IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

DAVID BEHAR, MD, Plaintiff,	:	
v.	:	No. 1: 09-CV-2453
	:	Judge Conner
COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF TRANSPORTATION, *et al.*, Defendants	:	Electronically Filed

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BRIEF OF *AMICI CURIAE* THE PENNSYLVANIA MEDICAL SOCIETY, THE AMERICAN MEDICAL ASSOCIATION, AND THE PENNSYLVANIA PSYCHIATRIC SOCIETY REGARDING PLAINTIFF'S OBJECTIONS TO THE MAGISTRATE'S REPORT AND RECOMMENDATION

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THE INTERESTS OF THE PENNSYLVANIA MEDICAL SOCIETY, THE AMERICAN MEDICAL ASSOCIATION, AND THE PENNSYLVANIA PSYCHIATRIC SOCIETY AS *AMICI CURIAE*

Amicus curiae the Pennsylvania Medical Society ("PAMED") is a Pennsylvania non-profit corporation that represents physicians of all specialties and is Pennsylvania's largest physician professional organization. PAMED was founded to extend medical knowledge and to advance medical science; to elevate and maintain the standards of medical education; and to uphold the ethics and dignity of the medical profession. PAMED traces its history to a gathering of physicians in 1848.

The American Medical Association ("AMA") is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all US physicians, residents and medical students are represented in the AMA's policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in every medical specialty area and in every state, including Pennsylvania.

The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical

societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

The Pennsylvania Psychiatric Society is a Pennsylvania non-profit corporation with approximately 1,700 members, all of whom are psychiatrists and almost all of whom practice in the Commonwealth. The Psychiatric Society is a District Branch of the American Psychiatric Association.

The confidentiality of health information is an important issue to patients and physicians. Reflecting that importance, all *amici* have participated in litigation, either as an *amicus* or as a principal party, and engaged in other forms of advocacy, on that issue. The AMA's Principles of Medical Ethics and opinions issued by its Council on Judicial and Ethical Affairs ("CEJA") both address these issues. Under PAMED's bylaws, the AMA's Principles of Medical Ethics govern the conduct of PAMED members in their relations to each other and to the public.

Because the outcome of this matter will affect physicians and their patients and because these physician organizations believe they can contribute to the proper decision of this case, they participate as *amici* in this matter.

STATEMENT OF THE CASE

Plaintiff David Behar is a licensed physician in Pennsylvania, specializing in psychiatry, including the treatment of persons with drug and/or alcohol abuse. His Complaint challenges the requirement in Pennsylvania statute and PennDOT regulations that physicians report patients with certain medical conditions that may affect their ability to operate a motor vehicle safely. Dr. Behar challenged this requirement as violating various statutory and constitutional rights, including his patients' right to privacy.

Defendants filed a Motion for Judgment on the Pleadings, which the Court referred to the Magistrate for a Report and Recommendation. Defendants argued generally that plaintiff failed to state a claim as to any theory asserted and that plaintiff lacked standing, primarily on the basis that PennDOT had assertedly not enforced the statute and regulations criminally against any physician.

The Magistrate issued his Report on October 6, 2010, granting the Motion with the sole exception of Count I (Supremacy Clause), to the extent PennDOT's regulations seek disclosure of the medical record of any individual participating in a federally-assisted alcohol or drug abuse treatment program.

ARGUMENT

PENNDOT REGULATIONS REQUIRE MEDICAL REPORTING IN CIRCUMSTANCES IN WHICH IT IS EITHER PROHIBITED BY FEDERAL LAW OR SERVES NO USEFUL PURPOSE AND IS THUS AN IMPERMISSIBLE INVASION OF PATIENTS' PRIVACY RIGHTS IN THEIR HEALTH INFORMATION

A. The Importance of Confidentiality of Patient Health Information

Patients' substantial interest in the confidentiality of their health information is widely recognized, both in medical ethics and law. That interest reflects two distinct concerns: (1) protecting patients' privacy, and (2) protecting the patients' relationship with their physician, which can be adversely impacted if patients fail to seek medical care or fail to provide physicians with the information necessary for proper diagnosis and treatment

The first AMA Principles of Medical Ethics,[1] in 1847, directed physicians that:

> Secrecy and delicacy, when required by peculiar circumstances, should be strictly observed; and the familiar and confidential intercourse to which physicians are admitted in their professional visits should be used with discretion, and with the most scrupulous, regard to fidelity and honor. The obligation of secrecy extends beyond the period of professional services; none of the privacies of personal and domestic life, no infirmity of disposition or flaw of character observed during professional attendance, should ever be divulged by him except when he is imperatively required to do so.

[1] Accessible at http://www.ama-assn.org/ama1/pub/upload/mm/369/1847Principles.pdf.

The current AMA Principles establish the same rule in fewer words: "[a] physician … shall safeguard patient confidences and privacy within the constraints of the law."[2] The American Psychiatric Association has drafted psychiatric-specific Annotations to the AMA Principles; they begin by stating that "even the identification of a person as a [psychiatric] patient, must be protected with extreme care", referencing as the basis the "special nature of psychiatric therapy" [3]

At law, many federal and state statutes reflect this concern. HIPAA, and the "Privacy Rule"[4] that implements it, reflect Congress' current recognition of "the importance of protecting the privacy of health information." 67 Fed. Reg. 53182 (Aug. 14, 2002). HIPAA protects even the fact that an individual is a patient. 45 CFR §164.514(a). Absent the statutory mandatory disclosure requirement here, HIPAA would allow disclosure of patients with potential driving impairments to PennDOT only if the physician believed that the disclosure was "necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public." 45 CFR § 164.512(j)(1)(i)(A).

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[2] Accessible at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/Principles-medical-ethics/principles-medical-ethics.shtml.

[3] Accessible at http://psych.org/MainMenu/PsychiatricPractice/Ethics/ResourcesStandards/PrinciplesofMedicalEthics.aspx.

[4] "HIPAA" refers to the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d--1329d-8, and the "Privacy Rule" refers to extensive regulations at 45 CFR Part 164, entitled ''Standards for Privacy of Individually Identifiable Health Information.''

The importance of confidentiality is most acute for mental health treatment, including substance abuse; it is often considered the "*sine qua non"* for successful treatment.[5] *Jaffee v. Redmond*, 518 U.S. 1, 10 (1996); *Zane v. Friends Hosp.*, 836 A.2d 25, 33 (Pa. 2004).[6] The "mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment," *Jaffee, id*. at 10, and disclosure can have "a chilling effect on mental health treatment in general," *Zane, id.* at 34. Information on diagnoses and treatment in these areas can have adverse employment, social, and other consequences.

Heightened protection for medical records in these areas is commonplace, again both in federal and state law. *See, e.g*., 42 U.S.C. § 290dd-2 (confidentiality of drug and alcohol treatment records); 45 CFR § 164.502(a)(1)(iii) and 164.508(a)(2) (HIPAA provision placing heightened restrictions on non-consensual

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[5] Drug and alcohol abuse are mental illnesses, included within the Diagnostic and Statistical Manual of Mental Disorders – IV ("DSM-IV"), which is the recognized treatise that defines mental illness and their diagnostic criteria. *See* http://www.psych.org/MainMenu/Research/DSM-IV.aspx. The DSM-IV includes a general category of "Substance Related Disorders", with numerous subcategories within it, such as "Alcohol Dependence" and "Opioid Abuse, Opioid-Induced Disorders." *See* http://www. psychiatryonline.com/content.aspx?aID=619. PennDOT regulations recognize the DSM as the authoritative source. 67 Pa. Code § 83.5(b)(5).

[6] A well-regarded treatise explains the importance of confidentiality to psychiatric care:

> Without the promise of confidentiality … many individuals in need of treatment would be afraid to seek it. … At best, the possibility of disclosure will prolong treatment by reducing the client's openness with the therapist; at worst, it will preclude thorough exploration of emotional conflict and aggravate symptoms.

Barbara A. Weiner, J.D., and Robert M. Wettstein, M.D., *Legal Issues in Mental Health Care,* 201-02, Plenum Press (1993).

use and disclosure of "psychotherapy notes"); 50 P.S. § 7311 (confidentiality of mental health records under Mental Health Procedures Act);[7] 71 P.S. § 1690.108 (same re drug /alcohol treatment records).

B. Privacy Rights as to Health Care Information

Patient health information is protected by the constitutional right of privacy, which includes "the individual interest in avoiding disclosure of personal matters." *Whalen v. Roe*, 429 U.S. 589, 599 (1977). *See also Doe v. Southeastern Pennsylvania Trans. Auth.*, 72 F.3d 1133, 1137 (3d Cir. 1995); *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570, 577 (3d Cir. 1980) ("no question that an employee's medical records … are well within the ambit of materials entitled to privacy protection. Information about one's body and state of health is a matter which the individual is ordinarily entitled to retain within the 'private enclave where he may lead a private life'.") (footnote omitted).[8]

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[7] The MHPA and implementing regulations, 55 Pa Code § 5100.31-.39, allow non-consensual release of treatment information in very limited circumstances that do not explicitly include driver-related reporting. *See* § 5100.32. The MHPA rules are "more stringent" than HIPAA's and thus HIPAA does not preempt them. *See* 45 CFR § 160.203(b) and definition of "more stringent" in 45 CFR § 160.202. To *amici's* knowledge, no court has addressed the relationship between the MHPA and PennDOT's regulations.

[8] Defendants' prior Brief (at 28) describes *Whalen*, inaccurately, as "refusing to extend the right to privacy to cover personal medical information," citing footnote 32. In fact, that footnote simply rejects the argument that "a constitutional privacy right emanates from the Fourth Amendment" and does not negate the earlier holding that the right of privacy "is founded in the Fourteenth Amendment's concept of personal liberty." *Id*. at 599. In any event, the subsequent decisions in *Doe v SEPTA* and *Westinghouse* leave no doubt on this issue.

Like most constitutional rights, the confidentiality of health care information is not absolute and is subject to a balancing test. *Whalen,* 429 U.S. at 600; *Westinghouse,* 638 F.2d at 578. *Whalen* noted that certain disclosures – "to doctors, to hospital personnel, to insurance companies, and to public health agencies," 429 U.S. at 602, – were "an essential part of modern medical practice." *Id*. HIPAA's regulations allow narrowly tailored non-consensual disclosure to be made in a variety of necessary or exigent circumstances. *See* 45 CFR §164.512. Pennsylvania law likewise requires reporting in certain public health-related circumstances, *e.g*., reportable diseases. 35 P.S. §§ 521.1 *et seq.* *Amici* recognize the need for disclosure in these and analogous situations in which the public interest is substantial and the disclosure is narrowly tailored to the need.

Whalen did not establish a test, but *Westinghouse*, 638 F.2d at 580, outlined a multi-part test for a court to consider:

> the type of record requested, the information it does or might contain, the potential for harm in any subsequent nonconsensual disclosure, the injury from disclosure to the relationship in which the record was generated, the adequacy of safeguards to prevent unauthorized disclosure, the degree of need for access, and whether there is an express statutory mandate, articulated public policy, or other recognizable public interest militating toward access.

See also Report and Recommendation at 25.

C. Issues Concerning Plaintiff's Standing/Case or Controversy

PennDOT raised several challenges to plaintiff's standing/existence of a case or controversy, which the Magistrate rejected. If PennDOT continues with these challenges, this Court should do likewise.

First, the ability of physicians to represent their patients' interests is firmly established. *Pennsylvania Psychiatric Society v. Green Spring Health Services, Inc.*, 280 F.3d 278 (3d Cir. 2002).

Second, there is a real case or controversy concerning physicians' obligations, notwithstanding defendants' assertion that PennDOT has never prosecuted a non-reporting physician. In this respect, PennDOT's website explains to physicians their "liability if I do or do not report":

> If you **DO** report, you are exempt from any civil or criminal liability. No action may be brought against any person or agency for providing the required information; however, if you **DO NOT** report, *there is a possibility that you could be held responsible as a proximate cause of an accident resulting in death, injury or property loss caused by your patient. Also, providers who do not comply with their legal requirement to report may be convicted of a summary criminal offense*.

(bold in original, italics added)[9]. PennDOT cannot inform physicians on its website of the serious consequences of non-compliance and then argue in court that there is no standing because its threat is entirely hollow. Physicians may or may not read

[9] Accessible at http://www.dmv.state.pa.us/pdotforms/misc/ReportingCondition.pdf.

PennDOT's website but they certainly have no knowledge of PennDOT's assertions in this case. PennDOT expects physicians to follow the law on reporting, and its website seeks to encourage if not coerce compliance.

Moreover, PennDOT's assertion, even if supported and found to be true, is irrelevant. The crux of the harm here is not criminal sanctions against physicians but disclosure of patient health information, with its likely sequella as to patient care. There is no dispute that physicians *are* and *have been* reporting patients; in at least some instances, as described more fully later in this Brief, the reports likely fall beyond the scope of what PennDOT can constitutionally require. Additionally, despite its agreement in connection with the pending Motion as to federal preemption, PennDOT has previously taken the contrary position. See note 11, *infra*. The controversy is thus quite real. The Magistrate discussed these issues in his discussion of the preemption issue, Report at 15, and did so correctly.

D. The Overbreadth of PennDOT's Medical Reporting Regulations

PennDOT's regulations are impermissibly overbroad in several distinct respects. First, they require reporting in circumstances where it is clearly prohibited, preempted by federal law. Second, they require reporting in circumstances in which, for a variety of reasons, there is no countervailing public interest. *Amici* discuss these below.

1. Confidentiality requirements for federally-assisted drug and alcohol abuse treatment programs

Federal law prohibits non-consensual disclosure by "any federally assisted alcohol and drug abuse program" of their treatment records or information. *See* 42 CFR § 2.3(a). This prohibition extends beyond mere diagnosis and treatment information to the fact that an individual received care from the program. 42 CFR § 2.13(c).[10] "Federal assisted" is itself broadly defined, encompassing direct and indirect forms of assistance. *Id*., § 2.12(b). There are criminal penalties for violation, 42 U.S.C. § 290dd-2(f); and "no State law may either authorize or compel any disclosure prohibited by these regulations," 42 CFR §2.20. The regulations do not even permit disclosure based on a subpoena, requiring a court order. *Id*., 2.61(b)(1).

PennDOT agrees, now.[11] *See* Reply Brief at 9 ("Defendants fully recognize that the federal regulations … prevent physicians from disclosing information about

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[10] Absent consent, the regulations allow a facility to acknowledge a patient's presence only if the "facility is not publicly identified as only an alcohol or drug abuse diagnosis, treatment or referral facility, and if the acknowledgement does not reveal that the patient is an alcohol or drug abuser." § 2.13(c)

[11] PennDOT has not always agreed. *See* Motion to Dismiss Brief at 8 ("federal regulations do not preempt the field and … there is no apparent conflict" between state and federal regulations). In making this argument, PennDOT asserted (*Id*.) that its regulations required physicians to report only the patient's name, date of birth and address rather than health information. In fact, PennDOT has developed a series of reporting forms (an "Initial Reporting Form" and specific ones for different impairing conditions, e.g., "Cardiovascular" or "Cognitive Impairment"), which request specific medical information. The Initial Reporting Form is accessible at

- footnote continued on next page -

individuals in a federally assisted alcohol and drug abuse program."); Report at 14 (reporting PennDOT's concession). It is, however, quite unclear what PennDOT does in practice. PennDOT's regulations do not reflect this exception nor does its website, as excerpted above. Instead, PennDOT's website directs physicians to report patients with drug or alcohol-related driving impairments; the regulations require reporting as to "mental disorder[s]" and "[u]se of any drug or substance, including alcohol, known to impair skill or functions …." 67 Pa. Code § 83(b)(5, 7).

Notwithstanding its agreement as to the force of federal law, PennDOT has argued (Reply Brief at 5) that "PennDOT Regulations, can and have consistently been applied in compliance with the federal regulations for the past thirty years." This argument appears to arise from the assertion that PennDOT has never sought to punish a non-reporting physician, *see* Brief at 11-12. Even if true, this assertion misses the point that PennDOT's regulations and website content direct compliance without regard to the exception. It is all but inevitable that PennDOT has received physician reports in circumstances that the federal regulations prohibit, and certainly PennDOT has taken no steps, at least as far as the record discloses, to prevent that from happening. PennDOT's argument also ignores that the regulation and

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http://www.dmv.state.pa.us/medicalReportingCenter/medicalreportingforms.shtml. The other forms are referenced there but are "password protected."

educational materials have, minimally, created confusion that could deter patients from seeking treatment and/or fully communicating with their physicians.

Addressing this point, the Magistrate correctly held, *Id*. at 15, that "[a]ssuming that such information [drug or alcohol treatment information from a federally-assisted program] has been disclosed from a health care provider to PennDOT, a violation of the federal provisions has occurred." *Amici* do not know if PennDOT will file objections to the Magistrate's recommendation that the Supremacy claim not be dismissed. What is clear is that PennDOT must revise its regulations and website to provide the information and exception it acknowledges is legally required.

2. Temporary driving impairments and situations in which there is no clear risk to public safety

Many transient or relatively short-lived (measured in weeks or months) medical conditions can affect driving. Fractures or surgery on arms, legs, or spine may impair the ability to perform the physical movements necessary for driving.[12] Corrected vision may fall below specified guidelines or otherwise impair driving due to acute, treatable conditions. Patients may be prescribed a medication with sedating effects for a relatively short period of time or, as sometimes occurs, the patient

[12] Insofar as support for this point is necessary, *see* "Driver Fitness Medical Guidelines" prepared by the National Highway Traffic Safety Administration and the American Association of Motor Vehicle Administrators ("the NHTSA/AAMVA Report"), at 94, accessible at http://ntl.bts.gov/lib/31000/31100/31148/6061_MedicalReviewGuide_10-1_v2a.pdf.

becomes accustomed to the drug and side effects disappear or moderate (a process known as "tachyphylaxis").[13] Drug and alcohol dependencies may ameliorate in response to an inpatient stay for detoxification and treatment; the typical duration of in-patient care is 30 days.

As to these conditions, the condition itself and/or its effect on driving, and thus the need for reporting, will have ended, in at least some circumstances, before PennDOT can even process the physician's notice and take action, including providing a prior hearing if requested.[14] The NHTSA/AAMVA Report explains (at 89) that because of this inevitable time lag, "temporary conditions" that may impair driving "are the purview of the treating clinician rather than the DMV"; it adds that "advice on fitness to drive should be included in the treating clinician's discharge instructions to his patient" and that "[p]atients who refuse to follow the advice of the treating clinician should be referred to the DMV …." *Id.*

PennDOT's regulations agree, but only to a point. Specifically, reporting in several identified areas, (joint/extremity impairment or rheumatic, arthritic, orthopedic, vascular or neuromuscular disease), require reporting only if the condition "has lasted or is expected to last longer than 90 days." 67 Pa. Code

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[13] *See* Medline Plus, accessible at http://www. merriam-webster.com/medlineplus/ tachyphylaxis.

[14] PennDOT is required to provide a hearing prior to recalling driver's privileges. *Commw., Dept. of Transportation v. Clayton*, 546 Pa. 342, 353, 684 A.2d 1060, 1065 (1996).

§§ 83.5(b)(2)(ii), (b)(3)(ii). No other regulation related to any other condition has a comparable exception or limitation, although the principle governing the rule applies equally in other circumstances. The result is that the regulations require reporting in a number of circumstances in which PennDOT likely has no use for the information and in which reporting, therefore, serves no purpose. Under any right-to-privacy balancing test, reporting in that scenario is an insufficient countervailing interest.

Although its regulations (except in the limited instances noted above) do not address this problem, PennDOT seems to recognize it. PennDOT's website material on "Information for Health Care Personnel" begins this way:

> According to state law, health care personnel are required to report every person over 15 years of age diagnosed as having a condition that could impair their ability to drive, *with the exception of medical conditions expected to last less than 90 days*.

(emphasis supplied).[15] Thus, the problem appears to be PennDOT's regulations rather than what PennDOT indicates its actual policy is. PennDOT needs to conform the former to the latter.

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[15] Accessible at http://www.dmv.state.pa.us/medicalReportingCenter/otherInformation.shtml (emphasis supplied). *See also* http://www.dmv.state.pa.us/medicalReportingCenter/submitReports.shtml (Section 1518(b) of the Vehicle Code requires reports on driving-impairing conditions but "not required if the condition is expected to last less than 90 days ….") The materials suggest that state law, in particular §1518(b) of the Vehicle Code, 75 Pa.C.S. § 1518(b), establishes the 90 day limitation. It does not, nor does any other Code provision.

There are other circumstances in which mandatory reporting by physicians produces little benefit and is therefore unwarranted. There are patients who upon being advised by their physician of the risks and reasons readily and credibly agree to stop driving entirely. Alternatively, patients may agree, on a physician's recommendation, to self -impose restrictions, such as limiting their driving to shorter and fewer trips, to daytime hours, and/or to non-rush-hour traffic and slower roadways. Just as physicians necessarily have vested in them the responsibility to counsel patients with short-term impairments, so physicians can satisfactorily address issues in other contexts with some patients.

PennDOT has argued (Brief at 28, n.5) that if disclosure of health information violates the right to privacy, allowing physicians to do so in some circumstances does so as well. That argument overlooks that infringements of the right to privacy are evaluated under a balancing test, which necessarily means that the circumstances matter and the results can vary accordingly. It is only reporting in the absence of a countervailing public need that violates privacy rights.

Pennsylvania, in its effort to protect the public from unsafe drivers, steps far further into private patient matters than is the norm. Fewer than ten states mandate physician (as opposed to driver) reporting and few of them have as many categories of reportable conditions. *See* AMA, Physician Guide to Assessing and Counseling

Older Drivers, Chap. 8, at pp. 69-141 (Second Ed.).[16] Instead, the overwhelming majority of states authorizes and encourages physicians to report driving-impaired patients rather than mandating physicians to do so. Some do so by, for example, providing immunity for reporting; under that arrangement, physicians can report when the patient's condition *and* conduct make that necessary, but not otherwise.

E. <u>The Ethical Role of Physicians vis a vis Impaired Drivers</u>

Contrary to assertions on PennDOT's web site,[17] the reporting scheme established by the regulations is not "in harmony" with medical ethics. Unlike the regulations, the AMA Council on Ethical and Judicial Affairs ("CEJA"), through Opinion 2.24, entitled "Impaired Drivers and Their Physicians, [18] adopts a stepped approach in which reporting is one of several options and is appropriate only when other, less intrusive, options prove ineffective. Specifically, the CEJA process directs physicians to first counsel patients as to their potential driving impairments, advise them to voluntarily restrict or terminate their driving when warranted, and report impaired patients only when patients are unwilling to take action voluntarily, thereby creating a clear threat to the public.

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16 Accessible at http://www.ama-assn.org/ama1/pub/upload/mm/433/older-drivers-guide.pdf). Among states with limited reporting laws are California (requiring reports as to patients diagnosed with "disorders characterized by lapses of consciousness", including Alzheimer's and "related disorders") and Nevada (reporting limited to seizure disorders or lapse of consciousness.)

17 *See* http://www.dmv.state.pa.us/medicalReportingCenter/confidentiality.shtml.

18 *Accessible at* http://www. ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion224.shtml.

More specifically, CEJA Opinion 2.24 outlines the ethically appropriate role of physicians as follows:

> (1) Physicians should assess patients' physical or mental impairments that might adversely affect driving abilities. …In making evaluations…:
>
> > (a) The physician must be able to identify and document physical or mental impairments that clearly relate to the ability to drive.
> >
> > (b) The driver must pose a clear risk to public safety.
>
> (2) Before reporting, there are a number of initial steps physicians should take. A tactful but candid discussion with the patient and family about the risks of driving is of primary importance. Depending on the patient's medical condition, the physician may suggest to the patient that he or she seek further treatment, such as substance abuse treatment or occupational therapy. Physicians also may encourage the patient and the family to decide on a restricted driving schedule. Efforts made by physicians to inform patients and their families, advise them of their options, and negotiate a workable plan may render reporting unnecessary.
>
> (3) Physicians should use their best judgment when determining when to report impairments that could limit a patient's ability to drive safely. In situations where clear evidence of substantial driving impairment implies a strong threat to patient and public safety, and where the physician's advice to discontinue driving privileges is ignored, it is desirable and ethical to notify the Department of Motor Vehicles.
>
> *****
>
> (5) Physicians should disclose and explain to their patients this responsibility to report.
>
> (6) Physicians should protect patient confidentiality by ensuring that only the minimal amount of information is reported and that reasonable security measures are used in handling that information.

See also CEJA Report 1 – I-99.[19]

CEJA Opinion 1.02 recognizes that "[i]n some cases, the law mandates unethical conduct." [20] In exceptional circumstances of unjust laws, the Opinion directs that "ethical responsibilities should supersede legal obligations." When, as here, a legal mandate is inconsistent with the recommended approach of medical ethics, the Opinion directs physicians to seek appropriate changes in the law. Dr. Behar, and *amici*, are doing so here.

F. <u>The Need for a Fuller Record on Which to Decide the Privacy Claim</u>

This matter is before the Court on Defendants' Motion for Judgment on the Pleadings. It thus lacks a factual context that *amici* believe is appropriate for the proper resolution of certain of the claims, primarily the claim asserting a privacy violation.

A court should only grant a motion for judgment on the pleadings if it is clear that the merits of the controversy can be fully and fairly decided in this summary manner. *See* Charles Alan Wright and Arthur R. Miller, Federal Practice and Procedure § 1369 (Supp. 1998). It is, in general, difficult to conduct a proper balancing test merely on the pleadings. This Brief has identified and asserted a number of facts and reports – *e.g.*, about the importance of privacy to medical care,

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19 *Accessible at* http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_1i99.pdf.

20 *Accessible at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion102.shtml.

including the deterrent impact of disclosure on patient's seeking care in the first place; about various short-term medical conditions that impair driving ability; about PennDOT's administrative process for acting on medical reports, its website content; and its actual policy as to reporting of drug and alcohol treatment and "short term" impairments. As another example, beyond assertions in Briefs and references to statutory requirements, the record does not reflect at all the actual confidentiality protections PennDOT provides; a statute directing PennDOT to maintain confidentiality is not the same as proof that it actually does so. Facts in those areas, and others, would provide a more fully informed record on which to decide the matter.

The Maryland Court of Special Appeals addressed this issue in an analogous context in *Maryland State Board of Physicians v. Eist*, 932 A.2D 783 (Md. App., 2007). Dr. Eist, a psychiatrist, challenged on privacy grounds the Board's right to review treatment records in investigating a disciplinary complaint. The Board asserted a blanket rule that privacy concerns always gave way to the state's interest in regulating the medical profession. The court disagreed, finding instead that "constitutional privacy challenges to disclosure of medical records to government agencies [were] to be made on a case by case basis," upon consideration of the applicable facts. *Id*. at 809. It continued, at 810:

> That state of the decisional law does not translate, however, into an unbridled 'across the board' rule favoring disclosure of subpoenaed

> medical records to government agencies. Particulars about the complaint that generated the subpoena for medical records -- its source, nature, substance, and the relationship between the complainant and the doctor -- all are pertinent to assessing the government's level of need for the subpoenaed records compared to the patients' level of privacy interest in those records.

The same is true here, not on a patient-by-patient basis but as to the major relevant categories of physical and mental conditions discussed in this Brief. Accordingly, *amici* respectfully submit that the Court should, at a minimum, reject the Magistrate's holding on the privacy claim and thereafter decide that issue on a fuller record after an opportunity for discovery and a hearing.

CONCLUSION

For these reasons, *amici curiae* the Pennsylvania Medical Society and the American Medical Association respectfully request that the Court reject the Magistrate's Report and Recommendation insofar as it granted judgment on the pleadings with respect to the claim of unconstitutional invasion of privacy.

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CERTIFICATION AS TO LENGTH OF BRIEF

I hereby certify that this Brief (from "Interests of *Amici*" to "Conclusion") contains 4,822 words as determined by the word-processing system used to prepare the brief.

/s/ Robert B. Hoffman
Robert B. Hoffman

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

DAVID BEHAR, MD,	:	
Plaintiff,	:	
	:	
v.	:	No. 1: 09-CV-2453
COMMONWEALTH OF PENNSYLVANIA,	:	Judge Conner
DEPARTMENT OF TRANSPORTATION, *et al.*,	:	Electronically Filed
Defendants	:	

CERTIFICATE OF SERVICE

I hereby certify that that I electronically filed this document on November 8, 2010, and that counsel listed below will receive a copy via the Court's ECF system:

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