); *In re "B,"* 482 Pa. at 484, 394 A.2d at 425-26 (patient's interest in keeping psychotherapeutic records confidential is rooted in patient's fundamental right to privacy as well as privilege statute).

A number of other jurisdictions have not formally adopted the constitutional testimonial privilege but have *de facto* applied the weighing of interest analysis that has developed under that test in California and Pennsylvania. These courts have thus indirectly adopted the test and have cited *Lifschutz* with approval as well as discussed the role of the patient's right of privacy to client's right of privacy in the determination regarding the privilege. *See* *Voho v. Lindsley*, 248 So. 2d 187, 190-92 (Fla. 1971) (determining privilege for purpose of relevancy requires balancing of interest and determination of roots of privilege); *Commonwealth v. Kobrin*, 395 Mass. 284, —, 479 N.E.2d 674, 679 (1985) (nota-

nial privileges as a component of a patient's or client's constitutional right to privacy with respect to health care information. The result is a much more expansive notion of testimonial privileges than is found in the statutory testimonial privilege cases.

In the last decade, there has been a development in Pennsylvania constitutional law that is important to the protection of the confidentiality of health care information that is sought as part of legal proceedings. The Pennsylvania Supreme Court has interpreted the guarantees of the right to privacy under the federal and state constitutions to include some protection for health care information and information contained in health records.²⁸² One of the consequences of this important development is that in some circumstances a testimonial privilege is available to patients or clients in Pennsylvania that is based upon the state and federal constitutional right to privacy. Therefore, even if the relationship-based testimonial privilege or the record-based testimonial privilege does not preclude disclosure of the information in a legal proceeding, the constitutionally based testimonial privilege may preclude such disclosure.

Since a constitutional right is involved, the testimonial privilege would come into play only where the government requires disclosure of health care information. This is because constitutional privacy rights under the state and federal constitutions only limit governmental action. However, where an agency or court compels a health care practitioner to disclose health care information, the government action requirement is satisfied, and the constitutional right to privacy would be implicated.²⁸³ This

tions of psychotherapist are privileged only to extent interest of state in fact-finding does not outweigh patient's interest in confidentiality); *State v. Odenbrett*, 349 N.W.2d 265, 268-69 (Minn. 1984) (state's interest in protecting child abuse victims must be balanced against patient's interest in keeping treatment records confidential in order to determine privilege); *Arena v. Saphier*, 201 N.J. Super. 79, 90, 492 A.2d 1020, 1026 (1985) (determination of privilege for psychologist's notes dependent on weighing of competing values); *Ex parte Abell*, 613 S.W.2d 255, 262-63 (Tex. 1981) (plaintiff's right to confidentiality vested in interrogatories at time of filing given party's interest in protecting information).

282. *Pittsburgh Action Against Rape*, 494 Pa. at 25-30, 428 A.2d at 130-32 (communications of sexual assault counselor with client are privileged only to extent that evidence must be viewed *in camera* rather than in open court); *Allegheny County*, 490 Pa. at 148, 415 A.2d at 76-77 (physician-patient privilege is founded upon statutory and constitutional footing); *In re "B,"* 482 Pa. at 481-86, 394 A.2d at 423-26 (constitutional right of privacy encompasses physician-patient communications).

283. The United States Supreme Court established some time ago that judicial action in enforcing private rights in civil rights cases is action by the

development in Pennsylvania is important to the protection of confidentiality of health care information.

The constitutionally based testimonial privilege first surfaced and was embraced by three members of the Pennsylvania Supreme Court in 1976 in *In re "B,"*²⁸⁴ where a contempt order directed at a psychiatrist by a common pleas court for not releasing patient records was vacated. The records had been requested from a psychiatric hospital as part of the court's placement of an individual that had been adjudicated a delinquent after escaping from a juvenile facility and committing several car thefts.²⁸⁵ Upon the recommendation of a psychiatrist associated with the court, the psychiatrist's records of the juvenile's mother were sought. Dr. Roth, a psychiatrist, brought the records to the court on behalf of the hospital and after refusing to turn them over to the court because their disclosure would infringe upon the mother's and other persons' privacy, he was held in contempt and fined \$100.00.²⁸⁶ Four of the seven supreme court Justices supported the reversal, but on several grounds. Justice Roberts found that the records were privileged under the psychologist testimonial privilege statute.²⁸⁷ Justice O'Brien concurred without opinion.²⁸⁸ Justice Manderino, with the support of Justice Lar-

"state" within the meaning of the fourteenth amendment. *See Barrows v. Jackson*, 346 U.S. 249, 257 (1953) (enforcement of racially restrictive covenant constitutes state action). Judicial enforcement of some private rights does not satisfy the state action requirement. *See, e.g., Evans v. Abney*, 396 U.S. 435, 445-46 (1970). However, in cases where the judiciary compels the testimony of a health care practitioner, there is no serious question as to whether the state action requirement is satisfied. *See, e.g., In re "B,"* 482 Pa. at 476-79, 394 A.2d at 421-22.

284. 482 Pa. at 484, 394 A.2d at 420-26.

285. *Id.* at 475, 394 A.2d at 420-21. "B" and his mother had been examined by the same psychiatrist. *Id.* During these court-ordered examinations, it was learned that the mother had previously undergone therapy. *Id.*

286. *Id.* at 475, 394 A.2d at 421. Dr. Roth appealed the contempt order to the Superior Court of Pennsylvania. The superior court decided the contempt order was criminal in nature and, therefore, ordered the appeal transferred to the Pennsylvania Supreme Court. *See In re "B,"* 247 Pa. Super. 395, 372 A.2d 884 (1977).

287. *In re "B,"* 482 Pa. at 487-94, 394 A.2d at 428-30 (Roberts, J., concurring). Justice Roberts viewed the psychiatrist as a medical doctor engaged in the work of a psychologist. *Id.* at 489, 394 A.2d at 428 (Roberts, J., concurring). Therefore, it was not difficult to find that such a practitioner is covered by at least one of the applicable statutes. *Id.* Justice Roberts concluded that it would be arbitrary to find that no privilege exists for communications between a psychiatrist and patient under the psychologist statute since there is "certainly no less need for confidentiality where psychiatric therapy is conducted by a physician." *Id.*

288. *Id.* at 487, 394 A.2d at 426 (Roberts, J., concurring).

sen, found that the constitutional right to privacy protected the psychiatric records and immunized them from disclosure in the juvenile proceedings.²⁸⁹ Of the three dissenting Justices, only Justices Pomeroy and Nix²⁹⁰ explicitly rejected Justice Manderino's notion that the right to privacy applied to the information sought from Dr. Roth. Chief Justice Eagen dissented on the basis that the state's interest in treating juveniles overrode the right to privacy that the patient had in the records.²⁹¹

By 1980, five of the seven Justices on the supreme court had accepted the position of Justice Manderino that the constitutional right to privacy applied to communications and records of the patients of health care practitioners. The occasion was the refusal of a hospital to turn over the records of patients to a grand jury investigating possible fraud in billing for tests. In *Allegheny County*,²⁹² the court found that the hospital did have to turn the records over to the grand jury. However, five members of the court assumed as a basis of the decision that the hospital had asserted a cognizable claim of constitutional privacy on behalf of the patients.²⁹³ The secrecy of grand jury proceeding and the public interest in enforcing criminal laws against fraud were

289. *Id.* at 481-86, 394 A.2d at 423-26. Justice Manderino found the records outside the scope of the statutory privilege because they did not contain "communications" and did not themselves blacken the patient's reputation. *Id.* at 479-80, 394 A.2d at 423. However, Justice Manderino concluded that the individual's interest in preventing disclosure of information revealed in the context of the psychotherapist-patient relationship has deep roots within the federal Constitution and the Pennsylvania Constitution. *Id.* Therefore, the interest enjoys the protection of the individual's right of privacy. *Id.* As it falls within the right of privacy, the competing state interest in disclosure must be carefully weighed. *Id.* at 486, 394 A.2d at 426. After weighing the state's interest in placing the child versus the invasion of the mother's right of privacy, Justice Manderino concluded that the state could not compel disclosure. *Id.*

290. *Id.* at 494-96, 394 A.2d at 430-31. Justice Pomeroy labeled Justice Manderino's fundamental right analysis as a "gratuitous creation." *Id.* at 494, 394 A.2d at 430. As it had not been argued on appeal by either party, Justices Pomeroy and Nix found the case improperly decided. *Id.* at 496, 394 A.2d at 431.

291. *Id.* at 494, 394 A.2d at 430. Justice Eagen stated: "Because of the important state interest in treatment and welfare of juveniles, I do not believe the right of privacy should prevail under the circumstances of this case." *Id.*

292. 490 Pa. at 143, 415 A.2d at 73. For a discussion of *Allegheny County*, see *supra* notes 114-17 & 164-66 and accompanying text. Justice Manderio was no longer a member of the supreme court.

293. Chief Justice Eagen and Justices O'Brien and Kaufman joined in the majority opinion. *Allegheny County*, 490 Pa. at 153, 415 A.2d at 77. Justices Larsen and Flaherty dissented. *Id.* at 154-55, 415 A.2d at 79-80. All five justices assumed that the hospital had standing to adjudicate the claim on behalf of the patients. Justice Roberts concurred in the result and found no constitutional impediment to the subpoena. *Id.* at 153, 415 A.2d at 78-79. Justice Nix con-

found to be sufficient to override the privacy interest and require disclosure in this case. Since *Allegheny County*, several appellate and trial courts in Pennsylvania have recognized that the constitutional right to privacy applies to health care information sought in legal proceedings.²⁹⁴

The development of the constitutional right to privacy in respect to health care information has just begun in Pennsylvania and the parameters of this fledgling concept have not yet been fully defined. Case law has, however, established certain important features of the constitutional testimonial privilege. One of the consequences of considering the testimonial privileges from a privacy perspective is that a more expansive rule of standing is warranted. This is because health care records, especially where developed as part of psychotherapy, contain highly personal and intimate information about not only the patient but other persons as well. Disclosure of health care records in legal proceedings with the consequences that result once the information becomes part of a judicial record raises serious threats to privacy. Therefore, it is appropriate for the custodian of health care records to raise the privacy rights of persons and patients identified in the health record. This is especially important where a subpoena for health care records is sought as part of a grand jury investigation for possible criminal law violations and the patient is not the subject of the investigation.

curred without addressing the constitutional privilege issue. *Id.* at 153-54, 415 A.2d at 79.

294. *Embick*, 351 Pa. Super. at 500, 506 A.2d at 459 (communications between psychologist and parent of child implicate parents' right of privacy in determining parental rights); *Commonwealth v. Petrino*, 332 Pa. Super. 13, 34, 480 A.2d 1160, 1170 (1984) (privacy right of individual defendant requires balancing of harm from disclosure of mental health examination versus benefit to state in determining sanity to stand trial in murder case), *cert. denied*, 471 U.S. 1069 (1985); *Pennsylvania Dental Ass'n v. Department of Health*, 75 Pa. Commw. 7, 13, 461 A.2d 329, 332-33 (1983) (dental records do not fall within physician-patient privilege); *McKay v. Commonwealth*, 52 Pa. Commw. 24, 34, 415 A.2d 910, 915 (1980) (any intrusion upon patient's privacy interest in allowing psychiatrist to testify about patient's competency to drive is justified by state's interest in safe highways); *Commonwealth ex rel. Platt v. Platt*, 266 Pa. Super. 276, 289-90, 404 A.2d 410, 416-17 (1979) (patients' right to privacy in action for involuntary commitment are outweighed by society's interest in safety so as to allow treating psychiatrist to testify as to emergency treatment); *In re Action Mental Health, Inc.*, 32 Pa. D. & C.3d 612, 620-21 (1983) (patients' right of privacy outweighs state's interest in fact gathering for criminal prosecution thereby nullifying use of records by state at hearing); *Stark Dental Assocs., P.C. v. Medical Serv. Ass'n*, 11 Pa. D. & C.3d 699, 702-04 (1978) (personal information in dental records sought for discovery are protected by individuals' right to privacy and, therefore, subject to privilege).

This was the view of the supreme court in *Allegheny County* when the constitutional right to privacy was raised as a defense to disclosure.²⁹⁵ The court found that, in view of the right to privacy, the hospital as custodian had standing to assert the constitutional privilege of the patients whose records were sought.²⁹⁶ Similarly, two recent common pleas court decisions allowed health facilities to raise the constitutional right to privacy of their patients and prevent disclosure in legal proceedings on information and health records.²⁹⁷

Another important consequence of a testimonial privilege that is based on the constitutional right to privacy is that the privilege applies to a greater range of health care information than does the statutorily based testimonial privileges since the constitutional privilege is not limited to communications or to information that is acquired as part of the delivery of health services by those few licensed professions that are specifically covered by the statutory testimonial privileges.²⁹⁸ The constitutional privilege

295. *Allegheny County*, 490 Pa. at 150-51, 415 A.2d at 77. For a discussion of the issues raised and resolved in *Allegheny County*, see *supra* notes 114-17 & 164-66 and accompanying text.

296. Interestingly, Chief Justice Eagen suggested that the patient would not have standing to raise testimonial privileges because the patient was not the target of the grand jury investigation. 490 Pa. at 149 n.5, 415 A.2d at 76 n.5. Justice Nix vigorously disagreed and would give patients in this situation notice and an opportunity to be heard and raise objections to disclosure including the contention that the information is privileged. *Id.* at 153-54, 415 A.2d at 79 (Nix, J., concurring).

297. *Action Mental Health*, 32 Pa. D. & C.3d at 612. In *Action Mental Health*, the court enjoined the district attorney from examining treatment records of patients in psychotherapy where they were seized pursuant to a valid search warrant as part of an investigation of the possible fraud on the part of the mental health facility in billing practices. *Id.* at 613-14. Access to health care information in the records of patients that were receiving treatment for weight loss was granted to the district attorney on the view that the privacy interest of such patients was less than the privacy interest of psychotherapy patients. *Id.* at 622. *Action Mental Health* is a classic application of the constitutional testimonial privilege where careful consideration of the competing interests of privacy and access to information is given and each of these important interests is furthered without excessive expense to the other. See also *Marcelli v. Commonwealth*, 23 Pa. D. & C.3d 600 (1982) (Haverford State Hospital, as custodian of psychiatric records, successfully asserted patient's constitutional right of privacy to prevent discovery of records in civil action brought against defendant patient).

298. See, e.g., *In re "B,"* 482 Pa. at 481, 394 A.2d at 421-23; *Allegheny County*, 490 Pa. at 151, 415 A.2d at 76-77. For a discussion of *In re "B,"* see *supra* notes 284-91 and accompanying text. For a discussion of *Allegheny County*, see *supra* notes 114-17 & 164-66 and accompanying text. For the text of the physician-patient testimonial privilege, see *supra* note 139. For the text of the psychologist-patient testimonial privilege, see *supra* note 138. For the full text of the sexual assault counselor-client testimonial privilege, see *supra* note 216. This is one of the consequences of the privilege having been grounded on the constitu-

has been applied to hospital records that were not covered under a statutory testimonial privilege,²⁹⁹ and the right to privacy has been recognized in respect to the records of psychiatrists that were not covered by a relationship-based testimonial privilege.³⁰⁰ Most significantly, the privilege has been applied to professionals engaged in psychotherapy and their records even though they were not licensed psychologists or psychiatrists.³⁰¹ In Pennsylvania, social workers are not licensed and yet perform individual and group psychotherapy, especially in respect to drug and alcohol abuse. Extending the constitutionally based testimonial privilege to non-licensed professionals who engage in psychotherapy is totally consistent with the privacy right view of health care information. Professional psychotherapists treat clients under circumstances where there is an expectation and duty of confidentiality. The information acquired is highly personal and intimate, especially where drug and alcohol treatment is involved. The constitutional privilege in Pennsylvania, as a threshold matter, applies to health care information that is acquired in the course of treatment by a licensed health care practitioner and to psychotherapy by an unlicensed professional.

Beyond the threshold determination that the information is covered by the privilege, courts must determine whether the privilege would preclude disclosure in a legal proceeding by weighing the relevant access needs against the right to privacy. In the weighing process, the type of professional-client relationship and the nature of the information that is acquired are factors to be considered. The courts in Pennsylvania that have considered the

tional right to privacy and not on the policy ground of preserving the integrity of the relationship. Judge Finkelhor aptly recognized this important difference in *Action Mental Health*:

Because the right to privacy information revealed in the psychotherapist-patient relationship is constitutionally based, such right exists irrespective of whether or not the legislature has chosen to recognize it through statutory enactment. In re: "B," . . . To the extent that persons are engaged in the process of providing services in the nature of psychotherapy, information revealed in the context of this relationship must be held to be privileged regardless of whether or not the individual may also assert a statutory privilege based on the special qualifications of his or her therapist.

32 Pa. D. & C.3d at 620-21.

299. See *Allegheny County*, 490 Pa. at 150-51, 415 A.2d at 77-78. For a discussion of *Allegheny County*, see *supra* notes 114-17 & 164-66 and accompanying text.

300. See *In re "B,"* 482 Pa. at 484, 394 A.2d at 423-26. For a discussion of *In re "B,"* see *supra* notes 284-91 and accompanying text.

301. See *Action Mental Health*, 32 Pa. D. & C.3d at 617-22. For a discussion of *Action Mental Health*, see *supra* notes 297-98 and accompanying text.

constitutional privilege have determined its applicability to health care information on the basis of a weighing of interest test. This approach is consistent with the way in which rights are determined in other areas of constitutional law as well.³⁰² Most of the cases have involved criminal prosecutions or investigations of violations of criminal law. Criminal law enforcement is a governmental interest that is fundamental, and this has been reflected in the cases where the constitutional privilege has been adjudicated. Pennsylvania courts have found that the need for information in a grand jury investigation of criminal activity outweighs the privacy interests of hospital patients³⁰³ because the secrecy requirements of grand jury proceedings reduced the extent to which the patients' privacy was affected, thus tipping the balance in favor of disclosure. Also, when insanity was raised as a defense by a patient in a murder prosecution, the constitutional privilege did not prevent the prosecutor from having access to the accused's past psychiatric records in view of the requirement that the prosecutor establish the defendant's sanity beyond a reasonable doubt.³⁰⁴ In addition, the interest in protecting the safety of a person who is allegedly so mentally ill so as to be dangerous to himself outweighs that patient's right to privacy in involuntary commitment proceedings under the Mental Health Procedure Act.³⁰⁵

In four instances, the weighing of interest test has been ap-

302. See, e.g., *Wisconsin v. Yoder*, 406 U.S. 205, 219-34 (1972) (right to freedom of religion); *Shapiro v. Thompson*, 394 U.S. 618, 631-42 (1969) (right to interstate travel); *NAACP v. Alabama*, 357 U.S. 449, 460-67 (1958) (right to political association).

303. *Allegheny County*, 490 Pa. at 152, 415 A.2d at 77-78. For a discussion of *Allegheny County*, see *supra* notes 114-17 & 164-66 and accompanying text.

304. *Commonwealth v. Petrino*, 332 Pa. Super. 13, 32-33, 480 A.2d 1160, 1170 (1984), *cert. denied*, 471 U.S. 1069 (1985). The court noted:

What has emerged in this area is the application of a balance between the public interest in having the person given proper care if needed and the individual's privacy interest in having information regarding his mental state remain confidential In this case, the need for the psychiatrist's testimony in proving Appellant's sanity beyond a reasonable doubt clearly outweighs Appellant's expectations of privacy when he has put the issue before the court.

Id. at 34, 480 A.2d at 1170.

305. *Commonwealth ex rel Platt v. Platt*, 266 Pa. Super. 276, 289-90, 404 A.2d 410, 416-17 (1979). The court noted that in any mental health case, the mental condition of the patient is "the essence" or "gravamen" of the proceeding. *Id.* at 289, 404 A.2d at 417. "To hold the psychiatrist incompetent to testify would be incongruous indeed." *Id.* Without the testimony of the treating psychiatrist, according to the court, the patient's privacy interest would be intact but his fate would be in the hands of laymen ill-equipped for such a task. *Id.* Therefore, the patient's right to privacy must give way to the interest of society in having that person treated. *Id.*

plied in favor of non-disclosure. In juvenile proceedings, the juvenile's mother's privacy interests were found to outweigh the court's interest in the health care information where information sufficient to adjudicate the issue involved was available from sources other than the health record. The patient's privacy interests were also found to be paramount when weighed against the interest in investigating potential criminal fraud in billing where a search warrant was procured for all of the health records of a private health service clinic.³⁰⁶ The records of patients involved with the clinic for weight loss treatment were available on the basis that the information in those records did not involve as weighty a privacy interest as records of psychotherapy.³⁰⁷ Privacy interests of patients were found to sufficiently outweigh the interests of plaintiffs in two other cases involving civil actions in common pleas courts.³⁰⁸

a. Countervailing Constitutional Right to Access to Health Care Information: The Sixth Amendment Right to Confrontation and Compulsory Process of Witnesses

In the preceding sections of this article, I have discussed the extent to which testimonial privileges as reflected in state statutory and constitutional policies restrict the admittance of health care information in legal proceedings. Where the federal Constitution requires that information be made available to a party in litigation, however, disclosure is mandated notwithstanding state legislative or constitutional testimonial policy to the contrary. The federal Constitution by operation of the supremacy clause overrides state policies regarding testimonial privileges even if they are based upon the constitution of the state.

Both the sixth amendment and the due process clause of the fourteenth amendment may provide defendants in criminal pros-

306. *In re "B,"* 482 Pa. at 486-87, 394 A.2d at 426; *Action Mental Health*, 32 Pa. D. & C.3d at 622. For a discussion of *In re "B,"* see *supra* notes 284-91 and accompanying text. For a discussion of *Action Mental Health*, see *supra* notes 297-98 and accompanying text.

307. 32 Pa. D. & C.3d at 620.

308. *Marcelli v. Commonwealth*, 23 Pa. D. & C.3d 600 (1982) (Haverford State Hospital, as custodian of psychiatric records, successfully asserted patient's constitutional rights of privacy to prevent discovery of records in civil action brought against defendant patient); *Stark Dental Assocs., P.C. v. Medical Serv. Ass'n*, 11 Pa. D. & C.3d 699, 702-04 (1978) (personal information in dental records sought for discovery are protected by individuals' right to privacy and, therefore, subject to privilege).

ecutions with access to health care information that is privileged and thus not admissible under state law.³⁰⁹

The sixth amendment right to confrontation may both directly and indirectly affect the scope of testimonial privileges. Confrontation rights may directly affect testimonial privileges by operating to override them. *Davis v. Alaska*,³¹⁰ decided by the United States Supreme Court dramatically demonstrates this. In *Davis*, a state trial judge prohibited defense counsel from questioning a witness because an Alaska state statute made the information sought by the counsel presumptively confidential. The Supreme Court found that the sixth amendment right to confront witnesses testifying against the defendant overrode the state policy of confidentiality in respect to the identity of juvenile defenders.

Sixth amendment confrontation rights may also indirectly affect the scope of testimonial privileges. This occurs when judicial construction of testimonial privileges is influenced by the constitutional policies of confrontation. It is an often-quoted principle of statutory construction in Pennsylvania and elsewhere that legislative enactments should be interpreted with a view that the legislature did not intend to violate the Constitution.³¹¹ Therefore, where the scope of a testimonial privilege is unclear, the court may construe the privilege strictly in criminal prosecutions to

309. For the pertinent text of the sixth amendment, see *supra* note 105.

310. 415 U.S. 308, 320 (1974). The Court held in *Davis* that a defendant's right of confrontation is paramount to any state interest in protecting a juvenile delinquent's records from scrutiny. *Id.* at 320. The Court noted the strong state interest in the juvenile's reputation but decided that "the State's policy . . . cannot yield so vital a constitutional right as the effective cross-examination for bias as an adverse witness." *Id.* For a discussion of *Davis* and its sixth amendment ramifications on confidentiality, see generally Hill, *Testimonial Privilege and Fair Trial*, 80 COLUM. L. REV. 1173 (1980).

311. See *Greene v. McElroy*, 360 U.S. 474 (1959). Chief Justice Warren, speaking for a majority of the Court in not finding that the Secretary of Defense had authority to deprive Greene, an aeronautical engineer, of his security clearance without granting him confrontation rights, stated the matter aptly:

Where administrative action has raised serious constitutional problems, the Court has assumed that Congress or the President intended to afford those affected by the action the traditional safeguards of due process. . . . These cases reflect the Court's concern that traditional forms of fair procedure not be restricted by implication or without the most explicit action by the Nation's lawmakers, even in areas where it is possible that the Constitution presents no inhibition.

Id. at 507-08; see also *Commonwealth v. Cacek*, 338 Pa. Super. 1, 517 A.2d 992 (1986) (interpreting sexual assault counselor testimonial privilege strictly to avoid sixth amendment issue).

avoid running afoul of the confrontation clause of the sixth amendment.

A recent United States Supreme Court decision involving important confidentiality policies in Pennsylvania has clarified the scope of the sixth amendment confrontation clause with respect to state evidentiary or testimonial privileges. In *Pennsylvania v. Ritchie*,³¹² the Supreme Court reversed the Pennsylvania Supreme Court's holding in *Commonwealth v. Ritchie*,³¹³ that the Sixth Amendment right to confrontation and compulsory process gave a defendant the right in the discovery phase of a criminal prosecution, to access to records compiled by a state agency that enjoyed stringent protection of confidentiality under the Child Protective Service Law.

Ritchie was prosecuted and convicted of rape, involuntary deviate sexual intercourse, incest, and corruption of minors. The victim and chief prosecuting witness was his minor daughter.³¹⁴ Ritchie's counsel sought to discover records from the Child Welfare Services in order to impeach the daughter's testimony and develop potential witnesses.³¹⁵ Counsel especially focused on a medical examination of the victim. The agency asserted that the medical examination was not in the file and refused to turn over the file on the basis of the Child Protective Services Law. The trial court reviewed the files and concurred, issuing an order denying access to the records.³¹⁶ On appeal, the superior court agreed with the defendant that the sixth amendment gave him a right to access to information in the record regarding the medical examination of his daughter.³¹⁷ However, the court concluded that the right was limited to disclosure of verbatim statements (or their equivalent) of the complainant concerning child abuse.³¹⁸ Such statements were to be disclosed by the court after in camera inspection of the file.³¹⁹ In addition, the court agreed that the

312. 107 S. Ct. 989 (1987).

313. See *Commonwealth v. Ritchie*, 509 Pa. 357, 502 A.2d 148 (1985), *aff'd in part and rev'd in part*, 107 S. Ct. 989 (1987).

314. *Id.* at 359, 502 A.2d at 149.

315. *Id.* Defendant's counsel argued at a pre-trial conference that the records were necessary to impeach and discredit the complainant and that they might lead to further evidence. *Id.* In particular, counsel sought a medical examination that the Child Welfare Service had performed in conjunction with an investigation into the case. *Id.*

316. *Id.*

317. *Commonwealth v. Ritchie*, 324 Pa. Super. 557, 472 A.2d 220 (1984).

318. *Id.* at 567, 472 A.2d at 225.

319. *Id.* at 567-68, 472 A.2d at 226.

defense counsel would have the entire file available in camera but solely for the purpose of arguing in support of the relevance of the statements.³²⁰

Both parties appealed the superior court ruling to the state supreme court.³²¹ The Commonwealth argued that the records were confidential under the Child Protective Services Law and that the superior court erred in allowing access to the entire file to argue relevance.³²² The defendant argued that the sixth amendment required that access to the entire file be granted so that determinations might be made regarding what information might be useful for preparation of a defense.³²³ The state supreme court agreed with the defendant and found that the Child Protective Services Law did not preclude access to the files when construed in light of confrontation rights.³²⁴ Allowing access to the complete file to defense counsel, the court made it clear that the right of confrontation applied to any material in the record relevant to preparation of a defense and for cross examination.³²⁵

In reversing the Pennsylvania Supreme Court on the confrontation clause issue, the Court was divided. Justice Powell's plurality opinion found that the confrontation clause protected only Ritchie's trial rights and has no applicability to information sought in the discovery phase of a criminal prosecution. Justice Blackmun concurred in the plurality's view that the right to confrontation was not violated by the trial court on the facts of the case, but concluded that in some instances the confrontation clause provided for more than the right to an opportunity to question a witness during trial. In appropriate circumstances Justice Blackmun concluded that the right to effective confrontation

320. *Id.* at 568, 472 A.2d at 226.

321. 509 Pa. at 361, 502 A.2d at 150.

322. *Id.* The Commonwealth further argued that even if the defendant had a sixth amendment right to the statements, the right existed for those statements alone and did not permit the perusal of the entire record by counsel, regardless of the purpose. *Id.*

323. *Id.* Defendant argued that access to the file was his "minimal" sixth amendment right. *Id.*

324. *Id.* The court found most persuasive the sixth amendment necessity of having the record available in order to have it reviewed with the eyes and the perspective of an advocate so as to advance the sixth amendment policy of a full defense. *Id.* at 366, 502 A.2d at 153.

The court further indicated in dicta that even if the law did, as a matter of statutory policy, preclude access to the record, the sixth amendment would provide a right of such access to the defendant. *Id.* at 367, 502 A.2d at 153.

325. *Id.* at 366-67, 502 A.2d at 153.

might require access to information in the discovery phase. He found that in camera inspection of the file by the trial judge to determine if there was "material" evidence satisfied the confrontation clause.³²⁶

In *Ritchie*, the Pennsylvania Supreme Court also suggested that the compulsory process clause of the sixth amendment was violated by not providing Ritchie, through counsel, with access to the record compiled under the Child Protective Service Law.³²⁷ On this question a majority of the Supreme Court disagreed. The majority found that the compulsory process clause did not provide a right to discover the identity of witnesses that was independent of the fourteenth amendment right to fairness under the due process clause.³²⁸

Turning then to the requirements of due process, the majority concluded that the requirement that the government turn over evidence in its possession that is favorable and material to guilt or punishment was satisfied by in camera review by the trial court to determine whether the CYS file contained information that was material to the defense.³²⁹ In so doing the Supreme Court affirmed one feature of the Pennsylvania Supreme Court's opinion in *Ritchie*, namely, to remand the case to the trial court for further proceedings.

Examination of the full impact of *Ritchie* is beyond the scope of this article. It is sufficient to note that *Ritchie* demonstrates that the strongest state policies of confidentiality in respect to health care information may be trumped by fundamental criminal proce-

326. 107 S. Ct. at 1006 (Blackmun, J., concurring). Justices Stevens, Brennan, Marshall and Scalia, dissented on the ground that the state court opinion was not final and therefore the Court did not have appellate court jurisdiction. *Id.* at 1009-10. Only Justices Marshall and Brennan dissented on the Confrontation Clause. *Id.* at 1006-09. They found that the failure to provide Ritchie with access to prior statements of the victim in the file violated the defendant's confrontation rights. *Id.* at 1006. (Brennan, Marshall, JJ., dissenting). They did not agree with the Pennsylvania Supreme Court that defense counsel should have been granted access to the file. *Id.* (Brennan, Marshall, JJ., dissenting).

327. There is not much explicit discussion of the sixth amendment right to compulsory process in the Pennsylvania Supreme Court decision in *Ritchie*. However, the court does rely upon Supreme Court decisions interpreting both the confrontation and compulsory process provisions of the sixth amendment and the dissenting opinion views the majority as grounded on both sixth amendment provisions. 509 Pa. at 365-71, 502 A.2d at 152-55. The Supreme Court thought the compulsory process provision was sufficiently referred to in the opinion to address the compulsory process issue on appeal in *Ritchie*.

328. 107 S. Ct. at 1001.

329. *Id.*

dure confrontation and due process rights under the federal constitution.

The extent to which confrontation and due process rights will override state policies of confidentiality in criminal prosecutions after *Ritchie* will depend upon a fact specific assessment of whether the interests in a fair trial with opportunity to prepare and conduct a defense and cross examination outweigh the state's interest in confidentiality.

The Pennsylvania Supreme Court's broader view of sixth amendment confrontation and compulsory process rights may surface at a later date if the court interprets the state constitution to provide for a broad right of access to health care information that might be useful in preparation for trial, and examination of witnesses.³³⁰

E. *General Defenses to Testimonial Privileges in Pennsylvania: Express and Implied Waiver*

As a personal right, the testimonial privilege may be waived by the patient or client. A waiver to be effective must be knowingly, intelligently and voluntarily made.³³¹ The waiver may be expressly communicated, either verbally or in writing. Generally, express waivers are quite expansive. They include access to health information for determining eligibility for insurance, claims for reimbursement and subsequent litigation between the insured and insurer.³³²

In addition, actions by clients or patients in initiating or responding to litigation may be viewed as an implied waiver of a testimonial privilege. Some jurisdictions refer to preclusion of assertion of the privilege as the litigant exception to testimonial

330. The Pennsylvania Supreme Court has interpreted provisions in the state constitution to provide for greater procedural rights in criminal trials than provided for by the Supreme Court in interpreting procedural rights under the federal constitution. *See, e.g.*, *Commonwealth v. Sell*, 50 Pa. 46, 470 A.2d 457 (1983).

331. *See Roberts v. Superior Court*, 9 Cal. 3d 330, 343, 508 P.2d 309, 317, 107 Cal. Rptr. 309 (1973) (waiver of psychotherapist-patient privilege by patient must be voluntary and knowing act done with sufficient awareness of relevant circumstances and likely consequences); *State v. Olsen*, 271 Or. 369, 378-79, 532 P.2d 230, 234 (1975) (conduct which manifests waiver of doctor-client privilege must be done with intent to waive). For a discussion of waivers, see *supra* notes 119-24 and accompanying text.

332. *See San Francisco v. Superior Court*, 37 Cal. 2d 227, 233, 231 P.2d 26, 29 (1951) (failure to exercise privilege results in waiver).

privileges.³³³ The extent to which a testimonial privilege is lost by involvement in litigation will vary. Some jurisdictions adopt a broad notion of waiver and essentially view the action of litigation itself as a waiver of the privilege.³³⁴ Other jurisdictions narrowly view the involvement of the patient in litigation as constituting an implied waiver of a testimonial privilege. Pennsylvania appears clearly to be in the latter category.³³⁵ In Pennsylvania, the cases do not recognize a litigant exception as such, but rather view each case individually, and on the basis of legislative policies and principles of waiver, determine whether the privilege is available.

1. *Legislatively Created Litigant Exceptions to Privileges*

If legislation protecting the confidentiality of health care information through a testimonial privilege exempts certain legal proceedings from coverage under the statute, a litigation exception is built into the confidentiality policy initially. The physician-patient testimonial privilege statute explicitly states the privilege is not applicable to personal injury actions brought by the patient. This is also the case under the Mental Health Procedure Act, which excepts from its confidentiality policies "a court in the course of legal proceedings authorized by this Act."³³⁶ Where commitment proceedings are initiated pursuant to the Act, then the testimony of health care practitioners may be compelled over the objection of the patient or client even though a privilege would attach to such testimony in other legal proceedings.³³⁷

333. For a discussion of the litigant exception to testimonial privileges, see *supra* notes 123-24 and accompanying text.

334. See *Weis v. Weis*, 147 Ohio St. 416, 430, 72 N.E.2d 245, 252 (1947) (calling doctor to testify at trial concerning all matters in hospital records constituted waiver of any privilege pertaining to records); C. McCORMICK, *supra* note 108, § 100; Annotation, *supra* note 128. For a discussion of the litigant exception, see *supra* notes 123-24 and accompanying text.

335. See *Goldblum*, 498 Pa. at 463-64, 447 A.2d at 239; *Commonwealth v. Edwards*, 318 Pa. 1, 7, 178 A. 20, 23 (1935) (patient's communications to jailhouse doctor not privileged). For a discussion of *Goldblum*, see *supra* notes 197-98 and accompanying text.

336. PA. STAT. ANN. tit. 50, § 7111(3) (Purdon Supp. 1986). For text of physician-patient privilege statute, see *supra* note 139. See also *Dennie v. University of Pittsburgh School of Medicine*, 638 F. Supp. 1005 (W.D. Pa. 1986) (implied waiver of privilege from earlier personal injury action held to be defense to subsequent breach of confidentiality action); *Miller v. Colonial Refrigerated Transp., Inc.*, 81 F.R.D. 741 (M.D. Pa. 1979) (holding statute applies to psychiatric records of patient).

337. See *Commonwealth ex rel. Platt v. Platt*, 266 Pa. Super. 276, 286, 404 A.2d 410, 414-15 (1979) (testimony of patient's psychiatrist in involuntary commitment proceeding not privileged for lack of blackening effects on patient's character).

The facial inconsistency between the testimonial privilege statutes and the exemption in the Mental Health Procedure Act has been resolved in the superior court by viewing the Act as superceding the testimonial privilege statute. In *Commonwealth ex rel. Platt v. Platt*,³³⁸ the court affirmed a common pleas court's admission of the testimony of a treating psychiatrist over a patient's objection in a commitment proceeding under the Act.³³⁹ The court applied two principles that have developed under the Statutory Construction Act to reach its conclusion.³⁴⁰ When a statute is in conflict with another statute, the one enacted later in time is given preference over the former.³⁴¹ In the case of conflicting statutes, one with a specific provision that addresses the issue before the court has also been found to be determinative.³⁴² In the case of a conflict between testimonial privileges provided to psychologists or psychiatrists and the Mental Health Procedure Act, both principles coalesce to warrant, as the *Platt* court decided, that preference be given to the Mental Health Procedure Act.³⁴³

The litigant exception in the Mental Health Procedure Act has been strictly construed. When termination proceedings were brought against an employee of a mental health institution for physical abuse of a patient, a commonwealth court in *Kakas v. Commonwealth Department of Public Welfare*,³⁴⁴ held that the exception in the Act was not applicable because the proceedings were not initiated pursuant to the Act.³⁴⁵ Although patients testified against the employee, confidentiality policies in the Act properly

338. 266 Pa. Super. 279, 404 A.2d 410 (1979).

339. *Id.* at 289-90, 404 A.2d at 414-15. The court noted that the information sought was not the type that would blacken the patient's character nor was it "communications" within the statutory definition, and thus no privilege was warranted. *Id.* at 285, 404 A.2d at 415.

340. *Id.* at 284-85, 404 A.2d at 415-16. The Statutory Construction Act is codified at 1 PA. CONS. STAT. ANN. app. § 1933 (Purdon 1986).

341. 1 PA. CONS. STAT. ANN. app. § 1935 (Purdon 1986) (providing that later general provisions shall control earlier specific, irreconcilable provisions passed by same assembly; likewise, irreconcilable provisions passed by different assemblies).

342. *Id.* § 1933.

343. *Platt*, 266 Pa. Super. at 287, 404 A.2d at 416; *see also* Borough of Millersville v. Lancaster Township, 2 Pa. Commw. 587, 592, 279 A.2d 349, 350-51 (1971) (language in statute broader than Constitution and thus controlling).

344. 65 Pa. Commw. 550, 442 A.2d 1243 (1982).

345. *Id.* at 553 n.1, 442 A.2d at 1244 n.4. The court reasoned that no exceptions applied "since (1) the hearing before the Commission was not a legal proceeding authorized by the Mental Health Procedure Act and (2) petitioner sought a personal examination of the records." *Id.* The statute required either the release to a treating professional or a court engaged in certain legal proceedings. *Id.*; *see* PA. STAT. ANN. tit. 50, § 7111 (Purdon Supp. 1986).

precluded access to the patients records by the employee in the termination proceeding.³⁴⁶

2. *The Litigant Exception: Implied Waiver from Participating in Litigation*

Where the appellate courts have dealt with the effect of client or patient participation in legal proceedings on the vitality of a testimonial privilege, waiver principles have been utilized. As a consequence, where a patient or client has not expressly waived the privilege, it remains intact, unless the patient or client has voluntarily brought the question of his or her mental or physical condition into the litigation.

In only one appellate court decision was waiver implied from a patient's involvement in litigation, and in that instance the patient had voluntarily introduced his health records into the case. He was thus found to have waived his right to the testimonial privilege when the prosecution sought to cross-examine the custodian of the records.³⁴⁷

In other cases where patients or clients have not voluntarily brought the issue of their mental condition into a lawsuit, although they were parties in criminal or civil proceedings, no waiver was found. This was the case, for example, when the patient was a witness for the prosecution, and defense counsel attempted to introduce testimony of his psychologist for impeachment purposes.³⁴⁸ Similarly, a defendant was found not to have waived the privilege when the plaintiff sought production of defendant's medical records.³⁴⁹ Finally, in a custody proceed-

346. 65 Pa. Commw. at 552, 442 A.2d at 1244.

347. See *Commonwealth v. El*, 273 Pa. Super. 1, 416 A.2d 1058 (1979). In *El*, the superior court allowed the prosecutor to cross-examine the custodian of his records at a drug treatment center, despite a Pennsylvania statute which states that drug and alcohol treatment records may not "be used to initiate or substantiate criminal charges against a defendant under any circumstances." *Id.* at 12-13, 416 A.2d at 1064. This was permitted because the defendant had brought the records into the courtroom and had questioned the head of a methodone clinic. *Id.* at 13, 416 A.2d at 1064. The court stated: "It would not be proper to disallow the district attorney to cross-examine [the custodian] and to review the other records which he had with him at that time." *Id.*; see also *Commonwealth v. Flynn*, 314 Pa. Super. 162, 175, 460 A.2d 816, 817 (1983) (privilege denied where insanity defense raised by patient) (dicta).

348. *Commonwealth v. Garcia*, 478 Pa. 406, 426, 387 A.2d 46, 56 (1978) (counsel for defense could not impeach prosecution witness' psychologist since patient had made no waiver).

349. *Stark Dental Assocs., P.C. v. Medical Serv. Ass'n*, 11 Pa. D. & C.3d 699, 702-04 (1978) (dental records protected by privilege, and litigation exception inapplicable).

ing, a husband could properly assert a testimonial privilege with respect to his psychiatrist because the privilege had not been expressly waived, and the court found that a stipulated agreement to participate in counseling did not constitute an implied waiver of the privilege.³⁵⁰

The Pennsylvania appellate court cases that have directly or indirectly dealt with implied waiver as a result of participation have limited the notion to cases where patients or clients have voluntarily brought the precise issue of their physical or mental conditions into the lawsuit.³⁵¹ Participation as a defendant or witness has properly not been viewed as sufficient to waive rights to a testimonial privilege. There is no litigation exception as such in Pennsylvania. Instead each case is viewed on its facts to determine whether the plaintiff's actions are sufficient to constitute an in-fact voluntary waiver of the privilege.³⁵²

F. *The Need for Legislative Reform*

Statutorily based testimonial privilege law in Pennsylvania badly needs to be revised. Testimonial privileges involve difficult legislative choices as to when privacy and preservation of the integrity of the health care relationship ought to outweigh truth-seeking policies. These choices need to be both comprehensive and coherent. The present legislative scheme is neither. Perhaps the most glaring anomalies are found in the legislative treatment of psychotherapy and counseling for mental illness.

The privilege for physicians and psychiatrists is unique in our legal system in its limited scope.³⁵³ Virtually all of the communications and information acquired in psychotherapy provided by patients to psychiatrists is not privileged. Yet the nature of such information provides the most powerful arguments for confidentiality. Psychologists are subject to a different statutory privilege that is broader in scope.³⁵⁴ However, the psychologist-client testimonial privilege is statutorily equated with the attorney-client

350. *Romanowicz v. Romanowicz*, 213 Pa. Super. 382, 386, 248 A.2d 238, 240 (1968) (stipulation must contain express waiver of patient-physician privilege to be effective).

351. For a discussion of Pennsylvania courts' treatment of the litigant exception to testimonial privilege, see *supra* notes 121-22 and accompanying text.

352. See *supra* notes 121-22 and accompanying text.

353. For a discussion of the physician-patient privilege as applied to psychiatrists, see *supra* notes 138-77 and accompanying text.

354. For a discussion of the psychologist-patient privilege, see *supra* notes 178-211 and accompanying text.

privilege. Yet the bundle of rights and duties, loyalties and goals of the lawyer-client and health care practitioner-client relationship are quite different.³⁵⁵ These differences are sufficient to raise doubt as to whether the psychologist testimonial privilege would attach to group or intra-family therapy. Professional social workers that do psychological counseling or therapy are not protected by a privilege. The testimonial privileges in Pennsylvania provided to rape counselors and to counseling of students in schools are the broadest in scope of all the legislatively granted testimonial privileges in Pennsylvania.³⁵⁶ Information acquired in the counseling of a student by all school personnel, including teachers and nurses, has much greater confidentiality than information acquired in psychotherapy with a psychiatrist. If a social worker is counseling in school, there is a broad privilege, but that same social worker doing group or individual therapy in private practice or in a mental health facility is not provided with a testimonial privilege. A psychiatrist counseling in schools engaged in talk therapy enjoys legal protection for most of the health care information that is exchanged as part of the service. When that same psychiatrist performs therapy in private practice to troubled children or adults, virtually none of the communications between the patient and therapist are privileged.

Recognition of a testimonial privilege based upon a patient's or client's constitutional right of privacy by the Pennsylvania Supreme Court is a significant development.³⁵⁷ The existence of the privilege has now been firmly established in case law. It is most appropriate that the Pennsylvania Supreme Court should be at the biting edge of our legal system in protecting patient and client privacy in health care information. Appellate courts in Pennsylvania have been bullish in protecting privacy in torts, criminal procedure and constitutional law for decades. One of the important and special features of the Pennsylvania legal system is that it views privacy as one of its enduring and fundamental values.

As lawyers representing health care facilities and health care practitioners continue to raise the privilege in response to subpoenas for health records and testimony, the parameters of the

355. For a discussion of the difficulties in analogizing the two privileges, see *supra* notes 190-211 and accompanying text.

356. For a discussion of these privileges, see *supra* notes 212-29 and accompanying text.

357. For a discussion of the constitutionally based privilege, see *supra* notes 271-308 and accompanying text.

constitutional privilege will become clearer. Presently, lawyers representing health care facilities and patients or clients have the clear option of raising the privilege where health care information is sought as part of legal proceedings and the patient or client objects to disclosure or is not available to consent to disclosure of the information.³⁵⁸ Given the ethical standards of health care professionals about confidentiality, in most cases where health care information is sought, lawyers may have an ethical and legal duty to assert the constitutional privilege on behalf of a non-consenting or unavailable patient or client. When the privilege is raised, courts are required to weigh the privacy of the patient or client with the need for the information in the legal proceedings.³⁵⁹ Where the interests pursued in the legal action may be furthered without disclosure of all or part of the information sought, the privilege would operate to bar disclosure of testimony or information in health records.

The constitutional privilege provides courts with an opportunity to develop a proper accommodation of the important conflicting values that are at stake when health care information is sought in legal proceedings. The availability of a comprehensive testimonial and evidentiary privilege in Pennsylvania goes a long way toward responding to some of the most glaring gaps in Pennsylvania legislation providing for testimonial privileges for health care practitioners. This is especially the case with information acquired in psychotherapy and counseling with psychiatrists and social workers, where the constitutional privilege will do much to protect confidentiality. As a constitutional concept, however, the constitutional privilege is not an ideal vehicle for dealing with confidentiality issues. The privilege is implemented with a weighing of interest analysis that effectively dictates that the scope of the testimonial privilege be determined on a case-by-case basis. Therefore, duties and rights will not generally be known in advance of litigation. Raising the privilege is costly both in terms of legal fees and protracted litigation, especially where there are appeals.

Clearer understanding of rights and duties and a more efficacious resolution of confidentiality questions would occur if the state legislature were to revise legislation providing for testimo-

358. For a discussion of the right of persons other than the patient or client to raise the privilege, see *supra* notes 295-97 and accompanying text.

359. For a discussion of this balancing test, see *supra* notes 302-08 and accompanying text.

nial privileges for health care professionals and their clients and patients. Such revisions should include comprehensive coverage of health care practitioners in terms of at least a limited testimonial privilege in some circumstances. Beyond that, current legislation reflects the judgment that certain kinds of health care information and relationships warrant greater protection with extended evidentiary and testimonial privileges. Much legislation suggests that this is the case with information about drug and alcohol treatment and treatment for mental illness.³⁶⁰ These judgments ought to carry over to all health care professions that are involved with drug and alcohol treatment or treatment for mental illness. In Pennsylvania and nationally, there is a clear pattern of the legislature not responding with comprehensive legislation, despite thoughtful and repeated calls to do so by commissions that have been assigned to study and make recommendations about various aspects of the special problems with confidentiality and health care information. In the interim, the constitutional testimonial privilege in Pennsylvania provides lawyers, patients and clients with an invaluable tool for protecting the confidentiality of health care information.

IV. DAMAGE REMEDIES FOR UNAUTHORIZED EXTRA-LEGAL DISCLOSURE OF HEALTH CARE INFORMATION

As previously discussed, the basic legal vehicle for protecting the confidentiality of health care information when such information is sought as part of legal proceedings are testimonial or evidentiary privileges.³⁶¹ Patients, clients and health care practitioners are also concerned with keeping health care information confidential and non-public when it is sought outside of legal proceedings. The range of situations in which health care information is disclosed is enormous. At one end of the spectrum are circumstances in which there is no discernible societal value fur-

360. For a discussion of the privilege granted in these situations, see *supra* notes 254-65 and accompanying text. See Knapp, VandeCreek & Zirkel, *Privileged Communications for Psychotherapists in Pennsylvania: A Time for Statutory Reform*, 60 TEMP. L.Q. 267, 269-75 (1987) (where the authors argue that there is a stronger case for testimonial privileges for psychotherapists than physicians). The authors suggest that Pennsylvania adopt a variation of Proposed Rule 504 of the Federal Rules of Evidence which would provide for a testimonial privilege for psychotherapists. Proposed Rule 504 was drafted by the Advisory Committee on the Federal Rules of Evidence but was never adopted by Congress but has heavily influenced legislation enacting a psychotherapist testimonial privilege in some states. See *id.* at 290.

361. For a discussion of these privileges, see *supra* notes 101-352 and accompanying text.

thered by disclosure. Examples of this might be gossip at a social gathering about someone's medical history or disclosure of treatment for purposes of blackmail or extortion. At the other end of the spectrum are circumstances in which important societal values might be furthered by disclosure. This would be the case where the information was sought for research or to evaluate the qualifications of certain applicants for employment.

Are damages or injunctive relief available to patients and clients in Pennsylvania for the unauthorized extra-legal disclosure of health care information? There is no square holding at the appellate court level in Pennsylvania granting damage relief for disclosure of health care information. However, there are several reasons why it is likely that the appellate courts in Pennsylvania would recognize a cause of action for the unauthorized extra-legal disclosure of such information. First, nearly all of the appellate courts in other jurisdictions that have been presented with the question have recognized a cause of action for disclosure.³⁶² Second, Pennsylvania has strong policies in respect to the protection of health care information. As has been pointed out in the previous sections, these policies are grounded not only in statutory law, but are also part of the state's constitutional policies.³⁶³ Many of the jurisdictions that have recognized the cause of action for unauthorized disclosure of health care information have done so under much less favorable confidentiality policies. Third, Pennsylvania has recognized privacy rights to a greater extent than most jurisdictions.³⁶⁴ Finally, there is strong dicta supporting a cause of action for unauthorized disclosure in the only Pennsylvania appellate court decision that has considered the

362. For a list of these jurisdictions, see *infra* note 408.

363. For a discussion of these policies, see *supra* notes 249-62 & 267-308 and accompanying text.

364. For some examples of the Pennsylvania Supreme Court's expansive view of constitutional privacy rights, see *Denoncourt v. Commonwealth of Pa. Ethics Comm'n*, 504 Pa. 191, 470 A.2d 945 (1983) (disclosure requirements of Ethics Act violate constitutional right to privacy) (plurality opinion); *Commonwealth v. Sell*, 504 Pa. 46, 470 A.2d 457 (1983) (adopting expansive standing rule to object to evidence seized in violation of rights of privacy by illegal searches and seizures); *Commonwealth v. Bonadio*, 490 Pa. 91, 415 A.2d 47 (1980) (holding prosecution under the Pennsylvania Voluntary Deviate Sexual Intercourse Act unconstitutional); *Commonwealth v. De John*, 486 Pa. 32, 403 A.2d 1283 (1979) (bank customer has legitimate expectation to privacy in bank records); *Bennett v. Norban*, 396 Pa. 94, 151 A.2d 476 (1959) (battery and humiliation of suspected shoplifter violation of right of privacy); *In re Mack*, 386 Pa. 251, 126 A.2d 679 (1956) (surreptitious photographing of felon violated tort right of privacy).

question.³⁶⁵

Assuming that Pennsylvania courts would recognize a cause of action, the jurisprudence developed in other jurisdictions might be a source of guidance for the Pennsylvania courts to the extent that this law is consistent with Pennsylvania confidentiality policies.

A. *Legal Theories*

There are several legal theories that appellate courts have utilized in recognizing a cause of action for damages against the person who discloses health care information without the authorization of the patient or client. Ironically, in most jurisdictions, the tort right of privacy is not an effective tool for protecting confidentiality. This may not be the case in Pennsylvania in view of a recent appellate court opinion that applies the right of privacy in an expansive way so that it may apply to disclosure of health care information.³⁶⁶

1. *The Tort Right of Privacy*

The basic framework for tort remedies for invasions of privacy has been largely influenced by the late Dean Prosser. In a 1960 article,³⁶⁷ and later in his handbook on torts,³⁶⁸ Prosser developed a system for categorizing 400 appellate court decisions involving privacy. This system was adopted by the *Restatement (Second) of Torts* and has been embraced as a general matter in Pennsylvania and most other jurisdictions.³⁶⁹ The Prosser system

365. *Alexander v. Knight*, 197 Pa. Super. 79, 177 A.2d 142 (1962); *Clayman v. Bernstein*, 38 Pa. D. & C. 543 (1940). The court in *Knight* stated:

We are of the opinion that members of a profession, especially the medical profession, stand in a confidential or fiduciary capacity as to their patients. They owe their patients more than just medical care for which payment is exacted; there is a duty of total care; that includes and comprehends a duty to aid the patient in litigation, to render reports when necessary and to attend court when needed. That further includes a duty to refuse affirmative assistance to the patient's antagonist in litigation. The doctor, of course, owes a duty to conscience to speak the truth; he need, however, speak only at the proper time.

197 Pa. Super. at 80, 177 A.2d at 146.

366. *Harris v. Easton Publishing Co.*, 335 Pa. Super. 141, 483 A.2d 1377 (1984). For a discussion of this case, see *infra* notes 386-401 and accompanying text.

367. Prosser, *Privacy*, 48 CALIF. L. REV. 383 (1960).

368. W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* (4th ed. 1971).

369. *RESTATEMENT (SECOND) OF TORTS* §§ 652 B, C, D, E (1976). For the law of Pennsylvania, see *Wells v. Thomas*, 569 F. Supp. 426 (E.D. Pa. 1983); *Marks v. Bell Tel. Co. of Pa.*, 460 Pa. 73, 331 A.2d 424 (1975); *Vogel v. W.T.*

has been aptly described as the variegated tort theory of privacy.³⁷⁰ Prosser's view was that the cases did not represent a single tort of privacy, but rather four torts that protect four different interests having nothing in common except a general protection of the plaintiff against the right to "be let alone." Prosser identified the four torts as (1) appropriation, (2) intrusion, (3) public disclosure of private facts and (4) false light.³⁷¹

It is commonplace in appellate court opinions in many jurisdictions, including Pennsylvania, to adopt this organization in a privacy tort case. There has been considerable controversy about the usefulness of viewing the right of privacy in this way. There is also considerable debate as to whether the appropriation and false light torts involve privacy at all.³⁷² Prosser himself encouraged this view. The appropriation tort is limited to the use of name or likeness for commercial or personal gain, and the false light tort essentially protects one's interest in reputation.³⁷³ The public disclosure and privacy intrusion torts do protect one's interest in limiting who shall have access to personal and intimate information about them and are very relevant to tort protection in Pennsylvania against the unauthorized acquisition and disclosure of health care information.

The privacy intrusion tort provides effective protection against individuals who, without authorization, acquire information from health records. To recover under the intrusion tort there must be a demonstration that the defendant intruded into the private affairs of the plaintiff by a method that would be offensive to a person of ordinary sensibilities.³⁷⁴ Information in health records would be a core example of private affairs within the

Grant Co., 458 Pa. 124, 327 A.2d 133 (1974); *Nagy v. Bell Tel. Co. of Pa.*, 292 Pa. Super. 24, 436 A.2d 701 (1981). Although the final draft of the *Restatement (Second)* has not been formally adopted by the Supreme Court of Pennsylvania, it is viewed by both state and federal courts as part of Pennsylvania law. See *Wells*, 569 F. Supp. at 426; *Martin v. Municipal Publications*, 510 F. Supp. 255 (E.D. Pa. 1981); *Harris v. Easton Publishing Co.*, 335 Pa. Super. 141, 483 A.2d 1377 (1984); *Nagy*, 292 Pa. Super. at 27, 436 A.2d at 701.

370. See, Gerety, *Redefining Privacy*, 12 HARV. C.R.C.L. REV. 233, 246-47 (1977).

371. Prosser, *Privacy*, *supra* note 367, at 389.

372. See generally Bloustein, *Privacy As An Aspect of Human Dignity: An Answer to Dean Prosser*, 39 N.Y.U. L. REV. 962 (1964); Gerety, *supra* note 370.

373. See RESTATEMENT (SECOND) OF TORTS § 652C (1976) (appropriation privacy tort); *id.* § 652E (false light privacy tort).

374. This much is clear from the text of section 652B (the privacy intrusion tort):

One who intentionally intrudes, physically or otherwise, upon the solitude or seclusion of another or his private affairs or concerns, is subject

meaning of this tort. Where the health record is examined or acquired by methods such as breaking into a computer bank or other surreptitious activity, a cause of action would clearly be available, because the method of acquiring the health care information would be offensive within the meaning of this tort.³⁷⁵ Under joint tortfeasor principles in tort, a cause of action would also be available against those persons who conspired with the person who directly acquired the health care information by infiltrating the health record.

The "offensive means" requirement of the tort would mean that a cause of action would not likely be available in instances where authorized persons showed a health record to unauthorized persons, where they did so in good faith and the unauthorized person did not misrepresent facts or their intentions, and where the person had good reasons for acquiring the information.³⁷⁶ If a custodian of health records turned records over to counsel who requested them in conjunction with a lawsuit, the lawyers would not be subject to liability under the intrusion tort unless they misrepresented themselves to the custodian.³⁷⁷ A cause of action might be available in these circumstances against the lawyers on one of the non-privacy tort theories to be discussed in the following section.³⁷⁸

Where health care information has been acquired by means that are not offensive, and is subsequently published, tort privacy remedies may be of limited application. The public disclosure tort would be invoked in such situations, and would require that private information be published to the public generally. The published information must be such that a person of ordinary sensibilities would find highly offensive if it were published about

to liability to the other for invasion of his privacy, if the intrusion would be highly offensive to a reasonable person.

RESTATEMENT (SECOND) OF TORTS § 652B (1976).

375. The surreptitious taking of pictures of someone in a private place is actionable under this tort. *See, e.g.*, *Dieteman v. Time, Inc.*, 449 F.2d 245 (9th Cir. 1971); *In re Mack*, 386 Pa. 251, 126 A.2d 979 (1956); *Clayman v. Bernstein*, 38 Pa. D. & C. 543 (1940). Information in health records would clearly be the "private affairs" of the patient or client for purposes of the intrusion tort. *See* RESTATEMENT (SECOND) OF TORTS § 652B comments a & b (1976).

376. *See Harris v. Easton Publishing Co.*, 335 Pa. Super. 141, 154, 483 A.2d 1377, 1383 (1984) (no intrusion on seclusion where newspaper published facts about plaintiff it received unsolicited from authorized custodian of welfare records).

377. *See id.* at 153-54, 483 A.2d at 1383-84.

378. For a discussion of these theories, see *infra* notes 402-10 and accompanying text.

him.³⁷⁹ Since the tort is available even though the published information is true, strong first amendment interests are generally at stake when claims are brought under the public disclosure tort. These first amendment concerns are reflected in the requirement that the plaintiff demonstrate that the publication was not newsworthy and not of legitimate public concern. Several Pennsylvania appellate court decisions have indicated that dissemination of information to an individual or small group of persons is not actionable under the public disclosure tort.³⁸⁰ So, for example, disclosure to unauthorized health care practitioners or personnel, or at a social affair, would not be actionable.

Even if there is general dissemination of health care information, the lack of public concern or newsworthiness requirements of the tort severely limits the circumstances under which recovery would be available. Two lines of authority have developed regarding the scope of the public concern and newsworthiness dimensions of the public disclosure tort. One line of authority views these liability limiting concepts expansively. These jurisdictions view the legitimate public concern concept as an embodiment of the first amendment principle that editors should have the right to decide what the public is interested in knowing. Under this view, letting judges or juries decide whether the public has an interest in knowing about true information that is published creates excessive self-censorship and violates the principle of editorial discretion. The result, under this approach, is an almost total evisceration of the public disclosure tort.³⁸¹ Other jurisdictions take a more restrictive view of what kinds of

379. Section 652D of the *Restatement (Second)* provides:

One who gives publicity to a matter concerning the private life of another is subject to liability to the other for invasion of his privacy, if the matter is of a kind that

(a) would be highly offensive to a reasonable person, and
(b) is not of legitimate concern to the public.

RESTATEMENT (SECOND) OF TORTS § 652D (1976).

380. See *Wells v. Thomas*, 569 F. Supp. 426 (E.D. Pa. 1983) (public disclosure tort unavailable where hospital staff member disclosed information concerning plaintiff's work performance at hospital to other staff members, because disclosure did not amount to "publicity"); *Vogel v. W.T. Grant*, 458 Pa. 124, 327 A.2d 133 (1974) (public disclosure tort unavailable where plaintiff's creditor disclosed fact that plaintiff's accounts were in arrears to plaintiff's employer and a few relatives).

381. See *Sidis v. F-R Publishing Corp.*, 113 F.2d 806 (2d Cir. 1940) (plaintiff who was "public figure" ten years before defendant newspaper published information about his current, secluded life lost his absolute right to privacy, and mere passage of time did not restore him to private-figure status); *Rawlins v. Hutchinson Publishing Co.*, 218 Kan. 295, 543 P.2d 988 (1975) (person who is a "public official" waives right to privacy as to any conduct pertaining to his fitness

information the public has legitimate concerns about. These courts view the concept as being within the competence of judges and juries to apply even in the face of serious first amendment considerations.³⁸²

Under either of the approaches to the public concern or newsworthy principle, information that is part of the records of contemporary judicial proceedings would not be actionable under the public disclosure tort.³⁸³ Those jurisdictions taking a stricter view might allow tort recovery of information that is part of records of judicial proceedings if the information is about a private individual, is not contemporary and the jury concludes that publication constitutes an unwarranted invasion of the person's privacy.³⁸⁴

Because Pennsylvania apparently follows the strict view of

for that office, even if 10 years have passed since time conduct occurred); see generally B. SANFORD, *LIBEL AND PRIVACY* §§ 11.3.3, 447 (Prentice Hall 1987).

382. See *Briscoe v. Reader's Digest Ass'n*, 4 Cal. 3d 529, 483 P.2d 34, 93 Cal. Rptr. 866 (1971) (trier of fact must determine whether plaintiff's public-figure status as criminal 11 years ago was such that his private status was not restored at time newspaper defendant published information about past crime); *Roshto v. Hebert*, 413 So. 2d 927 (La. Ct. App. 1982) (newspaper held to have invaded plaintiff's privacy when it published article concerning crime plaintiff committed 25 years ago, after plaintiff had become law-abiding citizen).

383. See *Cox v. Cohn*, 420 U.S. 469 (1975). In *Cox*, the United States Supreme Court held that a cause of action for invasion of privacy did not lie against a television station or reporter when they broadcasted the name of a rape victim which the reporter obtained from judicial records that were open to public inspection. In reaching its holding, the Court stated:

By placing the information in the public domain on official court records, the state must be presumed to have concluded that the public interest was thereby being served [A] public benefit is performed by the reporting of the true contents of the records by the media. The freedom of the press to publish that information appears to us to be of critical importance to our type of government in which the citizenry is the final judge of the proper conduct of public business.

Id. at 495.

384. See *Briscoe v. Reader's Digest Ass'n*, 4 Cal. 3d 529, 483 P.2d 34, 93 Cal. Rptr. 866 (1971). In *Briscoe*, the Reader's Digest published a story of plaintiff's criminal activity which occurred 11 years prior to publication. Legal proceedings concerning the crime had already concluded, and plaintiff had once again become "an anonymous member of the community." *Id.* at 538, 483 P.2d at 43, 93 Cal. Rptr. at 875. The Supreme Court of California reversed the lower court's dismissal of plaintiff's action, and remanded for the trier of fact to determine:

(1) whether plaintiff had become a rehabilitated member of society, (2) whether identifying him as a former criminal would be highly offensive and injurious to the reasonable man, (3) whether defendant published this information with a reckless disregard for its offensiveness, and (4) whether any independent justification for printing plaintiff's identity existed.

Id. at 543, 483 P.2d at 44, 93 Cal. Rptr. at 876.

the newsworthiness concept,³⁸⁵ the public disclosure tort may be available in some instances where there is general dissemination of health care information. This view was recently demonstrated in *Harris v. Easton Publishing Co.*³⁸⁶ where a cause of action for the invasion of privacy was sustained on a pleadings motion against a newspaper for publishing information about the plaintiff that was contained in records maintained by a state welfare agency.³⁸⁷ *Easton* is a significant decision for two reasons. First, the cause of action under the public disclosure tort of privacy was available even though the plaintiff and her family were not specifically mentioned in the article.³⁸⁸ The court concluded that the publication contained sufficiently distinct details for someone who knew the plaintiff to identify the plaintiff and her family as the subject of the newspaper column.³⁸⁹ The *Easton* court's position on this question is eminently sound. Where a publication contains details about an unnamed person that are peculiar to that person, the invasion of privacy is as great as if the person was named. There is no valid reason to immunize the media from liability under the public disclosure tort for disclosure of intimate information about someone where the subject is clear from the text simply because names were not utilized in the story line.³⁹⁰

385. See *Aquino v. Bulletin Co.*, 190 Pa. Super. 528, 533-34, 154 A.2d 422, 426 (1959).

386. 335 Pa. Super. 141, 483 A.2d 1377 (1984).

387. *Id.* at 148-49, 483 A.2d at 1388. Plaintiff filled out an application for medical assistance and food stamps, but refused to sign the application and subsequently withdrew it. *Id.* at 149, 483 A.2d at 1381. Plaintiff decided not to apply because she did not want the caseworker to photocopy certain documents, and because there was some question regarding household size and the income of her son. *Id.* Plaintiff discussed her difficulties in applying for benefits with an employee for the Department of Public Welfare. *Id.* The Department used plaintiff's story, after altering some facts and fictionalizing the account of plaintiff's inquiry, as a public interest story by sending it to various newspapers which published such stories for the Department. *Id.* The purpose of the column was to create better public understanding of the Department's operations and available services. *Id.*

388. *Id.*

389. *Id.* at 157, 483 A.2d at 1385. The court said:

The fact that the complainant was not specifically named in a defamatory publication or utterance does not prevent recovery in a libel action. In such circumstances, the court must initially decide whether the defamatory material was capable of being reasonably understood as intended to refer to complainant. The same analysis should be accorded to an alleged tort action pursuant to section 652D of the Restatement, regarding the element of publicity.

Id. (citations omitted).

390. As noted by the *Easton* court, by pleading inducement and colloquium, a plaintiff in a defamation action may introduce facts extrinsic to the publication to establish that the utterance was "of and concerning" the plaintiff within the

Second, *Easton* is most significant because of the court's generous interpretation of the scope of the public disclosure tort and the court's narrow view of the extent to which the public had a legitimate public concern in the welfare information in the case. In *Cox Broadcasting Corp. v. Cohn*,³⁹¹ the United States Supreme Court interpreted the first amendment as providing a qualified constitutional defense in public disclosure tort cases for information contained in a public record.³⁹² *Cox* involved publication of a rape victim's name by a television station several months after the crime was committed.³⁹³ The Court held that the first amendment prohibited the granting of damages in a privacy tort action for publication of information contained in court records.³⁹⁴ Some courts have extended the *Cox* decision beyond its facts and have viewed it as immunizing the media from liability for all information found in court records regardless of the vintage of the information.³⁹⁵ Other courts have limited *Cox* to its facts and have allowed a cause of action for information found in court records where considerable time has elapsed and the publication constitutes a serious invasion of privacy.³⁹⁶

The *Easton* court correctly distinguished the welfare records that were the source of the information in that case from the public court records in *Cox*.³⁹⁷ Noting that welfare regulations limit access to welfare records and specifically protect the confidentiality of some of the information in those records, the *Easton* court concluded that the information was private and that the offensive-

meaning of the tort. *Id.* at 156-57, 483 A.2d at 1385. Defamation and the public disclosure tort protect different interests: the former, reputation, the latter, privacy. But, as correctly pointed out by the *Easton* court, on the question of whether the publication was about the plaintiff, the concerns of the two torts are similar and the defamation law on colloquium should apply to the public disclosure tort. However, the court rejected applying the "publication" concept in defamation to the "publicity" requirement of the public disclosure tort. *Id.* at 155, 483 A.2d at 1384.

391. 420 U.S. 469 (1975).

392. *Id.* at 494-95.

393. For a discussion of the facts and reasoning in *Cox*, see *supra* note 383.

394. *Cox*, 420 U.S. at 497. The Court stated: "[T]he protection of freedom of the press provided by the First and Fourteenth Amendments bars the State of Georgia from making appellants' broadcast the basis of civil liability." *Id.*

395. For examples of court decisions that preclude recovery under the public disclosure tort beyond the facts or rationale of *Cox*, see *supra* note 381.

396. For examples of court decisions that have limited *Cox* to its facts or allowed recovery under the public disclosure tort for publication of dated information that is part of the records of judicial proceedings, see *supra* note 382.

397. *Easton*, 335 Pa. Super. at 158-59, 483 A.2d 1386.

ness of the disclosure was a factual question.³⁹⁸

Easton Publishing Company published the column in question to assist the public in understanding the welfare system and such other matters as the standards for getting assistance and the difficulties encountered by applicants in applying for assistance.³⁹⁹ The *Easton* court agreed that the public had an interest in general information about the welfare system but found as a matter of law that there was no public interest in knowing the intimate personal facts contained in the article.⁴⁰⁰

Easton provides an important precedent in Pennsylvania for use of the public disclosure privacy tort to award damages for the unauthorized publication of health care information which has been disseminated to the general public. By determining that, as a matter of law, the public did not have a legitimate public concern in knowing about the disclosed information, the *Easton* court clearly placed itself with those courts that view the public disclosure tort as providing significant protection for an individual's right to decide whether others shall have access to highly personal intimate information about them even when important first amendment activities are at stake.⁴⁰¹

398. *Id.* at 159, 483 A.2d at 1386-87. *Easton* also relied upon *McMullan v. Wohlgenuth*, 453 Pa. 147, 308 A.2d 888 (1973), *appeal dismissed*, 415 U.S. 970 (1974), in which the Supreme Court of Pennsylvania held that the confidentiality policies of the welfare regulations regarding welfare records overrode the "right to know" statute and the press's right to access. As stated by the court in *McMullan*:

The statutory ban against disclosing the names of public assistance recipients is a clear recognition and directive by the Legislature that the privacy of the recipient is a fundamental need worthy of protection. This court is bound to give great deference to this sound legislative judgment. The statutory limitation imposed on appellee's asserted First Amendment right to compel the disclosure of those receiving assistance is no greater than necessary to protect the substantial governmental and individual interests involved.

Id. at 165, 308 A.2d at 897.

399. *Easton*, 335 Pa. Super. at 149, 483 A.2d at 1381. For a discussion of the facts in *Easton*, see *supra* note 387.

400. *Easton*, 335 Pa. Super. at 160, 483 A.2d at 1387. The court stated: There can be no doubt as to the benefits inherent in the publication of information to aid those eligible for public assistance who encounter difficulties in applying for assistance or continuing their receipt thereof. However, there is no legitimate public concern in giving publicity to the actual circumstances of a person's application for assistance where intimate personal facts are revealed (1) in such a way as to imply that those facts are true and (2) where the personal facts are unnecessary to aid those interested in receiving advice in their applications for assistance.

Id.

401. For examples of those courts that view the public disclosure tort in this way, see *supra* note 382.

2. *The Breach of Confidentiality Tort*

Most courts utilize three interrelated theories as the basic approach to protecting the confidentiality of extra-legal disclosure of health care information. These theories combine doctrines from several areas of law as well as ethical concepts of the health care profession. The result is an emerging recognition in our legal system of a cause of action for the unauthorized disclosure of health care information and recovery of tort damages. One commentator has aptly described this emerging jurisprudence as the breach of confidentiality tort.⁴⁰²

a. Implied Contract Theory of Recovery

One approach to granting the patient or client recovery against the health care practitioner is to incorporate the ethical standards of confidentiality of the medical profession into the service contract between the professional and patient or client, and to imply a duty not to disclose as part of the contract.⁴⁰³

b. Public Policy Theory

Some courts, in addition to the implied contract theory, look to the public policy of the state as evidenced by the law of that state (constitutional and statutory), the promulgated code of ethics adopted by the profession of that state and the state professional licensing statute as imposing a legal duty upon the professional not to gratuitously disclose confidential information.⁴⁰⁴ Alternatively, divulgence of health care information is

402. See Note, *Breach of Confidence: An Emerging Tort*, 82 COLUM. L. REV. 1426 (1982).

403. See *Hammonds v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793 (N.D. Ohio 1965) (holding physician and attorney liable to patient when physician turned medical records over to attorney without patient's consent); *Horne v. Patton*, 291 Ala. 701, 287 So. 2d 824 (1973) (physician liable to patient for disclosing health care information to patient's employer); *Hague v. Williams*, 37 N.J. 328, 181 A.2d 345 (1962) (implied contractual promise not to disclose, but since patient's parents had filed claim for insurance benefits for deceased patient (child), privacy interest of company was defense to breach of duty not to disclose action).

404. See, e.g., *Hammonds v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793 (N.D. Ohio 1965). In *Hammonds*, the court looked to three separate indicia for determining a state's public policy for determining this legal duty. *Id.* at 797. The court stated them as being:

The promulgated code of ethics adopted by the medical profession on which the public has a right to rely; the privileged communication statute [of the state], which precludes the doctor from testifying in open court, and that part of the State Medical Licensing Statute which seals the doctor's lips in private conversation.

viewed as a palpable wrong which state courts have the inherent power and duty to remedy.⁴⁰⁵

c. Breach of Fiduciary Relationship Theory

The most expansive of the approaches is a breach of fiduciary relationship theory. Under this analysis, the relationship between the physician and patient is viewed as a fiduciary one so that disclosure of health care information would constitute a breach of the fiduciary relationship.⁴⁰⁶ This theory is borrowed from the law of estates and is available against third parties. By analogizing to the law of estates, a third party that induced the breach of the physician professional's duty of loyalty would, likewise, be liable to the patient for the breach of the fiduciary duty. The leading case invoking this theory imposed liability against an attorney for inducing a physician to reveal confidential information about a patient, who had initiated a malpractice action against the attorney's client.⁴⁰⁷

Although the majority of courts that have considered the question have decided to recognize a cause of action for unauthorized extra-legal disclosure,⁴⁰⁸ some jurisdictions have held,

Id.

405. *See, e.g.*, *Smith v. Driscoll*, 94 Wash. 441, 162 P. 572 (1917) (law provides remedy for so palpable wrong as physician's divulgence of confidential communication (*dicta*)).

406. *See, e.g.*, *Hammonds v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793 (N.D. Ohio 1965) (physician stands in fiduciary relationship to patient, from which flows duty not to disclose confidential information to third parties); *MacDonald v. Clinger*, 84 A.D.2d 482, 446 N.Y.S.2d 801 (1982) (same proposition).

407. *See Hammonds v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793 (N.D. Ohio 1965) (attorney who induced physician to reveal confidential information about patient, causing breach of physician's fiduciary duty to patient, held liable directly to patient).

408. The following jurisdictions have recognized a cause of action under one of the above theories either directly in a specific holding or in *dicta*: *Mull v. String*, 448 So. 2d 952 (Ala. 1984) (recognizing causes of action for breach of fiduciary duty and breach of implied contract resulting from physician's unauthorized disclosure of information acquired during physician-patient relationship); *Horne v. Patton*, 291 Ala. 701, 287 So. 2d 824 (1973) (same proposition); *Hannaway v. Cole*, 2 Mass. App. Ct. 847, 311 N.E.2d 924 (1974) (noting in *dicta* development in other jurisdictions of recognizing cause of action for physician's unwarranted disclosure of confidential information); *Wenninger v. Muesing*, 307 Minn. 405, 240 N.W.2d 333 (1976) (same observation); *Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920) (recognizing cause of action against physician based on state statute prohibiting "betrayal of a professional secret" when physician discloses confidential information acquired during physician-patient relationship); *Hague v. Williams*, 37 N.J. 328, 181 A.2d 345 (1962) (recognizing cause of action against physician for disclosing confidential information, thereby breaching implied duty of confidentiality owed to patient as part of contract between them); *MacDonald v. Clinger*, 84 A.D.2d 482, 446 N.Y.S.2d 801

or suggested in dicta, that the cause of action is limited to communications protected under a testimonial privilege statute. These courts reject the notion of implying a duty not to disclose from the physician-patient relationship, and do not view the ethical standards of the profession as creating a fiduciary relationship between the health care practitioner and patient or client.⁴⁰⁹

Most of the courts that have recognized a cause of action under any of the various theories referred to above have done so even though a testimonial privilege was not applicable to the information disclosed.⁴¹⁰

d. Limitations to the Breach of Confidentiality Tort

Recovery under the various theories discussed above has been subject to two major limitations. The most important of these occurs when there has been consent to the disclosure or when the disclosure furthers an overriding public interest.⁴¹¹

Express consent is an absolute defense to a cause of action for extra-judicial disclosure. Much health care information is disclosed pursuant to broad authorization granted by patients or clients in insurance contracts or other third-party payor agreements. Not only do most insurance contracts condition payment on release of health records, but many release forms also authorize the insurer to re-release the information to whomever they choose. Recently, some jurisdictions have restricted the legal scope of

(1982) (recognizing cause of action against psychiatrist who disclosed personal information acquired during course of treatment, for breach of fiduciary duty of confidentiality); *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S.2d 668 (1977) (recognizing cause of action against psychiatrist who disclosed personal information acquired during course of treatment, for breaching implied covenant of confidentiality in physician-patient relationship); *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958) (noting public policy, as evidenced by state statute, of encouraging confidence between physician and patient, breach of which is actionable).

409. See, e.g., *Coralluzzo v. Fass*, 450 So. 2d 858 (Fla. 1984) (holding that no law prohibited physician from extra-judicially disclosing information obtained from patient, and that breach of ethical standards of profession cannot give rise to legal remedy unless such standards are codified in law).

410. See *Horne v. Patton*, 291 Ala. 701, 287 So. 2d 824 (1973) (recognizing cause of action for breach of confidentiality, notwithstanding fact that state had not enacted doctor-patient testimonial privilege statute); *Hague v. Williams*, 37 N.J. 328, 181 A.2d 345 (1962) (same holding).

411. See *Gilbert v. Medical Economics Co.*, 665 F.2d 305 (10th Cir. 1981) (no invasion of privacy when private facts are published in connection with matters in which public may reasonably be expected to have legitimate interest); *McNally v. Pulitzer Publishing Co.*, 532 F.2d 69 (8th Cir. 1976) (no invasion of privacy for publication of private facts where such facts are matters within legitimate public interest).

such releases, and there are a few cases finding them not valid because of their scope.⁴¹² General consent to release and republication of health records is generally legally valid. In Pennsylvania, both the Mental Health Procedure Act⁴¹³ and the federal and state provisions governing patient consent to release mental health or drug and alcohol treatment records⁴¹⁴ prohibit republications and specify the contents of the release form. In addition, implied waiver of a cause of action against the health care practitioner may be found as a result of claims for reimbursement.

Where disclosure furthers an overriding public interest, no cause of action is available. In many instances, the public interest in disclosure is expressly granted in legislation where nonconsensual disclosure is expressly authorized.⁴¹⁵

3. *Damages Recoverable for Breach of Confidentiality and Liability for Unauthorized Disclosure*

Damages recoverable for unauthorized disclosure under the various theories discussed are those that are generally recoverable in tort. This is the case even when the theory of recovery is implied contract or breach of fiduciary relationship. Damages include compensatory damages for emotional and physical pain and suffering, out-of-pocket losses (special damages) and punitive damages where the disclosure was done with malice or recklessly.⁴¹⁶

B. *Authorized Extra-Legal Disclosure of Health Care Information*

1. *Disclosure to Medical Personnel for Purposes of Diagnosis and Treatment and for Research*

Legal provisions in Pennsylvania regulating disclosure of

412. For a discussion of waiver in insurance contracts, see *supra* note 120.

413. See 55 PA. CODE 7100.111.4(d).

414. See 4 PA. CODE §§ 255.5(a)(7), (b)(1)-(5); 28 PA. CODE § 8709.28(a)-(e).

415. See, e.g., *Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920) (no breach of confidence when physician disclosed information of plaintiff's contagious disease in compliance with state law requiring him to do so).

416. See generally *Birnbaun v. United States*, 588 F.2d 319 (2d Cir. 1978) (damages recoverable for mental anguish suffered by person upon discovery C.I.A. had opened his mail); *Monroe v. Darr*, 221 Kan. 281, 559 P.2d 322 (1977) (damages recoverable for invasion of privacy include those for mental distress and special damage caused by invasion, and punitive damages if invasion was malicious); *Trevino v. Southwestern Bell Tel. Co.*, 582 S.W.2d 582 (Tex. Civ. App. 1979) (damages for mental suffering recoverable without showing actual physical injury).

health care information without the written consent of the patient or client generally reflect the ethical standards of the profession and provide for disclosure to health care practitioners that are directly involved with care of the patient.⁴¹⁷ Where health care information is sought for research, again consistent with the standards of the profession, generally, such information is available only when the privacy of the patient or client is protected by eliminating identifying information.

As previously noted, the most stringent confidentiality policies in Pennsylvania are in respect to the records of patients or clients that are under treatment for drug abuse or dependency. Consequently, the circumstances under which disclosure is legally authorized even as a part of treatment without the consent of the patient are severely limited. The enabling statute limits disclosure of all information contained in patient records with the consent of the patient to specified situations including, "to medical personnel exclusively for purposes of diagnosis and treatment."⁴¹⁸ The Act provides for only one exception for nonconsensual release of records for treatment and that is, "in emergency medical situations where the life of the client is in immediate jeopardy."⁴¹⁹ The regulations provide that even if a patient consents and requests that records be transferred for treatment purposes, the only information that may be transferred are "the Client Admission Forms, the Treatment/Discharge Forms, and Discharge Summary Records."⁴²⁰ These limitations on disclosure of drug and alcohol treatment records even with consent and for treatment reflect the primacy that the legislature placed upon confidentiality under the 1972 Drug and Alcohol Abuse Control Act. In addition, it is important to recall that the Act applies to the records of all health care practitioners that treat patients for drug or alcohol abuse or dependency.

Nonconsensual disclosure of health care information in the custody of approved mental health treatment facilities in Pennsylvania is not as restricted as disclosure under the Drug and Alcohol Treatment Act but is significantly limited even in respect to release for treatment purposes. Except for those portions of the record that refer to drug or alcohol abuse or dependency which

417. For a discussion of these ethical standards, see *supra* notes 6 & 7.

418. PA. STAT. ANN. tit. 71, § 1690.108(b) & (c) (Purdon Supp. 1986). For the full text of this section, see *supra* notes 259 & 260.

419. PA. STAT. ANN. tit. 71, § 1690.108(b) (Purdon Supp. 1986).

420. 4 PA. CODE § 255.5(c) (1986).

are governed by the Drug and Alcohol Treatment Act, records in mental health treatment facilities may be released for treatment by the patient with the patient's consent.⁴²¹ Nonconsensual release of mental health records for treatment is limited to "emergency medical situations when release of information is necessary to prevent serious risk of bodily harm or death."⁴²² In nonemergency situations release of record information is limited to "relevant portions or summaries" to "those actively engaged in treating the individual, or to persons at other facilities . . . when necessary to provide for continuity of proper care and treatment."⁴²³ In both of the above cases, information that is released is limited to information that is relevant and necessary for treatment.

Regulations governing hospital records do not indicate whether there are circumstances where nonconsensual release of such records would be authorized beyond release to authorized personnel.⁴²⁴

Although hospital records regulations do not specifically address whether release of records for patients in emergency situations is authorized, such an exception has been generally recognized in law due to the traditional legal duties of health care practitioners. Release for emergency treatment, if carefully circumscribed by both hospitals and the health care practitioner would most certainly be legally permissible in Pennsylvania even though not governed by specific regulatory provisions.⁴²⁵

421. 55 PA. CODE § 7100.111.2(a), 7100.111.4 (1987). Section 7100.111.4 provides the circumstances under which consensual release to third parties is to occur. *Id.* § 7100.111.4. That section indicates that the director is to review and exercise discretion in releasing information and records with the consent of the patient. *Id.* The section refers to third parties generally and would apparently apply to other health care practitioners who were treating the patient outside of the facility. *See id.* Therefore, release for treatment would also be subject to discretionary review of the director of the facility.

422. *Id.* § 7100.111.2(9). Subsection 9 provides that specific information in an emergency may be released, but only that which is pertinent to the emergency. *Id.*

423. *Id.* § 7100.111.2.

424. 28 PA. CODE § 115.27 (1987).

425. *See id.* § 03.22(9) (provides for an emergency exception for informed consent to medical procedure). Release of records for emergencies clearly is implied in this provision. Tort law generally provides for an exception to the consent requirements in virtually all aspects of the duties owed by health care practitioners to patients where there is a bona fide emergency situation. This is the case, for example, with respect to consent to perform a medical procedure. *See Gray v. Grunnagle*, 423 Pa. 144, 223 A.2d 663 (1966); RESTATEMENT (SECOND) OF TORTS § 62 (1984); W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS, § 18 at 117-19 (5th ed. 1984).

C. *Disclosure to Third-Party Payors*

Release of health care information to government or private entities that, through contractual arrangement or governmental benefits programs, are under obligation to pay for all or part of the health care is generally provided for as part of the consensual arrangement between the patient and insurer or health care provider. Patients or clients are required to consent to release of their health records when requesting reimbursement from third-party payors or as a condition of treatment by a health care practitioner or in a health care facility. Such patient authorizations generally control release of information in Pennsylvania. However, strong legislative policies of confidentiality limit the content of information that may be disclosed to third-party payors even with the consent of the patient.

Nonconsensual release to third-party payors of information contained in records prepared or obtained pursuant to the state Drug and Alcohol Treatment Act is prohibited.⁴²⁶ Records in the custody of mental health treatment facilities that contain information about drug or alcohol treatment or abuse are also subject to this restriction as the Mental Health Procedure Act specifically incorporates the stricter confidentiality policies of the Drug and Alcohol Treatment Act in respect to overlapping records.⁴²⁷ Substantial restrictions on the release of information concerning drug or alcohol dependency and treatment to third-party payors with the consent of the patient are contained in the statute and regulations under the Act. On its face, the Act limits consensual disclosure to "government or other officials" for the purposes of obtaining benefits from treatment for drug or alcohol abuse or dependency.⁴²⁸ While there is no mention of release to private third-party payors, regulations promulgated pursuant to the Act provide for release in limited circumstances. An insurance company, health or hospital plan that has contracted with the client or patient may acquire limited information after a request for such information has been approved by the executive director of the treatment facility providing that the client has consented to the release in writing. Even then, the information that may be released is generally limited to the prognosis and present treatment

There is no reason to suppose that the same immunity from liability would not attach in an emergency situation to release of health care information.

426. *See* PA. STAT. ANN. tit. 71, § 1690.108(a)-(c) (Purdon Supp. 1986).

427. 55 PA. CODE § 7100.111.7 (1987).

428. *See supra* note 1.

status of the client and a brief statement about the progress of the client, including whether the client has relapsed into drug or alcohol abuse.⁴²⁹ Similar restrictions apply under federal regulations.⁴³⁰

Records subject to regulatory provisions under the Mental Health Procedure Act also limit the information that may be released to third-party payors, although release to third-party payors is authorized without the patient's or client's consent in limited circumstances. When the patient has consented in writing, third-party payors have a right to access to "excerpts or summaries" of relevant portions of the mental health record at the "discretion of the Director."⁴³¹ The regulations provide that when a patient has designated a third-party as payor for mental health services, the designation operates as consent on the part of the patient to release of information necessary to establish the claim of eligibility.⁴³² Without such designation or patient consent, information may be released to third-party payors specifically identified in the regulations as necessary to verify services.⁴³³ Information released to third-party payors governed by the Drug and Alcohol Treatment Act is prohibited from redisclosure by the third-party payor in all circumstances.⁴³⁴ Information disclosed under the Mental Health Procedure Act without the written consent of the patient may not be further disclosed.⁴³⁵ Information disclosed pursuant to the Act with the written consent of the patient may be redisclosed if authorization is contained in the written consent.⁴³⁶ Redisclosure by the third-party payor of hospital records or records of health care practitioners not subject to the restrictions of either the Mental Health Procedure or Drug and Alcohol Treatment Act may also be further disclosed if agreed to by the patient.

429. 4 PA. CODE §§ 255.5(a)(7), (b)(1)-(5) (1986).

430. See 42 C.F.R. § 2.37 (1986). Section 2.37 provides for disclosure to a third party payor only with a written consent and limits disclosure to that "information which is reasonably necessary for the discharge of the legal or contractual obligation of the third party payor or funding source." *Id.*

431. 55 PA. CODE § 7100.111.4 (1987).

432. *Id.* § 7100.111.4(b).

433. *Id.*

434. See 4 PA. CODE §§ 255.5(a)(7), (b)(1)-(5); 28 PA. CODE § 8709.28 (a)-(e). The federal regulations also clearly prohibit redisclosure. See 42 C.F.R. § 2.32 (1986). The federal regulations provide for redisclosure after getting patient consent for the specific redisclosure. See *id.* § 2.32(b).

435. 55 PA. CODE § 7100.111.4(d) (1987).

436. *Id.* § 7100.111.4(e).

D. *The Legal Duty to Disclose Health Care Information*

1. *Catch 22*

Even in view of the numerous legal obligations not to disclose health care information imposed upon health professionals in Pennsylvania, there are circumstances in which the failure to disclose health care information will result in liability to the health professional. In such situations, the professional may be confronted with conflicting ethical and legal duties or may have no clear idea of what his or her legal duties are.

2. *Disclosure of Information About Child Abuse*

In Pennsylvania, a legal duty to disclose is clearly imposed under a few statutory and regulatory provisions and may be imposed under the general common-law duty in negligence to act reasonably in protecting the safety of others. The most important and clearest of the statutory duties are those under the Child Protective Services Law.⁴³⁷ This law is an expression of strong policies to protect children from physical and mental abuse. These policies are implemented by clearly stated duties to report evidence of child abuse,⁴³⁸ stiff sanctions for not reporting⁴³⁹ and strong immunities against legal responsibilities for disclosure required or thought to be required under the Law.⁴⁴⁰

All health professionals who have reason to believe that a

437. See PA. STAT. ANN. tit. 11, §§ 2201-2224 (Purdon Supp. 1986).

438. *Id.* § 2204. Section 2204 provides in pertinent part:

Any persons who, in the course of their employment, occupation, or practice of their profession come into contact with children shall report or cause a report to be made in accordance with section 6 when they have reason to believe, on the basis of their medical, professional or other training and experience, that a child coming before them in their professional or official capacity is an abused child.

Id. § 2204(a) (footnote omitted).

439. *Id.* § 2212. Section 2212 states: "Any person or official required by this act to report a case of suspected child abuse who willfully fails to do so shall be guilty of a summary offense, except that for a second or subsequent offense shall be guilty of a misdemeanor of the third degree." *Id.*

440. *Id.* § 2211. This section provides:

Any person, hospital, institution, school, facility or agency participating in good faith in the making of a report, cooperating with an investigation or testifying in any proceeding arising out of an instance of suspected child abuse, the taking of photographs, or the removal or keeping of a child pursuant to section 8, shall have immunity from any liability, civil or criminal, that might otherwise result by reason of such actions. For the purpose of any proceeding, civil or criminal, the good faith of any person required to report pursuant to section 4 shall be presumed.

Id. (footnotes omitted).

child under 18 years of age is an abused child have a mandatory duty to report information of abuse.⁴⁴¹ Willful failure to report abuse is a criminal offense.⁴⁴² Further, the Child Protective Services Law clearly provides that health professionals who, in good faith, report evidence of child abuse will be immune from civil or criminal liability.⁴⁴³ The statute also provides that good faith is legally presumed, and judicial construction of the immunity provision of the Law has been faithful to the letter as well as the spirit of immunity for disclosures of child abuse.

An illuminating discussion of the good-faith presumption is provided by *Roman v. Appleby*,⁴⁴⁴ in which a high school student and his parents brought an action in federal court against a school counselor and a social worker for the Chester County Childrens' Service for violating the federal Constitution and state tort law by initiating a petition to have the child treated for mental problems over his parents' objection.⁴⁴⁵ The petition was dismissed, apparently without justification.⁴⁴⁶ All of the federal and state claims against the health care professionals were dismissed because the plaintiffs had not overcome the presumption of good faith under the Law.⁴⁴⁷ The court found that "good faith" was to be evaluated by an objective standard, under which the plaintiffs would have had to demonstrate that the defendants, at the time of their actions, could have clearly known that those actions were improper in light of the mandatory reporting provisions of the Law.⁴⁴⁸ In respect to the constitutional tort action, the court found that the federal qualified immunity standard protected the defendants, and that in view of the policies of the Child Protective

441. See PA. STAT. ANN. tit. 11, § 2204(a) (Purdon Supp. 1986). For the text of this provision, see *supra* note 438.

442. See PA. STAT. ANN. tit. 11, § 2212 (Purdon Supp. 1986). For the text of this section, see *supra* note 439.

443. See PA. STAT. ANN. tit. 11, § 2211 (Purdon Supp. 1986). For the text of this section, see *supra* note 440.

444. 558 F. Supp. 449 (E.D. Pa. 1983).

445. *Id.* at 452-54. The plaintiffs' federal constitutional allegations included: "a first amendment right to free exercise of religion; a right to maintain a private family relationship without unnecessary, unreasonable, and capricious governmental interference and control; a fourteenth amendment right to due process of law; and a fourteenth amendment right to equal protection of the law." *Id.* at 454. The plaintiffs also made allegations involving state claims for negligence, intentional infliction of emotional distress, libel and invasion of privacy. *Id.*

446. *Id.* at 453.

447. *Id.* at 459.

448. *Id.* For the text of the mandatory reporting provision of the Child Protective Services Law, see *supra* note 438.

Service Law, plaintiffs had not demonstrated that defendants had violated clearly established "statutory or constitutional rights that a reasonable person would have known."⁴⁴⁹

In Pennsylvania health professionals are also obligated to disclose health care information to public authorities in other instances. These include cases of epilepsy, venereal disease, cancer and treatment of injuries involving firearms.⁴⁵⁰ Although there is

449. *Id.* at 455; see *Harlow v. Fitzgerald*, 457 U.S. 800, 815-19 (1982) (discussing abrogation of subjective element of good faith immunity defense).

450. See PA. STAT. ANN. tit. 35, § 521.4 (Purdon 1977) (duty to disclose communicable diseases). Section 521.4 provides, in pertinent part, that:

(a) Every physician who treats or examines any person who is suffering from or who is suspected of having a communicable disease, or any person who is or who is suspected of being a carrier, shall make a prompt report of the disease in the manner prescribed by regulation to the local board or department of health which serves the municipality where the disease occurs or where the carrier resides, or to the department if so provided by regulation. . . .

(d) Every physician or every person in charge of any institution for the treatment of diseases shall be authorized, upon request of the secretary, to make reports of such diseases and conditions other than communicable diseases which in the opinion of the Advisory Health Board are needed to enable the secretary to determine and employ the most efficient and practical means to protect and to promote the health of the people by the prevention and control of such diseases and conditions other than communicable diseases. The report shall be made upon forms prescribed by the secretary and shall be transmitted to the department or to local boards or departments of health as requested by the secretary.

Id. § 521.4(a) and (d); see *id.* tit. 35 § 5636 (Purdon Supp. 1987) (duty to disclose cancer). Section 5636 provides in pertinent part:

(b) Persons in charge of hospitals and laboratories shall be required by the Department of Health, in accordance with its regulations adopted with the advice of the board to report cases of cancer on forms furnished by the department.

(c) The reports required pursuant to this act shall be confidential and not open to public inspection or dissemination. This shall not restrict the collection and analysis of data by the Department of Health or those with whom the department contracts, subject to strict supervision by the Department of Health to insure that the use of the reports is limited to specific research purposes.

Id. § 5636(a), (b); see 18 PA. CONS. STAT. ANN. § 5106 (Purdon 1983) (duty to disclose injury from firearms). Section 5106 provides that:

(a) Offense defined.—A physician, intern or resident, or any person conducting, managing or in charge of any hospital or pharmacy, or in charge of any ward or part of a hospital, to whom shall come or be brought any person:

(1) suffering from any wound or other injury inflicted by his own act or by the act of another by means of a deadly weapon as defined in section 2301 of this title (relating to definitions); or

(2) upon whom injuries have been inflicted in violation of any penal law of this Commonwealth, commits a summary offense if he fails to report such injuries immediately, both by telephone

no reported case law in Pennsylvania involving patients who have proceeded against health care professionals for disclosing health care information pursuant to these clear statutory or regulatory duties, implicit in such mandatory reporting requirements is an immunity from legal responsibility for good-faith disclosures.

3. *The Tarasoff Problem*

In 1976, the Supreme Court of California, in *Tarasoff v. Regents of University of California*,⁴⁵¹ found that upon the determination by a psychotherapist that a patient presented a serious threat of physical injury or harm to third persons, the psychotherapist had a duty to warn the third persons of such a threat.⁴⁵² This decision sent shock waves through the health care industry. There is much confusion and misunderstanding about the *Tarasoff* duty to warn. California decisions following the case limited the duty to the facts of the *Tarasoff* case.⁴⁵³ Thus, a duty to warn is imposed when there is a specific threat to harm someone and the psychotherapist reasonably believes that the threat is likely to be carried out.⁴⁵⁴ Other courts have somewhat extended the duty to

and in writing, to the chief of police or other head of the police department of the local government, or to the Pennsylvania State Police. The report shall state the name of the injured person, if known, his whereabouts and the character and extent of his injuries.

(b) Immunity granted.—No physician or other person shall be subject to civil or criminal liability by reason of making a report required by this section.

(c) Physician-patient privilege unavailable.—In any judicial proceeding resulting from a report pursuant to this section, the physician-patient privilege shall not apply in respect to evidence regarding such injuries or the cause thereof.

Id. § 5106.

451. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

452. *Id.* at 437, 551 P.2d at 340, 131 Cal. Rptr. at 25.

453. See *Thompson v. County of Alameda*, 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980). In *Thompson*, a juvenile delinquent, within 24 hours after being released to the custody of his mother, sexually assaulted and murdered the plaintiff's son. *Id.* at 730. The plaintiff's complaint alleged that the county had acted negligently in releasing from its psychiatric care a juvenile delinquent who was known to have "latent, extremely dangerous and violent propensities regarding young children" and who had "indicated that he would, if released, take the life of a young child residing in the neighborhood." *Id.* Despite the complaint's allegations, the California Supreme Court dismissed the plaintiff's case and concluded that the county had no duty to warn since the defendant made no "prior threat[s] to a specific identifiable victim." *Id.* at 753, 614 P.2d at 738, 167 Cal. Rptr. at 76.

454. See, e.g., *Mavroudis v. Superior Court*, 102 Cal. App. 3d 594, 600, 162 Cal. Rptr. 724, 729 (Cal. Ct. App. 1980) (therapist has duty to protect person

warn.⁴⁵⁵ However, courts have generally been restrained in recognizing and defining the scope of the duty, and in most cases adjudicated on the *Tarasoff* theory, the plaintiff has not prevailed against the psychotherapist.⁴⁵⁶ Judicial circumscription in treatment of the *Tarasoff* duty is understandable in view of the strong countervailing policies that are offended by the duty and the questionable assumptions upon which some aspects of the decision were based.⁴⁵⁷

Ethical standards of psychologists and the licensing standards in Pennsylvania incorporate a carefully limited *Tarasoff* exception to the duty of confidentiality so that warning is only required where there is a clear and imminent danger to an individual or society.⁴⁵⁸ In many instances, ethical standards and licensing provisions also provide for a general exception to

from danger presented by his patient once he determines, or reasonably should have determined upon "moments reflection," victim's identity).

455. See *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 194 (D. Neb. 1980) (doctor's liability extends to those individuals foreseeably endangered by patient, not just those whom patient may have specifically threatened); *Hedlund v. Superior Court*, 34 Cal. 3d 695, 705-06, 669 P.2d 41, 46-47, 194 Cal. Rptr. 805, 810-11 (1983) (therapist held liable for failing to warn identifiable potential victim and her minor child, since risk of harm to minor was reasonably foreseeable if patient attacked victim); *Petersen v. State*, 100 Wash. 2d 421, 428, 671 P.2d 230, 237 (1983) (psychiatrist who knew of patient's drug-related mental problems and that patient was "potentially dangerous person and that his behavior would be unpredictable," held liable for failing to petition court for 90-day commitment of patient when patient injured plaintiff while driving under influence).

456. See *Brady v. Hopper*, 570 F. Supp. 1333, 1339 (D. Colo. 1983) (psychiatrist, who had treated President Reagan's would-be assassin, John Hinckley, held not liable since Hinckley had not made "specific threats to specific victims"), *aff'd*, 751 F.2d 329 (10th Cir. 1984); *Hasenci v. United States*, 541 F. Supp. 999, 1012 (D. Md. 1982) ("[psychiatrist] owed no duty to plaintiffs to control [patient's] conduct, particularly since [psychiatrist's] assessment . . . carried with it a lack of prediction of any identifiable danger posed by [patient] to any person."); *Doyle v. United States*, 530 F. Supp. 1278, 1287 (C.D. Cal. 1982) (psychiatrist held not liable for failing to warn third persons of patient's dangerous intentions since no duty existed to warn unidentifiable and unforeseeable victims); *Matter of Estate of Votteler*, 327 N.W.2d 759, 762 (Iowa 1982) (estate of deceased psychiatrist held not liable for victim's injuries because there was no evidence that psychiatrist knew or should have known of danger).

457. One of the major criticisms of the *Tarasoff* decision is that the policy of public safety will not be promoted by disclosure because the patients with problems will be reluctant to talk to psychotherapists and that will result in more acting out and harm to the public. See *Tarasoff*, 17 Cal. 3d at 27, 551 P.2d at 346, 167 Cal. Rptr. at 440. Other countervailing policies that are offended included confidentiality and the special role that immunity from public access of information exchanged in psychotherapist-client relationships plays with respect to the therapy itself. See *id.*

458. For a discussion of the ethical standards and licensing standards for psychologists in Pennsylvania, see *supra* notes 6 & 7.

confidentiality where disclosure is legally required or where it would protect the "welfare" of the individual or the community.⁴⁵⁹ In Pennsylvania, the legal duty to warn is unclear. This is because there is no clear appellate court holding recognizing a *Tarasoff* duty and Pennsylvania's confidentiality policies are stronger than those of many other states including California. Although dicta in one Pennsylvania Superior Court case speaks favorably of the *Tarasoff* duty⁴⁶⁰ and one federal court decision has assumed that such a duty is part of Pennsylvania common law,⁴⁶¹ the scope of a health care practitioner's duty to warn third persons of danger is uncertain. This places the health care practitioner in a "Catch 22" situation where the practitioner faces possible legal liability if he or she either discloses to third parties or fails to do so.

Hopewell v. Adebimpe,⁴⁶² illustrates the current dilemma.⁴⁶³ In that case, a common pleas court found that a patient had a cause of action against a psychiatrist who disclosed, apparently under the perception that there was a *Tarasoff* duty in Pennsylvania, that the patient had threatened to harm someone in the workplace.⁴⁶⁴ The *Hopewell* court found that strong policies in the Mental Health Procedure Act⁴⁶⁵ regarding confidentiality for mental health records outweighed the duty to disclose, and thus the psychotherapist was liable for disclosing information in violation of

459. *See id.*

460. *See* Coath v. Jones, 277 Pa. Super. 479, 419 A.2d 1249, 1251 (1980) (discussing special relationship exception to general rule that there is no duty to control conduct of another).

461. *See* Leedy v. Hartnett, 510 F. Supp. 1125, 1130 (M.D. Pa. 1981).

462. 130 P.L.J. 107 (Pa. Commw. Ct. 1982).

463. *Id.* at 109.

464. *Id.* at 108.

465. PA. STAT. ANN. tit. 50, § 7111 (Purdon Supp. 1986). Section 111 of the Mental Health Procedure Act provides in pertinent part:

All documents concerning persons in treatment shall be kept confidential and, without the person's written consent, may not be released or their contents disclosed to anyone except:

- (1) those engaged in providing treatment for the person;
- (2) the county administrator, pursuant to section 110;
- (3) a court in the course of legal proceedings authorized by this act; and
- (4) pursuant to Federal rules, statutes and regulations governing disclosure of patient information where treatment is undertaken in a Federal agency.

In no event, however, shall privileged communications, whether written or oral, be disclosed to anyone without such written consent.

Id. (footnote omitted).

the proscriptions in the Mental Health Procedure Act.⁴⁶⁶ Unfortunately, the decision was not appealed and was apparently settled out of court.

It is suggested that the *Hopewell* decision is correct in one aspect of its reasoning but wrong in both its interpretation of the scope of the Mental Health Procedure Act and its assumptions about the *Tarasoff* duty. It was correct in noting that the California Supreme Court, in *Tarasoff*, grounded its decision, in part, on an exception to the testimonial privilege statute and that Pennsylvania has stronger confidentiality policies than California.⁴⁶⁷ However, since the psychiatrist was treating the patient on a voluntary outpatient basis, the Mental Health Procedure Act should not have applied to the records in the case.⁴⁶⁸ Moreover, since the psychiatrist did not believe that the client would actually cause harm and there was no specific threat to an individual, there would not have been a duty to disclose even in a jurisdiction that recognized the *Tarasoff* duty in principle.⁴⁶⁹

Hopewell does illustrate the quandary in which Pennsylvania health care practitioners find themselves in light of strong confidentiality policies expressed in several statutes and an ill-defined duty to warn third parties lurking in the common law. The problem is especially pronounced for school counselors. The testimonial privilege statute applicable to school counselors does not

466. 130 P.L.J. at 109.

467. A central feature of the *Tarasoff* court's reasoning that is sometimes overlooked is the role that the testimonial privilege statute played in the California court's weighing of interests. The court correctly characterized the interests at stake as confidentiality and public safety. In weighing these interests the court relied on the fact that the legislature had exempted disclosures that were harmful to other persons from the testimonial privilege statute for psychotherapists. See 17 Cal. 3d at 26-27, 551 P.2d at 348, 167 Cal. Rptr. at 440-41. No such exception is specifically found in the psychologist-patient testimonial privilege in Pennsylvania. Moreover, as restrictive as the testimonial privilege is for psychiatrists, it is arguably applicable to threats of violence, in that they implicate the patient in criminal behavior and would, therefore, blacken the character of the patient or client within the meaning of the statute. Beyond that, since Pennsylvania has very strong confidentiality policies, as expressed in the Mental Health Procedure Act and the Drug and Alcohol Treatment Act, it is arguable, as *Hopewell* suggests, that the legislature has chosen to view confidentiality as having primacy over public safety in respect to mental health records, drug and alcohol treatment records, and psychotherapy related to those problems. See 130 P.L.J. at 108.

468. See 130 P.L.J. at 107. For a further discussion of the scope of records that come within the mandatory confidentiality provisions of the Mental Health Procedure Act, see *supra* notes 56-60 and accompanying text.

469. For a discussion of the limitations on the *Tarasoff* duty, see *supra* notes 453-56 and accompanying text.

contain a *Tarasoff* exception.⁴⁷⁰ As previously noted, it is very broad and decisive in protecting confidentiality. Regulations promulgated by the state board of education refer to the testimonial privilege statute but appear to go beyond its requirements to provide an “iffy” *Tarasoff* exception. These regulations provide that “[i]nformation received in confidence from a student may be revealed to the student’s parents . . . or other appropriate authority where the health, welfare or safety of the student or other persons is clearly in jeopardy.”⁴⁷¹

Until the scope of the *Tarasoff* duty and how it fits with the confidentiality policies in Pennsylvania is clarified by the appellate courts, health care practitioners will find themselves faced with conflicting legal duties regarding disclosure where they have information which leads them to believe that their patients or third parties are in some kind of danger. Much, then, is left to the practitioner’s personal, ethical sense of duty and a kind of cost-benefit analysis. Where the ethical responsibility is to disclose and there is a reasonably perceived legal duty to do so, carefully circumscribed disclosure is perhaps the best course of action, since the legal cost of non-disclosure if one is wrong is considerably greater than the cost of disclosure if legal liability attaches.⁴⁷² Where the ethical duty and personal conscience of the health care practitioner is not to disclose and the legal duty is unclear, the choice is much more difficult, and is one that, under current

470. See PA. STAT. ANN. tit. 42, § 5945 (Purdon 1982). Section 5945 provides in pertinent part:

(a)—No guidance counselor, school nurse, school psychologist, or home and school visitor in the public schools or in private or parochial schools or other educational institutions providing elementary or secondary education, including any clerical worker of such schools and institutions, who, while in the course of his professional or clerical duties for a guidance counselor, home and school visitor, school nurse or school psychologist, has acquired information from a student in confidence shall be compelled or allowed:

(1) without the consent of the student, if the student is 18 years of age or over; or

(2) without the consent of his parent or guardian, if the student is under the age of 18 years; to disclose such information in any legal proceeding, trial, or investigation before any government unit.

Id. § 5945(a)(1), (2).

471. 22 PA. CODE § 22.12(b) (1987).

472. It is not, however, suggested that this is the only resolution of the problem of whether to disclose in these circumstances. Nevertheless, where a legal duty is unclear and the decision of the health care professional and counsel must be made without precise legal guidance, some type of cost-benefit analysis, taking into consideration the general principles of avoiding litigation and reducing costs, should certainly go into the decision of whether to disclose.

Pennsylvania law, is left to the conscience and professional judgment of the health care practitioner with the advice of counsel.

V. CONCLUSION

This article was prompted by numerous discussions with health care practitioners and health lawyers, as well as my research on privacy and the relationship between privacy and confidentiality. From these experiences, I was left with three general impressions. One is that there is a need to develop a structure for examining, in a coherent way, the various features of state and federal law that define the extent to which health care information is to be non-public or confidential. The second is that confidentiality concerns, from the internal perspective of lawyers and health professionals, focus on three phases of non-publicness: patient and client access, disclosure in legal proceedings and extra-legal disclosure of health care information. The final impression is that the blossoming right of privacy in Pennsylvania is playing a growing role in confidentiality policies and rights in the commonwealth. I have endeavored, in this article, to provide such a structure, and to look at confidentiality law in Pennsylvania from the internal perspective of the health professional and health lawyer with a view to the role played by privacy in protecting the confidentiality of health care information.

Much of the statutory and constitutional dimensions of legal protection for the confidentiality of health care information is reflected in statutes, regulations and case law that is less than two decades old. The federal and state regulatory provisions regulating mental health records and records of drug and alcohol treatment reflect unprecedented policies protecting the confidentiality of certain health care information. These laws and the recognition by the Pennsylvania Supreme Court of a patient's or client's constitutional right of privacy in their health records and information reflect a recognition by legislatures and courts of the importance of protecting such information despite increasing demands for health care information and the increasing accessibility to it. This new law of confidentiality and its impact on the rights of others to information that is in some way beneficial to them has only begun to take form. It is likely that the legal dimensions of maintaining confidentiality for health care information will continue to be more important to both health professionals and health lawyers.

Perhaps the most conspicuous feature of the statutory and

regulatory law in Pennsylvania is that the laws concerning patient-client access and testimonial privileges do not cover much health care information and many health care professional patient/client relationships. Rights of patient-client access to the records of most private practitioners and many health care facilities have not been addressed in the numerous statutes and regulations that have been enacted. I have argued that legislation is needed to provide for a comprehensive definition of these important rights and duties. Similarly, the statutory scheme identifying the relationships and health information to be insulated from access in legal proceedings is underinclusive and incoherent. I have argued that this is also an area that deserves attention by the state legislature.