HIPAAcratic Oath

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In the United States, the Health Insurance Portability and Accountability Act (HIPAA)< http://www.hhs.gov/ocr/privacy/ > governs security for personally identifiable health-related information; HIPAA determines which health-related information may be released and transferred to whom and how such information must be protected against unauthorized access, modification and destruction.

In the European Economic Community, the European Privacy Directive< http://ec.europa.eu/justice/data-protection/ > and related agreements< http://ec.europa.eu/justice/data-protection/document/national-policy/health-data/index_en.htm > provide rights for data subjects (sometimes differing from country to country) to access and control information about themselves, including health-related data.

Recently I realized that such laws have unintended consequences given the widespread availability of anonymous ratings of doctors on such services as Angies's List< http://reviews.angieslist.com/wellness/doctor.aspx >, iDashboards.com< http://www.idashboards.com/Solutions/For-Your-Industry/Healthcare.aspx >, Health Grades< http://www.idashboards.com/Solutions/For-Your-Industry/Healthcare.aspx >, and RateMDs< http://www.ratemds.com/ > (among many others).

My wife (light of my life) is Dr Deborah N. Black, MDCM, CPSQ, FRCP(C)< http://www.cvmc.org/news/2011-hire-deborah-black >. She's a brilliant neuropsychiatrist (she helps patients and psychiatrists diagnose and treat behavioural disorders that may be related to organic brain disease or trauma) who has over 30 years of experience in her field. She is *almost* universally adored by her patients, her staff and her colleagues; every time I visit her main office at the Central Vermont Medical Center< http://www.cvmc.org/ >, the moment someone finds out that I'm her husband, I get showered with praise for her.

Here's the problem: a couple of weeks ago, Deborah saw a patient with a variety of complaints – and promptly received a bunch of complaints about Deborah's responses! The patient was angry about everything: how he was received by the receptionists, how Deborah articulated the medical problems, and the results of the tests he had taken under the doctor's supervision. The irony was that every single complaint was ill-founded: he accused Deborah of writing things that had not, in fact, been written into the record and misinterpreted the meaning of specific tests despite Deborah's repeated attempts to correct his misunderstanding. For example, the patient was furious about the results of a particular test which he insisted on misinterpreting as an IQ (intelligence quotient) test and raging that an IQ of 50 was impossible for him. It was nothing of the sort, but nothing Deborah said changed his determination to be insulted by the "low IQ" result.

The angry patient left the office in a rage, with threats of posting comments about Deborah's "unprofessional" behaviour – which, as we say in Vermont, made Deborah "wicked mad" because some years ago, someone posted an inflammatory list of accusations, all of which were false, on an anonymous professionals' evaluation service on the Web. When Deborah contacted the organization responsible for the list, she was firmly informed that there was no way she could

have the insulting, defamatory comments removed without a court order.

So here's the dilemma for all professionals who abide by standards of protecting personally-identifiable information. If they ignore libellous postings, their reputation may be harmed. If they attempt to challenge the false information using actual details of a patient's history or even behaviour during office or clinic visits, they will assuredly violate privacy-protection laws.

My colleague Professor David Blythe, JD pointed out in discussions of this issue that during a civil action for defamation, the professional suing for elimination of the libellous postings or for damages could challenge the factual basis of the allegedly libellous material – and not be bound by the strictures of data protection during the legal proceedings. For US attorneys, lawyer-client privilege allows the *client* to control what information about their communications with their lawyer may be made public – but there is a specific provision in the rules of evidence to allow an attorney accused of malpractice to defend herself even if that defence compromises client confidentiality: "Exceptions: There is no privilege under this rule: …. As to a communication relevant to an issue of breach of duty by the lawyer to his client or by the client to his lawyer…."[Legislative Council of the General Assembly for the State of Vermont (2003). *Vermont Rules of Criminal Procedures and Vermont Rules of Evidence.* LexisNexis (ISBN 0-327-04424-1) §502(d), p383].

Another issue he pointed out is that by beginning legal proceedings, the victim of libel may inadvertently give wider visibility to the libel.

But doctors, in particular, are bound not only by legal regulations: they also adhere by tradition to the Hippocratic Oath< http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html > often rendered as "First, do no harm." Fighting back against libel perpetrated by a mentally ill patient could be construed as doing harm – and my wife is unwilling to go that route.

Quite a bind, eh?

I think that there are strong reasons for providing the protective umbrella of anonymity and pseudonymity< http://www.mekabay.com/overviews/anonpseudo.pdf > when the victims of despotic regimes and other criminal organizations want to mobilize public opinion for action against injustice. I am not convinced that it is in the public interest to encourage anonymous postings that vilify professionals who cannot, due to their professional standards, defend themselves with factual information to counter the libel.

I welcome commentary on this complex issue.

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