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The Discovery of Medical Records Maintained by Health Care Facilities: Inconsistent Law in Need of Legislative Correction

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THE DISCOVERY OF MEDICAL RECORDS MAINTAINED BY HEALTH CARE FACILITIES: INCONSISTENT LAW IN NEED OF LEGISLATIVE CORRECTION

SUSAN O. SCHEUTZOW*
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Health care facilities, such as hospitals, nursing homes, and outpatient health centers, generally maintain detailed medical records for all patients and residents. These records usually contain physicians' notes regarding diagnosis, treatment, and observations, but most often also contain nurses' and other health care professionals' notes, as well as test results and other information.

There is no law in the State of Ohio which grants medical records maintained by health care facilities absolute protection from discovery pursuant to judicial process. The only legal protection given to such records flows either from statutes granting protection to certain types of records or from the Ohio law of privileged communications, which protects some communications between patients and certain health care professionals. Under federal law, the protection given to such records is even more limited because there is no recognized privilege for communications made by patients to physicians or other health care professionals.

The law of privileged communications was developed at a time when health care delivery was markedly different from today's health care environment. When today's modern health care system is juxtaposed against the law of privileged communications created during this earlier time, confusing and inconsistent outcomes have occurred regarding the discovery and admissibility of medical records maintained by health care facilities.

Because of the ambiguities which exist under state and federal law, a health care facility, when faced with a subpoena for medical records, is placed in the difficult position of determining whether to release the requested records, to refuse to release any of the records, or to excise those portions of the records which the health care provider determines are protected and release the remainder. Failure to respond to the subpoena for records exposes the health care facility to contempt of court charges, while releasing the records may subject the facility to liability based on a cause of action for breach of confidentiality. Furthermore, the health care facility may be subject to significant expense due to the time and potential legal costs involved in determining how to respond to the subpoena.

This article will review current law in Ohio regarding the protection of medical records maintained by Ohio health care facilities. The Ohio law of privileged communications between health care professionals and patients also will be traced to show how only communications between patients and their physicians, dentists, psychologists, and social workers are currently protected. Since similar public policy reasons may apply to the protection of communications between a wider range of health care professionals and their patients as those communications with physicians, dentists, psychologists, and social workers, this article will discuss why the public policy reasons supporting the initial adoption of the law of privileged communications are not adequately served by Ohio's limited law.

This article will set forth a course of action to be utilized by health care facilities to protect their facility and patient records as fully as possible. This course of action, however, involves significant judicial involvement.
If followed, it will be an expense for health care facilities and place additional burdens on the judicial system. Finally, this article will comment on how the burden for determining whether records should be released is unfairly placed upon the health care provider. Suggestions will be given for legislation to rectify the current problems with Ohio law and for actions which may be taken by those involved in litigation to reduce problems with obtaining these records.

I. HOSPITAL RECORDS

A medical record maintained by an inpatient health care facility such as a hospital or nursing home contains information obtained from a myriad of sources. Central to most inpatient medical records are a physician, dentist, or podiatrist's notes, diagnosis, orders, and summaries.1 The record may also contain laboratory and other test results, and entries made by a wide variety of health care facility personnel, including admitting staff, nurses, physical therapists, social workers, respiratory care workers, laboratory technicians, and others. The record generally contains both information transmitted from the patient to the health care worker, as well as medical determinations made by the health care professional, treatment rendered to the patient, and advice and information given to the patient.

In addition to inpatient records, health care facilities maintain records for outpatient services such as emergency room visits, outpatient surgery, laboratory tests, and various types of therapy. Contrary to the inpatient setting, where there will always be diagnostic and treatment information supplied by the admitting physician, dentist, or podiatrist, the outpatient record may lack such information except for an initial order for the requested services. Thus, many outpatient records consist exclusively of lab tests and perhaps nurses' notes.

II. PROTECTION FROM JUDICIAL PROCESS OF PATIENT MEDICAL INFORMATION MAINTAINED BY HEALTH CARE FACILITIES

A. Limits on Discoverability and Admissibility of Health Care Information

Health care providers generally have an ethical duty to refrain from disclosing patient information to third parties. The protection of patients is the hallmark of the ethical practice of medicine and is recognized as

1 OHIO REV. CODE ANN. § 3727.06 (Page's 1988) provides that only a doctor of medicine, a doctor of osteopathic medicine, or a dentist who is a member of a hospital medical staff may admit a patient to a hospital while a podiatrist who is a member of a hospital medical staff may co-admit a patient to a hospital with a doctor of medicine or doctor of osteopathic medicine. Consequently, the notes, orders, and diagnoses of these individuals provide the basis for a patient's inpatient care.
an ethical standard by all major medical, mental health, counseling organizations\textsuperscript{2} and health care accreditation organizations.\textsuperscript{3} These ethical considerations have been codified in Ohio law as a standard of practice for many health care professionals.\textsuperscript{4} In fact, a professional may be disciplined by the appropriate licensing agency for betraying a patient's confidence by disclosing information to a third party.

The sanctions for a health care professional's breach of patient confidentiality are not limited to disciplinary actions before the appropriate licensing board. A patient who believes that his or her confidentiality

\textsuperscript{2} See, \textit{e.g.}, \textsc{American Medical Association, Revised Principles of Medical Ethics}, (1980); \textsc{Principle IV American Psychological Association, Ethical Principles of Psychologists, Principle V} (1981); \textsc{American Psychiatric Association, The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry} (1981); \textsc{National Association of Social Workers, Code of Ethics II} (1979).

\textsuperscript{3} \textsc{Ohio Rev. Code Ann. \textsection 3727.02 (Page's 1988)} provides that to operate in the state, a hospital must be accredited by either the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") or the American Osteopathic Association ("AOA") or be certified to provide hospital services pursuant to Title XVIII of the Social Security Act ("Medicare"). JCAHO, AOA and Medicare regulations all require that medical records remain confidential. See \textsc{Joint Commission on Accreditation of Healthcare Organizations 1990 Accreditation Manual, Standard-Medical Records 3; The American Osteopathic Association 1989 Accreditation Requirements for Acute Care Hospitals, Medical Records Maintenance p. 43; Medicare Conditions of Participation, 42 C.F.R. 482.24 (1988)}. JCAHO specifically requires that written patient consent is required for the release of medical information to persons not otherwise authorized pursuant to law to obtain such information, and AOA and Medicare regulations provide that patient information should not be released except in accordance with law, court orders or subpoenas. These accreditation and certification requirements do not, however, give a patient a private cause of action for an unauthorized release of the records by the healthcare providers.

Ohio law regarding the release of medical records by licensed nursing homes and rest homes, \textsc{Ohio Rev. Code Ann. \textsection 3721.13 (Page's Supp. 1990)} sometimes referred to as the resident's or patient's bill of rights, grants each nursing home and rest home patient the right to confidential treatment of personal and medical records and the right to approve or refuse the release of records to anyone outside the nursing home except to another home, hospital or health care system, as required by law or as required by third-party contract. A nursing home or rest home may lose its license to operate by repeatedly violating the resident's bill of rights. \textsc{Ohio Rev. Code Ann. \textsection 3721.03 (Page's 1990)} Any resident who believes his or her legal right to confidentiality of medical records has been violated may file a complaint with the Ohio Commission on Aging, and Ohio law specifically grants a resident of a home a private cause of action for a violation of the resident's bill of rights. Actual and punitive damages, as well as attorney's fees may be awarded to the prevailing party. \textsc{Ohio Rev. Code Ann. \textsection 3721.17 (Page's Supp. 1990)}. Federal regulations also provide that nursing homes protect patient records from any unauthorized use. 42 C.F.R. 442.318(a)(3).

\textsuperscript{4} Willfully betraying a professional confidence is an action which by statute may subject the following licensed professionals to suspension or revocation of their licenses or similar professional discipline: physicians assistants, \textsc{Ohio Rev. Code Ann. \textsection 4730.05(1) (Page's 1987)}; physicians and podiatrists, \textsc{Ohio Rev. Code Ann. \textsection 4731.22(B)(4) (Page's Supp. 1990)}; occupational therapists, \textsc{Ohio Rev. Code Ann. \textsection 4755.10(G) (Page's Supp. 1990)}; and psychologists, \textsc{Ohio Rev. Code Ann. \textsection 4732.17(D) (Page's 1987)}.
has been breached by a health care provider, may under some circumstances, have a civil cause of action against the health care provider on a number of legal theories.\textsuperscript{5} As a practical matter, however, lawsuits brought by a patient against a health care professional for breach of confidentiality are rare, in large part because (i) the law does not give absolute recourse to a patient whose confidentiality has been breached, and (ii) a patient considering bringing suit may determine that a lawsuit would only further disclose to the public sensitive information which the patient wishes to remain confidential.

\textsuperscript{5} Case law in Ohio has held that health care providers have a common law fiduciary duty to protect the confidentiality of patient information, and consequently, that a breach of contract action may be sustained for a breach of such duty. \textit{See} Hammonds v. Aetna, 237 F. Supp. 96 (N.D. Ohio); \textit{motion denied}, 243 F. Supp. 793 (N.D. Ohio 1965). In \textit{Hammonds}, the court determined that a common law fiduciary duty not to divulge professional confidences arises in Ohio between physicians and their patient because Ohio law recognizes a physician-patient privilege preventing a physician from testifying in court regarding confidential communications made by the patient to the physician, and because a physician may be disciplined by the State Medical Board for divulging a professional confidence. Given the reasoning of the court, presumably the fiduciary duty to keep information confidential exists for any health care provider who both is covered by the testimonial privilege not to divulge confidential communications and is subject to disciplinary action for breach of a professional confidence. Therefore, physicians, podiatrists, psychologists, counselors, and social workers, all of whom are subject to a testimonial privilege and may be disciplined for willfully betraying a professional confidence, arguably have a fiduciary duty to keep patient information confidential and may be liable to the patient for a breach of such duty. While the \textit{Hammonds} court pointed out that many states recognize a common law fiduciary duty not to disclose confidential information applicable to any health professional to whom the testimonial privilege applies, and other states recognize the duty for those professionals who may be disciplined for breach of a confidence, the court in \textit{Hammonds} did not conclude that a common law fiduciary duty to keep patient information confidential exists for professionals. For example, physician's assistants, who, while they may be disciplined for willfully betraying a professional confidence, are not covered by the law of privileged communications. A patient may have a cause of action against a nursing home for breach of confidentiality required by the patient bill of rights. \textit{See infra} note 12 and accompanying text.

A patient whose confidentiality is breached may also have a cause of action for breach of privacy. The right of privacy is the right of a person to be free from unwarranted appropriation or exploitation of one's personality, or 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 cause shame or humiliation to a person of ordinary sensibilities. Housh v. Peth, 165 Ohio St. 35, 133 N.E.2d 340 (1956). Ohio courts have held that a patient's privacy may be invaded by the release of confidential medical information to parties having no need to know such information, such as when a hospital released information regarding a patient's alcoholism treatment to the employer of the patient's husband. (Prince v. St. Frances - St. George Hospital, Inc., 20 Ohio App. 3d 4, 484 N.E.2d 265 (Hamilton Cty. 1985)), and when an employer's in-house medical claims examiner released information about one employee to another employee (Levias v. United Airlines, 27 Ohio App. 3d 222, 500 N.E.2d 370 (Cuyahoga Cty., 1985)).
While there is a general duty imposed upon health care facilities to keep patient information confidential, the law requires full disclosure of all relevant information in litigation, unless special protection is granted by law to protect information from disclosure. Despite the general requirement that information be released as part of the judicial process, two significant types of protection exist to protect certain medical records. First, specific protection is given to records regarding special types of treatment or illnesses such as drug abuse, alcoholism, and mental health treatment and information regarding testing persons for human immunodeficiency virus ("HIV"), diagnosed or treated for acquired immune deficiency syndrome ("AIDS") or an AIDS related condition ("ARC"). Second, protection also is given to the information constituting the privileged communication between the patient and the health care professional(s).

B. Statutes Protecting Certain Records from Judicial Disclosure

1. Alcohol and Drug Abuse Records

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, and the Drug Abuse Office and Treatment Act of 19727 ("Alcohol and Drug Abuse Acts"), provide that any drug abuse or alcoholism treatment program that either directly or indirectly receives federal funds must keep patient records and information strictly confidential, and may only release such records pursuant to judicial process in limited circumstances.8

The Alcohol and Drug Abuse Acts apply only to information and records maintained by distinct drug abuse and alcoholism treatment programs. For a treatment program of a general medical facility, such as a hospital, to be covered by the Alcohol and Drug Abuse Acts, the facility must have an identified unit which provides alcohol or drug abuse diagnosis, treatment or referral, or medical personnel whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral.9 Treating patients for alcohol or drug related conditions as part of the hospital’s general medical services is not sufficient to bring the records under the protection of these Acts. Furthermore, in order for a program to qualify

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6 See Ex parte Frye, 155 Ohio St. 345, 98 N.E.2d 798 (1951). OHIO R. CIV. P. 26(B) states: "parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action . . . including the existence, description, nature, custody, condition, and location, of any books, documents, or other tangible things . . . ." See Pereira v. United States, 347 U.S. 1 (1954).


8 Id.

for legislative protection, it must receive direct or indirect government support. Direct or indirect support exists, for example, in the case of a program (or a larger facility of which the program is a part) which qualifies for medicare reimbursement for its services or is part of a non-profit organization which is exempt from federal income tax.\textsuperscript{10}

The confidentiality requirements of the Alcohol and Drug Abuse Acts are extremely broad. For example, they provide that records regarding the identity, diagnosis, prognosis, or treatment of any patient connected with any covered drug or alcohol abuse program may be disclosed only upon the specific written authorization of the patient,\textsuperscript{11} or under limited circumstances\textsuperscript{12} such as an appropriate court order following a show cause hearing.\textsuperscript{13} A fine of $500 is imposed upon a program for the first incident of improper disclosure of patient information, and a $5,000 fine for each subsequent offense.\textsuperscript{14}

\textsuperscript{10} 42 C.F.R. 2.12(b) (1987).

\textsuperscript{11} For a patient's consent to be effective, the consent form must contain the following information: (1) the name of the program that is to make the disclosure; (2) the name or title of the person or organization to which disclosure is to be made; (3) the name of the patient; (4) the purpose or need for disclosure; (5) the extent or nature of information to be disclosed; (6) a statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon, and a specification of the date, event, or condition upon which it will expire without express revocation; (7) the date on which the consent is signed; and (8) the signature of the patient. 42 C.F.R. 2.31(a) (1987).

\textsuperscript{12} Patient information may be released in the following circumstances: (1) to medical personnel to the extent necessary to meet a bona fide medical emergency; (2) to qualified research personnel, providing that the patient's identity remains anonymous; (3) upon an appropriate court order following a show cause hearing; (4) to make reports of child abuse consistent with state law, (although such information may not be used in any subsequent civil or criminal action arising out of the subject of the report); (5) to law enforcement agencies if crimes are committed or threatened by a patient or former patient against personnel of the drug abuse or alcoholism program itself; (6) records maintained by programs run by the Veterans Administration; and (7) certain records maintained by the Armed Forces. 42 C.F.R. 2.51-2.67.

\textsuperscript{13} 42 C.F.R. 2.63 (1987) provides that a court order may be granted to release information only in the following circumstances:

Confidential communications.

(a) A court order under these regulations may authorize disclosure of confidential communications made by a patient to a program in the course of diagnosis, treatment, or referral for treatment only if:

(1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties;

(2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or

(3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

\textsuperscript{14} 42 C.F.R. 2.5 (1987).
A program subject to the Alcohol and Drug Abuse Acts confronts a serious dilemma when it receives a subpoena for a patient's records. The federal law requires that a provider not even acknowledge a patient's presence in the program. Therefore, should the provider tell a requesting party or the court that it cannot legally release the records, the provider will, in essence, have acknowledged that the patient was treated by the program. Consequently, the provider may be in violation of the federal law. In responding to a subpoena, the provider must, therefore, remain non-committal and inform the party issuing the subpoena that if the facility has any records, such records will be released after a proper show cause hearing has been held addressing whether or not the facility has records responsive to the subpoena.

To accomplish such a response to the subpoena, the facility should send a form letter to the court stating that the facility is not legally permitted to acknowledge the existence of any records pertaining to a specific person and requesting that the subpoena be withdrawn. If the subpoena is not withdrawn, the facility must respond to the subpoena either by filing a motion to quash the subpoena or by having a representative appear in court at the designated time and place and refuse to respond to questions or to turn over documents. However, if the court holds a show cause hearing in accordance with the law and the judge orders the documents to be released, the facility may then release the records without fear of improper disclosure.

2. Mental Health Records

Section 5122.31 of the Ohio Code\(^\text{15}\) provides that all records made in conjunction with the treatment and hospitalization of mentally ill patients be kept confidential and not be disclosed except pursuant to a court order and certain other limited circumstances.\(^\text{16}\) Therefore, unless another


\(^{16}\) Ohio Rev. Code Ann. § 5122.31 (Page's 1990) provides that mental health records may also be released in the following circumstances:
1. The patient or legal guardian or parent consents and the disclosure is in the best interest of the patient;
2. Disclosures to the Department of Mental Health for purposes of complying with Ohio Rev. Code § 5122 or Ohio Rev. Code § 5123.60;
3. Disclosures of necessary medical information to insurers to obtain payment for goods and services furnished to the patient, if properly authorized;
4. Disclosures to the patient made pursuant to the patient's request, unless specifically restricted in the patient's treatment plan for clear treatment reasons; or
5. Disclosures made by hospitals and other institutions and facilities within the Department of Mental Health to other hospitals, institutions, and facilities and with mental health clinical facilities with which the Department has a current agreement for patient care or services.
statutory exception applies, such as receiving appropriate patient consent, a facility should not release a patient's mental health records unless a judge has issued a court order for the specific records.

Section 5122.31 of the Ohio Revised Code, which governs mental health records, arguably conflicts with the law regarding privileged communications. Under the law of privileged communication, as discussed in Section C below, certain information maintained by physicians, dentists, podiatrists, psychologists, and social workers is not subject to discovery. Such information includes mental health records, as well as other records. However, Section 5122.31 implies that such information may be released pursuant to a court order and does not delineate the standards to be used by the judge in determining whether to grant the order. If a judge, when determining whether to issue a court order, applies the law of privileged communications, the judge will only authorize release of non-privileged information and there will not be any conflict between the two statutes. The mental health statute, however, does not affirmatively compel the judge to consider the law of privileged communications. Therefore, if the judge, when considering whether to grant a court order pursuant to Section 5122.31, does not accept that the law of privileged communications applies, the mental health confidentiality statute, which was intended to give added protection to mental health records, may actually eliminate the statutory protection generally given to privileged communications.

3. Acquired Immune Deficiency Syndrome (AIDS) Records

Ohio law requires that the manner in which HIV tests are performed and test results be kept confidential, as well as the identity of persons diagnosed with AIDS or ARC. Except in limited circumstances, no health care worker or health care provider may reveal to any third party, including another health care worker in the same facility, that a person was tested for HIV, the results of that test, or the identity of any person diagnosed with AIDS or ARC. The limited statutory exceptions provide for the release of this information in a civil proceeding when the plaintiff in the case has alleged that he or she contracted HIV from the defendant.

6. On notice to the patient and in the absence of the patient's objection, to a patient's family member involved in planning for or providing services to the patient;
7. Exchanged by community mental health agencies and the mental health board to provide services to a person who is committed pursuant to OHIO REV. CODE § 5722.15;
8. To the executor of a deceased patient's estate if the records are necessary to administer the estate; or
9. Upon the request of a prosecutor when the patient is committed pursuant to OHIO REV. CODE Chapter 2945.

See also HANDBOOK ON MENTAL HEALTH LAW Banks Baldwin.

19 Id.
and in criminal proceedings. Furthermore, a court ordered release of the HIV test of a particular person in any judicial proceeding may be required after an in camera review of a motion filed by a party asserting that the information is necessary for the proceeding.\textsuperscript{20} In the event that information regarding a patient is improperly disclosed to a third party, Ohio law provides that the patient shall have a civil action against the disclosing party, in which the patient may be awarded compensatory damages and attorney's fees.\textsuperscript{21} However, a facility which is sued by a patient for the acts of its personnel for improperly releasing such information may not be held liable "unless the person [staff personnel] knew or should have known of the violation."\textsuperscript{22}

Similar to mental health records, information regarding a person's HIV test or diagnosis of AIDS or ARC may also fall under the definition of privileged communications. While Ohio's AIDS law authorizes release of information regarding HIV, AIDS, or ARC in criminal proceedings and in certain civil proceedings, the law of privileged communications might preclude such release. To permit the release of such information pursuant to Ohio's AIDS law would be to take away protection otherwise given to privileged patient communications. It is likely, therefore, that the protection given AIDS information will be construed as being extra protection which is overlayed on the protection ordinarily afforded privileged communications. Therefore, the exceptions to confidentiality provided for in the AIDS law are most likely only applicable when dealing with information generally not regarded as privileged.

4. Application of the Special Protection Statutes

The protection given patient records pursuant to the Alcohol and Drug Abuse Acts flows from federal statutory law, and consequently, should be effective in criminal and civil actions in both federal and state court proceedings. Information protected by the Alcohol and Drug Abuse Acts should therefore only be released after an appropriate show cause hearing and court order, regardless of the forum.

The laws which protect records regarding mental health treatment, HIV, AIDS, and ARC are state-mandated restrictions. It is questionable, therefore, whether these laws will prohibit the release of patient medical records in federal court proceedings.\textsuperscript{23} If the statutes which provide special protection to mental health records, HIV test results, or records of persons

\textsuperscript{20} A court may not compel a blood bank, hospital blood center, or blood collection facility to disclose the results of HIV tests in a manner that reveals the identity of voluntary blood donors except in criminal proceedings. \textit{Ohio Rev. Code Ann.} § 3701.243(B) (Page's Supp. 1990).


\textsuperscript{23} See Section II, A.
diagnosed with AIDS or ARC are not held to apply in federal court, a health care facility may be left to rely solely upon the general federal principals of privileged communications regarding these types of medical records.24

C. Ohio Privileges for Communications with Health Care Professionals

Rule 501 of the Ohio Rules of Evidence provides that:

[the privilege of a witness, person, state or political subdivision thereof shall be governed by statute enacted by the General Assembly or by principles of common law as interpreted by the courts of this state in light of reason and experience.]

Rule 101 of the Ohio Rules of Evidence26 provides that the rule regarding privileges applies to all proceedings in the Ohio courts, proceedings before court-appointed referees and magistrates, as well as to all stages of actions, cases, and proceedings conducted pursuant to the Ohio Rules of Evidence.27 Similarly, Ohio Rule of Civil Procedure 26(B) provides that parties discover information regarding any matter that is not privileged but which is relevant to the subject matter of the lawsuit.28

Federal Rule of Evidence 501, from which Ohio Rule of Evidence 501 is patterned provides:

Except as otherwise required by the Constitution of the United States or provided by act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority, the privilege of a witness, person, government, state, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which state law supplies the rule of decision, the privilege of a witness, person, government, state, or political subdivision thereof shall be determined in accordance with state law.29

24 See Section II, D.
26 OHIO R. EVID. 501.
28 OHIO R. EVID. 101.
28 OHIO R. EVID. 101. While Rule 101(C) provides an exception to application of the Rules of Evidence to certain proceedings, including grand juries, miscellaneous criminal proceedings such as probation hearings, issuance of warrants, sentencing, and contempt proceedings, this rule specifically provides that these exceptions do not apply to the application of the law regarding privileges. Therefore, laws regarding privileges apply to all judicial proceedings in Ohio.
28 OHIO R. CIV. P. 26(B).
28 FED. R. EVID. 501.
This means that in federal civil cases based upon state claims, predominantly diversity cases and certain actions such as those brought under the Federal Tort Claims Act, the state law of privileges applies. In federal criminal cases and federal civil cases based upon federal claims, however, a court will only apply the federal law of privileges, which is extremely limited, as discussed in Section II, D below.

Similar to Ohio Evidence Rule 101(B), Federal Rule of Evidence 1101 provides that the rule regarding privileges applies to all actions and proceedings in federal court. The laws of privileges, whether state or federal, therefore apply to every aspect of judicial process in both criminal and civil cases, including discovery and pretrial actions.

The laws of privileges are evidentiary rules and only determine when persons may not be compelled to testify or otherwise release information in a judicial proceeding. As a result, these laws do not apply outside the judicial process.

There is no privilege at common law for communications made by patients to a health care provider. Rather, this area is entirely a creature of statute. Ohio adopted its first statutory version of the physician-patient privilege in 1880, and today that law is codified as a statutory privilege against disclosure of conversations between patients and physicians, dentists, or podiatrists, and between clients and psychologists, professional counselors, counselor assistants, social workers, social worker assistants, or independent social workers ("Health Care Professional-Patient Privileges").

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31 Fed. R. Evid. 1101.
32 Some quasi-judicial proceedings may adopt some or all of the Rules of Evidence or principles underlying such rules, and consequently, may adopt the law of privileged communications. See also State Medical Board v. Miller, 44 Ohio St.3d 136, 541 N.E.2d 602 (1989) (which provides when the physician-patient privilege is applicable in state Medical Board proceedings.). See, e.g., Ohio Motor Vehicle Dealers Bd. v. Remlinger, 8 Ohio St.3d 28, 457 N.E.2d 309 (1983); Chesapeake and Ohio Ry. Co. v. PUCO, 163 Ohio St. 252, 126 N.E.2d 314 (1955) (holding that administrative agencies may not act in complete disregard for the essential rules of evidence or the rights of the parties, and the law of privileges are generally applicable in administrative proceedings.)
33 See generally Smith, Medical and Psychotherapy Privileges and Confidentiality: On Giving With One Hand and Removing with the Other, 75 Ky. L. J. 473 (1986-87); DeWitt, Privileged Communications Between Physician and Patient, 10 W. Res. L. Rev. 488, 491-92 (1959).
The privilege granted communications between patients and physicians, dentists, podiatrists and psychologists is codified in Section 2317.02 of the Ohio Code, which provides that the above-referenced persons shall not testify in certain respects:

(B)(1) A physician [including a podiatrist] or a dentist concerning a communication made to him by his patient in that relation of his advice to his patient . . . . The testimonial privilege under this division is waived, and a physician or dentist may testify or may be compelled to testify in a civil action . . . under the following circumstances:
(a) If the patient or the guardian or other legal representative of the patient gives express consent;
(b) If the patient is deceased, the spouse of the patient or his executor or administrator gives express consent; and
(c) If a medical claim, dental claim, chiropractic claim, or optometric claim, as defined in section 2305.11 of the Revised Code, an action for wrongful death, any other type of civil action, or a claim under Chapter 4123 of the Revised Code is filed by the patient, the personal representative of the estate of the patient if deceased, or his guardian or other legal representative.

(2) If the testimonial privilege described in division (B)(1) of this section is waived as provided in division (B)(1)(c) of this section, a physician or dentist may be compelled to testify or to submit to discovery under the Rules of Civil Procedure only as to a communication made to him by the patient in question in that relation, or his advice to the patient in question, that related causally or historically to physical or mental injuries that are relevant to issues in the medical claim, dental claim, chiropractic claim, or optometric claim, action for wrongful death, other civil action, or claim under Chapter 4123 of the Revised Code.

Section 4732.19 of the Ohio Code specifically grants communications made to psychologists the same privilege as that extended to physicians, dentists and podiatrists pursuant to Section 2317.02(B).

The counselor and social worker privilege is codified at Section 2317.02(G) of the Ohio Code. That privilege provides that the following persons may not testify in the following instances:

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41 Id.
A school guidance counselor who holds a valid teacher's certificate from the state board of education as provided for in section 3319.22 of the Revised Code or a person licensed or registered under Chapter 4757 of the Revised Code and the rules adopted under it as a professional counselor, counselor assistant, social worker, social work assistant, or independent social worker concerning a confidential communication made to him by his client in that relation or his advice to his client unless any of the following apply:

1. The communication or advice indicates clear and present danger to the client or other persons. For the purposes of this division, cases in which there are indications of present or past child abuse or neglect of the client constitute a clear and present danger;

2. The client gives express consent to the testimony;

3. If the client is deceased, the surviving spouse or the executor or administrator of the estate of the deceased client gives express consent;

4. The client voluntarily testifies, in which case the school guidance counselor or person licensed or registered under Chapter 4757 of the Revised Code and the rules adopted under it may be compelled to testify on the same subject;

5. The court, pursuant to an in camera inspection, determines that the information communicated by the client is not germane to the counselor-client or social worker-client relationship; and

6. A court, in an action brought against a school, its administration, or any of its personnel by the client, rules after an in camera inspection that the testimony of the school guidance counselor is relevant to that action.44

The Ohio Tort Reform Act of 1987,45 effective January 5, 1988, made significant changes to the law of privileged communications made to health care providers. In effect, these changes greatly expanded waivers of the privilege by a party filing a civil action. The 1987 Act applies only to records sought in actions commenced on or after January 5, 1988, which are based upon tortious conduct which has occurred after January 5, 1988.46 Therefore, if the records of a health care provider are sought for

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44 Id.
45 Ohio Tort Reform Act of 1987, 142 v H1 (effective 1-5-88).
46 Id. at § 3(A). This provision reads as follows:

The provisions of the amendments to sections 1775.14, 2125.02, 2307.31, 2307.32, 2307.60, 2309.01, 2315.18, 2315.19, 2317.02, 2323.51, 4507.07, and 4513.263 of the Revised Code made in this act and the provisions of sections 2307.33, 2315.21, 2317.45, 2317.62, 2323.56, and 4705.15 of the Revised Code as enacted by this act shall apply only to tort or other civil actions that are commenced on or after the effective date of this act and that are based upon claims for relief that arise on or after that date, and only to tortious conduct that occurs on or after that date. Section 3(A).
actions filed prior to January 5, 1988 or for actions filed after that date, but based upon conduct which occurred prior to that date, the law which was in effect prior to the enactment of the Tort Reform Act of 1987 is operative.\footnote{The law regarding physician, podiatrist and psychologist-patient privileges prior to the Tort Reform Act provided:}

\begin{itemize}
\item \textbf{2317.02. Privileged communications and acts.} The following persons shall not testify in certain respects:
\begin{itemize}
\item \textbf{(A)} An attorney, concerning a communication made to him by his client in that relation or his advice to his client, except that the attorney may testify by express consent of the client or, if the client is deceased, by the express consent of the surviving spouse or the executor or administrator of the estate of the deceased client and except that, if the client voluntarily testifies or is deemed by section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the attorney may be compelled to testify on the same subject:
\begin{itemize}
\item \textbf{(1)} A physician concerning a communication made to him by his patient in that relation of his advice to his patient, except as otherwise provided in this division and division (B)(2) of this section, and except that, if the patient is deemed by section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the physician may be compelled to testify on the same subject.
\begin{itemize}
\item The testimonial privilege under this division is waived, and a physician may testify or may be compelled to testify in a civil action, in accordance with the discovery provisions of the Rules of Civil Procedure in connection with a civil action, or if connection with a claim under Chapter 4123 of the Revised Code, under the following circumstances:
\begin{itemize}
\item \textbf{(a)} If the patient or the guardian or other legal representative of the patient gives express consent;
\item \textbf{(b)} If the patient is deceased, the spouse of the patient or his executor or administrator gives express consent;
\item \textbf{(c)} If a medical claim, dental claim, chiropractic claim, or optometric claim, as defined in Section 2305.11 of the Revised Code, an action for wrongful death, any other type of civil action, or a claim under Chapter 4123 of the Revised Code is filed by the patient, the personal representative of the patient if deceased or of his estate, or his guardian or other legal representative.
\end{itemize}
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In order for information to be protected from judicial process by any of the Health Care Professional-Patient Privileges, the following three elements must be present: (1) there must be a patient or client; (2) a qualifying communication must be made; and (3) the communication must be made to or received by the health care professional who is recognized by statute as covered by the privilege.

1. Patients and Clients for Purposes of Privileged Communications

In order for a person to qualify as a patient or a client for purposes of any of the Health Care Professional-Patient Privileges, a person must intend or desire to become a patient and receive diagnostic services for treatment. Therefore, courts have held that a person does not become a "patient" by being a blood donor because such donor is not seeking medical services but is merely having blood drawn to donate. Similarly, neither does a person who receives treatment involuntarily, pursuant to a court order, nor a person who fraudulently communicates information to a health care professional, possess the requisite intent or desire to be a patient of that specific health care professional since that health care professional-patient relationship is based upon fraudulent statements.

2. Privileged Communications

a. What Constitutes a Communication

A communication for purposes of the physician, podiatrist, dentist and psychologist privileges is defined as acquiring, recording, or transmitting any information, in any manner, concerning any facts, opinions, or statements necessary to enable that health care professional to diagnose, treat, prescribe, or act for a patient. Communication further includes "any medical, office, or hospital communication such as a record, chart, letter, memorandum, laboratory test and result, x-ray, photograph, financial statement, diagnosis or prognosis" created to reflect the relationship between a patient and the statutorily recognized health care professional and includes any advice of any such health care professional to the patient or client as part of the health care relationship. While there was no

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48 One of the crucial policy reasons for the privileges is the promotion of free and full discourse between the patient or client and his or her health care professional. This reason is not present with an involuntary patient. See Doe v. Univ. of Cincinnati, 42 Ohio App. 3d 227, 538 N.E.2d 419 (Franklin Cty. 1988).

49 Id.


52 Id. While the statutory language lists laboratory tests and results as communications, tests and results generally are only communications if they are used by the health care professional to diagnose, treat, prescribe or act for the patient or client. Therefore, a test performed on donated blood which is not for diagnosis or treatment of the donor but for the benefit of the recipient of the blood does not constitute a communication for statutory privileges. Univ. of Cincinnati, 42 Ohio App. 3d at 528, N.E.2d at 419. OHIO REV. CODE ANN. § 2317.02(G) (Page's Supp. 1990).
statutory definition of "communication" prior to the Tort Reform Act of 1987, case law had interpreted communications to include physical examinations of the body and laboratory tests, as well as oral communications.53

The term "communication" for purposes of the counselor and social worker-client privilege is not defined by law. The privilege attaches to a "confidential communication" made by a client to his or her counselor or social worker and advice given to the client by the counselor or social worker.54

Records which merely establish the existence of a health care professional-patient relationship or evidence the fact that a patient was treated are not "communications" within the health care professional relationship and are not privileged.56 Therefore, absent special protection such as that granted by the Alcohol and Drug Abuse Acts, a health care facility may be required to disclose the names of patients and the dates they have been treated.

b. The Presence of Third Parties

A traditional interpretation of the law of privileges suggests that if third parties are present during the communication, then the parties did not intend for the communications to be confidential, and thus, the privilege does not apply.56 This issue was addressed in Urseth v. City of Dayton,57 where the court stated in dicta that:

53 See Baker v. Industrial Commission, 139 Ohio St. 491, 21 N.E.2d 529 (1939) (holding the exhibition of the body to a physician is covered by the privilege); State v. Dress, 10 Ohio App. 3d 258, 461 N.E.2d 1312 (Lucas Cty. 1982), and Kromenacker v. Bystone, 43 Ohio App. 3d 126, 539 N.E.2d 675 (Lucas Cty. 1987) (holding laboratory test is communications).

54 OHIO REV. CODE ANN. § 2317.02(G) (Page's Supp. 1990). Note that the counselor and social worker-client privilege limits the privilege to "confidential" communications, while the physician, podiatrist, dentist and psychologist privilege does not employ the word "confidential." This appears to be a meaningless difference, however, since historically all privileges apply only to confidential communications, and the Ohio courts generally have held that communications made to a physician by his patient or to the patient by the physician are only privileged if they were intended to be confidential. Therefore, prescriptions written by a physician but intended to be read by a pharmacist are not confidential communications and are not covered by the privilege. State v. Treadway, 328 N.E.2d 825 (Ohio App. 1974), and since a death certificate is a public record intended to be public, a physician's statements on such death certificate are not privileged, Perry v. Indus. Comm., 160 Ohio St. 520, 117 N.E.2d 34 (1954).


56 See Note, Evidence-Privileged Communications in Divorce Actions: Psychiatrist-Patient and Presence of Third Parties, 40 TENN L.REV. 110 (1972).

For example, the physician-patient privilege of Section 2317.02(B) has been construed as not extending to medical or hospital records, unless said records contain, in whole or in part, communications between the plaintiff and physician, not in the presence of third parties, regarding diagnosis and treatment.58

Thus, if a nurse or family member were present during the interaction between the physician and patient, then the communication would no longer be deemed privileged. Most probably, the average patient believes that any communication made to or received from the physician pursuant to a physician/patient relationship is confidential, even if it is made in the presence of a nurse or a companion of the patient. If the patient were asked why the privilege would apply in this case, the patient would probably state that the nurse is under the supervision of the physician, and therefore, is required to keep confidential all conversations between the physician and patient witnessed either from being present or from access to all the contents of the medical record. In addition, the patient probably does not realize that information conveyed to a physician in the presence of the patient’s spouse may cause the information to lose its privilege. Thus, under a traditional view, all patients and health care professionals should be aware that communications between health care professionals and their patients, in the presence of any third parties, are not privileged.

This narrow interpretation of confidential communications may render the Health Care Professional-Patient Privilege entirely non-existent when dealing with certain health care specialties. For instance, many obstetricians and gynecologists (“OB-GYN”) routinely have a nurse present during all examinations. The OB-GYN specialty is one in which there may be significant sensitive information which may be imperative for the patient to communicate to her physician such as information regarding AIDS or drug and alcohol abuse. To defeat the privilege by the mere existence of a nurse, who is after all also a health care professional, could have a chilling effect on open communications. For example, if patients become aware that such communications are not kept confidential, they may fail to disclose necessary and vital information to their health care practitioner.

While communications not intended to be confidential or those made in the presence of third parties are not protected by the Health Care Professional Privileges, courts have held that if a communication is otherwise a privileged communication, and the communication is transcribed into a patient’s chart where third parties have access to the information, the information still maintains its status as privileged information.59

58 Id. at 1066 n. 4 (emphasis added).
Presumably, this would also be the result if the physician or other health care professional protected by the privilege disclosed the information to nurses or other health care workers. This is logically consistent because it is the patient's intent to have the communication remain confidential which must determine whether the privilege attaches. Accordingly, the result should not be governed by what a third party, who is out of the control of the patient, does with the information.

3. Qualifying Providers for Purposes of Privileged Communications

Historically, the Ohio statutes addressing privileged relationships have been interpreted very narrowly granting protection to only those professionals specifically named in the statute. The courts have held that information given to non-physician health care providers, such as nurses and laboratory technicians, is not privileged, since these individuals are functioning as independent health care workers.\(^6\) The leading case in this area, *Weis v. Weis*,\(^6\) held that a nurse did not qualify for the physician-patient privilege because if the legislature had intended nurses and patients communications to be confidential, such protection would have been explicitly granted by the statute. Similarly, in *State v. McKinnon*,\(^6\) the court allowed a medical technologist to testify about a patient's test, even when the technician was carrying out the orders of a physician:

Nor can the test results be deemed protected on an agency theory, where the physician directed the medical technologist to run the test. That argument was specifically rejected in *Weis*, where the communications in dispute were made to nurses, who were employed by the hospital and worked under the direction of the attending physician. Communications made to a nurse in the performance of her duties are not privileged unless the nurse is also a physician or surgeon.\(^6\)

In an acute care setting, the majority of a patient's medical record will contain entries made by persons to whom communications are not statutorily protected. Therefore, following *Weis*, the majority of the medical records are discoverable when the individuals are not being treated for alcoholism, drug abuse, mental illness, or AIDS. It is inconsistent to protect small portions of a record when the discoverable portions most probably address the same topics. It must be questioned whether this is what the legislature intended when adopting the Health Care Professional-Privileges.

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\(^6\) 147 Ohio St. at 416, 72 N.E.2d at 245.

\(^6\) 38 Ohio App. 3d at 28, 525 N.E.2d at 821.

\(^6\) *Id.*
For example, if a patient enters the hospital for treatment on one matter and the physician diagnoses the patient as also having venereal disease, the physician would not be allowed to testify in court about this disease unless the patient waived the privilege. A nurse, however, who discussed the issue with the patient and was present during the physician’s visits to the patient would not be able to claim a privilege and could be called to testify. It may be questioned, then, why there should be statutory protection for communications between a physician and a patient, when a nurse is allowed legally to testify on any matter witnessed by the nurse. As this example illustrates, the narrow interpretation of the health care professional-patient privilege has not kept pace with modern health care facilities, procedures, and practices due to the proliferation of separately licensed and functioning health care workers.

In a very recent case, an Ohio Appellate Court in Johnston v. Miami Valley Hospital apparently adopted this reasoning by holding that a hospital’s records which consist of nurse’s notes are within the statutory definition of a protected communication pursuant to Ohio Revised Code § 23217.02(B)(3).64 The court stated that

"R.C. 2317.02(B)(3) defines ‘communication’ broadly to cover the acquisition by the physician of any facts, opinions or statements found in a hospital record necessary to enable a physician to diagnose, treat, prescribe, or act for a patient. This would clearly cover notations made by a nurse in the "nurses notes” portions of a hospital record. . . ."65

It is our reading of the present statute that such notes are privileged under the statute as they are included within the statutory definition of “communication.” This court did not challenge the Ohio Supreme Court’s reading of Ohio Rev. Code § 2317.02(B)(3) in the Weis decision that nurses are not granted a privilege but instead brought certain nurses notes under the statutory definition of “communication.” The Weis court, however, specifically stated that for the statute to grant protection to nurses’ notes, the Ohio General Assembly must take steps to amend the statute. Due to the inconsistent effect that the Weis and Johnston case have in interpreting the application of the law of privileges to nurses notes, it is unclear how courts in the future will apply Ohio Rev. Code § 2317.02. If the Johnston case is appealed, the Ohio Supreme Court will have the opportunity to reexamine the Weis case in light of the present day health care system.

4. Waiver of and Exceptions to Privileged Communications

a. Consent. The privilege for communications between a patient and a physician, podiatrist, dentist and psychologist provides that the patient, patient’s guardian, or a legal representative of the patient may expressly waive the privilege.66 While there is no definition of “legal representative”

65 Id. at pp. 84-85.
66 OHIO REV. CODE ANN. § 2317.02(B) (Page’s Supp. 1990).
in the law, this could be construed to include attorneys, guardians ad litem or other persons with legal authority to consent for the patient.\(^67\) The counselor and social worker-client privilege provides that only the client may give express consent to waive the privilege.\(^68\) It is unclear whether this is intended to mean that a guardian, attorney, or other legal representative is not empowered to consent for the client, or if this is merely the result of inconsistent legislative drafting. There does not appear to be any policy reason to give more protection to a person who seeks the assistance of a social worker than to a person who seeks the assistance of a psychiatrist or psychologist.

b. Waiver for Deceased. The right to protect communications made to health care professionals does not terminate upon the patient’s death, but the executor or administrator of the estate of a deceased patient has the authority to waive all statutory privileges for the deceased.\(^69\) However, an administrator or executor who requests the mental health records of a deceased person who was hospitalized must show that the records are necessary in order to administer the estate properly.\(^70\)

c. Filing Certain Claims. The physician, podiatrist, dentist, and psychologist-patient privileges are waived when any person (or such person’s estate or legal representative) files any civil action including a malpractice action, wrongful death, or workers compensation claim. The waiver, however, is only effective for communications related “causally or historically to physical or mental injuries relevant to issues in the claim filed.”\(^71\)

Waiver of the counselor and social worker-client privilege occurs when a client voluntarily testifies on a matter which is the subject of the counseling.\(^72\)

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\(^67\) See, e.g., OHIO REV. CODE ANN. § 1337.11 (Page’s Supp. 1990). (If patient is incompetent and has executed a durable power of attorney for health care.)

\(^68\) While the law states that a legal representative may waive the privilege for a patient, it is not always clear who has the legal authority to consent for a patient. This becomes a particular problem in the case of divorced parents of a minor or with elderly incompetent individuals for whom there is no court appointed guardian or power of attorney. See In re Guardianship of Escola, 41 Ohio App. 3d 42, 534 N.E.2d 866 (Stark 1987) which provides that the guardian of an incompetent patient is capable of waiving the physician-patient privilege. If there is doubt as to who may properly consent, the health care provider may wish to get a determination from the court.

\(^69\) OHIO REV. CODE ANN. §§ 2317.02(B)(1)(b), 2317.02(G)(3) (Page’s Supp. 1990).

\(^70\) OHIO REV. CODE ANN. § 5122.31(D) (Page’s Supp. 1990).


\(^72\) OHIO REV. CODE ANN. § 2317.02(G)(4) (Page’s Supp. 1990).
Public Policy Exceptions to Privileged Communications. For some time in Ohio, many courts had adopted a public policy exception to the physician-patient privilege when the operation of a motor vehicle while under the influence of alcohol was concerned. These cases generally arose when a patient was taken to a hospital following an automobile accident and a blood alcohol test was administered. If litigation arose, opposing counsel would attempt to get the results of the blood alcohol test at the hospital to prove that the patient was negligent while driving. Courts have held that the public policy considerations in the prosecution of persons who have driven while under the influence outweighed the policy considerations underlying the physician-patient privilege. Adopting the rationale from these drunk driving cases, at least one court ignored the statutory privilege and allowed privileged information to be released to a grand jury, holding that the public interest in releasing the information outweighed the interest in protecting the communication.

Nevertheless, in 1990, the Ohio Supreme Court in State v. Smorgala overruled these earlier cases and stated that blood alcohol tests obtained as part of the patient's treatment at a hospital were privileged, and the courts were not free to fashion a public policy exception to the law of privileges in criminal or other actions.

D. Federal Law Regarding Privileged Communications Made to Health Care Providers

Rule 501 of the Federal Rules of Evidence provides that for federal civil cases based upon state claims (generally diversity cases) the determination of whether a certain communication to a witness is privileged is based on the state law that is being applied to that specific case. With all other federal cases where federal law is applied, the privileges are based upon common law doctrine as interpreted by the federal courts. As previously noted, there is no recognition of privileged communication between health care professionals and patients at common law. While Rule 501 does not preclude the federal courts from adopting a federal common law privilege for communications made to health care providers, the federal courts have been reluctant to implement one.

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75 50 Ohio St. 3d 222 (1990).
76 See In re Zuniga, 714 F.2d 632 (6th Cir. 1983); United States v. Meagher, 531 F.2d 752 (5th Cir. 1975), cert. denied 429 U.S. 965 (1976). See also United States v. Mullings, 364 F.2d 173 (2nd Cir. 1966); 8 J. WIGMORE, EVIDENCE § 2380 (J. McNaughton rev. 1961); C. MCCORMICK, EVIDENCE § 101 at 211 (2d ed. 1972).
77 The court in General Motors Corp. v. Director of Nat'l Inst. for Occupational Safety and Health Dep't of Health, Educ. and Welfare, 636 F.2d 163 (6th Cir. 1980) stated that "a decision in this case based upon considerations of the physician-patient relationship would, in effect, expand the scope of the federal common law," and the court declined to do so.
While not recognizing a general physician-patient privilege, the Sixth Circuit has adopted a limited common law psychotherapist/patient privilege which applies to health care professionals engaging in psychotherapy. This privilege, however, only extends to information regarding treatment and does not extend to the identity of patients, the dates treated, or the length of treatment on each date. Therefore, except for limited information covered by the psychotherapist-patient privilege, there is no protection of the patient's medical records in proceedings in federal court where federal law is applied.

E. Discoverability and Admissibility of Patients' Hospital Records Which Are Not Privileged

The patient medical record maintained by health care facilities contains information placed in the record by a variety of sources. Central to the record is information placed there by a physician, dentist or podiatrist. But information is also placed in the record by nurses and a myriad of other health care workers. Ohio has no law which provides that all records maintained by health care facilities are privileged. Therefore, for patient medical records maintained by health care facilities not to be subject to disclosure, the records must be covered by one of the Health Care Professional-Privileges or be protected from discovery or admissibility because they are alcohol and drug abuse treatment records, mental health records or patient records regarding HIV, AIDS, or ARC. Even in these cases, as discussed earlier, the protection is not absolute, but varies greatly depending upon whether the information is sought pursuant to state or federal judicial process, and in the case of Health Care Professional-Privileges, whether the communications were made in a confidential setting and whether the privilege was waived in any manner.

Therefore, depending upon the types of information in a patient's record, a large portion of a patient's medical record maintained by a health care facility may be left unprotected. Records made by health care workers to whom communications are not statutorily protected, such as nurses, laboratory technicians, physical therapists and others, which are not related to alcohol, drug abuse, mental health and AIDS treatment may be discoverable and admissible if they are relevant to the lawsuit. These records would not be considered different from other types of records maintained by the health care facility.

A few courts have attempted to give broader protection to records maintained by health care facilities by creatively extending the Health Care Professional-Patient privilege. In Pollitt v. Mobay Chemical Corporation,

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78 In re Zuniga, 714 F.2d at 632.
79 Id.
80 See Weis v. Weis, 147 Ohio St. 416, 72 N.E.2d 245 (1947); Eikenberry v. McFall, 36 N.E.2d 27 (Preble Cty. 1941); Heinemann v. Mitchell, 8 Ohio Misc. 390, 220 N.E.2d 616 (Hamilton Cty. 1964). Such records are admitted pursuant to the business record exception to the hearsay rule.
the court held that hospital records which contain communications regarding diagnosis and treatment “in whole or in part” are not subject to disclosure. In a recent unreported decision, Johnston v. Miami Valley, the court broadly interpreted “communication” stating that “notations made by a nurse in the nurse's portion of a hospital record” constituted a privileged communication because such information is important for the physician to know in order to properly diagnose and treat the patient.

The court emphatically stated that:

[s]ince nurses often spend more time than physicians with hospital patients, their notes often comprise the bulk of the hospital records. It is our reading of the present statute that such notes are privileged under the statute as they are included within the statutory definition of communication.

This court tried to distinguish this case from the holding in Weis v. Weis, not by claiming that nurses are protected under the Health Care Professional-Privileges, but by redefining information created by nurses as a part of the physician-patient communication. While the Johnston court's subtle distinction was creative, it is doubtful whether a higher court would recognize such a distinction.

Most Ohio cases have made a restrictive reading of the law and have permitted notes or testimony by nurses or others, not specifically mentioned in the statutory Health Care Professional Privilege, to be admitted as part of the judicial process. In Heinemann v. Mitchell, the court stated:

[While it is well settled that Hospital records made in the regular course of business and pertaining to the business of hospitalization and recording observable acts, transactions, occurrences, or events incident to the treatment of a patient are admissible as evidence, it is equally well settled that where such records contain communications between physician and patient which have been reduced to writing and incorporated in the records, such portions of the records are privileged by virtue of the express provisions of Revised Code, Sec. 2317.02(A) and may not be introduced in evidence over the objection of the patient.]

This limited application of the law of privileges to medical records maintained by health care facilities was developed for a much different medical system than the one we have today, and it simply has not kept pace with today's modern system.

Hospitals began to appear in the United States in the 17th century. However, well into the 19th century, most persons were treated in their

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83 Id. at 7-8.
84 147 Ohio St. 416, 72 N.E.2d 245 (1947).
85 8 Ohio Misc. 390, 220 N.E.2d 616 (Hamilton Cty. 1964).
86 E. Hayt, L. Hayt & A. Groeschel, LAW OF HOSPITAL, PHYSICIAN AND PATIENT 84 (1972).
The first physician-patient privilege statute was enacted in 1828 in the State of New York; Ohio statutory law first recognized the physician-patient privilege in 1880. Therefore, the Ohio statutory physician-patient privilege was established when most persons sought treatment solely from a physician in their home rather than in a hospital. Thus, at the time the physician-patient privilege was adopted, there was no need for a patient-nurse or patient-lab technician privilege or privileges extending to other health care professionals. Given the nature of hospitals at that time, there was, in all probability, little concern about extending the privilege from the physician-patient context to cover hospital records as well. While the Ohio legislature has through the years granted a few other professionals the privilege, the legislature has not granted the privilege to the full range of professionals who may render care to the patient today.

In modern times most patients spend more time with nurses and other health care providers than with physicians. It is questionable then why as health care has changed, the legislature has not chosen to extend the range of health care professionals to whom the privilege applies. The major public policy reasons cited for the need for the existence of the Health Care Professional Privileges — namely, the encouragement of honest communications between patient and health care workers to aid effective treatment of disease, maintenance of the patient's privacy interests, and maintenance of the ethics of the medical professional — are not limited to the physician-patient relationship but apply to the nurse-patient relationship and the relationship between patients and other health care professionals as well. The limitations imposed upon the Health Care Professional Privileges serve to undercut the public policy the privilege was intended to protect. Certainly, open communication between patients and health care workers is not promoted if a patient understands that information told to professionals not covered by the privilege or to professionals covered by the privilege but treating the patient cooperatively with an uncovered professional is not granted protection. It is the sorry state of the law that the public policy of encouraging open communication will only be accomplished if the patient wrongly believes that the law protects all communications made in the health care context.

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89 Supra note 34.
Limiting the law of privileged communications to certain health care professionals also does little to meet the public policy goal of protecting a patient's privacy goals, nor does it protect the ethics of the health care professionals who are not covered by the privilege.

IV. THE DILEMMA OF HEALTH CARE FACILITIES

A health care facility confronts a serious dilemma when it receives a subpoena for a specific patient's medical records and must decide whether (i) to refuse the disclosure of any portion of the records, or (ii) to release the records in whole or in part.

Many health care facilities have internal written policies which are disseminated to their employees and independent contractors (i.e. physicians) in order to protect patient confidentiality to the fullest extent. In general, most facilities usually respond to each subpoena for a patient's medical records by filing with the court a motion to quash or other refusal to release the requested records. This approach creates a significant expense for the facility to fight each request for records.\(^9\)

Other facilities undoubtedly believe that there must be compliance with each subpoena and that the facility must release all requested information without question. This approach, while significantly less expensive, subjects the facility to possible civil liability for improper release of records. In *Pacheco v. Ortiz*,\(^2\) a Cuyahoga County Common Pleas court stated that "the law is quite clear that any hospital records of a party, albeit the plaintiff in this matter, may not be released to anyone if such matters are privileged unless such privilege is waived by the party being treated." The court proceeded to state that hospital records which contain some privileged information should not be released pursuant to a validly issued subpoena until there are safeguards that privileged information not be released.

Unless there is valid consent given by the patient, there are several decisions to be made by a health care facility in determining which portions of medical records may be released. The facility must first determine whether records involve alcoholism, drug abuse, mental health or AIDS records. Then the facility must decide whether the case is in federal or state court and if it is in federal court, whether state or federal law supplies the rules of privilege to be applied. If the matter is in state court or if state law governs in federal court, the provider must also decide, among other things, whether the communication was made to a health care provider covered by the privilege and whether third parties were present. Even if a privilege exists, it must be determined whether the privilege has been waived.

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\(^9\) See *State ex rel. Whitney v. McLain*, 49 Ohio St. 2d 155, 359 N.E.2d 442 (1977); *Ohio R. Crim. P. 17(B).*

\(^2\) 11 Ohio Misc. 2d 1, 2, 463 N.E.2d 670, 671 (Cuyahoga Cty. 1983).
It is extremely unreasonable to expect a health care facility to make these determinations. Usually, the subpoena only gives the caption of the case and the court involved. If the case is in federal court, the health care facility has no ability to determine whether state claims or federal claims are involved. Similarly, determining from the caption of the case whether a waiver has occurred is impossible. While Ohio law provides that a person waives a Health Care Professional-Privilege by filing a claim if the information is historically or causally related, the law does not provide that the mere fact of filing any lawsuit waives the privilege. While the health care facility may be aware that the patient for whom the records are sought is the plaintiff in the lawsuit, a determination must still be made as to whether the information sought is causally or historically related to the claim.

Despite the difficulty a health care provider has in making these determinations, one Ohio court has recently stated that the physician from whom the records are sought should be making determinations as to whether the privileges apply and, if the patient is the plaintiff, that the physician should determine if the records are causally and historically related to the case.\footnote{Baker v. Quick Stop Oil Change, Case No. CV89-10-0671 (C.P. Allen Cty., Ohio 1990).} We submit that this is unwise, however, because (as just noted) the physician usually does not have sufficient information upon which to make such an evaluation. Even if the facility goes to the effort of obtaining the relevant information, the facility, simply as the holder of the records, should not be forced to place itself in jeopardy by making such a determination. Facilities which review records and determine which portions of the records may be released pursuant to law and excise protected portions of the records are placing themselves in the position of being an arbiter of the case because the facility is determining the scope of the existing statutory privileges. Thus, to answer a subpoena in any manner other than a refusal to release records subjects a facility to significant legal expense to evaluate the case and subjects the facility to civil liability for improper release of records if their evaluation was incorrect.

The safest course for a health care facility is to answer each and every request for medical records with a refusal to release the records unless the facility has received an applicable signed release from the patient or a court order. Since a facility cannot ignore a validly issued subpoena, the receipt of the subpoena places the facility in the position of being required to respond to the subpoena in some manner. If the facility cannot receive agreement from the party who subpoenaed the records to withdraw the subpoena, the facility has two options: (1) it can file a motion to quash the subpoena or (2) the custodian of records can appear as requested in the subpoena and assert the relevant Health Care Professional Patient privilege. This then places the burden upon the party requesting the records to petition the court for an order directing release of the
V. LEGISLATIVE AND OTHER ACTIONS

If health care facilities begin to answer each and every subpoena for medical records with a refusal to release the records, and each matter is taken to a judge to rule on the motion to compel the production of documents, the litigation process may be considerably slowed, and the courts may become further clogged by hearing a number of motions regarding records.

This action, however, will take the burden for determining questions of medical records release from health care facilities where it does not appropriately belong and place it on the courts and litigants. To ease the burden of the courts determining countless medical records questions, there are a number of possible solutions.

A. Judicial Action

The courts could reevaluate the statutory privileges under Ohio law. The Weis case, which set forth the principle that communications to and by nurses and other health care professionals not named in the statute are not protected by the privilege, was decided in 1947. Forty-four years ago the health care system was very different from today. The courts could take notice of this and hold that the privileges are extended to a wide range of health care professionals. Thus, a nurse assisting a physician with a procedure would be deemed to keep the information confidential, just as the physician does.

While a judicial change would protect more information and clear up some ambiguities in the law, such a change would still not address the issues of who should determine whether the privilege has been waived when the patient fights a lawsuit, or who should determine if the information is admissible in federal court.

B. Legislative Action

The best resolution to the current problem with privileged information would be for the Ohio General Assembly to revisit its position regarding privileged communications. The General Assembly should first examine whether the public policy reasons for the Health Care Professional Privi-
ileges still exist. If not, all the Health Care Professional Privileges should simply be abolished. If, however, the General Assembly determines that the policy reasons for the physician-patient privilege are as vital today as when the privilege was originally adopted, the legislature should adopt one of the following or similar positions:

(1) recognize a general health care worker-patient privilege under which a covered health care worker would be defined broadly to include nurses, nursing assistants, laboratory technicians, receptionists, and any other persons who are present for communications with the patient or have access to the patient's medical records;

(2) recognize an all-encompassing health care facility-patient privilege whereby health care facility is defined broadly to incorporate hospitals, nursing homes, ambulatory surgery centers, all types of outpatient facilities, including urgent care centers and diagnostic laboratories, and any other type of health care facility; or

(3) extend the existing privilege in Ohio to make confidential all matters relating to the diagnosis and treatment of the patient within the health care facility.

Any of these changes would protect a great deal of patient medical information maintained by health care facilities and provide such facilities with clear guidance as to how to respond to subpoenas for medical records.

Another required legislative change in this area would be for Congress to address the issue of privileges or the lack thereof, so that there is national guidance on what types of communications are privileged and which are not privileged in federal actions. While both these legislative changes and the above-described judicial solutions would clear up ambiguities as to the scope of the privilege, questions would still remain.

If the legislature does not institute one of these proposals, it should at least grant health care facilities immunity for responding to a subpoena for medical records so long as the facility in good faith releases the records believing that it is acting in accordance with state law. This would eliminate the dilemma which health care facilities face when in receipt of a subpoena. Due to the ambiguities enumerated in this article, there are no clear-cut answers as to which parts, if any, of a patient's medical record must be released, and a health care facility which attempts to make a good faith determination places itself at risk of liability. If health care facilities are granted immunity, the facilities would be able to act in good faith and not be held civilly liable for breach of confidentiality due to the ambiguities in the law.

C. Prosecutors Obtain Consent

An action which would aid health care facilities greatly when receiving subpoenas in criminal actions is for prosecutors regularly to obtain the victim's consent for release of medical records when the prosecutor anticipates needing the victim's medical records. Prosecutors could work with the police to create a system under which consent is routinely obtained from victims for the release of the victim's records.
D. Defense Motions Under Criminal Rule 16(d)

Ohio Criminal Rule 16(d)\(^{96}\) requires prosecutors to release all medical records in the prosecutor's possession to defense counsel upon request. Prior to attempting to obtain records through a health care facility, defendants should be required instead to file a motion under Ohio Criminal Rule 16(d) to compel the prosecutor to turn over all records already obtained by the prosecutor. Defense counsel may be forced, in practice, to use this alternative if health care facilities begin to deny records.

E. Pretrial Discovery Motions Regarding Medical Records

Prior to subpoenaing the medical records from a health care facility, counsel may wish, as a routine part of litigation, to file a pretrial discovery motion for the release of medical records. A subpoena to a health care facility may therefore be accompanied by a court order signed by the judge which specifically states which records regarding a patient are to be released from the facility. This would permit the health care facility to review the records, excise the documents that are not to be released, and release the records without fear of breach of confidentiality.

VI. CONCLUSION

The law regarding release of medical records by health care facilities is currently ambiguous, confusing, and greatly at odds with the typical patient's expectations of confidentiality. The law of medical privileges was enacted at a time when medical care had little resemblance to our current health care system. Instead of fulfilling the public policies of encouraging open communications between patients and their health care providers, maintaining patient privacy and protecting the ethics of the health care profession, the law has given an inconsistent patchwork of protection which is not capable of logical interpretation.

Hospitals and other health care facilities, which are uninvolved bystanders to judicial action in which records are being sought are nonetheless subjected to great expense and potential for liability. If health care facilities remove themselves from the dispute and demand court orders prior to the release of records, litigants will be forced to turn to the courts for relief. When this happens, perhaps long overdue legislative reform will also occur.