Confidentiality of Medical Records: Does the Physician Have a Right to Privacy Concerning His or Her Own Health Records?

POSITION STATEMENT

Approved by the Board of Trustees, December 1980
Approved by the Assembly, May 1981

"Policy documents are approved by the APA Assembly and Board of Trustees...These are... position statements that define APA official policy on specific subjects..." -- APA Operations Manual.


It has been proposed that physicians (and students aspiring to become physicians) have a special duty to the public which can only be discharged by requiring that the physician's own health record, especially information pertaining to the physician's mental health, be exposed to the scrutiny of those who oversee the quality of medical care or the fitness of individuals to practice medicine. This supposed duty of disclosure is said to arise from the special role physicians have in society and the vulnerability of the public to potential harm from inept, malicious, or otherwise dangerous doctors. This role also places a burden on those who select physicians and scrutinize their performance so that the public interest is adequately safeguarded. This raises the general question, Does the expectation of medical confidentiality extend to the physician's own health records when the physician is a patient?

The short answer to this question is, No convincing argument has been advanced to show that a patient should be deprived of the right to the privacy of his or her medical record simply because he or she has chosen to study or practice medicine.

The traditional privacy of communications between a patient and his or her physician rests on the judgment that society benefits when sick people have unimpeded access to necessary medical treatment. This expectation of medical confidentiality is reflected in medical ethics (1), contract law (2), and the common law (3) and has been enacted into statutory law in a majority (N=36) of jurisdictions (4).** Recently, a federal district court found that the right to privacy of medical records has a Constitutional basis (5). We have been unable to find laws that except physicians from these protections when they become ill and seek treatment.

In attempting to balance the danger to the public from mental disorders in physicians against the rights of all patients to privacy, we believe that the reasonable protection of patients does not require the assumption that anyone who is or who has been a psychiatric patient is potentially so harmful to patients that he or she cannot practice medicine without first presenting his or her otherwise private medical record for public scrutiny. There is no evidence to suggest that the hazard is so great that normal safeguards are inadequate. Moreover, there is, in our view, a greater danger that individuals needing treatment will be barred from obtaining professional help if getting it would require them to bare their innermost secrets to public or private overseers. More likely, they would try to conceal the need and continue to practice without diagnosis and treatment for what might be curable ills.

*The Task Force (now a committee) included Robert E. Jones, M.D. (chairperson), Manuel M. Pearson, M.D., Stephen Scheiber, M.D., Douglas A. Sargent, M.D., and Robert Marvin, M.D. (Assembly liaison).

The competition for admission to medical school is severe and begins early. If it were to become generally known that potential physicians who had consulted psychiatrists or other mental health professionals would be required to disclose that fact in the medical school application process, many needing treatment either would not get it or would conceal the fact, viewing a “psychiatric history” as an impediment to acceptance. Further, as Silver and associates (6) have shown, there are no data correlating psychiatric diagnosis and treatment with performance in medical school or practice.

What is true for medical students is even more likely in the case of the practicing physician, who stands to lose his or her means of livelihood, cannot easily change a career already launched, and does not have the student's option of simply choosing not to enter medicine rather than have his or her secrets known. Recent experience with “snitch laws” in New York and elsewhere (7) suggests that this fear of disclosure is real and not merely theoretical, confirming Slovenko's suggestion (8) that mental disorder is today's "loathsome disease," the analogue of those socially impairing conditions that first led to the development of the physician-patient privilege. Citing Eldridge's The Law of Defamation, Slovenko said,

Surveys indicate that the general public regards a person seeking a psychiatrist with fear, distrust, or dislike. The public generally acts differently toward a psychiatric patient. This is reflected in the law of defamation where it is provided that a statement that a person is mentally ill is an “imputation of want of ability to discharge the duties of that person's ... profession ...” and thus slander on its face.

It is no comfort to the disturbed medical student or physician that the public's prejudices may not be shared by medical school admissions committees or medical practice boards, especially since experience suggests that physicians share the public view of psychiatry and our patients. Far from protecting the public, it is likely that abolition of the confidentiality of the physician's or medical student's personal health record would simply discourage troubled people, many with treatable disorders, from finding appropriate medical help and would hamper those who try to help them. We are naturally concerned, since we believe that such an impaired individual is far more likely to endanger patients than would be the case if medical treatment were a private matter for medical practitioners as it is for others.

Medical schools, hospitals, licensure boards, and other regulatory bodies seeking to know whether a history of medical or psychiatric disorder impairs present functioning are advised to do so on a case-by-case basis, as such a history has little predictive value. A medical psychiatric evaluation by a consultant hired for the purpose of determining present competence should be obtained for evaluating applicants whose fitness is questioned and who have given voluntary, informed consent. Such evaluations should be made only for cause and should not be routinely required of all applicants.

In short, the mandatory disclosure of the physician's confidential medical or personal history is without merit.

Both tradition and public policy, as reflected in the laws of privacy, favor access to therapy for all who need it, including physicians. The supposedly heightened protections for patients sought by those who would exclude physicians from the traditional safeguards of medical confidentiality are illusions. We urge support for the traditional view and oppose forced disclosure, which seems to promise more benefit than we think it can deliver.

1. American Medical Association Judicial Council: Section 9, in Principles of Medical Ethics. Chicago, AMA, 1969
2. Horne v Patton, 287 S 2d 824 (Ala S Ct 1974)
5. Hawaiian Psychiatric Society, District Branch, American Psychiatric Association v Ariyoshi, 481 S Supt 1028, 1052 (D Hawaii 1979)