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Legal Triage: Balancing Doctor-Patient And Attorney-Client Privilege

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As is so often the case, courts around the country are attempting to keep up with often rapid changes in our society and technology. The healthcare industry sits at a crossroads in medical technology and the systems in which healthcare is provided. Our courts have been tasked with setting the parameters of patient interactions with their medical providers, particularly in the context of civil litigation. On one hand, "modern public policy strongly favors the confidential and fiduciary relationship existing between a patient and his physician." *Petrillo v. Syntex Laboratories, Inc.*, 499 N.E. 952, 957 (1st Dist. 1986).

Straining against this maxim is the fact that "in the modern hospital setting, health-care services are provided to the patient not only by physicians, but by a wide array of hospital personnel. Individuals, who may require information with respect to the patient's medic history, current condition, and treatment include direct caregivers such as nurses and attendants; specialists such as radiologist, anesthesiologists and surgeons; and administrative personnel…" *Burger v. Lutheran Gen. Hosp.*, 759 N.E. 2d 533 (Sup. Ct. Illinois 2001). In the context of medical malpractice personal injury litigation, yet another competing interest must be considered, as the "attorney-client privilege recognizes that 'advocacy depends upon the lawyer being fully informed by the client" (a physician or medical corporation).' *McChristian v. Brink*, 65 N.E. 3d 428 (1st Dist. 2016). The outcome of this balancing of competing interests is dependent on both the jurisdiction and the specific facts of the case. However, to begin the analysis, courts necessarily consider the nature of the relationship between a patient and his or her doctor.

The Doctor-Patient Privilege

"The relationship of patient to physician is a particularly intimate one [because]] [t]o the physician we bare our bodies … in confidence that what is seen and heard will remain unknown to others. *Cua v. Morrison*, 626 N.E. 2d 581, 586 (Ind. Ct. App. 1993). There can be no doubt that society has a significant interest in ensuring quality healthcare. Quality care is fostered by frank and open discussions between a patient and his or her medical provider. "The healthcare fiduciary duty of confidentiality exists to foster appropriate medical treatment of patients by assuring patients that their honest and complete disclosures of symptoms and medical history to treating physicians will be kept confidential." *Sorensen v. Barbuto*, 177 P. 3d 614, 619 (Utah Sup. Ct. 2008).

Courts draw from numerous sources when defining and delineating the confidentiality of the physician-patient relationship. For example, the medical profession has promulgated a code of ethics which governs the conduct of the medical profession. The code of ethics for the medical profession is comprised of three separate "prongs": (1) the Hippocratic Oath; (2) The American Medical Association's (AMA) Principles of Medical Ethics; and (3) The Current Opinions of the Judicial Council of the AMA. *Petrillo*, 499 N.E. at 957. These sources "affirmatively advertise to the public that a patient can properly expect his physician to protect those medical confidences which are disclosed…" *Id*. A doctor, therefore, has an obligation to deal honestly with his patient and thereby avoid engaging in conduct that undermines the fiducial nature of the relationship. *Petrillo*, 499 N.E. at 961.

With this public policy interest in mind, courts must consider what effect filing a civil lawsuit has on a doctor's fiduciary duty and on patient confidentiality. "When a patient files suit, he implicitly consents to his physician releasing any of the medical information related to the mental or physical condition which the patient has placed at issue in the lawsuit." *Petrillo*, 499 N.E. at 959. The patient's implicit consent, however, is obviously and necessarily limited; he consents only to the release of his medical information (relative to the lawsuit) pursuant to the methods of discovery…" *Id*.

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***Ex-Parte* Communications**

Generally, there is no prohibition for an attorney to interview an unrepresented witness outside of formal discovery procedures. For example, the Illinois Pattern Jury Instructions (Illinois Pattern Jury Instruction, Civil, No. 20.06 (2d ed. 1071)) states: "[a]n attorney has a right to interview a witness for the purpose of learning what testimony a witness will give." Various jurisdictions have been called upon to determine if some aspect of the doctor-patient relationship mandates an exception to this general rule.

Some Courts have permitted *ex parte* conversations between defense counsel and a plaintiff's treating physician under the theory that it reduces litigation costs and increases candor. *See Doe v. Eli Lilly & Co. 99 F.R.D.126, 128 (D.D.C. 1983).* Other courts have noted that such interviews facilitate early settlement of cases. *See Trans-World Invs. V. Drobny*, 554 P.2d 1148, 1151-52 (Sup. Ct. Alaska 1976). "[P]rohibitition of all *ex parte* interviews would be inconsistent with the purpose of providing equal access to relevant evidence and efficient, cost-effective litigation. *Domako v. Rowe*, 475 N.W. 2d 30, 36 (Sup. Ct. Michigan 1991).

Other courts have concluded that there is not "… a single piece of information or evidence which [counsel] is able to obtain through an *ex parte* conference that [counsel] cannot obtain via the conventional methods of discovery." *Petrillo*, 499 N.E. at 959. *See also Alsip v. Johnson City Med. Ctr.*, 197 S.W. 3d 722, 727 (Sup. Ct. Tennessee 2006). Insisting on formal discovery procedures can be said to merely regulate the discovery process, not hide the truth. *Petrillo*, 499 N.E. at 969.

In evaluating the need for formal as opposed to informal discovery with respect to medical providers, a concern arises that "the physician might disclose intimate facts of the patient which are unrelated and irrelevant to the mental or physical condition placed at issue in the lawsuit." *Petrillo*, 499 N.E. at 962. A physician may have difficulty in determining whether a particular piece of information is relevant to the claim being litigated. Some courts have concluded that this determination is best made in a setting in which counsel for each party is present and the court is available to settle disputes. *Roosevelt Hotel Ltd. V. Sweeny*, 394 N.W. 2d 353 (Sup. Ct. Iowa 1986). "Counsel in a position adverse to the patient is an … unreliable advocate for the patient's interest." *Sorensen v. Barbuto*, 177 P. 3d 614 (Sup. Ct. Utah 2008).

Courts are likewise concerned with instances of defense attorneys retaining a plaintiff's treating physician for the purpose of acting as an expert witness in the defendant's case against the very patient the doctor was treating. *See Miles v. Farrell*, 549 F, Supp. 82 (N.D. Ill. 1982). *See also Sorensen*, 177 P. 3d 614. This scenario appears to pit at odds the interest of the treating physician and the interest of the patient. Further, formal discovery processes reduce the potential for tort or contract liability of non-party doctors for the disclosure of confidential information during informal interviews. *Alsip*, 197 S.W. 3d at 729.

Attorney-Client Privilege

Where courts have found confidentiality based on either a physician's fiduciary duty or physician-patient privilege, a complex issue arises where a plaintiff sues a hospital or a medical corporation under a theory of *respondeat superior* for the alleged negligence of a medical provider. Under that scenario, unless a carve-out is created, the patient-physician privilege would prohibit an entity's attorney from communicating with any of that entity's employees who treated the plaintiff.

A blanket prohibition of communication between an entity's attorneys and the entity's employed medical providers would significantly hamper its defense. Therefore, many courts have found that "the right of a defendant hospital to defend itself transcends the physician-patient privilege as to permit it to communicate with employees for whose conduct the hospital is alleged to be liable."

Ritter v. Rush-Presbyterian St. Luke's Medical Center, 532 N.E. 2d 327 (Sup. Ct. Illinois 1993). Therefore, "the privilege is waived as to those physicians for whom the medical corporation may be held vicariously liable. See *Id*.

A more complex question arises when an entity's attorney wishes to conduct *ex parte* conversations with an employee whose actions are not a basis of liability for the entity. Often, courts have held that an entity was barred from communicating with such an employee. Courts have typically looked to the pleadings to determine whether a particular employee/treater is named. *See Testin v. Dreyer Medical Clinic*, 605 N.E. 2d 1070 (2nd Dist. 1992) & *Morgan v. County of Cook*, 625 N.E. 2d 136 (1st Dist. 1993). The issue is further complicated by the possibility that the treating employees may become a basis for liability under liberalized joinder rules. *See Aylward v. Settecase*, 948 N.E. 2d 769 (1st Dist. 2011). Even in such circumstances, courts have disallowed *ex parte* communications with those employees, unless and until the actions of those employees are alleged to be a basis for Plaintiff's injuries. *Id*. At 774.

Hamstrung by this line of cases, hospitals lobbied for legislation that would allow the hospital's agents and employees to communicate at any time and in any fashion with legal counsel for the hospital. 210 ILCS 85/6.17(e). This places Illinois Hospitals in a distinguishable class from other types of defendants in medical malpractice lawsuits. *Burger*, 759 N.E. 2d at 540. One explanation as to the distinction is the fact that hospitals operate in a highly regulated environment, and it is therefore logical that hospital risk managers and counsel interact on a regular basis with hospital employees. *Burger*, 759 N.E. 2d at 547 "[h]ospitals must constantly investigate the quality of patient care, especially when an unexpected adverse event occurs." *Id*. At 546. Additionally, a hospital is not a third party with respect to its own medical information. *Id* at 555.

Courts have attempted to create compromise solutions to resolve this tension, particularly as it relates to medical corporations. Where a defendant physician's attorney wished to conduct *ex parte* discussions with a treating physician who was also a member of the control group of the defendant L.L.C, to which both doctors belonged, the court had to consider the non-defendant doctor's right to defend his own company and weigh it against the physician-patient privilege. *McChristian v. Brink*, 65 N.E. 3d 428 (1st Dist. 2016). Noting that the attorney-client privilege recognizes that advocacy depends upon the lawyer being fully informed by the client, the court placed certain limitations on patient confidentiality. *Id*. Defense counsel was prohibited from any *ex parte* communication with the treating physician until the plaintiff deposed the doctor on the issue of the nature and extent of the injury. *Id*. At 436. Afterward, defense counsel was permitted to discuss issues of negligence and causation with the doctor. *Id*.

Other courts have allowed corporate defense counsel to have *ex parte* communications with a plaintiff's nonparty treating physicians only where the communication meets the general prerequisites to the application of the attorney-client privilege, the communication is with a physician who has direct knowledge of the event or events triggering the litigation, and the communications concern the facts of the alleged incident. *Youngs v. PeaceHealth*, 216 P. 3d 1035, 1045 (Sup. Ct. Washington 2013). Therefore, interviews as to prior and subsequent treatment would still be barred. *Id*.

Conclusion

Patient care is advanced by both physician-patient confidentiality and intra-hospital communication. As powerful and important as the physician-patient privilege is, it must at times yield to the corporate attorney-client privilege, particularly where litigation over patient care is involved. The exact parameters of permissible *ex-parte* discussions between defense counsel and a patient's medical providers is highly fact-specific and varies greatly by jurisdiction. The competent defense attorney must make him or herself aware of the applicable particularities to ethically and zealously advocate for the client. In addition, defense counsel must be cognizant of the manner in which their relationships with the treatment providers working within the confines of their hospital will impact their ability to engage in *ex parte* communication with those providers.

This is particularly true when physicians are employed by third party entities tasked, pursuant to contractual relationships, with providing treatment within the confines of the hospital. The ability and obligation of these providers to communicate with defense counsel when litigation is involved should be addressed both by hospital policy and in the relevant contracts with third party providers. As is often the case, this is an evolving area of law and defense attorney's must remain constantly vigilant of changes and developments in their jurisdiction to ensure that no applicable privileges are being violated by their communication with treating physicians while, at the same time, ensuring that they are exploring all appropriate avenues of information that may aid them in the defense of their client.

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