Subject: Protection of Clinician-Patient Privilege (Resolution 237-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

INTRODUCTION

At the 2017 Annual Meeting, the House of Delegates (HOD) referred Resolution 237-A-17, “Protection of Clinician-Patient Privilege,” for report back at the 2018 Annual Meeting. This resolution was introduced by the Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont Delegations and asked that our American Medical Association (AMA):

Advocate to the relevant national bodies for the clinician-patient privilege to be regulated according to the privacy protections in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) without regard to where care is received.

This report provides information about the privacy protections and exceptions thereto found in the Family Education Rights and Privacy Act (FERPA) in post-secondary educational settings. It also compares such protections and exceptions to those found in HIPAA. Finally, it discusses which of the two standards is more appropriate for the AMA to support.

BACKGROUND

FERPA is a federal law that applies to educational institutions—including most public and private post-secondary institutions—that receive funding from the U.S. Department of Education. It protects the privacy of information found within students’ “education records,” which is broadly defined to mean those records that are (1) directly related to a student, and (2) maintained by an educational agency or institution or by a party acting for the agency or institution. FERPA prohibits a post-secondary institution from disclosing personally identifiable information (PII) from a student’s education records absent that student’s written consent, unless an exception applies.

Education records can include medical records (for example, immunization records), but are separate and distinct from “treatment records.” Treatment records are defined in post-secondary institutions as those made or maintained by a physician, psychiatrist, psychologist, or other recognized professional acting in his or her professional capacity and in connection with treatment of a student at the institution. By definition, these records may be disclosed only to individuals providing treatment to the student (not even to the student him or herself), unless the student provides written consent or an exception applies. Once a disclosure is made to anyone other than the student’s treating clinicians, the record is no longer considered a treatment record, but rather an education record subject to FERPA’s general disclosure rules.
As noted above, there are instances in which a school may disclose both education and treatment records even when the student does not provide written consent. Examples include:

- For the legitimate educational interests of other educational institutions;
- To make financial aid determinations;
- To authorized representatives of the United States government;
- To parents of dependent students;
- To comply with a judicial order or lawfully issued subpoena;
- If the educational institution initiates legal action against a parent or student; and
- If a parent or student initiates legal action against the educational institution.

HIPAA, the federal privacy law applicable to most medical records, prohibits the use and disclosure of protected health information (PHI) by covered entities (e.g., clinicians and health care facilities) absent written patient authorization, unless an exception applies. Common exceptions include:

- Treatment (including disclosure of information to other health care providers);
- Payment;
- Health care operations (including for litigation purposes where the covered entity is a party to the proceedings);
- For public health purposes;
- To authorized representatives of the United States government;
- To parents of minors; and
- To comply with a judicial order or lawfully issued subpoena.

DISCUSSION

Both HIPAA and FERPA permit disclosure of medical information without a patient’s written authorization for certain purposes. Specifically, with respect to disclosures for legal proceedings, HIPAA requires that a covered entity disclose only the minimum amount of information necessary to accomplish the intended purpose of the disclosure. Guidance from the U.S. Department of Education also notes that “without a court order or written consent, [educational] institutions that are involved in litigation between the institution and the student should not share, without consent, student medical records with the institution’s attorneys or courts unless the litigation in question relates directly to the medical treatment itself…and even then should disclose only those records that are relevant and necessary to the litigation.” This guidance also notes that “FERPA’s school official exception to consent should be construed to offer protections that are similar to those provided to medical records in the context of litigation between a covered health care provider, such as a hospital, and a patient under [HIPAA].

CONCLUSION

The patient should always be at the center of any privacy policy adopted by the AMA, and indeed, the AMA has strong policy protecting the privacy of patient information, included in the appendix. Regardless of the clinical care setting, whether it is an educational setting, a substance abuse clinic, or a physician’s office, the AMA should continue to advocate for HIPAA’s privacy protections to be the minimal level of privacy afforded to a patient. This position will permit more stringent privacy laws for patients where appropriate—for example, more protective state laws or federal laws, such as 42 CFR Part 2, which protects patients who seek treatment at substance abuse facilities. The AMA should also continue to ensure that any information disclosed without a
patient’s written consent is the minimum necessary to accomplish the disclosure’s intended purpose.

RECOMMENDATIONS

The Board of Trustees recommends that Policy H-315.983 be amended in lieu of Resolution 237-A-17 and the remainder of the report be filed:

Policy H-315.983, “Patient Privacy and Confidentiality”

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received. (Modify Current HOD Policy)

Fiscal Note: Less than $500.
REFERENCES

1 34 CFR 99.3; 20 USC 1232g(a)(4)(B)(iv).
2 34 CFR 99.30, 20 USC 1232g(b); 20 USC 1232g(d).
3 34 CFR 99.3; 20 USC 1232g(a)(4)(B)(iv).
4 34 CFR 99.3; 20 USC 1232g(a)(4)(B)(iv).
6 34 CFR 99.31; 20 USC 1232g(b).
7 45 CFR 164.502(a).
8 45 CFR 164.502(b); 45 164.514(d); see also “May a covered entity that is a plaintiff or defendant in a legal proceeding use or disclose protected health information for the litigation?”, available at www.hhs.gov/hipaa/for-professionals/faq/705/may-a-covered-entity-in-a-legal-proceeding-use-protected-health-information/index.html, accessed February 25, 2018.

APPENDIX — AMA POLICY

Policy H-315.983, “Patient Privacy and Confidentiality”
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients’ privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients,
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

Policy H-320.994, “Confidentiality”
Our AMA believes that: (1) there has been an erosion of the confidential relationships between the patient and health professional, which has resulted from growing outside demands for the information shared in this relationship for the purpose of patient care; (2) there is a need to sensitize the public to the intrusions into confidential medical information which can result from increased demands for accountability - in substantiating health insurance claims, in litigation, and in medical care evaluation; (3) much of the erosion has emanated from the public, and properly so; however, an over-emphasis on society's right to know, at the expense of the individual's right to privacy and confidentiality, has resulted and a better balance is needed; (4) one important contribution to restoring such balance would be greater education of patients and the public as to the full range of purposes for which confidential information is used, the policies governing the release of such information, and the individual's rights with respect thereto.

Policy H-315.975, “Police, Payer, and Government Access to Patient Health Information”
1. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

2. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.

3. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually
identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

4. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.

5. Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

Policy H-60.965, “Confidential Health Services for Adolescents”
Our AMA: (1) reaffirms that confidential care for adolescents is critical to improving their health; (2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law; (3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care; (4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements); (5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician; (6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis; (7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice; (8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and (9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.

Policy H-315.965, “Modernizing Privacy Regulations for Addiction Treatment Records”
Our AMA supports: (1) regulatory and legislative changes that better balance patients’ privacy protections against the need for health professionals to be able to offer appropriate medical services to patients with substance use disorders; (2) regulatory and legislative changes that enable physicians to fully collaborate with all clinicians involved in providing health care services to patients with substance use disorders; and (3) continued protections against the unauthorized disclosure of substance use disorder treatment records outside the healthcare system.