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BREACH OF MEDICAL CONFIDENCE IN OHIO

by

CRAIG E. JOHNSTON*

INTRODUCTION

In Ohio, the principle of confidentiality embodied in the Hippocratic Oath is more than an ethical principle espoused by the medical profession.¹ For physicians licensed to practice within this state, by virtue of Section 4731.22 of the Ohio Revised Code, the principle is a legal obligation, the breach of which may subject the practitioner to disciplinary action up to and including revocation of his medical license.² Unfortunately, the Ohio Revised Code's section on physician licensing is no more specific than the Hippocratic Oath in defining what "ought" not be disclosed. Furthermore, the medical licensing section applies only to a small fraction of those who have access to medical secrets. A multitude of social workers, health care professionals, insurance industry personnel and others have access to patient information equally capable of stigmatizing a patient for life.³

Fortunately, the patchwork of state and federal statutory, administrative, and case law has greatly limited unrestricted disclosure of medical secrets through the threat of civil and criminal liability. While the law governing the disclosure of medical information sorely lacks a comprehensive approach, one overriding principle emerges from this patchwork: the concern for confidentiality represented in the Hippocratic Oath is alive in Ohio and should guide the release of any medical secrets in the state. There are several statutes that regulate the release of certain types of medical information. For example, information concerning patients suffering from alcohol or drug abuse is covered

*The author is the Associate Director of Contracts Administration at The Ohio State University. B.A., *Summa Cum Laude*, University of Maryland (1980); J.D., with honors, The Ohio State University (1983).

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¹"Whatever in connection with my professional practice, or not in connection with it, I see or hear in the life of man, which ought not be spoken abroad, I will not divulge, thinking that all such should be kept secret." The Hippocratic Oath. See generally, AMERICAN MEDICAL ASS'N. PRINCIPLES OF MEDICAL ETHICS (1943).

²That section provides in relevant part that "[T]he (state medical) board . . . shall, to the extent permitted by law, limit, reprimand, revoke, suspend, place on probation, refuse to register, or reinstate a certificate (to practice medicine or surgery, or osteopathic medicine or surgery,) for . . . (4) Willfully betraying a professional secret." OHIO REV. CODE ANN. § 4731.22(B) (Baldwin 1984).

³See, e.g., Comment, *Public Health Protection and the Privacy of Medical Records*, 16 HARV. C.R.-C.L.L. REV. 265 (1981).

by Sections 523⁴ and 527⁵ of the Public Health Services Act, and the comprehensive regulatory scheme thereunder,⁶ and information concerning mental illness may be subject to the restrictions of Section 5122.31 of the Ohio Revised Code.⁷ The burden of regulating the disclosure of most types of medical

*This section provides as follows:

(a) Disclosure authorization:

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) Purpose and circumstances of disclosure affecting consenting patient and patient regardless of consent:

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the context of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Prohibition against use of record in making criminal charges or investigation of patient:

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) Continuing prohibition against disclosure irrespective of status of a patient:

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

42 U.S.C. § 290dd-3 (1983).

⁴42 U.S.C. § 290ee-3 (1984). This section provides limitations on the disclosure of drug abuse information identical to those provided for disclosure of alcohol abuse information under Section 523 of the Act. *See infra* note 4 for the full text of Section 523.

⁶42 C.F.R. §§ 2.11, 2.12 (1984).

⁷Section 5122.31 reads as follows:

All certificates, applications, records, and reports made for the purpose of Chapter 5122 of the Revised Code, other than court journal entries or court docket entries, and directly or indirectly identifying a patient or former patient or person whose hospitalization has been sought under Chapter 5122 of the Revised Code shall be kept confidential and shall not be disclosed by any person except:

(A) If the person identified, or his legal guardian, if any, or if he is a minor, his parent or legal guardian, consents, and if such disclosure is in the best interests of the person, as may be determined by the court for judicial records and by the head of the hospital for hospital records;

(B) When disclosure is provided for in this chapter or section 5123.60 of the Revised Code (provides for legal counsel to represent individuals hospitalized for mental illness);

(C) That hospitals may release necessary medical information to insurers to obtain payment for goods and services furnished to the patient;

(D) Pursuant to a court order signed by a judge;

(E) That a patient shall be granted access to his own psychiatric and medical records, unless access is specifically restricted in a patient's treatment plan for clear treatment reasons;

information, however, has fallen upon the common law. The common law also acts to close the gaps in statutory schemes seeking to limit the disclosure of a particular type of medical information. This article deals with the development of the common law in this area and the emergence of breach of confidence as a recognized tort in Ohio.

ELEMENTS OF TORTIOUS BREACH OF CONFIDENCE

As previously noted, aside from the physician licensing statute, which subjects a physician to possible disciplinary action for "willfully betraying a professional secret," there is no comprehensive statutory prohibition in Ohio governing the disclosure of medical information. Even the physician licensing statute is of little assistance for one attempting to develop a comprehensive policy on the release of medical information because of the vagueness of its prohibition. There is, however, case law that provides that the unauthorized disclosure of such information may result in civil liability. It also provides a fair amount of guidance to those holding such information as to when and how information may be released. While civil liability is potentially present where medical information is released in violation of a statutory prohibition, such as in the case of records pertaining to treatment of mental illness, in such situations civil liability merely provides an additional incentive to abide by statutes and administrative regulations. In such situations, civil liability cases are instructive when the regulatory or statutory scheme fails to address a particular issue relating to disclosure.

Several reported cases have imposed civil liability on physicians and others for the unauthorized release of information obtained about a patient during the course of treatment. These cases have relied on a number of legal theories as the basis for such liability, including breach of contract, breach of trust, invasion of privacy and defamation. Common among all of these cases, however, is the struggle of the courts to fit a breach of confidence within the parameters of a recognized cause of action.

In 1977, the Supreme Court of New York relied on the contractual theory of liability when it was confronted with the issue of unauthorized disclosure of confidential psychological information in a case styled *Doe v. Roe*.⁸ In this case, a psychiatrist and her husband, a psychologist, published a popular book

(F) That hospitals and other institutions and facilities within the department of mental health may release psychiatric medical records and interchange other pertinent medical information with other hospitals, institutions and facilities with which the department has a current agreement for patient care or services. The department of mental health shall adopt rules to implement this division.

The department of mental health shall adopt rules with respect to the procedures for the destruction of patient records. No person shall reveal the contents of a psychiatric medical record of a patient except as authorized by law.

OHIO REV. CODE ANN. § 5122.31 (Baldwin 1984).

⁸93 Misc.2d 201, 400 N.Y.S.2d 668 (Sup. Ct. 1977).

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containing verbatim disclosures by the plaintiff, a former patient of the defendant psychiatrist, involving the plaintiff's most intimate thoughts. Even though her name was not expressly given in the book, the material included sufficient biographical material for some of the plaintiff's friends and colleagues to identify her. The court found both the psychiatrist and her husband liable for breach of contract, stating:

[T]he liability of Dr. Roe to respond in damages is clear; and Mr. Poe's liability is equally clear. True, he and the plaintiff were not involved in a physician-patient relationship and he certainly had no contractual relationship to her. But the conclusion is unassailable that Poe, like anyone else with access to the book, knew that its source was the patient's production in psychoanalysis. . . . If anyone was the actor in seeing to it that the work was written, that it was manufactured, advertised and circulated, it was Poe. He is a co-author of the book and a willing, indeed avid, co-violator of the patient's rights and is therefore equally liable (citation omitted).⁹

Doe v. Roe is an excellent example of how the courts are struggling to provide an adequate remedy for unauthorized releases of confidential information. The courts frequently rely on traditional theories to find liability even though such theories are inadequate to support the liability imposed. In *Doe v. Roe*, the court relied upon the theory of breach of contract even though the court recognized that the traditional approach to the theory was insufficient to impose liability upon the defendant psychologist, who never actually had a contractual relationship with the plaintiff and against whom there was no evidence suggesting responsibility for inducing a breach of contract by the defendant psychiatrist, who did have a contractual relationship with the plaintiff.¹⁰

A number of cases have relied upon the traditional theory of invasion of privacy to impose liability for the unauthorized release of information by physicians and other allied medical professionals. The tort of invasion of privacy encompasses four separate theories of liability: (1) appropriation of a name or likeness, (2) intrusion of physical solicitude or seclusion, (3) public disclosure of private facts, and (4) creating a false light in the public eye. The first reported case to impose liability on a physician for invasion of privacy was *De May v. Roberts*,¹¹ decided by a Michigan court in 1881. In the *De May* case, a physician was held liable for permitting a layman to observe the birth of the plaintiff's child. Since the tort of invasion of privacy had yet to evolve, the *De May* court did not expressly hold that the plaintiff had a right to physical solicitude, but in retrospect, it is clear that the *De May* case falls most neatly

⁹*Id.* at 215, 400 N.Y.S.2d at 678.

¹⁰See generally Note, *Breach of Confidence: An Emerging Tort*, 82 COLUM. L. REV. 1426 (1982). See also *Hammonds v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793 (N.D. Ohio 1965).

¹¹46 Mich. 160, 9 N.W. 146 (1881).

into this category. Most recent cases involving the release of medical secrets fall within the scope of the "public disclosure of private facts" theory of liability.¹² While the "public disclosure of private facts" theory generally involves wide dissemination of the facts revealed, many courts have held that only limited disclosure is required where, as in the case of the physician-patient relationship, there is a breach of a confidential relationship.¹³ Thus, in both *Simonsen v. Swenson*,¹⁴ a case decided by the Nebraska Supreme Court in 1920, and in *Clark v. Geraci*,¹⁵ a New York case decided in 1960, liability was imposed upon a physician notwithstanding the lack of widespread publicity of the medical secrets disclosed.

While a number of American cases have relied upon the "public disclosure of private facts" theory of liability without the element of wide dissemination of the confidential information to impose liability on a physician for the unauthorized disclosure of medical information, no reported American case has expressly relied upon the English tort of breach of confidence as the basis for imposing liability under such circumstances. This is an important point since the English theory of breach of confidence differs significantly from the invasion of privacy theory. The breach of confidence theory not only permits recovery in the case of limited dissemination, it also permits a plaintiff to recover where the publication was not intentional.

Several cases, however, have implicitly recognized breach of confidence as a tort in its own right. An excellent example of such a decision is the New York case styled *MacDonald v. Clinger*.¹⁶ In *MacDonald*, a patient brought suit against his psychiatrist for disclosing confidential information to his wife. The traditional approach to the tort of public disclosure of private facts was obviously an insufficient theory of liability due to the lack of publicity. The court seemed to imply a tort based upon breach of confidence when it stated, "We believe that the relationship contemplates an additional duty springing from but extraneous to the contract and the breach of such duty is actionable as a tort."¹⁷ Similarly, in *Berry v. Moench*,¹⁸ a Utah case, the court relied heavily on the law of defamation in considering the potential liability of the defendant physician, who advised the plaintiff's fiancée "to run as fast and as far as she possibly could in any direction away from him," but the court seemed to endorse a breach of confidence approach when it stated:

(I)t is obligatory upon the doctor not to reveal information obtained in

¹²See, e.g., *Bazemore v. Savannah Hosp.*, 171 Ga. 257, 155 S.E. 194 (1930); *Banks v. King Features Syndicate, Inc.*, 30 F. Supp. 352 (S.D.N.Y. 1939).

¹³See PROSSER, *TORTS* 810 (4th ed. 1971).

¹⁴104 Neb. 224, 177 N.W. 831 (1920).

¹⁵29 Misc. 2d 791, 208 N.Y.S.2d 564 (Sup. Ct. 1960).

¹⁶84 A.D.2d 482, 446 N.Y.S.2d 801 (App. Div. 1982).

¹⁷*Id.* at 486, 446 N.Y.S.2d at 804.

¹⁸8 Utah 2d 191, 351 P.2d 874 (1959).

confidence in connection with the diagnosis or the treatment of his patient. It is our opinion that if the doctor violates that confidence and publishes derogatory matter concerning his patient, an action would lie for any injury suffered.¹⁹

The first Ohio case to expressly hold that the unauthorized release of medical information is actionable was *Hammonds v. Aetna Cas. & Sur. Co.*,²⁰ a federal case applying Ohio law. The *Hammonds* case is the leading opinion in the area of unauthorized disclosures of medical information. This is due in no small part to the number of legal theories that the court embraced for imposing liability for a physician's breach of confidence,²¹ including breach of contract and breach of fiduciary duty.

Federal jurisdiction in the *Hammonds* case was based on diversity of citizenship. The plaintiff brought suit against the defendant insurance company for inducing the plaintiff's physician to release medical information which the physician had obtained from the plaintiff in the course of treatment. The plaintiff was injured while under the physician's care when a hospital bed collapsed. The defendant insurer obtained medical information about the plaintiff from the physician for use in a negligence suit brought by the plaintiff against the hospital. The plaintiff alleged that the insurer induced the physician to release the information by falsely representing that the plaintiff had additionally threatened a malpractice suit against the physician. The *Hammonds* court held that, in Ohio, the physician-patient relationship is one founded in simple contract and, as an implied term of the contract, the physician warrants that any confidential information gained through the relationship will not be released without the patient's consent.²² The court stated:

Any time a doctor undertakes the treatment of a patient, . . . (d)doctor and patient enter into a simple contract, the patient hoping he will be cured and the doctor optimistically assuming that he will be compensated. As an implied condition of that contract, this Court is of the opinion that the doctor warrants that any confidential information gained through the relationship will not be released without the patient's permission. Almost every member of the public is aware of the promise of discretion contained in the Hippocratic Oath, and every patient has a right to rely upon this warranty of silence. . . . Consequently, when a doctor breaches his du-

¹⁹*Id.* at 196, 331 P.2d at 817. The theory of breach of confidence is well established in England. See also *Clark v. Geraci*, 29 Misc. 2d 791, 208 N.Y.S.2d 564 (Sup. Ct. 1960). For an excellent discussion of the English tradition and the emergence of the tort in the United States, see Note, *Breach of Confidence: An Emerging Tort*, 82 COLUM. L. REV. 1426 (1982).

²⁰243 F.Supp. 793 (N.D. Ohio 1965).

²¹Nearly every recent case involving the issue of unauthorized disclosure of medical records has heavily relied on the decision in *Hammonds*. See, e.g., *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S.2d 668 (Sup. Ct. 1977); *MacDonald v. Clinger*, 84 A.D.2d 482, 446 N.Y.S.2d 801 (Sup. Ct. 1982); *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958).

ty of secrecy, he is in violation of part of his obligations under the contract.²³

The court, therefore, went beyond treating confidentiality simply as an implied term of the physician-patient relationship and held that the physician has a fiduciary duty of secrecy with respect to the confidences of his patient. Consequently, any information obtained in the course of treating a patient is held by the physician in trust, and the public policy of the state of Ohio requires that the physician's breach of this trust be actionable in tort. In finding the physician-patient relationship to be fiduciary in nature, the court stated:

The defendant here has also challenged, in its Motion for Reconsideration, the Court's finding that one who induces a physician's treachery may also be held liable for damages. This finding was predicated upon the holding that the physician-patient relationship is a confidential one which imposes fiduciary obligations upon the physician. . . . As a consequence, all reported cases dealing with this point hold that the relationship of the physician and patient is a fiduciary one. . . . (I)t is readily apparent that the legal obligations of a trustee are imposed upon any person operating in a fiduciary capacity and the same principles of law governing the behavior of a trustee are applicable to all fiduciaries.²⁴

The *Hammonds* court concluded, then, that "the preservation of the patient's privacy is no mere ethical duty upon the part of the doctor; there is a legal duty as well,"²⁵ requiring that the unauthorized revelation of medical secrets, or any confidential communication given in the course of treatment, be held to be "tortious conduct which may be the basis for an action in damages."²⁶

In determining what the public policy of Ohio is with respect to the confidentiality of information transmitted between a patient and his physician, the court relied on the promulgated code of ethic adopted by the medical profession²⁷ upon which the court held the public has a right to rely; the privileged communications and acts statute,²⁸ which precludes the doctor from testifying in open court; and the state medical licensing statute,²⁹ which seals the doctor's

²³ *Id.*

²⁴ *Id.* at 802-03.

²⁵ *Id.*

²⁶ *Id.* at 801-02.

²⁷ "The confidences (of the patient) should be held as a trust and should never be revealed except when imperatively required by the laws of the state." AMERICAN MEDICAL ASS'N PRINCIPLES OF MEDICAL ETHICS Ch. II, § 1 (1943).

²⁸ That statute provides in relevant part that: "The following persons shall not testify in certain respects . . . (B) A physician concerning a communication made to him by his patient in that relationship or his advice to his patient." OHIO REV. CODE ANN. § 2317.02 (Baldwin 1984).

²⁹ That statute provides in relevant part that: "(B) The (state medical) board shall, to the extent permitted by law, limit, reprimand, revoke, suspend, place on probation, refuse to register, or reinstate a certificate (to practice medicine or surgery, or osteopathic medicine or surgery,) for . . . (4) Willfully betraying a professional secret. OHIO REV. CODE ANN. § 4731.22 (Baldwin 1984).

lips in private conversation.³⁰ Quoting the Supreme Court of Washington,³¹ the *Hammonds* court stated:

Neither is it necessary to pursue at length the inquiry of whether a cause of action lies in favor of a patient against a physician for wrongfully divulging confidential communications. For purposes of what we have to say it will be presumed that, for so palpable a wrong, the law provides a remedy.³²

The court also held that the same principles governing trustees apply to the physician's fiduciary duty of secrecy and to the liability of third parties participating in or inducing a breach of the physician's duty.³³

Since the *Hammonds* case was decided by a federal court applying state law, the decision is not binding precedent on the state courts of Ohio. However, two state courts of Ohio have adopted the *Hammonds* decision in reported cases and it is reasonable to assume that the sound opinion of the court in *Hammonds* will be followed when other Ohio courts are confronted with unauthorized disclosures of medical information. Not only does precedent from other jurisdictions favor the *Hammonds* result,³⁴ the growing concern over the privacy of medical information has led to considerable legislative activity limiting release of medical information by physicians and health care facilities.³⁵ Further, it is entirely reasonable to assume that Ohio courts will treat physician and health care facility releases of information in substantially the same manner since the same concerns are present.³⁶ The validity of these assumptions is reinforced by the decision in *Nationwide Mutual Insurance Co. v. Jackson*,³⁷ wherein the Court of Appeals for Cuyahoga County, albeit in dicta, endorsed the holding in *Hammonds* that a physician may be held liable in

³⁰*Hammonds*, 243 F. Supp. at 797.

³¹See *Smith v. Driscoll*, 94 Wash. 441, 442, 162 P. 572, 573 (1917).

³²*Hammonds*, 243 F. Supp. at 801.

³³The court stated that:

(T)he same principles of law governing the third party participation in breaches of trust must also apply to one who participates in or induces the breach of any fiduciary duty. The law is settled in Ohio and elsewhere that a third party who induces a breach of a trustee's duty of loyalty, or participates in such a breach, or knowingly accepts the benefit from such a breach, becomes directly liable to the aggrieved party. (Citations omitted.)

Id. at 803.

³⁴See, e.g., cases cited *supra* notes 8-11.

³⁵See, e.g., OHIO REV. CODE ANN. §§ 5122.31, 5123.89 (Baldwin 1984).

³⁶See, e.g., *Bazemore v. Savannah Hosp.*, 171 Ga. 257, 155 S.E. 194 (1930). Liability was imposed on hospital for release of photograph of nude baby with open heart. The theory of liability was that of invasion of privacy for wrongful appropriation of the deceased infant's likeness. Unlike most of the cases discussed involving unauthorized disclosures by physicians, *Bazemore* involved the element of wide dissemination which is required in the more traditional theory of tortious invasion of privacy. However, a number of reported cases have also imposed liability on banks for unauthorized disclosure of financial information with only limited dissemination. See, e.g., *Peterson v. Idaho First Nat'l Bank of Miami Springs*, 83 Idaho 578, 367 P.2d 284 (1961); *Milohnich v. First Nat'l Bank*, 224 So. 2d 759 (Fla. Dist. Ct. App. 1969).

damages for any unauthorized disclosure of medical information,³⁸ and by the decision in *Prince v. St. Francis-St George Hospital, Inc.*,³⁹ in which the Court of Appeals for Hamilton County not only applied the invasion of privacy theory to a physician's breach of confidence, but also expanded the doctrine to include negligent as well as intentional disclosures of confidential information.

In *Prince*, appellant Blanche Prince was treated as an inpatient in the care unit of St. Francis-St. George Hospital, in Hamilton County, Ohio, for an alcohol-related illness. She and her husband Russell Prince alleged that the hospital gave them written guarantees of privacy concerning her treatment. Mrs. Prince further alleged that, while in the hospital, she was treated by Doctors Neumann and Scharold as agents or employees of the hospital or agents or employees of Comprehensive Care Corporation, which had a contract with the hospital to operate the care unit in which Mrs. Prince was a patient.⁴⁰ Mr. and Mrs. Prince further alleged that, while Mrs. Prince was in the care unit of the hospital, a fellow employee of Mr. Prince received an insurance payment request sent by Dr. Scharold. The employee was not authorized to receive insurance payment request forms on behalf of his employer. Included on the claim form ostensibly sent by Dr. Scharold was the diagnosis of "Acute & Chronic Alcoholism Detoxification."⁴¹ The Princes' claimed that the publication of Mrs. Prince's chronic alcoholism, contrary to their express instructions, resulted in Mrs. Prince suffering extreme mental and emotional stress and medical expenses, and in Mr. Prince suffering extreme mental and emotional stress and lost employment opportunities.⁴²

The defendants were granted summary judgment by the trial court and the Princes appealed. The appellate court held that the assignment of error did not avail as to the hospital because both defendant doctors were private physicians who were not employees of the hospital and that, whatever tortious action was attributable to the two doctors, or their employer, Comprehensive Care Corporation, did not extend to the hospital.⁴³ As to the two treating physicians and their employer, however, the court found the appellants' assignment of error well taken.⁴⁴

The court rejected the argument advanced by counsel for the two physicians that appellants' cause of action must fail since there was no proof that the disclosure, if any, was intentional and that a mere negligent intrusion into one's private affairs does not constitute an actionable invasion of privacy.⁴⁵ In

³⁸*Id.* at 140, 226 N.E.2d at 762.

³⁹20 Ohio App. 3d 4, 484 N.E.2d 265 (1985).

⁴⁰*Id.* at 5, 484 N.E.2d at 266.

⁴¹*Id.* at 5, 484 N.E.2d at 267.

⁴²*Id.*

⁴³*Id.* at 6-7, 484 N.E.2d at 267.

⁴⁴*Id.*

⁴⁵In advocating this position, appellees Scharold and Neumann relied strongly upon *McCormick v. Haley*,
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so doing, the court stated:

We find puzzling the postulation in *McCormick v. Haley* that seems to conclude that "negligently" and "intentionally" are mutually exclusive. We believe that in given factual situations there could well be mixed negligence and intention. We do not elaborate on this point, nor is it necessary for us to do so. We also have some trouble with the statement in *McCormick v. Haley* that "a mere negligent intrusion into one's private activities does not constitute an actionable invasion of the right of privacy." It seems to us that a negligent invasion of the right of privacy, which is a distinct possibility in the factual scenario *sub judice*, can just as effectively invade one's right of privacy as an intention to do so.⁴⁶

The court relied heavily upon the following language in *Housh v. Peth*,⁴⁷ in which the Ohio Supreme Court used the broad language of "wrongful intrusion," as opposed to "intentional intrusion," in defining an actionable invasion of privacy:

An actionable invasion of the right of privacy is the unwarranted appropriation or exploitation of one's personality, the publicizing of one's private affairs with which the public has no legitimate concern, or the wrongful intrusion into one's private activities in such a manner as to outrage or cause mental suffering, shame or humiliation to a person of ordinary sensibilities.⁴⁸

Holding physicians liable for negligent disclosures of confidential information is eminently sound. While the language used by the *Prince* court was sufficiently broad, as was the *Housh* language upon which it relied, to encompass virtually any action for invasion of privacy, on close inspection the holding may actually have little application outside of the realm of confidential, professional relationships such as that of the physician and patient. The reason for this lies in the very nature of negligence as an actionable tort. In order for one to be held liable for negligence, one must be found to have had a duty of care and to have failed to meet that duty.⁴⁹ In the case of a defendant not privy to a confidential professional relationship, the legal standard should, at the very least, be less than that applied to the professional in a confidential relationship. Indeed, in many cases one might be found to have no duty of care

37 Ohio App. 2d 73, 307 N.E.2d 34 (1973), wherein the court stated that:

A mere negligent intrusion into one's private activities does not constitute an actionable invasion of the right of privacy. Thus, if the trier of the facts were to accept, as the trial court did, the defendant's testimony that the communications were only negligently and not intentionally sent, there could be no right of recovery.

Id. at 78, 307 N.E.2d at 38.

⁴⁶20 Ohio App. 3d at 7, 484 N.E.2d at 268.

⁴⁷165 Ohio St. 35, 133 N.E.2d 340 (1956).

⁴⁸*Id.* at 35, 133 N.E.2d at 341.

⁴⁹See PROSSER, TORTS 324-50 (4th ed. 1971).

whatsoever, thus limiting liability to the more traditional situation of intentional publication. This distinction also points out the uniqueness of unauthorized disclosures of confidential information in a professional setting and the need to recognize breach of confidence as a tort in its own right.

In the case of the physician-patient relationship, the duty of care required of the physician to maintain the confidences of his patients is clear, if not from the nature of the physician-patient relationship alone, then from the plethora of statutes mandating confidentiality in the physician-patient relationship.⁵⁰ Additionally, several statutes actually imply a right of action on the part of the patient in the event of unauthorized disclosure. For example, Section 3701.261 of the Ohio Revised Code, a statute that authorizes disclosure of information about malignant diseases to cancer registries, provides that no physician or treating facility

furnishing such information . . . to any such cancer registry, with respect to a case of malignant disease treated or examined by such physician . . . or hospital, shall by reason of such furnishing be deemed to have violated any confidential relationship, or be held liable in damages to any person, or be held to answer for betrayal of a professional secret.⁵¹

Similarly, Section 2305.24 of the Ohio Revised Code provides that no person or institution providing information to a state or local medical society or hospital utilization committee shall be held liable in damages or for betrayal of a professional secret.⁵² Even more interesting, however, is that Section 2305.24 expressly states that "a right of action similar to that a patient may have against an attending physician for misuse of information . . . arising out of the physician-patient relationship, shall accrue against a member of a utilization committee for misuse of any such information . . . furnished to such committee by an attending physician."⁵³ Thus, these sections demonstrate the Ohio

⁵⁰See *supra* notes 4-7 and accompanying text.

⁵¹OHIO REV. CODE ANN. § 3701.261 (Baldwin 1983). Section 3701.261 reads in full as follows:

Any information, data, and reports with respect to a malignant disease which are furnished to, or procured by, any cancer registry in this state shall be confidential and shall be used only for statistical, scientific, and medical research for the purpose of reducing the morbidity or mortality of malignant disease. No physician, surgeon, dentist, institution, or hospital furnishing such information, data, or report to any such cancer registry, with respect to a case of malignant disease treated or examined by such physician, or surgeon, dentist or confined in such institution or hospital, shall by reason of such furnishing be deemed to have violated any confidential relationship, or be held liable in damages to any person, or be held to answer for betrayal of a professional secret within the meaning and intent of section 4731.22 of the Revised Code.

Id.

⁵²OHIO REV. CODE ANN. § 2305.24 (Baldwin 1983).

⁵³*Id.* Section 2305.24 provides in full that:

Any information, data, reports, or records made available to a utilization committee of a hospital, or a utilization committee of a state or local medical society composed of doctors of medicine or doctors of osteopathic medicine and surgery shall be confidential and shall be used by such committee and the committee members only in the exercise of the proper functions of such utilization committee. A right of action similar to that a patient may have against an attending physician for misuse of information, data, reports, or records arising out of the physician-patient relationship, shall accrue against a member of a utilization committee for misuse of any such information, data, reports, or records furnished to such committee by an attending physician. No physician, surgeon, institution, or hospital

Legislature's concern for confidentiality in the physician-patient relationship and its endorsement of the theory of breach of confidence first set forth in Ohio by the *Hammonds* holding.⁵⁴

DUTIES AND CONDITIONAL PRIVILEGES TO RELEASE MEDICAL INFORMATION

The Ohio courts are free to endorse any or all of the legal theories relied upon by other courts to impose civil liability for the unauthorized disclosure of medical information. While each theory has different elements which must be met and different potential remedies for the successful plaintiff,⁵⁵ for the most part it is likely to make little difference which theory or theories are applied since most of the courts confronted with the problem of unauthorized disclosures have relied upon a number of legal theories for imposing liability.⁵⁶ Frequently, while finding that such disclosures are actionable, the courts fail to specify the exact basis for imposing liability,⁵⁷ or, while specifying a theory of liability, the courts ignore the precise elements of the theory and its limitations.⁵⁸ Of greater concern than the theory or theories of liability likely to be

furnishing information, data, reports, or records to any such committee with respect to any patient examined or treated by such physician or surgeon or confined in such institution or hospital shall, by reason of such furnishing, be deemed liable in damages to any person, or be held to answer for betrayal of a professional secret within the meaning and intent of section 4731.22 of the Revised Code. Information, data, or reports furnished to a utilization committee of a state or local medical society shall contain no name of any person involved therein.

As used in this section, "utilization committee" is the committee established to administer a utilization review plan of a hospital or extended care facility as provided in the "Health Insurance for the Aged Act," 79 Stat. 313 (1965), 42 U.S.C. 139x(k).

Id.

Additionally, Section 2305.251 of the Revised Code provides for the confidentiality of utilization committee records as follows:

Proceedings and records of all review committees described in section 2305.25 of the Revised Code shall be held in confidence and shall not be subject to discovery or introduction in evidence in any civil action against a health care professional or institution arising out of matters which are the subject of evaluation and review by such committee. No person within attendance at a meeting of such committee shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of such committee or as to any finding, recommendation, evaluation, opinion, or other action of such committee or member thereof. Information, documents, or records otherwise available from original sources are not to be construed as being unavailable for discovery or for use in any civil action merely because they were presented during proceedings of such committee nor should any person testifying before such committee or who is any member of such committee be prevented from testifying as to matters within his knowledge, but the witness cannot be asked about his testimony before such committee or opinion formed by him as a result of such committee hearing.

OHIO REV. CODE ANN. § 2305.251 (Baldwin 1983).

⁵⁴See *supra* textual discussion of duties to disclose medical records accompanying notes 72-76.

⁵⁵For a detailed analysis of the different legal theories upon which liability for release of medical information may be based see Note, *Action For Breach of Medical Secrecy Outside the Courtroom*, 36 U. CIN. L. REV. 103 (1967).

⁵⁶See, e.g., *Hammonds v. Aetna*, 243 F. Supp. 793 (N.D. Ohio 1965) (relying on contract, trust, and tort); *Horne v. Patton*, 291 Ala. 701, 287 So. 2d 824 (1973) (relying on contract, invasion of privacy, and breach of confidential relationship).

⁵⁷See, e.g., *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958) (appeared to impose liability based on tort of breach of confidence but failed to clearly identify nature of action and its elements).

⁵⁸See, e.g., *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S.2d 668 (Sup. Ct. 1977) (contractual liability imposed on both defendants where only one defendant had a contractual relationship with plaintiff).

endorsed by the state courts of Ohio are the circumstances under which the courts are likely to find that a disclosure is privileged. An obvious privilege exists where the patient or his duly authorized agent or legal guardian has consented to the release or has waived his right to confidentiality. In fact, a number of cases have held that where the patient authorizes a physician or hospital to release information, there is a legal obligation to provide that information.⁵⁹

There is also existing law to the effect that the public interest may provide a conditional privilege where the public interest outweighs the interest of the patient in the secrecy of his communications to his physician. For example, in *Simonsen v. Swenson*,⁶⁰ a Nebraska case decided in 1920, the court, while recognizing that a patient generally has a right to have his confidences in his physician maintained, excused the defendant physician's disclosure of the patient's condition as privileged. The plaintiff was a transient telephone company employee boarding at a hotel when he consulted the defendant physician about a condition the defendant preliminarily diagnosed as a venereal disease. The plaintiff refused to leave the hotel at the request of the defendant, who feared that the disease might spread. The defendant informed the hotel owner of his concern that the plaintiff had a contagious disease and advised the owner to disinfect his sheets, but the owner ejected the plaintiff from the hotel. Another physician was subsequently unable to prove the disease, but confirmed that the defendant physician had reasonable grounds for his suspicion. The court found that the defendant exercised reasonable judgment in balancing the interest of the public against the plaintiff's interest in his privacy.⁶¹

Several courts have raised the conditional public interest privilege to the level of a duty. In a New York case styled *Wojcik v. Aluminum Co. of America*,⁶² for example, an employer who provided free x-rays to employees was held liable to an employee and his family members who contracted a disease for failing to warn them of a danger which the employer had become aware of through those x-rays.

In a similar vein, the Ohio Legislature has weighed the public interest in having access to records held by state institutions against the privacy interest of patients admitted to state, county, and municipal hospitals and has determined that the public's right to know outweighs the privacy interest of the patient to the extent that the institutions are required to disclose the fact of ad-

⁵⁹See, e.g., *Bishop Clarkson Memorial Hospital v. Reserve Life Insurance Co.*, 350 F.2d 1006 (8th Cir. 1965); *Pyramid Life Insurance Co. v. Masonic Hospital Ass'n*, 191 F. Supp. 51 (W.D. Okla. 1961); *Murphy v. Godwin*, 303 A.2d 668 (Del. Super. Ct. 1973).

⁶⁰104 Neb. 224, 177 N.W. 831 (1920).

⁶¹*Id.* at 225, 177 N.W.2d at 832.

⁶²18 Misc. 2d 740, 183 N.Y.S.2d 351 (Sup. Ct. 1959).

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mission, discharge, birth and death upon request.⁶³ Further, the Ohio Revised Code places affirmative duties on physicians to report medical information concerning occupational diseases,⁶⁴ contagious and infectious diseases,⁶⁵ indicia

⁶³See, e.g., OHIO REV. CODE ANN. § 149.43 (Baldwin 1983).

⁶⁴OHIO REV. CODE ANN. §§ 3701.25, 4123.71 (Baldwin 1983). Section 3701.25 provides in relevant part: Every physician attending on or called in to visit a patient whom he believes to be suffering from poisoning from lead, phosphorus, arsenic, brass, wood alcohol, mercury, or their compounds, or from anthrax or from compressed air illness and such other occupational diseases and ailments as the department of health shall require to be reported, shall within forty-eight hours from the time of first attending such patient send to the director of health a report stating:

- (A) Name, address, and occupation of patient;
- (B) Name, address, and business of employer;
- (C) Nature of disease;
- (D) Such other information as may be reasonably required by the department.

OHIO REV. CODE ANN. § 3701.25 (Baldwin 1984).

Section 4123.71 provides in relevant part:

Every physician in this state attending on or called in to visit a patient whom he believes to be suffering from an occupational disease as defined in section 4123.68 of the Revised Code shall, within forty-eight hours from the time of making such diagnosis, send to the industrial commission a report stating:

- (A) Name, address, and occupation of patient;
- (B) Name and address of business in which employed;
- (C) Nature of disease;
- (D) Name and address of employer of patient;
- (E) Such other information as is reasonably required by the commission.

OHIO REV. CODE ANN. § 4123.71 (Baldwin 1984).

⁶⁵OHIO REV. CODE ANN. §§ 3701.24, 3701.52, 3707.06 (Baldwin 1984). Section 3701.24 provides:

Boards of health, health authorities or officials, and physicians in localities in which there are no health authorities or officials, shall report to the department of health promptly upon the discovery of the disease, the existence of any one of the following diseases:

- (A) Asiatic cholera;
- (B) Yellow fever;
- (C) Diphtheria;
- (D) Typhus or typhoid fever;
- (E) Any other contagious or infectious diseases that the public health council specifies.

OHIO REV. CODE ANN. § 3701.24 (Baldwin 1984).

Section 3701.52 provides:

Every physician, surgeon, obstetrician, midwife, nurse, maternity home or hospital of any nature, parent, relative, or any others attendant on any person with inflammation of the eyes, knowing either condition, defined in section 3701.51 of the Revised Code, to exist, within six hours thereafter, shall report such facts, as the department of health shall direct, to the health commissioner of the city or general health district within which such person may reside.

OHIO REV. CODE ANN. § 3701.52 (Baldwin 1984).

Section 3707.06 provides:

Each physician or other person called to attend a person suffering from cholera, plague, yellow fever, typhus fever, diphtheria, typhoid fever, or any other disease dangerous to the public health, or required by the department of health to be reported, shall report to the health commissioner within whose jurisdiction the sick person is found the name, age, sex, and color of the patient, and the house and place in which the sick person may be found. In like manner, the owner or agent of the owner of a building in which a person resides who has any of the listed diseases, or in which are the remains of a person having died of any of the listed diseases, and the head of the family, immediately after becoming aware of the fact, shall give notice thereof to the health commissioner.

OHIO REV. CODE ANN. § 3707.06 (Baldwin 1984).

of child abuse,⁶⁶ various vital statistics,⁶⁷ and certain evidence of serious criminal conduct to various state agencies.⁶⁸

⁶⁶OHIO REV. CODE ANN. § 2151.421 (Baldwin 1984). Section 2151.421 provides in relevant part:

Any attorney, physician, including a hospital intern or resident, dentist, podiatrist, practitioner of a limited branch of medicine or surgery as defined in section 4731.15 of the Revised Code, registered or licensed practical nurse, visiting nurse, or other health care professional, licensed psychologist, speech pathologist or audiologist, coroner, administrator or employee of a child day-care center, or administrator or employee of a certified child care agency or other public or private children services agency, school teacher or school authority, social worker, or person rendering spiritual treatment through prayer in accordance with the tenets of a well recognized religion, acting in his official or professional capacity, having reason to believe that a child less than eighteen years of age or any crippled or otherwise physically or mentally handicapped child under twenty-one years of age has suffered any wound, injury, disability, or condition of such a nature as to reasonably indicate abuse or neglect of the child, shall immediately report or cause reports to be made of such information to the children services board or the county department of welfare exercising the children services function, or a municipal or county peace officer in the county in which the child resides or in which the abuse or neglect is occurring or has occurred.

Anyone having reason to believe that a child less than eighteen years of age or any crippled or otherwise physically or mentally handicapped child under twenty-one years of age has suffered any wound, injury, disability, or other condition of such nature as to reasonably indicate abuse or neglect of the child may report or cause reports to be made of such information to the children services board or the county department of welfare exercising the children services function, or to a municipal or county peace officer.

The reports shall be made forthwith by telephone or in person forthwith, and shall be followed by a written report, if requested by the receiving agency or officer. . . .

When the attendance of the physician is pursuant to the performance of services as a member of the staff of a hospital or similar institution, he shall notify the person in charge of the institution or his designated delegate who shall make the necessary reports. . . .

Anyone or any hospital, institution, school, health department, or agency participating in the making of the reports, or anyone participating in a judicial proceeding resulting from the reports, shall be immune from any civil or criminal liability that might otherwise be incurred or imposed as a result of such actions. Notwithstanding section 4731.22 of the Revised Code, the physician-patient privilege shall not be a ground for excluding evidence regarding a child's injuries, abuse, or neglect, or the cause thereof in any judicial proceeding resulting from a report submitted pursuant to this section.

Id.

⁶⁷See, e.g., OHIO REV. CODE ANN. § 3705.14 (Baldwin 1984). Section 3705.14 provides in relevant part that "[T]he attending physician or midwife shall file, within ten days after every birth, with the local registrar of vital statistics of the district a certificate of birth giving all the particulars therein required. . . . Birth certificates shall not be invalid because of delayed filing." *Id.*

⁶⁸OHIO REV. CODE ANN. § 2921.22 (Baldwin 1984). Section 2921.22 provides in relevant part:

- (A) No person, knowing that a felony has been or is being committed, shall knowingly fail to report such information to law enforcement authorities.
- (B) No physician, limited practitioner, nurse, or person giving aid to a sick or injured person, shall negligently fail to report to law enforcement authorities any gunshot or stab wound treated or observed by him, any serious physical harm to persons that he knows or has reasonable cause to believe resulted from an offense of violence, any second or third degree burn that was inflicted by an explosion or other incendiary device, or any burn that shows evidence of having been inflicted in a violent, malicious, or criminal manner.
- (C) No person who discovers the body or acquires the first knowledge of the death of any person shall fail to report the death immediately to any physician whom the person knows to be treating the deceased for a condition from which death at such time would not be unexpected, or to a law enforcement officer, ambulance service, emergency squad, or the coroner in a political subdivision in which the body is discovered, the death is believed to have occurred, or knowledge concerning the death is obtained.
- (D) No person shall fail to provide upon request of the person to whom he has made a report required by division (C) of this section, or to any law enforcement officer who has reasonable cause to assert the authority to investigate the circumstances surrounding the death, any facts within his knowledge that may have a bearing on the investigation of the death.
- (E) Division (A) or (D) of this section does not require disclosure of information, when any of the following applies:

The interest of a specific third person may also create a privilege. In *Berry v. Moench*,⁶⁹ for example, the court considered the types of conditional privileges a physician might assert to a claim of breach of confidentiality. The court stated that the physician's duty to keep the confidences of his patients might be outweighed where there is a sufficiently important interest to protect in a third person.⁷⁰ In determining when a third person's interest is sufficient to justify an unauthorized disclosure of confidential medical information, the *Berry* court stated:

We recognize that such a privilege may also extend to protection of the interests of third persons under proper circumstances. Where life, safety, well-being or other important interest is in jeopardy, one having information which could protect against the hazard, may have a conditional privilege to reveal information for such purpose, even though it be defamatory and may prove to be false. But the privilege is not something which arises automatically and becomes absolute merely because there is an interest to protect. It has its origin in, and it is governed by, the rule of good sense and customary conduct of people motivated by good will and proper consideration for others. This includes due consideration for the subject being informed about as well as the recipient being protected. . . . (T)he law imposes upon one publishing derogatory information, even for laudatory purposes, the responsibility of exercising due care in what he

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- (1) The information is privileged by reason of the relationship between attorney and client, doctor and patient, licensed psychologist or licensed school psychologist and client, priest and penitent, clergyman or rabbi or minister or priest and any person communicating information confidentially to him for a religious counseling purpose in his professional character, or husband and wife.
 - (2) The information would tend to incriminate a member of the actor's immediate family.
 - (3) Disclosure of the information would amount to revealing a news source, privileged under section 2739.04 or 2739.12 of the Revised Code.
 - (4) Disclosure of the information would amount to disclosure by an ordained clergyman of an organized religious body of a confidential communication made to him in his capacity as such by a person seeking his aid or counsel.
 - (5) Disclosure would amount to revealing information acquired by the actor in the course of his duties in connection with a bona fide program of treatment or services for drug dependent persons or persons in danger of drug dependence, which program is maintained or conducted by a hospital, clinic, person, agency, or organization registered pursuant to section 5122.51 of the Revised Code.
 - (6) Disclosure would amount to revealing information acquired by the actor in the course of his duties in connection with a bona fide program for providing counseling services to victims of crimes that are violations of section 2907.02, 2907.05, or 2907.12 of the Revised Code. . . .
 - (F) No disclosure of information pursuant to this section gives rise to any liability or recrimination for a breach of privilege or confidence.
 - (G) Whoever violates division (A) or (B) of this section is guilty of failure to report a crime. Violation of division (A) of this section is a misdemeanor of the fourth degree. Violation of division (B) of this section is a misdemeanor of the second degree.
 - (H) Whoever violates division (C) or (D) of this section is guilty of failure to report knowledge of a death, a misdemeanor of the fourth degree.

Id.

⁶⁹8 Utah 2d 191, 331 P.2d 814 (1958). This case involved a physician's advice to his patient's fiancée to "run as far as she could in any direction away" from the patient because of the patient's record of trouble. *Id.* at 195, 331 P.2d at 816.

does and in knowing whereof he speaks.⁷¹

As is readily apparent, the privilege to disclose confidential information to protect the interest of a third person and the privilege to protect the public safety are very similar in nature. The only distinction seems to be whether the interest of one or several persons is threatened. Just as in the case of a public interest, a number of courts have raised the *conditional privilege* of disclosure to a third person to a *duty* to disclose under proper circumstances. A case in point is *Tarasoff v. Regents of University of California*,⁷² wherein the Supreme Court of California held that a physician who is aware of a threat to a third person owes a duty to that person to warn him of the peril in spite of the general duty of confidentiality the physician owes to his patient.⁷³ The *Tarasoff* holding has been cited by a number of other courts in other jurisdictions with approval.⁷⁴

In a similar case, the Supreme Court of Ohio held that a physician has a duty to protect third persons from the risk of contracting a contagious disease by alerting both the responsible health officials and any individuals he knows are likely to have contact with his patient. The case was styled *Jones v. Stanko, Admx.*,⁷⁵ and involved an action to recover damages resulting from the wrongful death of the plaintiff's husband, alleged to have been caused by the negligence of the defendant physician. The death of a neighbor of the plaintiff was caused by black smallpox, and the defendant was the sole attending physician seeing the patient every day until the day the patient died. The plaintiff alleged that her husband inquired of the defendant whether the patient was suffering from any contagious disease, and the defendant assured him that his patient was not and that he (the plaintiff's husband) bore no risk from visiting the patient in his illness. By reason of these assurances from the defendant, the plaintiff's husband not only visited his neighbor, but also waited upon him prior to his death and performed certain services with reference to his preparation for burial after death. It was admitted in the record that the defendant also failed to notify the appropriate health authorities, as he was required by law to do, of the fact that he was treating a patient for a contagious disease. The only matter in dispute in the case was whether the defendant was negligent in failing to discover that his patient was suffering from the contagious disease of black smallpox and in failing to give notice thereof to the appropriate public health officials and to those who were coming into the presence of his patient. In its syllabus, the Ohio Supreme Court put forth the rule of law as follows:

It is the duty of a physician who is treating a patient afflicted with

⁷¹*Id.* at 197-98, 331 P.2d at 817-18. See RESTATEMENT (SECOND) OF TORTS § 595 (1977).

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

⁷³*Id.* at 435-42, 551 P.2d at 343-48, 131 Cal. Rptr. at 823-28.

⁷⁴See, e.g., *MacDonald v. Clinger*, 84 A.D.2d 482, 484, 446 N.Y.S.2d 801, 805 (1982).

⁷⁵17 Ohio St. 47, 160 N.E. 456 (1928).

smallpox to exercise ordinary care in giving notice of the existence of such contagious disease to other persons who are known by the physician to be in dangerous proximity to such patient; and a failure to discharge this duty will constitute negligence on the part of the physician available to any person in the recovery of damages resulting directly and proximately from such neglect on the part of the physician.⁷⁶

The *Jones* case is important for three reasons. First, it clearly demonstrates that the Ohio common law rule is that a physician can have a duty to third parties with whom he has no professional relationship. Second, it places on the physician an affirmative duty to warn others not only of a danger that he *is aware of*, but also of a danger that he *should be aware of* by exercising the standard of care that he owes to his patient. Third, a physician is not relieved of his duty to others merely by reporting the danger to the appropriate governmental agency. His duty continues beyond any statutory obligation of reporting to require direct notice to specific persons he knows are at risk.

Under proper circumstances, the self-interest of the attending physician or health care facility may create a conditional privilege. For example, in the *Hammonds* case the court recognized that the physician could disclose the patient's confidences where necessary to defend a malpractice suit.⁷⁷ The current version of the Ohio testimonial privilege statute expressly permits the physician to disclose otherwise confidential information in defending a suit against him that relates to the treatment given to the patient.⁷⁸ This issue was addressed by the Montgomery County Court of Common Pleas in a case styled *Otto v. Miami Valley Hospital*,⁷⁹ wherein the court stated:

(T)he privileged communication statute has no application to an adversary action between the two parties to the communication where the testimony is essential either to maintain or to defend the particular action. To deny relief or defense by denying evidence would be unconstitutional. . . .

⁷⁶*Id.* at 147, 160 N.E. at 457.

⁷⁷*Hammonds*, 243 F. Supp. at 805. (In letting others view evidence, a physician releasing information leaves himself open to potential liability where the disclosure is not necessary to defend a claim pending against the physician.)

⁷⁸OHIO REV. CODE ANN. § 2317.02(B) (Baldwin 1984). Section 2317.02(B) provides in relevant part:

The following persons shall not testify in certain respects: . . .

(B) A physician concerning a communication made to him by his patient in that relation or his advice to his patient but *the physician may testify* by express consent of the patient or if the patient is deceased by the express consent of the surviving spouse or the executor or administrator of the estate of such deceased patient or if the patient voluntarily testifies the physician may be compelled to testify on the same subject, or *if the patient, his executor or administrator, files a medical claim*, as defined in division (D)(3) of section 2305.11 of the Revised Code, such filing shall constitute a waiver of this privilege with regard to the care and treatment of which complaint is made. The provisions of this division apply to doctors of medicine, doctors of osteopathic medicine, and doctors of podiatric medicine.

Id. (emphasis added.)

⁷⁹26 Ohio Miss. 73, 266 N.E.2d 270 (Montgomery County Ct. of C.P. 1971).

We agree that in an action against a physician for malpractice the doctor may disclose communications. (Citation omitted.) And we add that when a patient sues his doctor for malpractice, the patient must disclose in pleading and in discovery if he wishes to proceed.⁸⁰

The *Otto* decision must be distinguished from the *Hammonds* decision. Since the plaintiff in *Hammonds* had neither brought suit nor actually threatened it against the physician (as the insurance company had represented to the physician), the *Hammonds* court found that there was no privilege on the mere possibility that the patient might bring an action.⁸¹ The *Otto* court, on the other hand, faced a situation where the patient had actually brought suit against the attending physician. The physician's need to disclose confidential information in order to defend himself in a malpractice suit is widely recognized and so obviously necessary that the issue has seldom been litigated.⁸²

In *Patton v. Jacobs*,⁸³ an Indiana court held that a physician may disclose the patient's medical bill in an effort to collect an overdue debt. This seems logical, and is probably the law in Ohio, but it is important to note the discussion below concerning the limits placed upon conditional privileges. The type of information which a physician may release to collect a just debt should be limited to that which is necessary to collect the debt.

In all situations where the release of the medical information is permissible, the scope of the waiver, authorization, privilege or duty must be considered. For example, the court in the *Hammonds* held that where a plaintiff deposed his physician, the plaintiff waived any right to object to an opposing party's deposition of that physician.⁸⁴ The court also held that the waiver was limited in scope and did not permit the physician to engage in *ex parte* disclosures of information that the physician obtained during the course of treatment.⁸⁵ The same should be true with respect to the physician's duty to disclose certain information to public health officials.⁸⁶ Such a duty would not prevent liability for disclosing that information to individuals to whom the physician has no legal duty to report.

In a Utah case styled *Berry v. Moench*,⁸⁷ the court provided the following summary of the limitations placed on conditional privileges in the area of defamation to guide a lower court in its determination of whether or not a

⁸⁰*Id.* at 74-75, 266 N.E.2d at 272.

⁸¹*Hammonds*, 243 F. Supp. at 804-05.

⁸²*See* Annot., 7 A.L.R. 3d 1458 (1966).

⁸³118 Ind. App. 358, 78 N.E.2d 789 (1948).

⁸⁴*Hammonds*, 243 F. Supp. at 805.

⁸⁵*Id.*

⁸⁶*See, e.g.*, OHIO REV. CODE ANN. § 3701.05 (Baldwin 1984). (Physician must report occupational disease to the Ohio Department of Health.)

⁸⁷8 Utah 2d 191, 331 P.2d 814 (1958).

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physician should be liable for providing confidential information about a patient to that patient's fiancée:

(A)n examination of the authorities reveals that quite generally, when the matter is actually in issue, they are in accord upon a principle which we consider sound and salutary: that the privilege to pass on derogatory information, which proves false, must have been exercised with at least reasonable discretion, or the publisher will be held responsible therefor. This is well summarized in [Section 595 of] the Restatement of Torts: "Even though an occasion is so privileged, a particular person cannot avail himself of the privilege arising therefrom if he abuses the occasion. . . . The occasion may be abused by the publisher's lack of belief or reasonable grounds for belief in the truth of the defamatory matter . . . ; by publication of the defamatory matter for some improper purpose . . . ; by excessive publication . . . ; or by the publication of defamatory matter not reasonably believed to be necessary to accomplish the purpose." [A privilege] must be exercised with certain cautions: (a) it must be done in good faith and reasonable care must be exercised as to its truth, (b) likewise, the information must be reported fairly, (c) only such information should be conveyed, and (d) only to such persons as are necessary to the purpose.⁸⁸

While the *Berry* court summarized limitations on conditional privileges in the area of defamation, it is likely that any court dealing with the unauthorized release of patient information by a physician will look to this area of law in deciding whether or not a particular communication should be held privileged. The court in *Hammonds* appears to have taken this approach in deciding whether or not there was a privilege as to the communication at issue in that case.⁸⁹

SUMMARY

The case law from Ohio and other states indicates that the unauthorized disclosure of medical information by anyone in a confidential relationship with the patient to whom the information relates is an actionable tort. The precise nature of the tort and its contours are still emerging as the case law on the subject develops. While the courts that have dealt with unauthorized disclosures of medical information have relied upon a number of legal theories to impose liability on the practitioner making such a disclosure, it is clear that the courts have, in fact, given little consideration to the actual elements and defenses to the various established legal theories and have freely bent the limits of such theories or glossed over their elements to reach the ultimate result of finding

⁸⁸*Id.* at 198-99, 331 P.2d at 818-19 (quoting RESTATEMENT (SECOND) OF TORTS § 595 (1977)).

⁸⁹*Hammonds*, 243 F. Supp. at 803-05.

unauthorized and unjustified disclosures of medical information actionable. The following elements generally have been present in cases where liability has been imposed for release of medical information:

1. There has been a disclosure of medical information to a third party;
2. The publisher obtained the information during the course of a professional relationship with the patient or from someone else who obtained the information in the course of a professional relationship with the patient;
3. The professional relationship was of such a nature as to cause the patient to have a reasonable expectation that the information would be held in confidence; and
4. The publisher communicated the information, either intentionally or negligently, to a third party without reasonable justification, or while justification was present, the publisher exceeded the limits of the justification by publishing more information than was necessary or by providing the information to more people than was necessary to accomplish the purpose of the justification.

In addition to finding various conditional privileges to disclose otherwise confidential communications, such as when a physician seeks to collect a just debt or defend against a suit brought against the physician by the subject of the information, the courts in limited circumstances also have imposed a duty upon the physician and others holding medical information to disclose the information to a third party where there is a risk of substantial harm to the third party. In such cases, the duty to disclose arises only where the holder of the medical information either is or should be aware of the potential harm and has an opportunity to convey the information to the individual or group at risk or to an appropriate public official who is responsible for the well-being of such individual or group. In deciding whether or not to make such a communication to protect the interests of another individual or group, one must engage in a delicate balancing process of weighing the privacy interest of the patient against the risk of harm to others, bearing in mind the gravity of the decision and the potential for personal liability.

