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Pennsylvania Workers' Compensation Bulletin

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Ex Parte Communications with Claimant's Physician

Recently, claimants have begun asserting that employers and their counsel are prohibited from discussing the claim with the claimants' treating physicians. In essence, claimants posit that they control the treating physicians' ability to discuss the matter with third parties. Frequently accompanying these averments are "threats" that any contact with claimant's treating physician will be considered actionable.

Naturally, this raises the question: What are the legal boundaries and ramifications related to *ex parte* communications with claimant's treating physician? This question is easily answered in a civil litigation context because the Pennsylvania Rules of Civil Procedure prohibit these types of communications. *Pa.R.C.P. 4003.6*. In contrast, however, the Workers' Compensation Act does not provide a similar prohibition. Nor has any court held that *ex parte* communications during the course of an administrative proceeding are disallowed. Accordingly, employers should be confident that the lack of an administrative or procedural rule or statute regarding the issue strongly infers that there is no boundary concerning these types of communications.

Attorneys for some claimants have alleged that any attempt to discuss a matter with claimant's treating physician will be considered actionable as an invasion of privacy. Contrary to those counselors' assertions, the common law tort of invasion of privacy offers no support for the allegation.

Invasion of privacy torts stem from the right to be left alone, but to be actionable, the alleged invasion must be unlawful or unjustifiable. As such, the action for invasion of privacy actually comprises four distinct torts: 1) intrusion upon seclusion; 2) appropriation of name or likeness; 3) publicity given to a private life; and 4) publicity placing a person in a false light. Review of the four torts reveals that none of them would be viable actions in the present context. An intrusion upon seclusion protects persons from an intentional intrusion upon the person's private affairs or concerns; however, recovery is only available if the intrusion would be highly offensive to a reasonable person. This requirement precludes claimant from recovery in the instant scenario because investigation of claimant's medical condition during judicial proceedings is not only reasonable, it is expected. *See, e.g., Moses v. McWilliams, 549 A.2d 950 (Pa.Super. 1988).* Analysis of the other three invasion of privacy torts reveals that they are clearly not applicable to the situation of employers discussing claimant's condition with a treating physician. *2 Summary of Pennsylvania Jurisprudence*. § 22.

A second, and perhaps more compelling tort to allege, is a breach of the physician-patient privilege. Pennsylvania recognizes a cause of action for breach of the physician-patient privilege, which is codified at 42 Pa.C.S. §5929. That section provides:

> *No physician shall be allowed, in any civil matter, to disclose any information which he acquired in attending the patient in a professional capacity, and which was necessary to enable him to act in that capacity, which shall tend to blacken the character of the patient, without consent of said patient, except in civil matters brought by such patient, for damages on account of personal injuries.*

Notably, this section applies to a workers' compensation

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COMMONWEALTH COURT CASE REVIEWS

Lebanon Valley Brethren Home and Workers' Compensation Security Fund v. Workers' Compensation Appeal Board (Flamer), No. 2016 C.D. 2007, Filed March 11, 2008, Reported May 20, 2008.

(Security Fund—The Security Fund is a statutorily created entity and not an "insurer" under the Act and cannot be assessed penalties or attorneys' fees.)

Claimant was employed as a nurse manager when she sustained a work-related injury to her back. Employer issued a Notice of Compensation Payable and began paying claimant workers' compensation disability and medical benefits. Employer's workers' compensation coverage was provided by Legion Insurance Company, which was found insolvent and placed into liquidation. Consequently, the Security Fund became responsible for payment of Legion's workers' compensation claims.

On June 6, 2005, claimant filed a penalty petition alleging that the Security Fund violated the Workers' Compensation Act because it failed to pay her medical and indemnity benefits in a timely manner. The Security Fund did not contest its liability for the claimant's benefits; however, it did contest its liability for penalties.

The Workers' Compensation Judge granted claimant's petition and awarded penalties and attorneys' fees for unreasonable contest. The Security Fund appealed to the Workers' Compensation Appeal Board, which reversed the WCJ's award of penalties, but affirmed the award of attorneys' fees for unreasonable contest.

The Security Fund then petitioned the Commonwealth Court for review, arguing that it is not an insurer for purposes of the Act and, therefore, cannot be assessed attorneys' fees for an unreasonable contest.

The Court noted that, because the Security Fund is a statutorily created entity and is not mentioned as an "insurer" in §401 of the Act, the Security Fund cannot be penalized for violations of the Act. Consequently, the Fund's contest of claimant's penalty petition was reasonable.

Further, the Court noted that the Security Fund is not an "insurer" with respect to §440(a) of the Act which permits the assessment of unreasonable contest attorneys' fees. Therefore, the Security Fund may not be assessed attorneys' fees under any circumstances. This is true even if the Fund's contest of the claimant's penalty petition had been unreasonable.

The WCAB's decision affirming the award of unreasonable contest attorneys' fees was reversed.

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Pope & Talbot v. Workers' Compensation Appeal Board (Pelosi), No. 1193 C.D. 2007, Filed May 21, 2008.

(Joinder—Employer defending a claim petition on the ground that the injury occurred while claimant was employed elsewhere need not join that other employer before it can pursue its defense.)

Claimant was employed by Pope as a journeyman mechanic when, on July 17, 1997, he fell and injured his right elbow. Pope issued a Notice of Temporary Compensation Payable acknowledging the injury as "bursitis—right elbow." Three months later, claimant returned to work and his benefits were suspended.

In August of 1998, Pope sold its plant to Plainwell. On July 21, 1999, while employed by Plainwell, claimant hit his right elbow against a wall. Plainwell assumed liability for this "recurrence" of his 1997 elbow injury and began payment of benefits. Benefits were suspended when claimant returned to work.

Claimant continued to work for Plainwell until October 1, 1999, when he fell, fracturing three ribs. A Notice of Compensation Payable was issued, describing the injury as bruised ribs. Claimant did not return to work thereafter.

In December of 2000, Plainwell filed a termination petition alleging claimant had fully recovered from the injury to his ribs. Claimant then filed a claim petition, seeking full disability and medical benefits as of September 7, 2000, when he had surgery performed on his right elbow. Claimant named Pope as the sole defendant. The claim petition was consolidated with Plainwell's termination petition.

The Workers' Compensation Judge found claimant had fully recovered from the rib injury and granted Plainwell's termination petition. The WCJ also found claimant disabled by the injuries to his elbow. Although the WCJ directed Pope to pay benefits to claimant, he did not state whether the 1999 elbow injury was a recurrence or aggravation.

Before the Workers' Compensation Appeal Board, Pope argued that the evidence proved that claimant's elbow problems were attributable to the 1999 elbow injury sustained while claimant was employed by Plainwell. Plainwell argued that it could not be held liable because claimant had not named it as a defendant in his claim petition.

The WCAB remanded the case to the WCJ for a determination as to whether claimant's right elbow problem was a recurrence attributable to Pope or an aggravation attributable to Plainwell. On remand, the WCJ held Plainwell liable for claimant's benefits based on the credited medical testimony that the 1999 elbow injury was a new injury. Plainwell appealed to

the WCAB. The WCAB reversed, holding that because Plainwell was not named a defendant to the claim petition, it could not be held liable. The WCAB imposed liability on Pope even though the WCJ found that the injury occurred while claimant was employed by Plainwell. The WCAB held that it had been Pope's responsibility to join Plainwell as a defendant to the claim petition.

Pope then sought review by the Commonwealth Court, arguing that it was not obligated to join Plainwell as a defendant to the claim petition. The Court noted that the WCAB found that Pope had not taken reasonable steps to contest its liability inasmuch as it failed to join Plainwell. The Court disagreed, stating that it was not Pope's obligation to join Plainwell. Rather, it is the claimant who bears the burden of proving all elements required for an award of benefits.

While Pope could have joined Plainwell, joinder is permissive and not mandatory. Pope had no obligation to join Plainwell in order to contest its own liability. The finding that claimant's 1999 elbow injury was a new injury foreclosed the imposition of liability on Pope.

The Court also noted that Plainwell was a party to the consolidated proceedings. It cross-examined both Pope's and claimant's medical witnesses. It cross-examined claimant. Though the opportunity was present, it failed to present any medical evidence on its own behalf. Plainwell was a party to the consolidated proceedings and was not beyond the reach of an order issued by the WCJ that was supported by the evidence. The WCAB erred in holding that Plainwell could not be held liable for claimant's ongoing elbow problems.

The WCAB's order holding Pope liable was reversed, and the WCJ's decision to hold Plainwell liable was reinstated.

(Editor's Note: It is questionable as to whether the same result would have occurred if Plainwell had not been a party to the consolidated proceedings. Despite the holding of the Court that joinder is not necessary, the better course of action is to join another employer as a defendant if the evidence warrants joinder.)

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WAWA v. Workers' Compensation Appeal Board (Seltzer), No. 2292 C.D. 2007, Filed May 22, 2008.

(Challenge—Timeliness—In the absence of direct evidence of the date of claimant's receipt of Notification of Modification, WCJ may make an inferences as to when claimant received the Notification and thus determine that claimant's challenge is timely.)

After being off for several years due to a work injury, claimant returned to work for employer on November 22, 2004 at a loss of earnings. That same day, employer issued a notification of modification (NOM) under §413 (d) of the Act. Claimant worked on November 22, but did not return to work after that date due to his pain.

On December 20, 2004, claimant filed a challenge to the NOM. Employer argued that claimant's challenge was untimely under the Act, which provides that a claimant may contest the averments of a NOM by filing a challenge within 20 days of receipt of the NOM.

The Workers' Compensation Judge determined that claimant received the NOM on November 29, 2004 and, therefore, claimant's challenge was timely filed. Concluding that the WCJ's finding was supported, the Workers' Compensation Appeal Board affirmed.

Employer appealed to the Commonwealth Court, arguing that the WCJ's determination that claimant filed the challenge within 20 days of receipt of the NOM is based on mere speculation and is, therefore, not supported by substantial evidence. In fact, neither party offered evidence as to when claimant actually received the NOM. The WCJ merely noted that the NOM was dated November 22, 2004, Thanksgiving Day was November 25, 2004, and the NOM was sent from Pennsylvania to claimant's residence in Virginia. The WCJ thus concluded that it was "most likely" that claimant received the NOM on November 29, 2004, the Monday after the Thanksgiving Day weekend.

The Court agreed with the WCAB's conclusion that the WCJ had a reasonable basis for his conclusion about the date of receipt:

1) The NOM was dated November 22, 2004;
2) No party offered direct proof of the place, time or manner of mailing the NOM;
3) No party offered proof of business custom as to mailing of the NOM;
4) No party proved where the NOM was notarized;
5) The third day after the date of the NOM was Thanksgiving, a legal holiday;
6) The NOM was sent by some means to Virginia; and,
7) No party offered direct evidence of the date of receipt (such as a certified mail receipt or some other form of proof of delivery).

As such, the decision of the WCAB was affirmed.

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YDC New Castle—PA DPW v. Workers' Compensation Appeal Board (Headland), No. 230 C.D. 2008, Filed June 11, 2008.

(Claim Petition—An injured worker may be entitled to collect compensation benefits from the date of injury even if he does not seek medical care immediately following the injury.)

Claimant sustained a work-related injury on September 3, 2004. He reported the incident to his supervisor and continued to

finish his shift. Later that day, he developed pain in his neck. Although he was scheduled to work, claimant called off the following day. Ultimately, claimant missed two months of work due to the injury.

Employer issued a Notice of Compensation Payable acknowledging the injury as a cervical sprain/strain. Claimant received benefits as of September 6, 2004. He did not receive any benefits for September 4, 2004 and September 5, 2004. Instead, he was required to use his sick leave.

Claimant filed a claim petition seeking benefits for the two days immediately after his work injury. Employer argued that claimant was not entitled to benefits for September 4, 2004 and September 5, 2004 because claimant had no medical documentation to support his absences on those dates.

Before the Workers' Compensation Judge, claimant testified that he did not receive medical care until September 8, 2004. His injury occurred on a Friday. The doctor's office was closed on Saturday and Sunday. Monday and Tuesday were claimant's normal days off. Claimant testified that he did not believe he was capable of working on the two days he was scheduled to work prior to his medical examination due to the pain in his neck and shoulders.

Employer submitted its employment manual which requires medical documentation to support absences from work. Employer also submitted an excerpt from its handbook requiring medical documentation that supports from the first day any absence resulting from a work injury.

The WCJ concluded claimant met his burden of proof and granted benefits. Employer appealed to the Workers' Compensation Appeal Board, which affirmed.

Employer then sought review by the Commonwealth Court, contending that the WCJ capriciously disregarded its policy that claimant had to provide medical documentation for his absences as a result of the injury, that claimant was aware of the policy, and that claimant failed to provide such evidence.

The Court disagreed, noting that a WCJ is free to determine the chronological length of a claimant's disability based on all evidence presented, including claimant's own testimony. The Court further noted that, regardless of the fact that employer may have bargained with the union for the right to establish a policy requiring an employee to provide a medical excuse, such an agreement cannot be used to limit the period of time that compensation would otherwise be payable under the Workers' Compensation Act.

The decision of the WCAB was, thus, affirmed.

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John Lindner v. Workers' Compensation Appeal Board (Acme Markets and Broad spire Services, Inc.), No. 2080 C.D. 2007, Filed June 11, 2008.

(Utilization Review—One progress note submitted by provider under review is sufficient to facilitate review by URO.)

Claimant suffered a work injury on August 20, 1991, for which he received treatment by Mark Avart, D.O.

In September of 2004, employer filed a Utilization Review Request (UR Request) seeking a determination as to the reasonableness and necessity of Dr. Avart's treatment on and after August 5, 2004. The matter was assigned to a utilization review organization (URO) that, in turn, requested Dr. Avart's records. In response, Dr. Avart forwarded his progress note of August 5, 2004. The URO assigned the matter to Mitchell Antin, D.O., who found the treatment unreasonable and unnecessary. In his report, Dr. Antin noted that Dr. Avart's failure to provide more than one progress note for review was the predominant basis for his determination.

Claimant then filed a UR Petition. In order to meet its burden, employer submitted Dr. Antin's report, as well as two reports of another physician, Wilhelmina Korevaar, M.D. In response, claimant presented a packet of Dr. Avart's records, as well as a report from Dr. Avart.

The Workers' Compensation Judge denied claimant's petition. The WCJ felt that she lacked jurisdiction under County of Allegheny v. WCAB (Geyser), 875 A.2d 1222 (Pa.Cmwlth. 2005) inasmuch as the report issued by the reviewer indicated that no substantive review took place. In the alternative, the WCJ found that the reports of Dr. Korevaar and Dr. Antin were more credible than the evidence submitted by claimant.

Claimant appealed to the Workers' Compensation Appeal Board, which concluded that the WCJ erred in finding that she did not have jurisdiction. Under Geyser, a WCJ lacks jurisdiction to determine the reasonableness and necessity of treatment if a UR report is not prepared because the provider has failed to supply medical records to the reviewer. Here, Dr. Avart's office note of August 5, 2004 was provided for purposes of facilitating review and a report was issued by the reviewer. Consequently, the WCAB found Geyser to be inapplicable, such that the WCJ did have jurisdiction. Nevertheless, the WCAB found that employer met its burden of proof through the reports of Dr. Korevaar and Dr. Antin. Consequently, the WCAB affirmed the WCJ's decision.

Claimant then sought review by the Commonwealth Court, arguing that the WCJ failed to consider all of his medical evidence. The Court disagreed, noting that it was apparent from the WCJ's decision that she considered claimant's evidence. The WCJ reviewed Dr. Avart's records and

noted little variation in claimant's complaints over Dr. Avart's 14 years of treatment.

The decision of the WCAB was, thus, affirmed.

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HCR ManorCare v. Workers' Compensation Appeal Board (Bollman), No. 2320 C.D. 2007, Filed July 2, 2008.

(Utilization Review—A WCJ has jurisdiction to determine if a URO's request for medical records is properly perfected and, as such, has jurisdiction to order the records to be re-reviewed by the URO.)

Claimant suffered a work injury on November 13, 2001. As a result, claimant received treatment from Dr. LoDico. Employer requested Utilization Review of all office visits, all treatments, prescriptions, operative procedures and diagnostic testing provided by Dr. LoDico from August 31, 2005 and forward.

The Bureau assigned the request to a Utilization Review Organization (URO), which obtained Dr. LoDico's records. Because the required Verification form did not accompany the records, the URO did not forward Dr. LoDico's records to Dr. Johnson, who was to perform the Utilization Review. Because he received no records from Dr. LoDico, Dr. Johnson issued a Utilization Review Determination concluding that the treatment at issue was neither reasonable nor necessary.

Claimant then filed a petition for review of the Utilization Review Determination. At the hearing, claimant offered testimony from the URO's Utilization Review Coordinator, who confirmed that she received the records from Dr. LoDico but did not forward them to Dr. Johnson because there was no signed Verification form enclosed. Claimant also offered a letter from Dr. LoDico's office assistant stating that she had requested a Verification form from the URO, but one was never received.

The Workers' Compensation Judge concluded that there should be an order for another Utilization Review of Dr. LoDico's treatment and issued an order assigning the request for a Utilization Review Determination to the URO.

Both parties appealed to the Workers' Compensation Appeal Board, which affirmed the WCJ's decision.

Employer then sought review by the Commonwealth Court, arguing that the WCJ lacked jurisdiction because the provider failed to properly transmit his medical records to the URO. The Court disagreed, noting that the WCJ believed that there was a problem between Dr. LoDico and the URO involving the request for medical records, including uncertainty over the sending and receipt of the Verification form. Because the WCJ's decision addressed whether the URO"s request for the medical records was properly perfected and was not a decision on the merits of the petition, the WCJ had jurisdiction to order the records to be re-reviewed by the URO.

The decision of the WCAB was affirmed.

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Allegheny Power Service Corporation and Acordia Employer Service, Inc. v. Workers' Compensation Appeal Board (Cockroft), No. 242 C.D. 2007, Filed July 22, 2008.

(Bilateral Loss—Section 306(c)(23) of the Act allows a bilateral loss claimant to continue to receive total disability benefits even though he has returned to work and is receiving wages.)

During the course and scope of his employment with Allegheny Power, claimant sustained severe electrical burns to both of his upper extremities. As a result, his right arm was amputated just below the elbow. Although fitted with an artificial arm, claimant has no leverage in the artificial arm. Claimant's left hand was also badly injured, resulting in the amputation of the third and fourth fingers of his hand. Because of damage to his tendons, claimant's index finger was relocated to the site of the fourth finger; however, the relocation was unsuccessful and claimant has no use of the transplanted finger.

Claimant subsequently returned to work in a restricted duty position. Employer unilaterally ceased payment of claimant's benefits, and claimant filed a penalty petition and a challenge petition seeking reinstatement of total disability benefits under §306(c)(23) of the Act, which provides: "*Unless the board shall otherwise determine,* the loss of both hands or both arms or both feet or both legs or both eyes *shall* constitute total disability, to be compensated according to the provisions of §306(a) of the Act."

Employer stipulated that claimant suffered a loss of such severity so as to come within §306(c)(23) of the Act. As such, the Workers' Compensation Judge concluded that the statutory provisions obligated employer to pay total disability benefits unless the Workers' Compensation Appeal Board determined otherwise. Accordingly, the WCJ reinstated claimant's benefits and awarded penalties and attorneys' fees.

Employer then sought a determination by the WCAB that claimant was not totally disabled and requested a modification of benefits in accordance with claimant's actual earnings. At the WCAB's request, the matter was assigned to a WCJ.

Before the WCJ, employer presented testimony from Dr. Kann, who opined that claimant would be able to work in a sedentary duty position, with a number of restrictions given the claimant's limited use of his left hand. Further, employer presented testimony from an employment consultant who opined that, given the

restrictions outlined by Dr. Kann, there are positions within the general labor market in which claimant could be employed.

In rebuttal, claimant presented testimony from Dr. Cowan who opined that claimant is not employable. Dr. Cowan noted that claimant was employed only because employer had provided claimant with a special position in a familiar job setting. Claimant also offered testimony of a rehabilitation counselor who opined that if claimant was unable to continue working at the modified position with employer, he would be unemployable.

The WCJ credited claimant's witnesses and found claimant to be totally disabled under §306(c)(23) of the Act and concluded that employer is not entitled to credit for claimant's post-injury earnings.

Employer appealed to the WCAB, which affirmed the WCJ's decision. The WCAB relied on the discretionary authority provided to it by §306(c)(23) and determined that claimant remains totally disabled and is entitled to benefits despite his earnings.

Employer then sought review by the Commonwealth Court. In an opinion authored by the Honorable Rochelle S. Friedman, the Court affirmed the WCAB's determination. Judge Friedman concluded that, by providing that awards under §306(c)(23) are to be compensated according to §306(a), the legislature did not intend to transform the award itself into something other than an award for a specified permanent bilateral loss, which is governed by §306(c). Instead, in declining to limit compensation payable to claimants who suffer bilateral losses, the legislature recognized the devastating impact of the loss of both hands, arms, feet, legs and eyes. The legislature determined that the compensation for the effects of these bilateral losses is presumed to be total disability, to be limited only by the WCAB. The WCAB had the discretionary authority to determine that claimant was totally disabled, with regard to, or in spite of, his earning capacity. Accordingly the decision of the WCAB was affirmed.

Judge Renee Cohen Jubelirer filed a dissenting opinion noting that §306(a) of the Act also provides that: "nothing in this act shall require payment of total disability compensation benefits under this clause for any period during which the employe is employed or receiving wages." Judge Cohen Jubelirer also noted that the majority's opinion gives the WCAB unbridled discretion, thereby rendering appellate review by the Commonwealth Court (and Supreme Court) nothing more than an illusion.

(Editor's Note: Given the majority's opinion in this case, what incentive do employers have to create positions for injured workers? Here, the employer ended up paying the claimant both wages *and* total disability benefits. Economically speaking, the employer would have been in a better position had the claimant never been allowed to return to work. The effect of the majority's opinion may be to prevent injured individuals in the future from returning to work and becoming productive members of society—an effect the legislature never intended.)

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Christopher Combine v. Workers' Compensation Appeal Board (National Fuel Gas Distribution Corporation), No. 539 C.D. 2008, Filed August 14, 2008.

(Impairment Rating Evaluation—Under §306(a.2) of the Act, the IRE physician must first determine if the injured worker is at MMI prior to calculating the impairment rating.)

Claimant sustained a work injury to his left knee in the nature of a medial meniscus tear. Claimant subsequently underwent an impairment rating evaluation (IRE) and was found to have a 20% impairment. As such, employer filed a modification petition seeking to change claimant's disability status from total to partial. Claimant filed an answer asserting that modification was not appropriate as he had not yet reached maximum medical improvement (MMI).

The Workers' Compensation Judge granted employer's petition and rejected claimant's argument that a finding that he has reached MMI must be made prior to calculating his impairment rating. Claimant appealed the WCJ's decision to the Workers' Compensation Appeal Board, which affirmed.

Before the Commonwealth Court, claimant again argued that the Act requires an IRE physician to determine that an injured worker is at maximum medical improvement as a prerequisite to calculating the workers' impairment rating.

The Court noted that §306(a.2) of the Act provides that: "The degree of impairment shall be determined based upon an evaluation by a physician...pursuant to the most recent edition of the American Medical Association "*Guides to the Evaluation of Permanent Impairment.*" The Court then looked to the language contained in the most recent edition of the AMA's *Guides* (6th ed. 2008), which provides at section 2.3c:

> **When are impairment ratings performed?**
> *Only permanent impairment may be rated according to the Guides, and only after the status of "Maximum Medical Improvement (MMI) is determined, as explained in Section 2.5e…*

Section 306(a.2) of the Act plainly provides that when a claimant submits to an IRE, his degree of impairment shall be determined .pursuant to the AMA

Guides. Since the *Guides* indicate that impairment may be calculated only after an individual reaches MMI, the physician conducting the IRE must first determine that the claimant has reached MMI prior to determining his percentage of impairment due to the work-related injury.

Here, the IRE physician found claimant to be a candidate for a total knee replacement. Thus, the IRE physician did not opine that claimant was at MMI. His opinion was insufficient to support a modification of claimant's benefit status. The WCAB's order was reversed.

(Continued from page 1)

claimant seeking benefits and may provide a remedy. *Doe v. WCAB (USAir, Inc.), 653 A.2d 715 (Pa.Cmwlth. 1995).* Nonetheless, a plaintiff's burden of proof pursuant to this statute necessarily precludes recovery in the normal workers' compensation claim. The statute's plain language makes clear that the communications must tend to blacken the character of the patient. *See, e.g., Evans v. WCAB (Julia Ribaudo Home), 617 A.2d 826 (Pa.Cmwlth. 1992).* The blackening of a patient's character is a high bar to hurdle. For example, in *Evans*, *supra*, one of claimant's physicians testified at a petition for modification of benefits hearing. Claimant contended that the physician's testimony was inadmissible because it characterized her as a faker. The court disagreed and concluded that the testimony stated the doctor's medical opinion of claimant's reactions to the tests he administered; the physician believed that claimant demonstrated a weakness not supported by the medical evidence. As such, the court held that the testimony did not refer to a communication protected by the privilege. *Evans* represents the normal context in which an employer would contact a treating physician. In other words, the employers' basis for initiating contact is not to learn information that would blacken a patient's character, but rather to ascertain the physician's diagnosis.

A perfect illustration of the purposes for which employers contact treating physicians and the courts' interpretation of the same was seen in Grimminger v. Maitra, 887 A.2d 276 (Pa.Super. 2005). In that case, the plaintiff was referred in February of 1997 to Dr. Maitra, a board certified physician in general and vascular surgery, for a diagnosis of the plaintiff's complaints regarding numbness and pain in his left arm. Dr. Maitra diagnosed plaintiff with a subclavian vein thrombosis. After a second visit in 2000, Dr. Maitra recommended that plaintiff refrain from any strenuous activity with his left arm. Dr. Maitra concluded, upon his examination, that plaintiff was to restrict his lifting to five pounds with his left hand because lifting contributed to his chronic pain syndrome. Thereafter, in 2002, plaintiff's employer wanted to question Dr. Maitra's about plaintiff's work limitations. Dr. Maitra agreed to review a surveillance film of plaintiff to determine whether he was acting outside the work restrictions that Dr. Maitra had established over two years earlier. Dr. Maitra answered specific questions about plaintiff's limitations and agreed to give his opinion without plaintiff's authorization. After learning Dr. Maitra's new opinions, the employer issued a termination notice to plaintiff. Plaintiff subsequently brought suit against Dr. Maitra alleging a breach of confidential relationship. The Court considered one issue on appeal: whether Dr. Maitra breached plaintiff's confidentiality by offering information and opinions to plaintiff's employer without his knowledge or consent.

Initially, the Court highlighted that case law "has drawn a distinction between information learned by a physician through communication to him by a patient and information acquired through examination and observation." The Court continued:

> *The distinction originates in the rationale of the statute which was designed to create a confidential atmosphere in which a patient will feel free to disclose all possible information which may be useful in rendering appropriate treatment. Therefore, the privilege is limited to information which would offend the rationale of the privilege. Grimminger, 887 at 279.*

The Court concluded that the communications plaintiff complained of did not trigger the physician-patient privilege. Plaintiff cited three statements made by Dr. Maitra to plaintiff's employer to prove breach of the privilege. First, he argued that Dr. Maitra's statement to the employer that plaintiff told him that he could not do the activities shown in the video violated the privilege because it required disclosure of a communication between a physician and patient. The court determined that this type of communication could not be interpreted as information that would blacken plaintiff's character.

Second, plaintiff contended that Dr. Maitra made a new diagnostic statement when he told plaintiff's employer that it appeared plaintiff had recovered from his condition. Again, the court noted that plaintiff "fail[ed] to prove that Dr. Maitra's comment was a diagnosis which rises to the level of an exposure which would blacken his character[.]" Id. at 281.

Finally, plaintiff asserted that Dr. Maitra told his employer that there were no objective findings to support plaintiff's complaints of pain and therefore he had to determine the restrictions based on subjective complaints. Again, the court believed that this statement failed to blacken plaintiff's character. As such, the court held that plaintiff failed to state a cause of action for breach of the physician-patient privilege.

As evidenced by courts' interpretations of the statute and the requirements attendant thereto, this cause of action is not viable where an employer seeks, *ex parte*, to obtain non-confidential communications and/or information from a claimant's treating physician.

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Send questions to: Harry W. Rosensteel, Esquire, Thomson, Rhodes & Cowie, P.C., 1010 Two Chatham Center, Pittsburgh, PA 15219.

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