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Can a Nightingale Sing? Assessing the Need for a Nurse-Patient Privilege[*]

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> "I . . . will hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my profession."[1]

Introduction

Evidentiary privileges,[2] also commonly referred to as testimonial privileges,[3] permit parties and potential witnesses to withhold relevant and material evidence,[4] both

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[*] A nightingale is a type of thrush or "any of various other birds noted for their sweet song or for singing at night," while Florence Nightingale was a renowned English nurse. MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 837, 1496 (11th ed. 2005); *see also* Lance P. Steahly, *The Civil War: Military Care in the War Between the States*, *in* BORDEN INST., THE EVOLUTION OF FORWARD SURGERY IN THE US ARMY 65, 99 (Lance P. Steahly & David W. Cannon eds., 2018) ("In the nursing heritage, the name of Florence Nightingale stands out. . . . In America, nurses were often referred to as 'Nightingales' because of her work."). To "sing" in turn can mean not only "to produce musical or harmonious sounds," but "to give information or evidence." MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY, *supra*, at 1163; *see, e.g.*, United States v. Kojayan, 8 F.3d 1315, 1318 (9th Cir. 1993) (describing a government witness who was expected to "sing like a nightingale").

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[1] Nightingale Pledge, *quoted in* Roberson v. Liu, 555 N.E.2d 999, 1002 (Ill. App. Ct.), *leave to appeal denied*, 561 N.E.2d 707 (Ill. 1990). Written in the latter part of the nineteenth century, the Nightingale Pledge reflects "the general [ethical] obligations of those in the nursing profession." JOHN P. KENNY, PRINCIPLES OF MEDICAL ETHICS 55 (2d ed. 1962). It was formulated by a committee working under the direction of Lystra Gretter, an accomplished nurse-educator. *See Roberson*, 555 N.E.2d at 1002; John R. Clark, *The Smoking Gun: Patient Confidentiality*, AIR. MED. J., Jan./Feb. 2012, at 13, 14. The Pledge was first administered to the graduating class of Detroit's Farrand Training School, now Harper Hospital, in 1893, and it continues to be recited during nursing graduation exercises today. *See* Christine Godsil Cooper & Nancy J. Brent, *The Nursing Profession and the Right to Separate Representation*, 58 CHI.-KENT L. REV. 1053, 1057 n.11 (1982). *See generally* Helen W. Munson, *Lystra E. Gretter*, AM. J. NURSING, June 1949, at 344 (providing a summary of Gretter's impressive career).

[2] *See In re* Agosto, 553 F. Supp. 1298, 1306 (D. Nev. 1983) ("The word 'privilege' itself, a derivative of the Latin phrase 'privata lex', is described as 'a prerogative given to a particular person or class of persons.'" (quoting Daniel R. Coburn, *Child-Parent Communications: Spare the Privilege and Spoil the Child*, 74 DICK. L. REV. 599, 602 (1970))); Pastore v. Samson, 900 A.2d 1067, 1074 (R.I. 2006) ("Etymologically, the word 'privilege' is derived from a combination of two Latin words meaning 'private law.'").

[3] *See, e.g.*, United States v. Pineda-Mateo, 905 F.3d 13, 15 (1st Cir. 2018) ("The spousal testimonial privilege is an evidentiary privilege that protects a defendant's spouse from having to

at trial and during pretrial discovery.[5] Because these privileges contravene the public's right to "every person's evidence" in a court of law,[6] as well as the corresponding obligation of every person to testify when called upon to do so,[7] courts generally view them with disfavor.[8] As the Arizona Supreme Court explained, because a privilege "results in the exclusion of evidence it runs counter to the widely held view that the fullest disclosure of the facts will best lead to the truth and ultimately to the triumph of justice."[9]

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take the witness stand to testify against the defendant."); John T. Soma & Lorna C. Youngs, *Confidential Communications and Information in a Computer Era*, 12 HOFSTRA L. REV. 849, 850 (1984) (stating that the physician-patient relationship is "protected by an evidentiary or testimonial privilege"); *see also* Lincoln Am. Corp. v. Bryden, 375 F. Supp. 109, 111 (D. Kan. 1973) (acknowledging "the existence of a testimonial or evidentiary privilege created by statute or common law").

[4] *See* Ulibarri v. Superior Ct., 909 P.2d 449, 456 (Ariz. Ct. App. 1995) ("[U]pholding a privilege amounts to suppression of relevant evidence and . . . the cost of doing so is an increased risk of . . . injustice in individual cases."), *review denied sub nom.* Ulibarri v. Hancock, 924 P.2d 109 (Ariz. 1996); Church of Jesus Christ of Latter-Day Saints v. Superior Ct., 764 P.2d 759, 763 (Ariz. Ct. App. 1988) ("A privilege in the law of evidence is a right which a person has in a given instance to prevent the revelation of otherwise material and relevant evidence." (quoting MORRIS K. UDALL & JOSEPH M. LIVERMORE, LAW OF EVIDENCE § 71, at 123 (2d ed. 1982))).

[5] *See* Bain v. Superior Ct., 714 P.2d 824, 826 (Ariz. 1986) ("[P]rivileges, once they attach, prohibit not only testimonial disclosures in court but also pretrial discovery of information within the scope of the privilege."); Grimm v. Ariz. Bd. of Pardons & Paroles, 564 P.2d 1227, 1235 (Ariz. 1977) (noting that privileges are "generally applicable to discovery"); State Farm Mut. Auto. Ins. Co. v. Lee, 4 P.3d 402, 405 ¶ 8 (Ariz. Ct. App. 1999) (stating that "privileged communications or materials are not discoverable"), *vacated on other grounds*, 13 P.3d 1169 (Ariz. 2000).

[6] Hosp. Corp. of Am. v. Superior Ct., 755 P.2d 1198, 1200 (Ariz. Ct. App. 1988); *see also* Tracy v. Superior Ct., 810 P.2d 1030, 1050 (Ariz. 1991) (observing that "testimonial privileges have been held to contravene the fundamental principle that 'the public has a right to every man's evidence"' (quoting Trammel v. United States, 445 U.S. 40, 50 (1980))).

[7] *See* State v. Superior Ct., 609 P.2d 1070, 1072 (Ariz. Ct. App. 1980) ("The duty to testify has been recognized as a basic obligation of every citizen since the public has the right to every man's evidence."); *see also* City of Phoenix v. Peterson, 462 P.2d 829, 833 n.4 (Ariz. Ct. App. 1969) ("It is a general principle of law that the courts are entitled to have made available the testimony and documentary evidence possessed by any person." (quoting MORRIS K. UDALL, LAW OF EVIDENCE § 102, at 187 (1960))).

[8] *See* Johnson v. O'Connor, 327 P.3d 218, 225 (Ariz. Ct. App. 2014) (observing that privileges are "weighed unfavorably against other policy considerations"); Ellison v. Maryland, 500 A.2d 650, 652 (Md. Ct. Spec. App. 1985) ("[T]he . . . principle is . . . well-settled that all of the various testimonial privileges, as derogations from full and accurate fact finding, are looked upon with disfavor.") (footnote omitted), *aff'd*, 528 A.2d 1271 (Md. 1987).

[9] Hitch v. Pima Cty. Superior Ct., 708 P.2d 72, 78 (Ariz. 1985) (quoting Hughes v. Meade, 453 S.W.2d 538, 540 (Ky. Ct. App. 1970) (citing R.M. Weddle, *Disclosure of Name, Identity, Address, Occupation, or Business of Client as Violation of Attorney-Client Privilege,* Annot. 16 A.L.R 3d 1047, 1050 (1967))); *see also* Page v. Va. State Bd. of Elections, 15 F. Supp. 3d 657, 660 (E.D. Va. 2014) ("Testimonial and evidentiary privileges exist against the backdrop of the general principle that all reasonable and reliable measures should be employed to ascertain the truth of a disputed matter.").

Nevertheless, by protecting the confidentiality of certain private communications,[10] evidentiary privileges foster important personal and professional relationships and serve valuable privacy interests that are not directly related to the production or admission of evidence,[11] or to the adversary system's corresponding search for truth.[12] For example, like the more widely recognized physician-patient privilege with which it can be compared,[13] a nurse-patient privilege would encourage patients to disclose sensitive information about their health in order to facilitate proper medical diagnosis and treatment,[14] while occasionally impeding the judicial search for truth by prohibiting the use of those disclosures in subsequent legal proceedings.[15]

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[10] *See, e.g.*, Granger v. Wisner, 656 P.2d 1238, 1240 (Ariz. 1982) (noting that the attorney-client privilege "protects . . . confidential communications between a client and his … attorney"); *see also* Church of Jesus Christ of Latter-Day Saints v. Superior Ct,, 764 P.2d 759, 764 (Ariz. Ct. App. 1988) ("[C]onfidential communications [are] promoted by the recognized areas of evidentiary privilege.").

[11] *See, e.g.*, Readenour v. Marion Power Shovel, 719 P.2d 1058, 1062 (Ariz. 1986) ("Privilege statutes prohibit the use of highly relevant evidence in order to further policy goals such as physician-patient confidentiality."); *see also Church of Jesus Christ of Latter-Day Saints*, 764 P.2d at 764 ("Compelling privacy needs are served . . . by the recognized areas of evidentiary privilege."); Danielson v. Superior Ct., 754 P.2d 1145, 1150 (Ariz. Ct. App. 1987) ("The theoretical basis for an evidentiary privilege is that secrecy and confidentiality are necessary to promote the relationship fostered by the privilege.").

[12] *See* Indus. Comm'n v. Superior Ct., 595 P.2d 166, 167 (Ariz. 1979) ("Privileges from discovery lead to the suppression of truth and the defeat of justice."); *see also* Blazek v. Superior Ct., 869 P.2d 509, 511 (Ariz. Ct. App. 1994) (observing that "privilege statutes . . . exclude relevant evidence and impede the fact-finder's search for the truth"). *See also* State v. Watton, 793 P.2d 80, 85 (Ariz. 1990) ("Anything that inhibits a court's . . . access to information undermines the truth-seeking function of the judicial process and threatens the adversary system.").

[13] *See* Lewin v. Jackson, 492 P.2d 406, 410 (Ariz. 1972) ("It is well-settled that the purpose of the physician-patient privilege is to insure that the patient will receive the best medical treatment by encouraging full and frank disclosure of medical history and symptoms by a patient to his doctor."); State v. Poetschke, 750 N.W.2d 301, 304 (Minn. Ct. App. 2008) (noting that the purpose of the physician-patient privilege "is to encourage patients' full disclosure of information, which will enable medical providers to extend the best medical care possible," but that the privilege is "an impediment to truth-finding" (quoting State v. Gillespie, 710 N.W.2d 289, 297 (Minn. Ct. App. 2006); and then State v. Heaney, 689 N.W.2d 168, 174 (Minn. 2004)).

[14] *See* People v. Wilber, 664 N.E.2d 711, 715 (Ill. App. Ct. 1996) ("The purpose of the physician-patient privilege is to encourage full disclosure in order to ensure the best diagnosis and treatment for the patient. Further, the privilege has been applied not only to physicians, but also to nurses and hospital staff.") (citation omitted); Rebecca J. Pierce, Comment, *Statutory Solutions for a Common Law Defect: Advancing the Nurse Practitioner-Patient Privilege*, 47 J. MARSHALL L. REV. 1077, 1087 (2014) ("[T]he necessity of encouraging people to divulge private medical information is not limited to communications between physicians and patients, but extends to communications between nurses and patients.").

[15] *See* Darnell v. State, 674 N.E.2d 19, 22 (Ind. Ct. App. 1996) ("[W]ere we to recognize that all communications between nurses and patients were privileged, we would be limiting the amount of testimony which could be offered at trial and, thereby, impeding the search for truth."); Jimmie Smith, *Privileged Communication: Psychiatric/Mental Health Nurses and the Law*, PERSPECTIVES IN PSYCHIATRIC CARE, 1990, at 26, 28 (discussing the argument that a nurse-patient privilege would "diminish[] the authority of the courts to seek information and to establish the truth.").

Despite Arizona's longstanding recognition of the physician-patient privilege,[16] there is no Arizona statutory or decisional law recognizing a corresponding nurse-patient privilege.[17] Most other states also have yet to recognize the nurse-patient privilege.[18] There has been virtually no scholarly examination of the nurse-patient privilege in Arizona,[19] and relatively little academic discussion of the privilege in other jurisdictions.[20] While this dearth of authority might be seen as an implicit rejection of the privilege,[21] this article challenges that perception,[22] and advocates the recognition of a broadly applicable nurse-patient privilege in order to encourage patients to share sensitive information about their health with their nurses.[23]

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[16] *See* Barnes v. Outlaw, 937 P.2d 323, 327 (Ariz. Ct. App. 1996) (observing that "Arizona has long acknowledged and protected the confidential nature of relationships between physicians and their patients." (citing ARIZ. REV. STAT. § 12-2235)), *vacated in part on other grounds*, 964 P.2d 484 (Ariz. 1998); Michael Miller, *The Medical Records Privilege: An Expanding Concept*, ARIZ. ATT'Y, July/Aug. 2008, at 28 (noting that "Arizona's physician-patient privilege dates back to territorial days.").

[17] *See* Pierce, *supra* note 14, at 1087 n.67 (identifying Arizona as among the states that "do not recognize a nurse-patient privilege, but do codify a physician-patient privilege.").

[18] *See* JOSEPH P. DEMARCO ET AL., ETHICAL & LEGAL ISSUES IN NURSING 212 (2019) (asserting that "in most states there is no nurse-patient privilege."); Kathy B. Wright, *Professional, Ethical and Legal Implications for Spiritual Care Nursing*, 30 J. NURSING SCHOLARSHIP 82 (2007) (observing that "nurse-client interactions are not considered legally privileged in most states."); Kerry L. Morse, Note, *A Uniform Testimonial Privilege for Mental Health Professionals*, 51 OHIO ST. L.J. 741, 745 (1990) (stating that "nurses have not widely received the protection of privileges.").

[19] *See* Miller, *supra* note 16, at 28-29, n.7.

[20] *See, e.g.*, Timothy R. Byrnes, Comment, *Medical Privilege in Oregon*, 55 OR. L. REV. 459, 460 n.10 (1976) ("[OR. REV. STAT. §] 44.040(1)(g) (1975) provides for a nurse-patient privilege. This privilege will not be discussed because it is similar to the physician-patient privilege and has not been interpreted in Oregon cases.") One commentator has asserted that even "the volume of law review and other secondary literature on the physician-patient privilege is relatively small." Chris Chambers Goodman, *When Privacy Is Not an Option: Codifying the Contours of Necessary Third Parties in Emergency Medical Situations*, 63 SYRACUSE L. REV. 399, 428-29 (2013). For a notable exception, see Pierce, *supra* note 14.

[21] *See, e.g.*, People v. Sambo, 554 N.E.2d 1080, 1087 (Ill. App. Ct. 1990) (holding that a student's communications with a school nurse were not privileged because her parents "cited no authority to support their 'nurse-patient' privilege argument."); *see also In re* Grand Jury Proceedings, Unemancipated Minor Child, 949 F. Supp. 1487, 1495 n.11 (E.D. Wash. 1996) ("[A]n absence of authority expressly recognizing a privilege tends to be interpreted to mean that none exists.").

[22] *See, e.g.*, Doe v. Rankin Med. Ctr., 195 So.3d 705, 713 (Miss. 2016) ("Under Mississippi law, all communications made to a nurse are privileged." (citing MISS. CODE ANN. § 13-1-21)); *see also* Pierce, *supra* note 14, at 1079 ("Currently there is a split of authority among the states whether or not . . . a [nurse-patient] privilege exists.").

[23] *Cf.* Pierce, *supra* note 14, at 1079 (advocating recognition of the privilege "throughout the states."). The present article focuses on the potential recognition of a nurse-patient privilege in Arizona. *See generally* Steven R. Smith, *Medical and Psychotherapy Privileges and Confidentiality: On Giving With One Hard and Removing with the Other*, 75 KY. L.J. 473, 550 (1986) ("[I]n some cases real protection of confidentiality requires a national approach. Nevertheless, a single state can do much to rationalize its laws protecting confidentiality."). However, the article also discusses pertinent authority from a number of other states, including Colorado, Indiana, Missouri, and Ohio, and it is hoped that the analysis here will be useful in any jurisdiction in which adoption of the privilege is being considered. *Id. See generally* Moses v. Albert Einstein Med. Ctr., 25 Phila.

Part I of the article describes the nurse's professional ethical obligation to maintain the confidentiality of a patient's health care information.[24] In Parts II and III, the author notes that no common law nurse-patient privilege has ever been recognized,[25] and that the privilege has been adopted by statute or court rule in only a few states.[26] In Parts IV and V, the author examines the current status of the privilege in Arizona and Ohio.[27] Part VI discusses a case in which a divided Missouri appellate court debated whether any recognition of the privilege should be limited to situations in which the nurse was acting as the agent of a physician at the time the patient's communications were made.[28]

In Parts VII and VIII, the author examines the respective roles of the state legislatures and the courts in the potential recognition of a nurse-patient privilege.[29] In Part IX the author argues that the existence of a physician-patient privilege is a practical prerequisite to the recognition of a nurse-patient privilege.[30] Part X identifies some inequities caused by the lack of a widely recognized nurse-patient privilege,[31] and in Part XI the author concludes that Arizona and other states that have not yet adopted the privilege should promptly do so, either by statute or judicial decision.[32]

I. The Nurse's Ethical Duty of Confidentiality

The "Nightingale Pledge"[33] is essentially the nursing equivalent of the Hippocratic Oath,[34] which memorializes the physician's ethical obligation to maintain patient confidentiality.[35] Although perhaps not as familiar to the public as its

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Cty. Rptr. 389, 406 (Pa. C.P. 1993) ("[E]ach state is free to enact her own privileges, and typically does so in a common law and/or legislative manner.").

[24] *See infra* notes 33–66 and accompanying text.

[25] *See infra* notes 67–83 and accompanying text.

[26] *See infra* notes 84–106 and accompanying text.

[27] *See infra* notes 107–73 and accompanying text.

[28] *See infra* notes 174–205 and accompanying text.

[29] *See infra* notes 206–99 and accompanying text.

[30] *See infra* notes 300–61 and accompanying text.

[31] *See infra* notes 362–408 and accompanying text.

[32] *See infra* notes 409–21 and accompanying text.

[33] *See* Robinson v. Liu, 555 N.E.2d 999, 1002 (Ill. App. Ct.), *leave to appeal denied*, 562 N.E.2d 707 (Ill. 1990) (quoting the Nightingale Pledge).

[34] *See* Clark, *supra* note 1, at 14 (describing the Nightingale Pledge as "a modified 'Hippocratic Oath'"); Donald H.J. Hermann, *Lessons Taught By* Miss Evers' Boys: *The Inadequacy of Benevolence and the Need for Legal Protection of Human Subjects in Medical Research*, 15 J.L. & HEALTH 147, 151 (2001) (stating that the Pledge "embodies the main tenets of the oath of Hippocrates"); KENNY, *supra* note 1, at 55 (asserting that the Pledge "is patterned after the Oath of Hippocrates").

[35] *See* Duquette v. Superior Court In & For Cty. of Maricopa, 778 P.2d 634, 641 (Ariz. Ct. App. 1989) ("The Hippocratic Oath acknowledges the physician's obligation to keep in trust patient confidences.") (footnote omitted); Carson v. Fine, 867 P.2d 610, 618 (Wash. 1994) ("[T]he Hippocratic Oath taken by all doctors honors the confidentiality of information obtained from a patient."); Seltrecht v. Bremer, 536 N.W.2d 727, 729 (Wis. Ct. App. 1995) (stating that the Hippocratic Oath "prohibits a patient's treating physician from divulging confidential information absent the patient's consent").

counterpart in the Hippocratic Oath,[36] the nurse's ethical obligation to maintain patient confidences,[37] which is also embodied in modern professional nursing codes,[38] is no less imperative than the one that binds physicians.[39] As noted elsewhere:

> The long-standing duty of health care practitioners has been to maintain the privacy and security of the patient's health care information. For medicine, this obligation dates back to the 4th century BC and is documented in the Hippocratic Oath. For nursing, the Nightingale Pledge, circa 1893, indicates that the nurse will "hold in confidence" the patient's personal information.[40]

Indeed, all primary health care providers[41] – a term that includes not only physicians[42] but many nurses[43] and physician assistants[44] – arguably have an ethical

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[36] *See* Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801 (N.D. Ohio 1965) ("Almost every member of the public is aware of the promise of discretion contained in the Hippocratic Oath, and every patient has a right to rely upon this warranty of silence."); Tighe v. Ginsberg, 540 N.Y.S.2d 99, 101 (App. Div. 1989) ("A physician's duty to maintain the confidentiality of information regarding the treatment of his patient is one which is well known and recognized by society in general."); Britt v. Promise Redeemer, L.L.C., 268 P.3d 542, 546 (Okla. Civ. App. 2011) ("Probably the best known medical oath in the Western world is the Hippocratic Oath . . .. This ancient principle of medical confidentiality is believed to date from around 400 B.C." (quoting Bernard Friedland, *Physician-Patient Confidentiality: Time to Re-Examine a Venerable Concept in Light of Contemporary Society and Advances in Medicine*, 15 J. LEGAL MED. 249, 256 (1994) (footnote omitted))).

[37] *See* Hageman v. Sw. Gen. Health Ctr., 893 N.E.2d 153, 156 (Ohio 2008) (citing 45 C.F.R. § 164.502). Nurses and physicians also may have a statutory obligation to maintain the confidentiality of patient communications under the Health Insurance Portability and Accountability Act ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936 (1996), and comparable state laws prohibiting health care providers "from disclosing health information except in certain specific circumstances." *Id.* However, this obligation is not the equivalent of an evidentiary privilege. *See, e.g.*, Wade v. Vabnick-Wener, 922 F. Supp. 2d 679, 685 (W.D. Tenn. 2010) ("Neither HIPAA nor the Tennessee Patients' Privacy Protection Act creates an evidentiary . . . privilege."); *see also* T.M. v. Elwyn, Inc., 950 A.2d 1050, 1059-60 (Pa. Super. Ct. 2008) (noting that "courts have rejected the notion that HIPAA creates an evidentiary privilege").

[38] *See* Patricia I. Carter, *Health Information Privacy: Can Congress Protect Confidential Medical Information in the "Information Age"?*, 25 WM. MITCHELL L. REV. 223, 237 (1999) (noting that "the American Nurses Association's code of ethics includes a requirement that nurses judiciously protect confidential information"); William H. Minor, *Identity Cards and Databases in Health Care: The Need for Federal Privacy Protection*, 28 COLUM. J.L. & SOC. PROBS. 253, 279 n.139 (1995) ("[T]he American Nurses Association adopted a code of ethics in 1950 that included a requirement that nurses judiciously protect confidential information.").

[39] *See generally* Vanessa Merton, *Confidentiality and the "Dangerous" Patient: Implications of* Tarasoff *for Psychiatrists and Lawyers*, 31 EMORY L.J. 263, 302 n.94 (1982) (stating that "the professional ethical obligation of physicians to maintain confidentiality is shared by nurses").

[40] *See* Tracey L. Murray et al., *Privacy, Confidentiality, HIPAA, and HITECH: Implications for the Health Care Practitioner*, 7 J. NURSE PRAC. 747 (2011) (footnotes omitted).

[41] Robinson v. Magovern, 521 F. Supp. 842, 850 n.4 (W.D. Pa. 1981), *aff'd*, 688 F.2d 824 (3d Cir. 1982). Primary health care has been defined as "the monitoring of a person's basic state of health and the diagnosis and treatment of common, relatively minor illnesses." *Id.* Primary care can be distinguished from secondary care, which "involves more sophisticated treatment and may include cardiology, respiratory care and physical therapy," and tertiary care, which "usually

obligation "not to violate the privileged and confidential relationship of primary care provider and patient."[45] In *Fairfax Hospital ex rel. INOVA Health System Hospitals v. Curtis*,[46] the Virginia Supreme Court described the rationale underlying this obligation:

> [C]onfidentiality is an integral aspect of the relationship between a health care provider and a patient and, often, to give the health care provider the necessary information to provide proper treatment, the patient must reveal the most intimate aspects of his or her life to the health care provider during the course of treatment.[47]

Despite widespread legal recognition of this obligation,[48] it does not rise to the level of an evidentiary privilege,[49] and thus does not enable nurses to avoid the

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includes heart surgery and such cancer treatments as chemotherapy and requires still more sophisticated equipment than primary or secondary services do." United States v. Carilion Health Sys., 707 F. Supp. 840, 843 (W.D. Va.), *aff'd*, 892 F.2d 1042 (4th Cir. 1989).

[42] *See, e.g.*, Short v. United States, 908 F. Supp. 227, 234 (D. Vt. 1995) (noting that "both internists and family practice physicians are primary care physicians"); *see also* Coleman v. Schwarzenegger, 922 F. Supp. 2d 882, 933 (E.D. Cal. 2009) (stating that "primary care provider positions . . . include physicians and surgeons").

[43] *See, e.g.*, Cook v. Workers' Comp. Dep't, 758 P.2d 854, 859 (Or. 1988) ("Nurse practitioners are licensed to provide primary health care and are, by rule, 'independently responsible' for health services." (quoting OR. ADMIN. R. § 851-50-005(2))); *see also* Runkle v. Kemen, 529 F. App'x 418, 425 (6th Cir. 2013) ("Nurse practitioners, by definition, may serve as primary care providers . . ."). Although qualifications vary by jurisdiction, a nurse practitioner is broadly defined as "a registered nurse with an advanced degree in nursing." United States v. Rosenberg, 585 F.3d 355, 356 (7th Cir. 2009). The training such nurses receive enables them "to diagnose and manage many common and chronic illnesses and to prescribe medications." Reimann v. Frank, 397 F. Supp. 2d 1059, 1077 (W.D. Wis. 2005).

[44] *See, e.g.*, Layton v. Labor Comm'n, 440 P.3d 954, 956 (Utah Ct. App. 2019) (noting that a patient's "primary care provider" was "a family-practice physician assistant"); *see also* Harvey v. Kindred Healthcare Operating, Inc., 578 S.W.3d 638, 646 (Tex. App. 2019) (referring to "primary care providers, including physicians, nurse practitioners, and physician assistants"). The principal difference between nurse practitioners and physician assistants is that nurse practitioners typically "practice under their own license and are independent," while physician assistants practice "only under the direction and within the scope of practice of a licensed physician." Kristin E. Schleiter, *Retail Medical Clinics: Increasing Access to Low Cost Medical Care Amongst a Developing Legal Environment*, 19 ANNALS HEALTH L. 527, 567 (2010). Nevertheless, in many jurisdictions both nurse practitioners and physician assistants "can assess symptoms, make a diagnosis, and prescribe medicine." Cara H. Drinan, *Getting Real About* Gideon: *The Next Fifty Years of Enforcing the Right to Counsel*, 70 WASH & LEE L. REV. 1309, 1340 (2013).

[45] *See* Ann Lawrence O'Sullivan, *Privileged Communication*, 80 AM. J. NURSING 947, 949 (1980); *see also* Clark, *supra* note 1, at 14 ("Most [health care] professions have a similar commitment to patient privacy, and the societal norm has become that everyone in health care will protect a patient's confidence."); Murray et al., *supra* note 40, at 747 ("Health care ethics requires all health care providers to protect patient privacy.").

[46] 492 S.E.2d 642 (Va. 1997).

[47] *See id.* at 644; *see also* Sorenson v. Barbuto, 177 P.3d 614, 617 (Utah 2008) ("[G]ood medical care requires a patient's trust and confidence that disclosures . . . will be used solely for the patient's welfare and that a patient's privacy with regarding to those disclosures will be respected and protected").

[48] *See* Lawrence O. Gostin et al., *Balancing Communal Goods and Personal Privacy Under a National Health Informational Privacy Rule*, 46 ST. LOUIS U. L.J. 5, 13 (2002) ("Most states recognize via

compelled disclosure of confidential patient communications in subsequent judicial proceedings.[50] As one jurist observed: "In the absence of a privilege, a person called as a witness can normally be compelled to disclose confidential communications, regardless of any professional standard of confidentiality and regardless of what personal assurances . . . were given to the communicants."[51]

Thus, nurses who are not protected by an evidentiary privilege occasionally may be faced with an ethical dilemma.[52] One commentator described the problem in the following manner:

> If . . . the nurse truly believes that withholding her/his testimony is in the best interests of the client, the nurse can refuse to testify. However, nurses who do so risk being held in contempt of court.

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common and statutory law the legal duties of confidentiality of certain health care professionals (including physicians, nurses and lab technicians) not to disclose health information."). *But see* Maureen Cochran, *The Real Meaning of Patient-Nurse Confidentiality*, *in* NURSING ISSUES IN THE 21ST CENTURY 190, 193 (Eleanor C. Hein ed., 2001) ("In fact, there is no law enacted in any state mandating nurse-patient confidentiality.").

[49] *See* DEMARCO ET AL., *supra* note 18, at 229. "Despite the existence of federal privacy laws such as HIPAA and professional obligations such as those codified in the [American Nurses Association's] Code of Ethics, most states do not have a nurse-patient privilege."; *cf.* Sorensen v. Barbuto, 2008 UT 8, ¶ 11, 177 P.3d 614, 617 (Sup. Ct.) ("[A] physician's duty of confidentiality is different and distinct from the physician-patient testimonial privilege . . . .").

[50] *See In re* McCann, 422 S.W.3d 701, 713 n.11 (Tex. Crim. App. 2013) (Price, J., dissenting). "Of course, a professional who is called to testify in judicial proceedings cannot lawfully refuse to do so based exclusively on a duty of confidentiality in the absence of any recognized privilege." *Id.* (quoting Robert A. Pikowsky, *Privilege and Confidentiality of Attorney-Client Communication via E-mail*, 51 BAYLOR L. REV. 483, 490-91 (1999) (footnote omitted)); *cf.* Clinton DeWitt, *Medical Ethics and the Law: The Conflict Between Dual Allegiances*, 5 W. RES. L. REV. 5, 7 (1953). "However binding the Hippocratic Oath may be as a creed or commandment, it cannot be considered as transcending the legal duty imposed upon every citizen to testify when lawfully summoned and sworn as a witness in a court of justice." *Id.*

[51] State *ex rel.* Allen v. Bedell, 454 S.E.2d 77, 85 n.10 (W. Va. 1994) (Cleckley, J., concurring) (quoting CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE § 5.2, at 336 (1994)); *see also* O'Sullivan, *supra* note 45, at 949 ("In states where nurses are not expressly included in the laws on privileged communication, the courts generally have held that the nurse can be called on to testify concerning information obtained from a patient in the performance of traditional duties.").

[52] *See* Pierce, *supra* note 14, at 1095-96 n.115:

> Without the privilege, the [health care] provider is confronted with a difficult choice: on the one hand he has a duty to obtain an accurate compilation of signs and symptoms regarding his patient, and has a duty to maintain confidential information he obtain[s] from his patient private. On the other hand, he has a duty to speak the truth on the witness stand.

Id. (citation omitted); *Developments in the Law – Privileged Communications*, 98 HARV. L. REV. 1450, 1476-77 (1985) ("The absence of a privilege . . . would present the professional with conflicting duties: the duty to obtain complete information, the duty to maintain the communicator's confidences, and the duty to testify before a court.").

> Obviously, this produces [a] dilemma – the choice between violating one's ethical beliefs and violating the law.[53]

Significantly, this ethical dilemma[54] does not merely impact nurses,[55] who in some cases might attempt to elicit less information from their patients than they would if their communications were protected by an evidentiary privilege.[56] In those situations,[57] the treatment patients receive may be based on inaccurate or incomplete

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[53] Sheri B. Stern, *Privileged Communication: An Ethical and Legal Right of Psychiatric Clients*, 26 PERSPECTIVES IN PSYCHIATRIC CARE 22, 25 (1990); *see also* Nancy Winters, *Whether to Break Confidentiality: An Ethical Dilemma*, 39 J. EMERGENCY NURSING 233, 234 (2013) (describing the ethical dilemma that arises when a nurse faces competing tensions to protect patient information and follow the legal duty to disclose that information for a criminal proceeding); MARY E. O'KEEFE, NURSING PRACTICE AND THE LAW: AVOIDING MALPRACTICE AND OTHER LEGAL RISKS 62 (2001).

[54] *See* Butterfield v. State, 992 S.W.2d 448, 451 (Tex. Crim. App. 1999) (citing Brogan v. United States, 522 U.S. 398, 404 (1998)) (referring to the dilemma in a comparable context as a "cruel trilemma," the third prong of which is the "blatant lie" that might subject a testifying witness – in this case a nurse – to a perjury charge); William Whitmore Hague, Comment, *The Psychotherapist-Patient Privilege in Washington: Extending the Privilege to Community Mental Health Clinics*, 58 WASH. L. REV. 565, 572 (1983). "Under the 'cruel trilemma,' psychotherapists are obligated to choose among one of three undesirable results: (1) to violate the extraordinary trust imposed upon them by their clients and profession; (2) to lie, and thereby commit perjury; or (3) to refuse to testify and thereby be held in contempt of court." *Id.* (footnote omitted).

[55] *See* Bhd. of R.R. Trainmen v. Long, 53 S.W.2d 433, 437 (Ark. 1932). "Our statute . . . makes the information which a doctor or trained nurse obtains, acting in their professional capacities, which is necessary to enable them to prescribe as a physician or act as a trained nurse, privileged, and this statute was passed for the protection not only of themselves, but for their patients." *Id. See also* Waldron v. State, 82 N.Y.S.2d 822, 823 (Ct. Cl. 1948) (finding any nurse-patient privilege presumably would be "designed to protect the patient."); *Developments in the Law – Privileged Communications, supra* note 52, at 1476. "[T]he behavioral impact of a privilege must be evaluated in terms of its effect both on the communicator and on the professional." *Id.*

[56] *See* Pierce, *supra* note 14, at 1096 n.115 (noting that a nurse might "elicit less information" under pressure "to balance multiple duties"); DEMARCO ET AL., *supra* note 18, at 210. "A nurse certainly should not encourage the disclosure of potentially damaging information and should, when necessary, inform a patient in a respectful way that such information might not be confidential." *Id. Developments in the Law – Privileged Communications*, *supra* note 52, at 1477. "In order to reconcile the duty to maintain confidences and the duty to testify about them, professionals might well be less aggressive in eliciting information, thus failing to fulfill their duty to obtain complete information." *Id.*

[57] *See, e.g.*, Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801-02 (N.D. Ohio 1965) ("The unauthorized revelation of medical secrets, or any confidential communication given in the course of treatment, is tortious conduct which may be the basis for an action in damages."). Nurses might discourage their patients from making full disclosure in an effort to avoid professional discipline, or even tort liability, for breaching patient confidentiality. *Id. See also* Melissa Prober, Note, *Please Don't Tell My Parents: The Validity of School Policies Mandating Parental Notification of a Student's Pregnancy*, 71 BROOKLYN L. REV. 557, 586 n.173 (2005) ("[R]equiring . . . health care providers to disclose confidential information may subject them to liability or disciplinary action for professional misconduct."); *see generally* Alan B. Vickery, Note, *Breach of Confidence: An Emerging Tort*, 82 COLUM. L. REV. 1426 (1982) (giving a more comprehensive discussion of the risk disclosure brings).

information.[58] One commentator described the potential consequences of this possibility in the following terms:

> The failure to disclose symptoms or known health conditions might have a tremendously negative impact upon the quality and efficiency of healthcare. Medical treatment depends on complete and accurate information – holding back information will undermine . . . the quality of care. The symptoms may go undetected, [and] the patient may not be adequately treated while their condition potentially becomes more serious.[59]

By relieving nurses of the obligation to disclose confidential patient communications in subsequent judicial proceedings,[60] the recognition of a nurse-patient privilege would eliminate this dilemma,[61] thereby improving the quality of nursing care.[62] Although this is a laudable objective,[63] in many jurisdictions the existence of a nurse-

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[58] *See* Lawrence O. Gostin, *Health Information Privacy*, 80 CORNELL L. REV. 451, 491 (1995). "The consequence of incomplete information is that patients may not receive adequate diagnosis and treatment of important health conditions." *Id.* Grace-Marie Mowery, Comment, *A Patient's Right of Privacy in Computerized Pharmacy Records*, 66 U. CIN. L. REV. 697, 728-29 (1998). "If the information a patient gives is incomplete, diagnosis and treatment might be incorrect." *Id.*

[59] Françoise Gilbert, *Emerging Issues in Global AIDS Policy: Preserving Privacy*, 25 WHITTIER L. REV. 273, 279 (2003); *see also* Pierce, *supra* note 14, at 1096 n.115 ("[B]ecause the [health care] provider does not press the patient . . . and thus fails at his duty to obtain a complete history, the effects may be compounded.").

[60] *See, e.g.*, *In re* Banker, 615 P.2d 1168, 1170 (Or. Ct. App. 1980) ("A licensed professional nurse shall not, without the consent of a patient who was cared for by such nurse, be examined in a civil action or proceeding, as to any information acquired in caring for the patient, which was necessary to enable the nurse to care for the patient.") (quoting OR. REV. STAT. § 44.040(1)(g))); *see also* O'Sullivan, *supra* note 45, at 947-48. "[I]n Arkansas, New York, Oregon, Vermont, and Wisconsin . . . [nurses are] covered by the privilege of confidential communication and . . . exempt from giving information obtained in a professional capacity…" *Id.*

[61] *See, e.g.*, Aufrichtig v. Lowell, 650 N.E.2d 401, 404 (N.Y. 1995) (noting that a "motivation for the existence of the [physician-patient] privilege is the avoidance of a Hobson's choice for physicians: choosing between honoring their professional obligation with respect to their patients' confidences or their legal duty to testify truthfully"). Avoiding this type of ethical dilemma is one of the perceived benefits of any professional evidentiary privilege. *Id.* *See also* People v. Mirque, 758 N.Y.S.2d 471, 473-74 (N.Y. Crim. Ct. 2003) (asserting that the physician-patient privilege is designed "to make it unnecessary for a physician to choose between the duty to honor a patient's confidences and the duty to give evidence in court . . . "); Hague, *supra* note 54, at 572 ("[T]he psychotherapist-patient privilege prevents the courts from forcing psychotherapists into a 'cruel trilemma.'").

[62] *See In re* Vioxx Prods. Liab. Litig., 230 F.R.D. 473, 477 (E.D. La. 2005) ("Confidentiality reduces the stigma attached to seeking treatment for some infectious diseases and invites patients to provide information about previous ailments with greater candor. This effect allows . . . more thorough preventative care.") (footnote omitted); Wright, *supra* note 18, at 82 ("A nurse's ability to listen and support patients . . . with the assurance of protection of nurse-client privilege potentiates a healthier patient outcome.").

[63] *See* Misericordia Hosp. Med. Ctr. v. NLRB, 623 F.2d 808, 814 n.9 (2d Cir. 1980) (noting that "under the Code for Nurses of the American Nurses' Association . . . nurses [are] bound to act to improve the standards of nursing care and to join with others to meet the public's health care

patient privilege is, at best, a matter of conjecture,[64] leaving nurses uncertain as to their potential obligation to reveal their patients' confidences,[65] and patients in doubt about whether their nurses can be trusted with private information about their health.[66]

II. No Common Law Nurse-Patient Privilege Exists

The concept of an evidentiary privilege came to this country as part of the common law of England.[67] The concept arose in response to the English courts' emerging authority (nonexistent until the sixteenth century)[68] to compel witnesses to testify.[69] However, relatively few evidentiary privileges originally existed under English

needs . . ."); Gates v. Brewer, 442 N.E.2d 72, 75 (Ohio Ct. App. 1981) (discussing the "legitimate purpose of improving the quality of health care administered to the public").

[64] *See* Erline A. Reilly, *Nurses and the Law*, 26 N.H. Bus. J. 7, 19 (1984) (asking rhetorically whether "a nurse's ethical obligation to maintain patient confidentiality rise[s] to the level of patient/nurse privilege"); *cf.* Michael K. McChrystal, *No Hiding the Ball: Medical Privacy and Pro Sports*, 25 MARQ. SPORTS L. REV. 163, 165 n.6 (2014) ("The physician-patient relationship generally entails a duty of confidentiality that has been extended to other health care providers. This principle of the common law has informed the scope of the evidentiary privilege with respect to information supplied to health care providers . . .").

[65] *See generally* DeMarco et. al., *supra* note 18, at 210 ("Nurses should understand the extent to which patient information is protected in their states, keeping in mind that most states do not protect [sic] a nurse-patient privilege."); Pierce, *supra* note 14, at 1087 (observing that "in many states, when compelled to testify, nurses' conversations with their patients are not protected").

[66] *See* Cochran, *supra* note 48, at 193 ("In all probability, patients . . . expect that what they say to their nurses will be held in confidence, but although support for this expectation is present in professional codes and institutional policies, it is not universally present in common law or statutory law."); *cf.* Pierce, *supra* note 14, at 1100 ("Above all, patients want to feel comfortable in disclosing personal information to their healthcare providers. These communications are not only necessary for treatment but may reveal certain intimate details about an individual's life that he or she does not wish anyone else to hear.").

[67] *See* Elson v. Bowen, 436 P.2d 12, 14 (Nev. 1967) ("The common law of evidence has long recognized certain rules of privilege which authorize the withholding of pertinent facts in a judicial proceeding."); Cook v. King Cnty., 510 P.2d 659, 661 (Wash. Ct. App. 1973) (describing privilege as a "common law concept"); Philip A. Elmore, Comment, "*That's Just Pillow Talk, Baby": Spousal Privileges and The Right to Privacy in Arkansas*, 67 ARK. L. REV. 961, 964 (2014) (noting that "American courts adopted evidentiary privileges from English common law").

[68] *See* U.S. v. Gecas, 120 F.3d 1419, 1441 (11th Cir. 1997) (observing that "all nonparty witness testimony was voluntary until the mid-sixteenth century"); *In re* Marshall, 805 N.W.2d 145, 151 (Iowa 2011) ("Common law in the fifteenth century did not recognize the right to compel a witness to testify in criminal proceedings. Over time, however, the common law evolved to the point where witnesses had a duty to testify and could be compelled to do so.").

[69] *See* Matter of Contempt of Wright, 700 P.2d 40, 47 (Idaho 1985) (Bistline, J., concurring) (noting that the concept of privilege "developed only after witnesses could be compelled to testify"); Howe v. Detroit Free Press, Inc., 487 N.W.2d 374, 386 (Mich. 1992) (Boyle, J., concurring in part and dissenting in part) ("At common law, the rules of privilege were developed as a protection against the court's power to compel testimony."); Shawn P. Davisson, *Balancing the Scales of "Confidential" Justice: Civil Mediation Privileges in the Criminal Arena – Indispensable, Impracticable, or Merely Unconstitutional?*, 38 MCGEORGE L. REV. 679, 695 (2007) ("A derivation of English common law, privileges first arose with the establishment of the compulsory process – now guaranteed by the Sixth Amendment – which created a right of the accused to call witnesses and the coinciding duty of those witnesses to testify.") (footnote omitted).

common law,[70] and a privilege for confidential communications between nurses and their patients was not one of them.[71]

Indeed, while the practice of nursing is often said to have originated in England,[72] it was not generally considered to be an independent profession,[73] and therefore potentially warranting the protection of a privilege,[74] until at least the latter half of the nineteenth century,[75] and much later than that in some American

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[70] *See* Hyde Constr. Co. v. Koehring Co., 455 F.2d 337, 345 (5th Cir. 1972) (Godbold, J., concurring in part and dissenting in part) (asserting that "the whole concept of privilege" was "largely unknown to the common law"); Terre Haute Reg'l Hosp., Inc. v. Trueblood, 600 N.E.2d 1358, 1360 (Ind. 1992) ("Most privileges were unknown at common law . . . ."); Jeffrey J. Lauderdale, *A New Trend in the Law of Privilege: The Federal Settlement Privilege and the Proper Use of Federal Rule of Evidence 501 for the Recognition of New Privileges*, 35 U. MEM. L. REV. 255, 260-61 (2005) ("[A]t common law, very few privileges were defined and recognized.").

[71] *See* N.Y. City Council v. Goldwater, 31 N.E.2d 31, 33 (N.Y. 1940) (Finch, J., dissenting) (stating that "at common law the information acquired by . . . nurses acting in a professional capacity was not privileged'); People v. Fitzgerald, 422 N.Y.S.2d 309, 311 (N.Y. Cnty. Ct. 1979) (stating that the nurse-patient privilege was "not found in the common law"); Morse, *supra* note 18, at 745 (noting that "[t]he common law did not provide a privilege for nurses"). *See generally* Sean A. Devlin, Comment, *Union Communications Privilege: Is It Time for Ohio to Protect Union Representative-Member Communications?*, 45 CAP. U.L. REV. 677, 684 (2017) ("Originally, the only privileges recognized at common law were the attorney-client and marital privileges.").

[72] *See* Beggs v. State Workmen's Ins. Fund, 89 Pa. D. & C. 579, 581 (Pa. Com. Pleas 1954) ("Florence Nightingale, following her return from the Crimean War, established the first nurses' training school in St. Thomas' Hospital, London, England, in 1860."); Tsvetelina Gerova-Wilson, Comment, *Nursing is Not a Lesser Included Profession: Why Physicians Should Not Be Allowed to Establish the Nursing Standard of Care*, 16 QUINNIPIAC HEALTH L.J. 43, 45 (2012-2013) ("[I]t was not until the mid-to-late 19th century in England that society started recognizing the need for specific licensing, and thereby acknowledged nursing as a vocation, requiring education and skills superior to those of 'common' people.") (footnote omitted).

[73] *See generally* Frank J. Cavico & Nancy M. Cavico, *The Nursing Profession in the 1990's: Negligence and Malpractice Liability*, 43 CLEV. ST. L. REV. 557, 559 (1995) (discussing the "evolution and maturation of nursing into a 'profession'").

[74] *See* Wright, *supra* note 18, at 82 ("'[T]he ministry, medicine, and the law are three great and learned professions: Their common purpose is to help other human beings in the spiritual, physical and secular aspect of their lives.' . . . [N]ursing encompasses these common purposes as well and should be protected by nurse-patient privilege." (quoting Turton v. State Bar, 775 S.W.2d 712, 718 (Tex. App. 1989) (Biery, J., dissenting))); *cf.* DEMARCO ET AL., *supra* note 18, at 211 ("If . . . nurses were not considered to be health-care professionals in their own right, it might follow that information disclosed to them would be no more privileged than if the information were disclosed to a layperson."). *See generally* Alan Kirtley, *The Mediation Privilege's Transition from Theory to Implementation: Designing a Mediation Privilege Standard to Protect Mediation Participants, the Process and the Public Interest*, 1995 J. DISP. RESOL. 1, 20 ("Most traditional privileges arise when a professional relationship is established: attorney-client, physician-patient or cleric-parishioner.").

[75] *See* Anita Bernstein, *Engendered by Technologies*, 80 N.C. L. REV. 1, 54 (2001) (asserting that "nursing developed a self-conscious identity as a modern profession in the late nineteenth century, even though it has extensive antecedents stretching back for centuries"); Walter T. Eccard, Note, *A Revolution in White – New Approaches in Treating Nurses as Professionals*, 30 VAND. L. REV. 839, 841 (1977) ("Steps to remedy this lack of professional identification began in 1893 with the first national meeting of nurses and the formation in 1896 of the first national organization of nurses.") (footnote omitted).

jurisdictions[76] – including Arizona.[77] This was long after the common law of privilege had begun to develop,[78] and after the English courts had rejected arguments for the judicial recognition of a physician-patient privilege.[79] Thus, like the physician-patient privilege ultimately adopted by statute in most American states,[80] but still not recognized in England[81] or under American common law,[82] the recognition of a nurse-patient privilege would be in derogation of the common law.[83]

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[76] *See* Lambert v. Mullan, 83 So.2d 601, 602 (Fla. 1955). For example, as late as the mid-1950s the Florida Supreme Court described nursing as being "at variance with the attributes of generally recognized professions . . . as distinguished from mere skill in employment habitually engaged in for livelihood or gain." *Id.* Nevertheless, the practice of nursing is now widely regarded "as a profession subject to its own general standards of care and qualifications." Brogdon v. Nat'l Healthcare Corp., 103 F. Supp. 2d 1322, 1333 (N.D. Ga. 2000).

[77] *See* State v. Borah, 76 P.2d 757, 760 (Ariz. 1938). Nursing was not treated as an independent profession in Arizona until 1928, when the state legislature for the first time established minimum qualifications for the practice of registered nursing and provided for the imposition of a penalty upon "anyone who assumes to be or practices as a registered nurse without securing a license as such." *Id.* Prior to the enactment of that legislation, nursing was regarded as an activity "falling within the general practice of medicine." *Id.* at 759.

[78] *See In re* Contempt of Wright, 700 P.2d 40, 47 (Idaho 1985) (Bistline, J., concurring) ("The concept of privilege arose in England in the 1600's."); Elmore *supra* note 67, at 964 (asserting that certain English common law privileges "were recognized as early as the sixteenth century").

[79] *See* United States v. Chase, 340 F.3d 978, 997-98 (9th Cir. 2003) (Kleinfeld, J., concurring) (noting that Lord Mansfield rejected the physician-patient privilege "as a matter of common law" in the "'notorious Duchess of Kingston's Case' in 1776" (quoting 8 JOHN H. WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2286, at 531 (John T. McNaughton rev. ed. 1961))); *In re* Vioxx Prods. Liab. Litig., 230 F.R.D. 473, 477 (E.D. La. 2005) ("In 1776, the English case of Elizabeth, Duchess of Kingston, established that the physician-patient privilege did not exist as a matter of English common law.").

[80] *See* Filz v. Mayo Found., 136 F.R.D. 165, 168 n.4 (D. Minn. 1991) ("As of 1985, 40 states and the District of Columbia had enacted physician-patient privilege statutes." (citing *Developments in the Law – Privileged Communications*, *supra* note 52, at 1532)); Mariner v. Great Lakes Dredge & Dock Co., 202 F. Supp. 430, 433 (N.D. Ohio 1962) ("The physician-patient privilege, founded in state statute, has been honored in most jurisdictions.").

[81] *See* Holbrook v. Weyerhauser Co., 822 P.2d 271, 278 (Wash. 1992) (Utter, J., dissenting) ("[E]ven to this day, there is no common law or statutory physician-patient privilege in England."); David Weissbrodt et al., *Piercing the Confidentiality Veil: Physician Testimony in International Criminal Trials Against Perpetrators of Torture*, 15 MINN. J. INT'L L. 43, 80 (2006) ("Under English rules of evidence, communications with doctors . . . are not privileged. English courts have consistently held that testimonial privileges for professionals are of a very limited character…") (footnote omitted).

[82] *See, e.g.*, United States v. Kansas City Lutheran Home & Hosp. Ass'n, 297 F. Supp. 239, 244 (W.D. Mo. 1969) ("Defendants cite no cases in which the . . . privilege of physician-patient has ever been recognized, absent a state statute . . . This Court will not create such a privilege as a matter of federal common law . . ."); s*ee also* Mathis v. Hildebrand, 416 P.2d 8, 8 (Alaska 1966) ("The physician-patient privilege has never been recognized in England, nor at common law in the United States."); Hermanson v. Multi-Care Health Sys., Inc., 448 P.3d 153, 160 (Wash. Ct. App. 2019) ("Neither federal nor state law has recognized a physician-patient privilege at common law."), *review granted*, 456 P.3d 399 (Wash. 2020).

[83] *See* State v. Vietz, 973 P.2d 501, 502 (Wash. Ct. App. 1999) ("As with the physician-patient privilege statute, [the nurse-patient] privilege statute is in derogation of common law and should be strictly construed." (discussing WASH. REV. CODE § 5.62.020)); *cf.* Geisberger v. Willuhn, 390 N.E.2d 945, 947 (Ill. App. Ct. 1979) ("In a number of cases . . . the [physician-patient] privilege

III. Few States Have Recognized Nurse-Patient Privilege by Statute or Court Rule

Although modern American courts are not limited to applying evidentiary privileges that existed under English common law,[84] no state or federal court in the United States has adopted a nurse-patient privilege.[85] In fact, courts in several states have held that unless they fall within the explicit terms of a legislatively enacted privilege,[86] confidential communications between nurses and their patients are not protected from compelled disclosure in subsequent judicial proceedings.[87]

However, a few states have adopted a nurse-patient privilege by statute[88] or court rule.[89] The earliest such adoption of the privilege occurred more than a century

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has been denied to nurses on the theory that it is in derogation of the common law and should be particularly confined to those expressly named.").

[84] *See, e.g.*, Hatfill v. Gonzales, 505 F. Supp. 2d 33, 44 (D.D.C. 2007) (noting that "[p]reviously unrecognized common law testimonial privileges may be recognized by federal courts" (citing FED. R. EVID. 501)); Springfield Local Sch. Dist. Bd. of Educ. v. Ohio Ass'n of Pub. Sch. Emps., Local 530, 667 N.E.2d 458, 467 (Ohio Ct. App. 1995) ("The absence of a . . . previous judicial ruling creating . . . a privilege . . . does not itself foreclose our formulation and application of such a privilege if justice so requires."); *see also* Lembke v. Unke, 171 N.W.2d 837, 842 (N.D. 1969) ("In determining the common law . . . [courts] are not restricted to the law as it has evolved over the centuries in England.").

[85] *See* Pierce, *supra* note 14, at 1086 ("While the case law indicates various attempts to create a nurse patient privilege through common law, those attempts have proven unsuccessful."); *cf.* Cunningham v. State, 488 S.W.2d 117, 121 (Tex. Crim. App. 1972) ("[I]n the absence of statute the courts have rarely extended to other relationships the protection which the common law afforded to communications between attorney and client and husband and wife." (quoting 1 CHARLES T. MCCORMICK & ROY R. RAY, TEXAS LAW OF EVIDENCE § 502, at 424-25 (2d ed. 1956))) (ellipsis omitted). *See generally* CLINTON DEWITT, *Privileged Communications Between Physician and Patient*, 10 CASE WESTERN L. REV 488 (1958) ("At common law, a nurse is no more a privileged witness than a physician, and she may be compelled to testify as to what she sees or learns in her contacts with patients, and as to communications made to her by them.").

[86] *See generally* Samuel J. Knapp et al., *Privileged Communications for Psychotherapists in Pennsylvania: A Time for Statutory Reform*, 60 TEMP. L.Q. 267, 276 (1987) ("Generally, courts strictly interpret privilege laws and refuse to grant a privilege to professionals unless the privilege statute explicitly includes them."); Naoma Lee Stewart, *Physician-Patient Privilege in Ohio*, 8 CLEV.-MARSHALL L. REV. 444, 448 (1959) ("Practically all courts agree that [privilege] statutes afford protection only to those relationships specifically named therein.").

[87] *See* Myers v. State, 310 S.E.2d 504, 505 (Ga. 1984) ("Some jurisdictions have held that in [the] absence of a statutory privilege nurse-patient communications are not protected."); Patricia A. Furci, *The Sexual Assault Nurse Examiner: Should the Scope of the Physician-Patient Privilege Extend That Far?*, 5 QUINNIPIAC HEALTH L.J. 229, 242 (2002) ("[T]here are . . . jurisdictions that hold if the statutes do not expressly include nurses within the testimonial privilege of physician, then the privilege will not be extended to nurses.").

[88] *See* Pierce, *supra* note 14, at 1085 ("[T]here are statutes currently in the United States that recognize the nurse-patient privilege."). For example, Vermont's statutory privilege prohibits "a registered professional or licensed practical nurse" from disclosing "any information acquired in attending a patient in a professional capacity." VT. STAT. ANN. TIT. 12, § 1612(a) (2020); *see also* Touchstone v. Touchstone, 682 So.2d 374, 379-80 (Miss. 1996) (observing that "Miss. Code Ann. § 13-1-21 provides a privilege for communications between a patient and . . . nurse").

ago,[90] when the New York legislature amended that state's physician-patient privilege statute[91] to include within its protection a patient's confidential communications with a professional or registered nurse.[92] This amendment reflected the legislature's determination that "the same reasons which caused the extension of [a] privilege to physicians applied with equal force to professional nurses."[93]

Beginning first in Arkansas,[94] other states gradually followed New York's lead,[95] and a dozen states now have adopted some form of nurse-patient privilege.[96]

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[89] *See, e.g.*, OR. R. EVID. 504-2 ("A licensed professional nurse shall not, without the consent of a patient who was cared for by such nurse, be examined in a civil action or proceeding, as to any information acquired in caring for the patient, which was necessary to enable the nurse to care for the patient."); Maryann Zavez, *The Ethical and Moral Considerations Presented by Lawyer/Social Worker Interdisciplinary Collaborations*, 5 WHITTIER J. CHILD & FAM. ADVOC. 191, 214 (2005) (stating that "Vermont Rule of Evidence 503, in accordance with the [Vermont] statute, is entitled 'Patient's Privilege,' and it covers . . . nurses").

[90] *See* Griebel v. Brooklyn Heights R.R. Co., 68 A.D. 204, 207 (N.Y. App. Div. 1902). Shortly before the New York legislature enacted the nation's first nurse-patient privilege statute, an appellate court in that state described the legislature's critical role in any expansion of evidentiary privilege law:

> If the law-making power desires to extend the privilege of secrecy to all statements of every kind made by an injured person to his medical attendant, it is very easy to say so in plain and unmistakable language. Up to the present time, however, the Legislature has refused to go so far as that. It has limited the privilege to information necessary to enable [a] physician or surgeon to act in the capacity of physician or surgeon; and . . . there is no reason why the courts should be sedulous to create a protection which the Legislature has not seen fit to bestow.

Id.

[91] *See* Wheeler v. Comm'r of Soc. Servs., 662 N.Y.S.2d 550, 553 n.3 (N.Y. App. Div. 1997). New York also was "the first state to codify the physician-patient privilege." *Id. See also* Grand Jury Subpoena Duces Tecum v. Kuriansky, 505 N.E.2d 925, 927 (N.Y. 1987) ("The physician-patient privilege originated in this State. It did not exist at common law and the first statute to recognize the privilege was adopted by the New York Legislature in 1828.").

[92] *See* Hamnyack v Prudential Ins. Co. 87 N.E. 769, 770 (N.Y. 1909) ("This was the first time the privilege of physicians on the witness stand was extended to professional and registered nurses. The amendment took effect on September 1, 1904 . . ."); *see also* People v. Fonseca, 514 N.Y.S.2d 189, 189 (N.Y. Crim. Ct. 1987) (noting that New York's physician-patient privilege statute provides that "no physician or nurse shall disclose any communication concerning a patient without the patient's actual waiver" (discussing N.Y. C.P.L.R. 4504)).

[93] Culver v. Union Pac. R.R. Co., 199 N.W. 794, 797 (Neb. 1924) (discussing the legislative intent underlying the New York statute); *see also* Meyer v. Russell, 214 N.W. 857, 862 (N.D. 1926) (quoting *Culver*, 199 N.W. 794).

[94] *See* Hyatt v. Wroten, 43 S.W.2d 726, 728 (Ark. 1931) (discussing an early Arkansas statute providing that "physicians and nurses shall not be compelled to disclose information which they have acquired from a patient while attending him in a professional capacity"); Ragsdale v. State, 432 S.W.2d 11, 12 (Ark. 1968) ("Ark. Stat. Ann. § 28-607 (Repl. 1962) . . . provides that no doctor or nurse shall be compelled to disclose any information which is acquired from his patient to enable him to prescribe, provided the patient can waive the privilege.").

[95] *See, e.g.*, *Meyer*, 214 N.W. at 862 ("New York and Arkansas have amended their [physician-patient privilege] statutes so as to include, 'a professional or registered nurse.'"); *see also* Joseph R.

Washington's statute is illustrative.[97] It provides, in relevant part, that subject to certain enumerated exceptions,[98] registered nurses cannot be compelled to testify in any civil or criminal case "as to any information acquired in attending a patient in the registered nurse's professional capacity."[99]

Although the enactment of these statutory privileges might be indicative of an emerging trend,[100] most states that have adopted the physician-patient privilege do not recognize a corresponding nurse-patient privilege.[101] In addition, some of the states that do recognize a nurse-patient privilege significantly limit its application.[102] Washington's privilege,[103] for example, protects a patient's confidential communications with a registered nurse,[104] but does not apply to a patient's communications with a licensed

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Quinn, *The Physician-Patient Privilege in Colorado*, 37 U. COLO. L. REV. 349, 352 n.24 (1965) ("A few states have expressly included nursing within the [physician-patient] privilege." (citing ARK. STAT. ANN. § 28-607 (1947) and N.M. STAT. ANN. § 20-1-12 (1953))).

[96] *See* Pierce, *supra* note 14, at 1083-84 ("Currently there are twelve states that identify, via statute, the existence of either a nurse practitioner- or nurse-patient privilege.").

[97] *See* Hermanson v. MultiCare Health Sys., Inc., 448 P.3d 153, 164 (Wash. Ct. App. 2019) ("[T]he legislature has provided [a] statutory . . . nurse-patient privilege[]."), *review granted*, 456 P.3d 399 (Wash. 2020); State v. Ross, 947 P.2d 1290, 1293 n.2 (Wash. Ct. App. 1997) ("In 1985 . . . the Legislature enacted [WASH. REV. CODE §] 5.62.020 [(1985)], creating a privilege for communications made to registered nurses."), *review denied*, 960 P.2d 939 (Wash. 1998).

[98] *See, e.g.*, State v. Butler, 766 P.2d 505, 510 (Wash. Ct. App. 1989) ("Washington's legislative enactments impose a duty on . . . registered or licensed nurses who '[have] reasonable cause to believe that a child . . . has suffered abuse or neglect' to 'report such incident, or cause a report to be made, to the proper law enforcement agency . . . .'") (quoting WASH. REV. CODE § 26.44.030(1) (2020)); *see also In re* Marriage of Madison, No. 54064-5-I, 2005 Wash. App. LEXIS 1582, at *8 (Wash. Ct. App. July 5, 2005) (noting that "the nurse-patient privilege is subject to the same limitations and exemptions as [the] physician-patient privilege" (citing WASH. REV. CODE § 5.62.030 (1985))).

[99] *See* WASH. REV. CODE § 5.62.020. Other Washington statutes also now "establish a privilege for optometrists and psychologists, as well as a limited privilege for social workers, therapists, and other counselors." *Id.* State v. Cahoon, 799 P.2d 1191, 1194 n.3 (Wash. Ct. App. 1990), *review denied*, 807 P.2d 883 (Wash. 1991). *See generally* State v. Harris, 755 P.2d 825, 828 (Wash. Ct. App. 1988) ("The creation of a testimonial privilege is a recognized function of legislative power.").

[100] *See generally* Limbaugh v. State, 887 So.2d 387, 400 (Fla. Dist. Ct. App. 2004) (May, J., concurring in part and dissenting in part) ("[legislative developments] demonstrate the trend to enhance . . . the privacy afforded to patients"); Gunn v. Sound Shore Med. Ctr., 772 N.Y.S.2d 714, 715 (App. Div. 2004) ("The modern-day legislative trend is to protect a medical patient's privacy.") (citation omitted).

[101] *See generally* DEMARCO ET AL., *supra* note 18, at 16 ("[A] nurse-patient privilege does not exist in most states. For many experts this fact in anomalous, as the large majority of states have a physician-patient privilege."); Pierce, *supra* note 14, at 1086 ("[M]any states that support a physician-patient privilege do not recognize a general nurse-patient privilege.").

[102] *See* OR. R. EVID. 504-2. For example, Oregon's version of the nurse-patient privilege only applies "in a civil action or proceeding." *See also* DEMARCO ET AL., *supra* note 18, at 208 ("[C]ertain of the states that do recognize a nurse-patient privilege do so only on a conditional or derivative basis.").

[103] *See* § 5.62.020.

[104] *See* State v. Cahoon, 799 P.2d 1191, 1194 n.3 (Wash. Ct. App. 1990) ("[T]he Legislature has enacted a statute which now establishes a privilege for information given a registered nurse, if the

practical nurse.[105] Other states also limit the types of nurses protected by the privilege.[106]

IV. Nurse-Patient Privilege Has Not Been Recognized in Arizona

Arizona is among the jurisdictions in which confidential communications between nurses and their patients do not appear to be protected by an evidentiary privilege.[107] However, this perception is not based on any Arizona state court's consideration of the issue,[108] but on the nearly century-old decision of the United States Court of Appeals for the Ninth Circuit in *Southwest Metals Co. v. Gomez*.[109] Thus, while the presumption that nurse-patient communications are not privileged in Arizona has

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information was necessary to enable the nurse to act in that capacity for the patient."), *review denied*, 807 P.2d 883 (Wash 1991); *cf.* O'Sullivan, *supra* note 45, at 947 ("Statutes specifying privileged communication between the registered nurse and the patient exist in Arkansas, New York, Oregon, Vermont and Wisconsin.").

[105] *See* State v. Vietz, 973 P.2d 501, 503 (Wash. Ct. App. 1999) (holding that the privilege statute "does not apply to [licensed] practical nurses"). The Arizona Court of Appeals has explained that registered and licensed practical nurses possess "varying levels of education, experience, and, consequently, expertise in the broad health profession of nursing." *Id.* Cornerstone Hosp. of Se. Ariz. v. Marner, 290 P.3d 460, 471 (Ariz. Ct. App. 2012); *see also* Isett v. Aetna Life Ins. Co., 947 F.3d 122, 133 (2d Cir. 2020):

> The practice of registered nursing is characterized primarily by the ability to act independently of direction, or under minimal supervision, on the basis of collected clinical data. Licensed practical nurses collect patient clinical data and likely even analyze it, but are not trained to interpret it in a way that allows them to act independently or without supervision.

Id. (footnote omitted).

[106] *See* Reutter v. Weber, 179 P.3d 977, 982 n.3 (Colo. 2007). For example, there is some question as to whether Colorado's privilege "is limited to physicians, surgeons and registered nurses or whether the statutory privilege also includes other medical providers such as nonregistered nurses and respiratory therapists." *Id. See also* DEWITT, *supra* note 85, at 91 n.6 ("Arkansas includes 'trained nurses'; New Mexico 'a professional or registered nurse'; New York 'a registered professional or licensed practical nurse.' If the witness does not come strictly within the class of nurses designated in the statute, she may testify.").

[107] *See* Algeria v. United States, No. CV-11-809-TUC-BGM, 2015 U.S. Dist. LEXIS 192073, at *3 (D. Ariz. Apr. 10, 2015) ("The Ninth Circuit Court of Appeals has determined that nurses are not covered by the physician-patient privilege [in Arizona] . . ." (citing Sw. Metals Co. v. Gomez, 4 F.2d 215, 217-18 (9th Cir. 1925))); Response to Motion to Suppress Statements, at 3, State v. Kitts, No. CR-2002-1869, 2002 AZ. Sup. Ct. Motions LEXIS 479, at *3 (Ariz. Super. Ct. Pima Cty. Oct. 25, 2002) (stating that the *Southwest Metals* court "declined to extend the physician-patient privilege to nurses").

[108] *See Algeria*, 2015 U.S. Dist. LEXIS 192073, at *3 (asserting that the issue of whether nurses are "covered by the physician-patient privilege . . . has not been resolved by the Arizona state courts"); Response to Motion to Suppress Statements, *supra* note 107, at 4, 2002 AZ. Sup. Ct Motions LEXIS 479, at *5 ("Arizona case law has not dealt specifically with the issue.").

[109] 4 F.2d 215 (9th Cir. 1925) (holding that the physician-patient privilege does not extend to nurses).

existed for quite some time,[110] the question of whether Arizona's state courts would recognize a nurse-patient privilege remains an open one.[111]

The trial court in *Southwest Metals* prevented the defendant from calling as a witness a nurse who was present during a medical procedure in which the plaintiff was injured.[112] Addressing an unsettled issue of Arizona evidence law,[113] the Ninth Circuit characterized the plaintiff's argument for the recognition of a nurse-patient privilege as a close question.[114] It nevertheless concluded that the trial court's exclusion of the nurse's testimony was erroneous,[115] and reversed the judgment that had been entered in the plaintiff's favor.[116]

In reaching this result, the Ninth Circuit rejected the contention that the protection of Arizona's physician-patient privilege[117] should extend to "an agent of or assistant to the physician" who was present and overheard a confidential

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[110] *See* Miller, *supra* note 16, at 28-29. "[M]ore than 75 years ago the Ninth Circuit held that communications to a nurse assisting a physician were not privileged because the physician-patient privilege statute did not include nurses. This statutory construction principle still applies." *Id.* (citing *Sw. Metals*, 4 F.2d at 218) (footnote omitted).

[111] *See generally* Andrade v. City of Phoenix, 692 F.2d 557, 559 (9th Cir. 1982) ("The courts of a state alone can define the authoritative meaning of state law."); Knapp v. Cardwell, 667 F.2d 1253, 1259 (9th Cir. 1982) ("It has long been the prerogative of the highest state court to interpret, or reinterpret, state statutes.").

[112] *See Sw. Metals*, 4 F.2d at 216.

[113] *See* Bunker's Glass Co. v. Pilkington PLC, 47 P.3d 1119, 1127 (Ariz. Ct. App. 2002), *aff'd*, 75 P.3d 99 (Ariz. 2003). Because "Arizona is located in the Ninth Circuit," the Ninth Circuit is occasionally called upon to decide unsettled questions of Arizona law. *Id. See, e.g.*, City of Flagstaff v. Atchison, Topeka & Santa Fe Ry. Co., 719 F.2d 322, 323 (9th Cir. 1983) ("This diversity case requires our interpretation of Arizona law, where the issue appears to be one of first impression. . . . [H]aving the case before us we must decide it as we think the Arizona courts would.").

[114] *See Sw. Metals*, 4 F.2d at 217 ("The claim of privilege on behalf of [a] nurse presents a . . . difficult question."); *cf.* State v. Raymond, 431 A.2d 453, 470-71 (Vt. 1981) (holding that a nurse's observation of a patient's physical or mental condition constitutes privileged information if the observation was "necessary to enable her to act in her professional capacity" (construing VT. STAT. ANN. TIT. 12, § 1612(a))).

[115] *See Sw. Metals*, 4 F.2d at 218; *cf.* Miss. Power & Light Co. v. Jordan, 143 So. 483, 485 (Miss. 1932) (holding that "a nurse is not a privileged witness as to what she sees and learns in her contact with patients"), *superseded by statute*, MISS. CODE ANN. § 13-1-21.

[116] *See Sw. Metals*, 4 F.2d at 218.

[117] *See* Goldsmith v. Dutton, CV 13-0051-H-DWM-RKS, 2014 U.S. Dist. LEXIS 124552, at *4 (D. Mont. Sept. 5, 2014) (citing *In re* Grand Jury Proceedings, 801 F.2d 1164, 1169 (9th Cir. 1986)). There is "no physician-patient privilege recognized under federal common law or in the Ninth Circuit." *Id.* However, federal courts are required to apply state privilege law in civil cases involving "a claim or defense for which state law supplies the rule of decision." FED. R. EVID. 501. In this regard, the Arizona legislature "has adopted physician-patient privilege statutes for both civil and criminal proceedings." Samaritan Health Servs. v. City of Glendale, 714 P.2d 887, 889 (Ariz. Ct. App. 1986) (discussing ARIZ. REV. STAT. ANN. §§ 12-2235 & 13-4062(4)). Because the wording of the two statutes "is not significantly different," the Arizona Supreme Court has stated that "there is no sound reason why the legal interpretation of the statutes should be any different." State v. Santeyan, 664 P.2d 652, 654 (Ariz. 1983).

communication between the physician and patient.[118] Noting that the physician-patient privilege did not exist at common law[119] and thus is "statutory only,"[120] the court concluded that the privilege must be strictly construed.[121] And because, like its counterparts in a number of other states,[122] Arizona's statute is "limited by its terms to physicians and surgeons,"[123] the court concluded that only the Arizona legislature could extend the privilege to encompass a patient's confidential communications with a nurse acting as the agent of a physician.[124]

In the absence of a contrary Arizona state court decision[125] or intervening legislative enactment,[126] it may be reasonable to assume the Ninth Circuit's

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[118] *See Sw. Metals*, 4 F.2d at 217; *cf.* Darnell v. State, 674 N.E.2d 19, 21-22 (Ind. Ct. App. 1996) (noting with approval "the idea that patients who are being treated by a physician should be entitled to trust someone who works under the close supervision of the physician to the same degree that they can trust the physician").

[119] *See Sw. Metals*, 4 F.2d at 217 ("At common law communications between physician and patient were not legally privileged" (quoting Howe v. Regensburg, 132 N.Y.S. 837, 838 (N.Y. App. Term. 1912))). Not only did the privilege not exist at common law, "it has been roundly criticized by common-law scholars." Green v. Superior Ct., 33 Cal. Rptr. 604, 606 (Cal. Ct. App. 1963). See *infra* notes 312–29 and accompanying text for a discussion of the criticism the privilege has received.

[120] *See Sw. Metals*, 4 F.2d at 217. This is the situation in virtually every jurisdiction in which the physician-patient privilege is recognized. *See* Hardy v. Riser, 309 F. Supp. 1234, 1237 (N.D. Miss. 1970) ("[W]ith one or two rare judicially created exceptions, the [physician-patient] privilege is a pure creature of statute.") (footnote omitted); *cf.* Hague v. Williams, 181 A.2d 345, 348 (N.J. 1962) (discussing cases that purportedly "extend some judicial recognition to a limited extra-statutory physician-patient privilege").

[121] *See Sw. Metals*, 4 F.2d at 218 (asserting that "such statutes . . . are strictly construed and limited to cases falling within the principles on which they are based"); *cf.* Indus. Comm'n v. Superior Ct., 595 P.2d 166, 167 (Ariz. 1979) (holding that "statutes creating evidentiary privileges are strictly construed"); Salvation Army v. Bryson, 273 P.3d 656, 662 (Ariz. Ct. App. 2012) ("[W]e will strictly construe a privilege granted by statute.").

[122] *See Developments in the Law – Privileged Communications*, *supra* note 52, at 1533 (asserting that physician-patient privilege statutes "most often use the general terms 'physician' or 'physician or surgeon' to denote the individuals covered"); *cf.* Mélanie E. de Wit et al., *Supporting Second Victims of Patient Safety Events: Shouldn't These Communications Be Covered by Legal Privilege?*, 41 J.L. MED. & ETHICS, Winter 852, 856 (2013) ("'Physician-patient' privilege laws at the state level differ greatly in which professional credentials convey protections.").

[123] *Sw. Metals*, 4 F.2d at 217; *cf.* State v. Peltz, 391 P.3d 1215, 1223 (Ariz. Ct. App. 2017) (noting that "[i]nformation is privileged when acquired by a *physician or surgeon* in a consultation with the patient") (emphasis added).

[124] *See Sw. Metals*, 4 F.2d at 218 (asserting that any extension of the privilege "to nurses and other attendants who are neither physicians nor surgeons . . . should be made by the Legislature, not by judicial construction"); *cf.* People v. Ernst, 725 N.E.2d 59, 64 (Ill. App. Ct. 2000) ("The source of the physician-patient privilege is statutory and the scope of that privilege is generally a matter for the legislature.").

[125] *See* Response to Motion to Suppress Statements, at 3, State v. Kitts, No. CR-2002-1869, 2002 AZ. Sup. Ct. Motions LEXIS 479, at *3 (Ariz. Super. Ct. Pima Cty. Oct. 25, 2002) (describing *Southwest Metals* as the only "Arizona case" that "has addressed the issue of whether nurses should be considered doctors for the purposes of the physician-patient privilege"); *cf.* Andrade v. City of Phoenix, 692 F.2d 557, 559 (9th Cir. 1982) ("If there were a decision by the Supreme Court of Arizona construing [a state] statute, the federal courts would be bound by that decision.").

interpretation of Arizona's physician-patient privilege is correct.[127] Whether correct or not,[128] the interpretation is binding on federal courts sitting in Arizona and other states located in the Ninth Circuit until it has been repudiated by the Arizona state courts.[129] The Ninth Circuit's analysis in *Southwest Metals* has influenced the outcome of cases in jurisdictions outside the Ninth Circuit as well.[130]

The Ninth Circuit's analysis is also consistent with cases in which Arizona state courts have held that the physician-patient privilege, being statutory in nature,[131] must be strictly construed.[132] Indeed, the Arizona Court of Appeals specifically relied on

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[126] *See, e.g.*, Roman Catholic Diocese v. Superior Ct., 62 P.3d 970, 973 (Ariz. Ct. App. 2003) (noting that the legislature "amended the civil attorney-client privilege statute to broaden the privilege for corporations in civil cases" in response to the Arizona Supreme Court's interpretation of the privilege in *Samaritan Foundation v. Goodfarb*, 862 P.2d 870 (Ariz. 1993)). The Arizona legislature has demonstrated its ability to override judicial interpretations of the state's privilege statutes with which it disagrees. *Id.* Conversely, "legislative acquiescence" in the judicial construction of a privilege statute may be "sufficient to effect an incorporation of that construction into the statute." Weiss v. Indus. Comm'n, 347 P.2d 578, 580 (Ariz. 1959), *overruled in part on other grounds by* Dutra v. Indus. Comm'n, 659 P.2d 18, 21 (Ariz. 1983).

[127] *See, e.g.*, Etheridge v. Ariz. State Bd. of Nursing, 796 P.2d 899, 902, 910 (Ariz. Ct. App. 1989) (affirming trial court's finding that nurses "lacked standing . . . to invoke the patient-physician privilege"); *see also* Taylor v. Reo Motors, Inc., 275 F.2d 699, 703 (10th Cir. 1960) (describing the Ninth Circuit's conclusion that a physician-patient privilege statute "should not be construed to extend the privilege to an attending nurse" as a "well considered view").

[128] *See generally* State v. Schroeder, 524 N.W.2d 837, 840 (N.D. 1994) ("Because the physician-patient privilege did not exist at common law and is a creature of statute or rule, its . . . scope depends upon the specific language of the statute or rule authorizing it. The language of those statutes and rules varies extensively.").

[129] Unlike Arizona's state courts, federal courts in Arizona are bound by the Ninth Circuit's interpretation of Arizona law "in the absence of any subsequent indication from the state courts that the . . . interpretation was incorrect." Pershing Park Villas Homeowners Ass'n v. United Pac. Ins. Co., 219 F.3d 895, 903 (9th Cir. 2000) (quoting Owen v. United States, 713 F.2d 1461, 1464 (9th Cir. 1983)) (bracketing omitted). *See also* Nammo Talley Inc. v. Allstate Ins. Co., 99 F. Supp. 3d 999, 1003 (D. Ariz. 2015) ("Simply stated, 'stare decisis requires that this Court follow the [Ninth] Circuit's earlier determination as to the law of a state in the absence of any subsequent change in the state law'" (quoting Newell v. Harold Shaffer Leasing Co., 489 F.2d 103, 107 (5th Cir. 1974))) (bracketing altered).

[130] *See, e.g.*, Prudential Ins. Co. v. Kozlowski, 276 N.W. 300, 302-03 (Wis. 1938) (relying on *Southwest Metals* in "limiting application of the [Wisconsin physician-patient privilege] statute to the persons and the conditions expressly covered by it"); *see also* First Tr. Co. v. Kansas City Life Ins. Co., 79 F.2d 48, 53 (8th Cir. 1935) (finding the Ninth Circuit's "well-reasoned opinion" in *Southwest Metals* "convincing").

[131] *See* State v. Steelman, 585 P.2d 1213, 1228 (Ariz. 1978) ("The doctor-patient privilege is created by statute in Arizona."); Duquette v. Superior Ct., 778 P.2d 634, 637 (Ariz. Ct. App. 1989) ("We . . . note that the physician-patient privilege in Arizona is statutory.").

[132] *See, e.g.*, Johnson v. O'Connor, 327 P.3d 218, 225 (Ariz. Ct. App. 2014) (noting that the physician-patient privilege "did not exist at common law" and therefore "must be strictly construed"); State v. Morales, 824 P.2d 756, 759 (Ariz. Ct. App. 1991) ("Because there was no such privilege at common law, the statute must be strictly construed."). *See generally* Found. Dev. Corp. v. Lochmann's, 788 P.2d 1189, 1194 (Ariz. 1990) ("Generally, we strictly construe statutes that are in derogation of the common law.").

Southwest Metals in *Benton v. Superior Court*,[133] where it agreed with the Ninth Circuit's conclusion that the privilege's application "is restricted to physicians."[134]

Nevertheless, the *Southwest Metals* decision is not binding on Arizona's state courts,[135] on other state courts,[136] or on federal courts located outside the Ninth Circuit.[137] Nor is the analysis in *Benton v. Superior Court*[138] and other Arizona Court of Appeals' decisions interpreting the physician-patient privilege[139] binding in subsequent Arizona appellate court cases.[140] This is particularly true of cases being decided by the

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[133] 897 P.2d 1352, 1356 (Ariz. Ct. App. 1994).

[134] *See id.* at 1355 (citing Sw. Metals Co. v. Gomez, 4 F.2d 215 (9th Cir. 1925)). The *Benton* court also relied on *State v. LaRoche*, where the court held that New Hampshire's physician-patient privilege did not apply to the defendant's statements to the emergency medical technicians who transported him to a hospital because the statutory privilege applied "only to physicians and surgeons and those working under their supervision," and there was no evidence that the emergency medical technicians were working under the supervision of a physician at the time the statements were made. *See* State v. LaRoche, 442 A.2d 602, 603 (N.H. 1982) (interpreting N.H. REV. STAT. ANN. § 329:26). However, the *Benton* court was not considering the potential recognition of a nurse-patient privilege, but whether "the State may, without the permission of a victim, obtain the victim's medical records when such records are needed for the prosecution of a criminal case." *Benton*, 897 P.2d at 1353.

[135] *See, e.g.*, Planning Group of Scottsdale v. Lake Mathews Mineral Props. Ltd., 246 P.3d 343, 348 (Ariz. 2011) ("[D]ecisions of the Ninth Circuit . . . are not binding on this Court."); *see also* State v. Hummer, 911 P.2d 609, 614 (Ariz. Ct. App. 1995) ("Ninth Circuit interpretations of Arizona law do not bind Arizona courts."); Skydive Ariz., Inc. v. Hogue, 360 P.3d 153, 161 ¶ 29 (Ariz. Ct. App. 2016) ("[D]ecisions of the Ninth Circuit, although persuasive, are not binding on Arizona courts.").

[136] *See, e.g.*, Prudential Ins. Co. v. Kozlowski, 276 N.W. 300, 302 (Wis. 1938) (holding that Wisconsin courts are "not bound to follow" *Southwest Metals* and other cases "from jurisdictions beyond [the] state"); *see also* People v. McCoy, 35 Cal. Rptr. 3d 366, 371 (Ct. App. 2005) ("Even on federal questions . . . Ninth Circuit cases do not bind state courts.").

[137] *See, e.g.*, Peters v. Ashcroft, 383 F.3d 302, 305 n.2 (5th Cir. 2004) ("[T]his court is not bound by the Ninth Circuit's construction of Arizona law. While sister circuits' experience construing the laws of the states within their jurisdiction may render their decisions persuasive, we are not bound by those decisions.") (citation omitted); Clark v. Prudential Ins. Co. of Am., 736 F. Supp. 2d 902, 922 (D.N.J. 2010) ("The Ninth Circuit's interpretation of . . . state law is only persuasive, not binding, on this Court.").

[138] 897 P.2d 1352 (Ariz. Ct. App. 1994).

[139] *See, e.g.*, State v. Howland, 658 P.2d 194, 199 (Ariz. Ct. App. 1982) (stating that Arizona's statutory physician-patient privilege "applies only to physicians and surgeons"); *see also* Hosp. Corp. of Am. v. Superior Ct., 755 P.2d 1198, 1200 (Ariz. Ct. App. 1988) ("The physician-patient privilege did not exist under the common law. Accordingly, we must look to the statutes to ascertain the existence and scope of the physician-patient privilege.") (citations omitted).

[140] *See* Francis v. Ariz. Dep't of Transp., 963 P.2d 1092, 1094 (Ariz. Ct. App. 1998) ("Under the doctrine of stare decisis, once a point of law has been established, it must be followed by all courts of *lower rank* in subsequent cases where the same legal issue is raised.") (emphasis added); Castillo v. Indus. Comm'n, 520 P.2d 1142, 1148 (Ariz. Ct. App. 1979) ("[W]e would not be absolutely bound by prior Court of Appeals decisions . . . ."). On the other hand, the state's trial courts are bound to follow decisions of the Arizona Court of Appeals until those decisions are superseded by contrary Arizona Supreme Court authority. *Francis*, 963 P.2d at 1094. "The superior court is bound by the decisions of the court of appeals; its precedents furnish a proper guide to that court in making its decisions." *Id.* at 1094.

Arizona Supreme Court,[141] which is the ultimate arbiter of questions of Arizona law,[142] and thus – absent further legislative action[143] – presumably will have the final say with respect to whether a nurse-patient privilege is to be recognized in Arizona.[144]

V. Nurse-Patient Privilege's Existence and Evolution in Ohio

In attempting to determine whether Arizona's state courts are likely to adopt the Ninth Circuit's interpretation of the physician-patient privilege,[145] it is useful to consider the reasoning in cases from other jurisdictions as well.[146] In contrast to the Ninth Circuit,[147] courts in several of those jurisdictions have held that the privilege

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[141] *See* Wilderness World, Inc. v. Dep't of Revenue, 895 P.2d 108, 112 (Ariz. 1995). "[W]e, as the court of last resort on [an] issue [of Arizona law], are not bound by a court of appeals opinion." *Id.*

[142] *See* United States v. Gila Valley Irrigation Dist., 859 F.3d 789, 807 (9th Cir. 2017) ("The Arizona Supreme Court is the final arbiter of Arizona law . . ."); Scheele v. Justices of Ariz. Supreme Ct., 120 P.3d 1092, 1106 (Ariz. 2005) (describing the Arizona Supreme Court as the "court of last resort" in interpreting "questions of Arizona law"); *cf.* Senor T's Rest. v. Indus. Comm'n, 641 P.2d 877, 880 (Ariz. Ct. App. 1981), *vacated on other grounds*, 641 P.2d 848, 853 & n.2 (Ariz. 1982) (Froeb, J., concurring) ("Recognizing that the Arizona Supreme Court is the final arbiter of the law in Arizona, the court of appeals nevertheless has the duty and responsibility of declaring the law in Arizona in the absence of supreme court precedent."), *vacated on other grounds*, 641 P.2d 848, 853 & n.2 (Ariz. 1982).

[143] *See* State *ex rel.* Thomas v. Schneider, 130 P.3d 991, 995 (Ariz. Ct. App. 2006) (stating that "in promulgating its evidentiary rules" the Arizona Supreme Court "specified that questions of privilege are governed by the common law *except when statute dictates otherwise*" (construing ARIZ. R. EVID. 501)) (emphasis added); Humana Hosp. Desert Valley v. Superior Ct., 742 P.2d 1382, 1387 (Ariz. Ct. App. 1987) (noting that "privileges may be established by statute" (discussing ARIZ. R. EVID. 501)).

[144] *See State ex rel. Thomas*, 130 P.3d at 995 ("In this state, it is the province of the supreme court to make rules governing evidentiary privileges." (citing ARIZ. CONST. art. VI, § 5)); *cf.* Sw. Metals Co. v. Gomez, 4 F.2d 215, 217 (9th Cir. 1925) (observing that Arizona's physician-patient privilege statute, "*as construed by its highest court*, is controlling") (emphasis added). In a case that did not involve the potential recognition of a nurse-patient privilege, the Arizona Supreme Court concluded that the witness whose testimony is at issue "must be a physician or surgeon" in order for the physician-patient privilege to apply. State v. Beaty, 762 P.2d 519, 526 (Ariz. 1988). However, the Arizona Supreme Court has the authority to revisit its interpretation of the physician-patient privilege, as well as to adopt an "independent" common law nurse-patient privilege. *Id. See also* McKay v. Indus. Comm'n, 438 P.2d 757, 759 (Ariz. 1968) ("Whether prior decisions of the highest court in a state are to be disaffirmed is a question for the court which makes the decisions.").

[145] *See generally* Geisberger v. Willuhn, 390 N.E.2d 945, 947 (Ill. App. Ct. 1979) ("In a number of cases . . . the privilege has been denied to nurses on the theory that it is in derogation of the common law and should be particularly confined to those expressly named").

[146] *See* Hodai v. City of Tucson, 365 P.3d 959, 968 n.8 (Ariz. Ct. App. 2016) ("Although . . . Arizona courts are not bound by precedent from other states, our courts may look to cases from other jurisdictions as persuasive authority.") (citation omitted); *cf.* Kotterman v. Killian, 972 P.2d 606, 624 (Ariz. 1999) ("We alone must decide how persuasive the legal opinions of other jurisdictions will be to our holdings.").

[147] *See generally* Duronslet v. Kamps, 137 Cal. Rptr. 3d 756, 770 (Cal. Ct. App. 2012) ("Courts . . . have reached conflicting results when considering whether the physician-patient privilege impliedly extends to nurses when the statute does not specifically mention nurses.").

necessarily extends to nurses,[148] particularly when they are "acting under the direction of the physician examining or treating the patient."[149] The existing split of authority is illustrated by the courts' vacillating treatment of the issue in Ohio.[150]

In a case that was subsequently criticized by a prominent evidence scholar,[151] the Ohio Supreme Court held in *Weis v. Weis*[152] that because nurses were not then listed among those protected by the Ohio statute governing privileged communications,[153] a patient's communications with a nurse during the performance of her duties were not privileged unless the nurse was also a physician.[154] Relying on the analysis in *Southwest Metals Co.*[155] and other similar cases,[156] the *Weis* court concluded that if the protection of

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[148] *See, e.g.*, LoCoco v. XL Disposal Corp., 717 N.E.2d 823, 827 (Ill. App. Ct. 1999) (observing that the Illinois physician-patient privilege "has been applied to nurses in a number of cases"), *appeal denied*, 724 N.E.2d 1269 (Ill. 2000); *see also* Jasper v. State, 269 P.2d 375, 378 (Okla. Crim. App. 1954) ("It has been held that [a] statute making communications by patient to physician and knowledge obtained by him from examination incompetent applies to a nurse who hears communications or sees the examination." (citing Williams v. State, 86 P.2d 1015 (Okla. Crim. App. 1939))).

[149] *See* Ostrowski v. Mockridge, 65 N.W.2d 185, 190-91 & n.4 (Minn. 1954) (citing cases); *see, e.g.*, State v. Henderson, 824 S.W.2d 445, 450 (Mo. Ct. App. 1991) ("Communications made to or in the presence of a nurse may be privileged if the nurse is acting under the direction of a physician or assisting him in his treatment."); State v. Etheridge, 352 S.E.2d 673, 676 (N.C. 1986) (stating that the physician-patient privilege "applies to communications with a nurse acting under the direction of a physician"). *See also* UTAH R. EVID. 506(b) (extending the protection of the physician-patient privilege to "other persons who are participating in the diagnosis or treatment [of a patient] under the direction of the physician").

[150] *See* James D. Hapner, Comment, *The Physician-Patient Privilege in Ohio*, 11 OHIO ST. L.J., 378, 378 (1950) ("As to communications to the agents of a physician such as nurses, the earlier determinations regarded these as privileged. A later determination of the Supreme Court of Ohio has held that . . . no privilege is recognized in the situation of communications to nurses." (discussing Humble v. John Hancock Life Ins. Co., 28 Ohio N.P. (n.s.) 481 (Ct. C.P. Montgomery Cty. 1931), *aff'd*, 31 N.E.2d 887 (Ohio Ct. App. 1932), and Weis v. Weis, 72 N.E.2d 245 (Ohio 1947))) (footnote omitted).

[151] *See* Ohio Op. Att'y Gen. No. 88-027, at 2-112 n.5 (1988) (noting that Professor Charles McCormick criticized the Ohio Supreme Court's decision in Weis v. Weis, 72 N.E.2d 245 (Ohio 1947) in his influential evidence law treatise (citing EDWARD W. CLEARY, MCCORMICK ON EVIDENCE § 101, at 251 (3d ed. 1984))).

[152] 72 N.E.2d 245 (Ohio 1947).

[153] *See id.* at 252 ("A nurse is not included among those named in the statute governing privileged communications."). This is no longer the case. *See* OHIO REV. STAT. ANN. § 2317.02(B) (recognizing a privilege for "advanced practice registered nurse[s]").

[154] *See* Weis v. Weis, 72 N.E.2d 245, 252 (Ohio 1947); *see also* Wills v. Nat'l Life & Accident Ins. Co., 162 N.E. 822, 824 (Ohio Ct. App. 1928) (holding that a patient's communications with a nurse were not privileged because she was "not a physician, and [was] not named in the statute relating to privileged communications").

[155] 4 F.2d 215 (9th Cir. 1925).

[156] *See Weis*, 72 N.E.2d at 252. The *Weis* court also cited *First Trust Co. v. Kansas City Life Insurance Co.*, 79 F.2d 48 (8th Cir. 1935) and *Prudential Insurance Co. of America v. Kozlowski*, 276 N.W. 300 (Wis. 1938) in support of its holding. *Id.* Like the Ninth Circuit in *Southwest Metals*, the courts in these cases effectively held that if the physician-patient privilege is to be "extended to nurses or other attendants who are neither physicians nor surgeons, the change should be made by the legislature." *See* Eureka-Md. Assurance Co. v. Gray, 121 F.2d 104, 107 (D.C. Cir. 1941) (summarizing the view represented by *Southwest Metals, First Trust Co.* and *Prudential Insurance Co.*).

Ohio's physician-patient privilege was to be extended to nurses,[157] the change would need to be made by the Ohio General Assembly.[158]

The *Weis* court nevertheless acknowledged that the physician-patient privilege occasionally has been held to encompass a patient's confidential communications with a nurse employed by a physician "and acting for him as his personal assistant."[159] Indeed, even before the Ohio General Assembly accepted the *Weis* court's implicit invitation to amend the state's physician-patient privilege statute to protect a patient's confidential communications with a nurse,[160] there was authority in Ohio suggesting that the privilege encompasses such communications if the nurse was acting as a physician's agent at the time the communications were made.[161]

In *State v. Wood*,[162] for example, the Ohio Court of Appeals acknowledged the *Weis* court's holding that a patient's communications with a nurse are not privileged,[163]

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[157] *See* State v. Tu, 478 N.E.2d 830, 834 (Ohio Ct. App. 1984). The Ohio courts' reluctance to extend the scope of the physician-patient privilege may reflect misgivings about its effectiveness.;

> Historically, there is no evidence whatsoever to suggest that people were more "deterred" from seeking medical treatment and advice *before* physician-patient privileges were enacted than afterward. Moreover, in jurisdictions presently having either *no* physician-patient privilege or an extremely limited one, people are no more "deterred" from exchanging private, confidential information with their physicians than they are in those jurisdictions having a broadly drawn statutory privilege.

Id.

[158] *See Weis*, 72 N.E.2d at 252; *cf.* State v. Grohowski, No. L-95-292, 1996 Ohio App. LEXIS 4220, at *7 (Ohio Ct. App. Sept. 30, 1996) ("The physician-patient privilege is purely statutory creature. Because the General Assembly created it, the General Assembly can amend it).

[159] *Weis*, 72 N.E.2d at 252 (citing Culver v. Union Pac. R.R. Co., 199 N.W. 794 (Neb. 1924)); *see, e.g.*, Meyer v. Russell, 214 N.W. 857, 862 (N.D. 1926) (stating that Nebraska's physician-patient privilege statute "specifies physicians and surgeons, and has been held to include necessary intermediaries whose intervention was necessary to enable physicians to obtain information essential to the performance of his duty, such as an assistant nurse or agent of the physician or surgeon" (noted in Culver v. Union Pac. R.R. Co., 199 N.W. 794 (Neb. 1924)).

[160] *See* Brief in Opposition to Plaintiff's Motion to Compel on Behalf of All Defendants, at 6, Freudeman v. Landing of Canton, 5:09-CV-00175, 2010 U.S. Dist. Ct. Motions LEXIS 13071, at *9 (N.D. Ohio Feb. 1, 2010) ("[T]he Ohio Legislature did exactly what the *Weis* court eluded [sic] to when it extended the physician-patient privilege to nurses upon the enactment of Ohio Revised Code section 2317.02.").

[161] *See* City of Cleveland v. Haffey, 703 N.E.2d 380, 391 (Ohio Mun. Ct. 1998) ("Recent appellate decisions have interpreted the language of the statute to include certain information acquired by a nurse in the performance of her duties, if the acquisition was intended to assist the physician in the treatment or diagnosis of the patient, as being protected by the privilege."); *cf.* Hobbs v. Lopez, 645 N.E.2d 1261, 1263 (Ohio Ct. App. 1994) ("[T]he Ohio Supreme Court [has] extended the attorney-client privilege to communications through persons acting as the attorney's agents. Applying [this] holding . . . to a situation where a physician-patient privilege existed, one would conclude that the privilege applied as well to a nurse acting as an agent for a doctor." (construed in State v. Post, 513 N.E.2d 754 (Ohio 1987))).

[162] 752 N.E.2d 990 (Ohio Ct. App. 2001).

and that because the physician-patient privilege statute is in derogation of the common law,[164] "only those relationships specifically mentioned therein are afforded protection."[165] The *Wood* court nevertheless observed:

> [W]hen the nurse is the private nurse of a patient's physician, and has obtained knowledge of the patient's condition while acting as the physician's assistant, then the nurse cannot disclose any information, so acquired, that the physician, himself, could not disclose, otherwise, the privilege granted by statute would rarely be effective, given the reliance most physicians place on their nurses.[166]

Courts that have adopted the latter view have relied primarily on a theory of agency.[167] Like the court in *Wood*, these courts reason that nurses and other nonphysician health care providers working in conjunction with physicians are often privy to communications protected by the physician-patient privilege.[168] In order for the physician-patient privilege to be effective in those situations,[169] the communications

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[163] *See id.* at 993 (citing Weis v. Weis, 72 N.E.2d 245, 252 (Ohio 1947)); *see also* Melissa O'Neill, *Ohio's Patient-Physician Privilege: Whether Planned Parenthood Is a Protected Party*, 17 J.L. & HEALTH 297, 309 (2003) ("The rule in Ohio has long been that the patient-physician privilege is to be 'strictly construed.' Generally, this has meant that only licensed physicians are specifically seen as a privileged party. Thus, nurses . . . are excluded from the patient-physician privilege.").

[164] *See* Kromenacker v. Blystone, 539 N.E.2d 675, 677 (Ohio Ct. App. 1987) (noting in "the statute granting the physician-patient privilege is in derogation of the common law and is to be strictly construed.").

[165] *Wood*, 752 N.E.2d at 992 (citing Weis v. Weis, 72 N.E.2d 245 (Ohio 1947)); *see also* Niemann v. Cooley, 637 N.E.2d 943, 951 (Ohio Ct. App. 1994) (stating that "since the physician-patient privilege is in derogation of the common law, Ohio courts have strictly construed it to afford protection only to those relationships enumerated in the statute").

[166] *Wood*, 752 N.E.2d at 993; *see also* Humble v. John Hancock Life Ins. Co., 28 Ohio N.P. (n.s.) 481, 489 (Ct. C.P. Montgomery Cty. 1931) ("If the privilege granted by the statute is to be effective, it must extend to the nurse in her capacity as an assistant to the physician so that she can not disclose what she learns in such capacity when the physician, himself, can not disclose it."), *aff'd*, 31 N.E.2d 887 (Ohio Ct. App. 1932).

[167] *See* Myers v. State, 310 S.E.2d 504, 505-06 (Ga. 1984) (discussing courts that "hold, based on the theory of agency, that even in [the] absence of a statutory privilege, statements made to a nurse who is assisting a doctor in treating the communicant are privileged"); State v. Gonzales, 652 S.W.2d 719, 724 n.2 (Mo. Ct. App. 1983) (referring to "cases which hold that statements made to a nurse as the physician's agent may be privileged"); *Developments in the Law – Privileged Communications, supra* note 52, at 1534 ("[S]ome courts, even in the absence of an expansive statutory privilege, have employed an agency theory to protect communications made to a nurse assisting or acting under the direction of a physician").

[168] *See, e.g.*, Smith-Bozarth v. Coal. Against Rape & Abuse, Inc., 747 A.2d 322, 326 (N.J. Super. Ct. App. Div. 2000) ("[D]octors must afford nurses . . . access to patient files and other confidential information in order to efficiently perform their professional responsibilities."); *see also* Peter A. Winn, *Confidentiality in Cyberspace: The HIPAA Privacy Rules and the Common Law*, 33 RUTGERS L.J. 617, 623 (2002) ("In order to properly treat their patients, doctors . . . must share with other providers, such as nurses, druggists, lab technicians, and other medical personnel, sensitive information about their patients."); Smith, *supra* note 23, at 543 ("The use of assistants in providing medical care . . . increases the number of persons with access to information.").

[169] *See generally* Duronslet v. Kamps, 137 Cal. Rptr. 3d 756, 771 (Ct. App. 2012) (noting that "extend[ing] the physician-patient privilege to nurses working under the supervision of a

must remain confidential despite the presence of a nurse, or another nonphysician providing assistance,[170] at the time they were made.[171] The Nebraska Supreme Court appears to have first articulated this principle in *Culver v. Union Pacific Railroad Co.*,[172] a case decided nearly a century ago:

> A nurse is often necessarily present at conversations between the patient and the doctor with respect to the ailment or condition of a patient, and little good would be subserved if the lips of the doctors might be sealed by the statute as to such conversations but the nurse . . . might freely testify to all that was said and everything that was done.[173]

VI. Conflicting Judicial Views of the Agency Requirement

Some courts that have adopted the views expressed in *Wood* and *Culver* have concluded that the physician-patient privilege should encompass a patient's confidential communications with a nurse *only* when the nurse is acting as a physician's agent.[174] The court in one such case described this limitation on the privilege's application in the following terms: "Not all information which a nurse may acquire is privileged, but only such information as is necessarily imparted to the nurse as an assistant of the physician

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physician or as an agent of a physician . . . may be practical and, in some situations, advisable, particularly given the role nurses currently play in providing medical care").

[170] *See, e.g.*, Blevins v. Clark, 740 N.E.2d 1235, 1239 (Ind. Ct. App. 2000), ("Our supreme court has extended [the physician-patient] privilege to third persons who aid physicians or transmit information to physicians on behalf of patients." (citing Springer v. Byram, 36 N.E. 361, 363 (Ind. 1894))), *transfer denied*, 753 N.E.2d 16 (Ind. 2001); *see also* Hofmann v. Conder, 712 P.2d 216, 217 (Utah 1985) (Zimmerman, J., dissenting) ("A third person's presence should not avoid an otherwise available privilege if the third person's presence is reasonably necessary under the circumstances."); Smith, *supra* note 23, at 543 (asserting that individuals assisting physicians in the provision of medical care "normally would be expected to have the obligation to maintain the confidentiality of any information they received").

[171] *See* Kramer v. Policy Holders Life Ins. Ass'n, 42 P.2d 665, 671 (Cal. Ct. App. 1935) (discussing cases "in which it is held that when a nurse or other third person is actually working as agent and assistant under the supervision of the doctor in charge, such agent is covered by the [physician-patient] privilege"); Geisberger v. Willuhn, 390 N.E.2d 945, 947 (Ill. App. Ct. 1979) ("[C]ourts have recognized the privilege for agents, specifically nurses, on the view that it would be ineffective if agents could, in fact, testify.").

[172] 199 N.W. 794 (Neb. 1924).

[173] *Id.* at 797. *See also* Suesbury v. Caceres, 840 A.2d 1285, 1288 (D.C. 2004) ("It is widely acknowledged that the nurse who attends a physician during a consultation or examination . . . [is] bound by the [physician-patient] privilege. These decisions simply reflect the reality of medical practice, where many individuals may work in concert") (citations and footnote omitted).

[174] *See, e.g.*, Ladner v. Ladner, 436 So.2d 1366, 1373 (Miss. 1983) (stating that a "nurse, as [an] independent person, receiving medical confidences as such, is not within the physician privilege, but [a] nurse acting as [a] physician's agent is within [the] privilege" (summarizing the holding in Miss. Power & Light Co. v. Jordan, 143 So. 483 (Miss. 1932), *superseded by statute*, MISS. CODE ANN. § 13-1-21)); *cf.* Plunkett v. Ginsburg, 456 S.E.2d 595, 597 (Ga. Ct. App. 1995) (holding that Georgia's statutory psychiatrist-patient privilege "does not extend . . . to any communications made to nurses or attendants, unless they were acting as agents of the attending psychiatrist").

in administering to the patient, and which is necessary to enable the physician to prescribe."[175]

This interpretation of the privilege is exemplified by the analysis in *State v. Shirley*.[176] In that case, the Missouri Court of Appeals concluded that although Missouri's physician-patient privilege statute applies by its terms only to physicians,[177] a patient's confidential communications with a nurse may fall within the protection of the privilege,[178] but only if the communications are made when the nurse "is acting under the direction of a physician or assisting him in treating his patient."[179] Because the statements at issue in *Shirley* were made to a nurse who was *not* "assisting or working under the direction of any physician,"[180] the court held that the nurse could be compelled to testify to those statements.[181]

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[175] *See* Meyer v. Russell, 214 N.W. 857, 863 (N.D. 1926); *see also* Ostrowski v. Mockridge, 65 N.W.2d 185, 190 (Minn. 1954) (noting that "courts have *permitted* [a nurse's] testimony where it appears the information sought to be elicited was acquired from sources separate and distinct from action in concert with a physician.") (emphasis added). *See generally* DEWITT, *supra* note 85, at 91:

> Except in jurisdictions which expressly include nurses within the provisions of the physician-patient privilege statutes, the general rule is that a nurse who acts as an independent person is competent to testify as to communications made to her by the patient and to disclose all that she sees, hears, or learns concerning the patient in the performance of her duties, however confidential and intimate such communications or information may be.

Id. (footnote omitted).

[176] *See* State v. Shirley, 731 S.W.2d 49 (Mo. Ct. App. 1987).

[177] *See id.* at 52 (discussing MO. REV. STAT. § 491.060(5)). *See* William R. Peterson, *The Patient-Physician Privilege in Missouri*, 20 U. KAN. CITY L. REV. 122 (1951), and Amy J. Sokol, *Missouri's Physician-Patient Privilege Presents Problems*, 60 J. MO. B. 32 (2004) for broader discussions of Missouri's version of the privilege.

[178] *See Shirley*, 731 S.W.2d at 52-53 ("The precedents by which we are bound indicate that a nurse may come within the scope of [the privilege] . . ." (citing State v. Scott, 491 S.W.2d 514, 519 (Mo. 1973), and State v. Burchett, 302 S.W.2d 9, 17 (Mo. 1957))); *cf.* O'Sullivan, *supra* note 45, at 949 ("[S]ome courts have granted privilege to nurses as an extension of the physician-patient privilege").

[179] *Shirley*, 731 S.W.2d at 53; *cf.* Binkley v. Loughran, 714 F. Supp. 776, 779 n.3 (M.D.N.C. 1989) (concluding that North Carolina's physician-patient privilege statute "protects a patient only from disclosure by physicians and any nurses . . . who assisted or acted under the direction of [a] physician" (citing State v. Efird, 309 S.E.2d 228 (N.C. 1983))).

[180] *Shirley*, 731 S.W.2d at 53. The nurse in *Shirley* instead "was working for and under the direction of" a psychiatric hospital. *Id. See also* State v. Henderson, 824 S.W.2d 445, 450 (Mo. Ct. App. 1991) ("Communications made to or in the presence of a nurse may be privileged if the nurse is acting under the direction of a physician or assisting him in his treatment. Here, however, the nurses were not working under the direction of a doctor or psychologist.") (citation omitted).

[181] *See Shirley*, 731 S.W.2d at 53; *cf.* State v. McCoy, 425 P.2d 874, 875 (Wash. 1967) (holding that the testimony of two hospital emergency room nurses did not fall within the protection of Washington's physician-patient privilege statute because the nurses "were not acting under the direction of any physician or surgeon" at the time of the events to which the nurses testified).

This interpretation of the privilege is far from universal.[182] In a concurring opinion in *Shirley*, Judge Almon Maus criticized the majority's conclusion that the physician-patient privilege should encompass confidential nurse-patient communications only when the nurse is acting as the agent of a physician.[183] While acknowledging that this interpretation of the privilege is supported by some authorities,[184] Judge Maus asserted that it does not reflect the realities of modern medical practice.[185] He argued that because nurses today have assumed many functions once performed only by physicians,[186] the preferable view "is that of the courts which have based their decisions upon whether the communication was functionally related to diagnosis or treatment."[187]

Judge Maus had the better of the argument.[188] Many of the cases holding that nurse-patient communications are privileged only if the nurse was acting as a physician's

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[182] *Cf.* State v. Phillips, 517 A.2d 1204, 1209 n.5 (N.J. Super. Ct. App. Div. 1986) ("Any applicable [physician-patient] privilege should also protect confidential statements made to a treating nurse, acting *either as an agent* under the supervision of a doctor *or in her professional capacity*.") (emphasis added). *See generally* DEMARCO ET AL., *supra* note 18, at 209-10 (asserting that a requirement that the nurse be an agent of the physician at the time the communications were made would lead to uncertainty due to the difficulty in determining whether "the requisite degree of control by a physician over a nurse exists in any particular situation").

[183] *See Shirley*, 731 S.W.2d at 53 (Maus, J., concurring) (declining to subscribe to the view that "the privilege extends only to a nurse who is acting as an agent for a licensed physician").

[184] *See id.* (Maus, J., concurring). One of the authorities Judge Maus cited for this principle was *Ramon v. State*, 387 So.2d 745 (Miss. 1980). *Id.* In *Ramon*, the Mississippi Supreme Court reaffirmed its previously expressed view that "if a nurse at the time of receiving medical information was an agent of the physician attending the patient and the nurse's presence was in connection with the physician's treatment, that knowledge is privileged." *Ramon*, 387 So.2d at 750 (discussing Miss. Power & Light Co. v. Jordan, 143 So. 483, 485 (Miss. 1932)). The *Ramon* court nevertheless held that the testimony of two nurses who obtained a urine sample form an emergency room patient at the behest of a police officer was not privileged because it was unrelated to "treatment by a physician." *Id.*

[185] *See Shirley*, 731 S.W.2d at 53 (Maus, J., concurring); *cf.* Ohio Op. Atty Gen. No. 88-027, at 2-112 n.5 (1988) (noting that "one commentator, in examining the physician-patient privilege, has stated that 'the application of strict agency privileges . . . seem[s] inconsistent with the realities of modern medical practice'" (quoting CLEARY, *supra* note 151 § 101, at 250)).

[186] *See, e.g.*, Wash. Cty. Mem'l Hosp. v. Sidebottom, 7 S.W.3d 542, 546 (Mo. Ct. App. 1999) ("Appellant, as a nurse practitioner, performed many of the medical services traditionally performed by a family practice physician."); *see also* Robinson v. Prudential Ins. Co. of Am., 776 N.E.2d 458, 463 (Mass. App. Ct. 2002) (noting that "nurses and nurse practitioners now assume many of the duties of physicians").

[187] *Shirley*, 731 S.W.2d at 53 (Maus, J., concurring) (quoting CLEARY, *supra* note 151 § 101, at 250). Implicit support for Judge Maus's view can be found in other Missouri cases. *See, e.g.*, Smith v. Tabakian, 284 S.W.3d 775, 775 (Mo. Ct. App. 2009) (upholding a lower court's finding that information disclosed by nurses "was not privileged because it did not relate to medical treatment"); *see also* Cavin v. State, 855 S.W.2d 285, 288 (Ark. 1993) ("It is true that a confidential communication with a nurse can fall within [the] privilege. . . . In order to be privileged, the communication must be made for the purpose of diagnosis or treatment of a physical, mental or emotional condition.").

[188] *See* Pierce, *supra* note 14, at 1086 ("[T]he type of interpersonal relationships that develop between nurses and their patients, as well as the similarity of patient care outcomes between nurses' patients and physicians' patients magnify the need for a nurse-patient privilege."); *cf.* DEWITT, *supra* note 85, at 93-94.

agent (or as in *Southwest Metals Co.*,[189] that they are not privileged even under those circumstances)[190] were decided when the nursing profession was still in its infancy,[191] while "modern cases have held that the privilege does indeed extend to protect communications between nurses and patients."[192]

In this regard, the practice of nursing has changed dramatically since its inception,[193] with nurses now often acting independently in the provision of patient care,[194] rather than primarily or exclusively,[195] as agents of a physician.[196] In Arizona,

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> [T]he prohibition against disclosure is only applicable and operative as a bar if the testimony sought to be elicited from the nurse would disclose confidential information which was acquired in attending the patient and was necessary to enable the nurse to care for and treat the patient, or was acquired as a necessary incident of such care or treatment.

Id.

[189] 4 F.2d 215 (9th Cir. 1925). *See supra* notes 112–124 and accompanying text.

[190] *See* Ostrowski v. Mockridge, 65 N.W.2d 185, 190 (Minn. 1954) ("A number of courts hold that the statutory privilege does not exclude the testimony of a nurse attending the physician."); *see also* Taylor v. Reo Motors, Inc., 275 F.2d 699, 702-03 (10th Cir. 1960) (referring to "the divided question whether an attending nurse comes within the statutory privilege expressly applicable to physicians"); State v. Gibson, 476 P.2d 727, 730 (Wash. Ct. App. 1970) (noting that "the states are roughly divided" on whether the physician-patient privilege "should be construed to include agents of the physician").

[191] *See, e.g.*, Response to Motion to Suppress Statements, at 3, State v. Kitts, No. CR-2002-1869, 2002 AZ. Sup. Ct. Motions LEXIS 479, at *4 (Super. Ct. Pima Cty. Oct. 25, 2002) (discussing the assertion that the Ninth Circuit's analysis in *Southwest Metals* is no longer "relevant" because "the role of nurses has changed substantially" since the case was decided); *see also* Eccard, *supra* note 75, at 842 ("[E]arly court decisions . . . refused to treat nurses as professionals. By appreciating the historical context of the early decisions, it is possible to limit those cases to their proper historical period."). *See generally* Elizabeth J. Armstrong, Note, *Nurse Malpractice in North Carolina: The Standard of Care*, 65 N.C. L. REV. 579, 581 (1987) ("Some appreciation for the historical development of American nursing is necessary to place the case law in proper perspective.").

[192] O'Neill, *supra* note 163, at 311; *see also* Michael E. Paulhus et al., *Navigating the Complex Waters of Diverse Privilege and Confidentiality Doctrines in Health Care FCA Actions*, 12 J. HEALTH & LIFE SCI. L. 121, 136 (2018).

> The scope of the protection provided by the [physician-patient] privilege varies by state. For example, some state privileges require the communication be made directly to a physician or a health care practitioner working under the direction of a physician. Other states also protect from disclosure communications made directly to a registered professional nurse.

Id. (footnotes omitted).

[193] *See* Maloney v. Wake Hosp. Sys., Inc., 262 S.E.2d 680, 684 (N.C. App. 1980) ("[N]urses . . . play a much greater role in the actual diagnosis and treatment of human ailments than previously. The role of the nurse is critical to providing a high standard of health care in modern medicine.") (citation omitted); Armstrong, *supra* note 191, at 581 (noting that "profound changes . . . have occurred in nursing during the last century").

[194] *See, e.g.*, Smith v. Pavlovich, 914 N.E.2d 1258, 1262 (Ill. App. Ct. 2009) (describing an advanced practice nurse who "could independently see and care for patients, order and interpret tests, and write prescriptions without being required to confer with or seek the approval of a

registered nurses can now diagnose and treat patients without physician supervision.[197] Nurses have been granted similar authority in Missouri,[198] where *Shirley* arose,[199] and the same is true of nurse practitioners in Maryland,[200] Oregon,[201] and many other states as well.[202]

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doctor"); *see also* NLRB v. St. Mary's Home, Inc., 690 F.2d 1062, 1066 (4th Cir. 1982) ("[N]ursing is a profession in which the nurse normally exercises independent judgment in rendering direct patient care."); Fraijo v. Hartland Hosp., 160 Cal. Rptr. 246, 252 (Ct. App. 1979) (asserting that "nurses . . . with superior education and experience often exercise independent judgment as to the care of patients").

[195] *See, e.g.*, William O. Morris, *The Negligent Nurse – The Physician and the Hospital*, 33 BAYLOR L. REV. 109, 122 (1981) ("A nurse . . . is not permitted to exercise broad judgment in diagnosing or treating symptoms that the patient may develop. The nurse's duty is to report such symptoms to the physician. Any treatment or medication must be prescribed by the physician."); *see also* Lauren E. Battaglia, Note, *Supervision and Collaboration Requirements: The Vulnerability of Nurse Practitioners and Its Implications for Retail Health*, 87 WASH. U. L. REV. 1127, 1142 (2010) (referring to "traditional nursing practice where nurses are generally viewed as being entirely dependent on physicians in providing care").

[196] *See* Sullivan v. Edward Hosp., 806 N.E.2d 645, 659 (Ill. 2004) (noting the "growing recognition on the part of courts that nursing, as a profession, has moved beyond its former dependence on the physician" (quoting Carole F. Kehoe, *Contemporary Nursing Roles and Legal Accountability: The Challenge of Nursing Malpractice for the Law Librarian*, 79 L. LIBR. J. 419, 428 (1987))); Ohio Op. Att'y Gen. No. 88-027, at 2-112 n.5 (1988) (noting that "a nurse is not necessarily an agent of the physician, and the nurse's care is not limited to treatment performed solely under a physician's order, control and full responsibility").

[197] *See* Rasor v. Nw. Hosp. LLC, 419 P.3d 956, 961 (Ariz. Ct. App. 2018) (discussing ARIZ. REV. STAT. § 32-1601.23); *cf.* Bustamante v. Colvin, No. CV-13-02080-PHX-ESW, 2015 U.S. Dist. LEXIS 2504, at *17 (D. Ariz. Jan. 8, 2015) ("Arizona is one of almost 20 states that allow nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, [and] initiate and manage treatments (including prescribe medications) without the supervision of a physician."). The movement toward more independent nursing has roots in Arizona, where the nation's first nurse-managed health care center began operating in 1977. *See* Michael B. Zand, *Nursing the Primary Care Shortage Back to Health: How Expanding Nurse Practitioner Autonomy Can Safely and Economically Meet the Growing Demand for Basic Health Care*, 24 J.L. & HEALTH 261, 263 (2011).

[198] *See* Sermchief v. Gonzales, 660 S.W.2d 683, 689 (Mo. 1983). The Missouri legislature has substantially expanded "the scope of authorized nursing practice," resulting in "the elimination of the requirement that a physician directly supervise nursing functions." *Id.*

[199] *See supra* notes 176–187 and accompanying text. See also Audrey L. Ennen, Note, *Interpreting Missouri's Nursing Practice Act*, 26 ST. LOUIS U. L.J. 931 (1982) for a discussion of the legislation that ushered in expanded nursing practice in Missouri.

[200] *See* Richardson v. Astrue, No. SKG-10-614, 2011 U.S. Dist. LEXIS 98932, at *22 (D. Md. Aug. 31, 2011) (explaining Maryland law accords nurse practitioners considerable authority in the diagnosis and treatment of patients). *See also* Louise Kaplan, *Maryland's Nurse Practitioner Full Practice Authority Act of 2015*, 40 NURSE PRAC. 8 (2015) (summarizing this aspect of nursing practice in Maryland).

[201] *See* Cook v. Workers' Comp. Dep't, 758 P.2d 854, 859 (Or. 1988). Nurse practitioners in Oregon are authorized to provide "comprehensive, independent medical care in the form of diagnosis, treatment, advice and referrals." *Id. See also* Tara D. Gregory, *The Role of the Nurse Practitioner in Oregon's Health Care Reform*, OR. NURSE, Winter 2014, at 7 (discussing nurse practitioners' authority in Oregon).

[202] *See, e.g.*, Pierce, *supra* note 14, at 1087 n.67. Stating that "Alaska, Arizona, Idaho, Montana, North Dakota, Wyoming, Nevada, New Mexico, Hawaii, [and the] District of Columbia all have nurse practice acts that provide nurse practitioners autonomous practice environments,

Extending the protection of an evidentiary privilege to confidential nurse-patient communications regardless of whether the nurse was acting as a physician's agent when the communications occurred reflects this movement away from a "passive, servile" nursing paradigm[203] toward a more independent form of professional nursing.[204] As one advocate of the nurse-patient privilege explained:

> [W]here nurse practitioners are relatively autonomous and do not work under the direction of a physician, agency theory will not extend the privilege from the physician to the nurse. If those states do not recognize a nurse-patient privilege then the patient's confidential communications to his nurse practitioner will not be safe from compulsion in court.[205]

VII. The State Legislatures' Role in Recognizing Nurse-Patient Privilege

A. Development of Privileges is Often Held to Be a Legislative Prerogative

Despite the persuasiveness of Judge Maus's argument,[206] courts in Missouri[207] and many other states continue to hold that any expansion of the physician-patient

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independent of physicians." *Id.* *See also* Ann Ritter & Tina Hansen-Turton, *The Primary Care Paradigm Shift: An Overview of the State-Level Legal Framework Governing Nurse Practitioner Practice*, 20 HEALTH LAW. 21 (2008) (noting that "[S]ome states allow nurse practitioners to practice independently without physician involvement . . . .").

[203] *See* Bleiler v. Bodner, 479 N.E.2d 230, 234 (N.Y. 1985). *See also* Emily Chase-Sosnoff, Note, *The Nursing Standard of Care in Illinois: Rethinking the Wingo Exception in the Wake of* Sullivan v. Edward Hospital, 88 CHI.-KENT L. REV. 245, 274 (2012). Despite recent advances in the practice of nursing, "the public perception of nurses as physicians' subordinates" lingers. *Id.* *See also* Cooper & Brent, *supra* note 1, at 1057 n.11. "[A] factor which affected the development of the personality of the nursing profession was . . . the view of nursing as a subordinate part of medical practice. As a result, the profession and its members became passive, and these passive traits have been difficult to overcome." *Id.*

[204] *See Bleiler*, 479 N.E.2d at 234. "[T]he role of the registered nurse has changed . . . to that of an assertive, decisive health care provider. Today, the professional nurse monitors complex physiological data, operates sophisticated lifesaving equipment, and coordinates the delivery of a myriad of patient services." *Id.* *See also* Cavico & Cavico, *supra* note 73, at 570. "No longer physician's servants, nurses' responsibilities have expanded and intensified and they now frequently exercise independent professional judgment." *Id.*

[205] Pierce, *supra* note 14, at 1093.

[206] *See generally* O'Sullivan, *supra* note 45, at 950. "With the expansion of the nursing role to include primary care, it seems logical and essential that the nurse-patient interaction be protected. In this role, the nurse is not functioning as an employee . . . assisting the physician." *Id.* Pierce, *supra* note 14, at 1079. "With new changes in our health care system, reason and experience speak to the necessity of the nurse-patient privilege." *Id.*

[207] *See, e.g.*, Rodriguez v. Suzuki Motor Co., 996 S.W.2d 47, 64 (Mo. 1999). In Missouri the physician-patient privilege "is set by statute, and any change to the scope of the privilege is solely a legislative prerogative . . . ." *Id.* State v. Beatty, 770 S.W.2d 387, 391 (Mo. Ct. App. 1989). "The physician-patient privilege . . . is statutory in origin, and may only be modified, expanded, or abolished by the legislature." *Id.*

privilege must come from the legislature.[208] In *Darnell v. State*,[209] the appellant asserted that because many nurses now have the authority to provide care that traditionally could be provided only by a physician,[210] the state's physician-patient privilege should be interpreted to include confidential communications between patients and nurses as a matter of public policy.[211] Although this argument mirrors Judge Maus's reasoning in *Shirley*,[212] the Indiana Court of Appeals refused to hold that communications between nurses and their patients are privileged.[213] Employing reasoning similar to that of the Ninth Circuit in *Southwest Metals*[214] and the Ohio Supreme Court in *Weis*,[215] the *Darnell* court instead deferred the question of whether such communications should be protected by an evidentiary privilege to the Indiana General Assembly.[216]

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[208] *See, e.g.*, State v. Ross, 947 P.2d 1290, 1293 (Wash. Ct. App. 1997). "[The appellant] argues that the privilege should be extended to paramedics because they are highly trained and act as physician extenders. Regardless of the merit of the argument, the Legislature, not the court, has the authority to extend the literal language of the privilege to include paramedics." *Id.* *See also* Lembke v. Unke, 171 N.W.2d 837, 856 (N.D. 1969) (Knudson, J., dissenting).

> The [physician-patient] privilege exists only . . . to the extent allowed by statute. Such statutory privilege is one which the legislature may modify, limit or abolish in whole or in part, but the courts may not do so, except as power may be conferred on them by the legislature.

Id.

[209] 674 N.E.2d 19 (Ind. Ct. App. 1996).

[210] *See id.* at 20; *see, e.g.*, Cox v. Levenhagen, No. 3:12-cv-320 PS, 2013 U.S. Dist. LEXIS 91880, at *16 (N.D. Ind. July 1, 2013) (noting that "licensed nurse practitioners can prescribe medications under Indiana law" (citing 848 IND. ADMIN. CODE § 5-1-1)), *aff'd sub nom.* Cox v. Brubaker, 558 F. App'x 677 (7th Cir. 2014).

[211] *See Darnell*, 674 N.E.2d at 20. In an earlier case the Indiana Supreme Court held that although the physician-patient privilege statute "is limited in its wording to only 'physician[s]' who are called upon to testify," the privilege "naturally extends to those acting as an agent or arm of the physician when he is in consultation with or is treating a patient." Green v. State, 274 N.E.2d 267, 272 (Ind. 1971). The *Darnell* court acknowledged this interpretation of the privilege, but concluded that there had not been a sufficient showing of physician supervision and control over the nurse to bring her testimony within the protection of the privilege. *See Darnell*, 674 N.E.2d at 21-22.

[212] *See supra* notes 183–187 and accompanying text.

[213] *See Darnell*, 674 N.E. 2d at 22. In reaching this result, the court concluded that because nurses were not listed among those protected in the physician-patient privilege statute itself, "the legislature did not intend to make all communications between nurses and patients privileged." *Id.*

[214] 4 F.2d 215 (9th Cir. 1925); *see supra* notes 112–124 and accompanying text.

[215] 72 N.E.2d 245 (Ohio 1947); *see supra* notes 152–158 and accompanying text.

[216] *See Darnell*, 674 N.E.2d at 22 ("[T]he decision to create a privilege covering an entirely new class of persons should be left to the legislature. . . . As a result, we must decline [the appellant's] invitation and leave such policy decisions to the legislature."); *cf.* Watters v. Dinn, 633 N.E.2d 280, 287 n.3 (Ind. Ct. App. 1994) (concluding that "any extension of the statutory physician-patient privilege to third parties must come from the Legislature"). The outcome in *Darnell* is consistent with the analysis in an earlier case in which the Indiana Court of Appeals concluded that whether nurses should be included within the class of persons protected by the physician-patient privilege was "a matter solely for the legislature and the statute could be extended to

B. Some State Legislatures Have Expanded the Physician-Patient Privilege

There certainly have been instances in which state legislatures, including the Indiana General Assembly,[217] have acted to extend the protection of the physician-patient privilege to nurses and other nonphysician health care providers.[218] In 2016, the Ohio General Assembly amended that state's privileged communications statute to include within its protection a patient's communications with an advanced practice registered nurse.[219] This amendment presumably was enacted in response to the conclusion reached in *Weis*[220] and other Ohio cases[221] that the statute as originally enacted did not protect confidential nurse-patient communications.[222]

Other state legislatures have enacted similar legislation.[223] In Colorado, for example, the physician-patient privilege statute originally provided that a "physician or

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cover nurses only by it and not by judicial construction." Gen. Accident, Fire & Life Assurance Co. v. Tibbs, 2 N.E.2d 224, 233 (Ind. Ct. App. 1936).

[217] *See, e.g.*, State v. Pelley, 828 N.E.2d 915, 918 (Ind. 2005) (noting that the Indiana legislature has "extended to counselors the same privilege that exists for physicians" (discussing IND. CODE § 25-23.6-6-1)); Whitehead v. State, 511 N.E.2d 284, 294 (Ind. 1987) ("[B]y enacting Ind. Code § 25-33-1-17, the Legislature has extended the [physician-patient] privilege to cover confidences made to certified psychologists.").

[218] *See, e.g.,* Ladner v. Ladner, 436 So.2d 1366, 1373 n.3 (Miss. 1983) ("[A] new amendment to the statute, to take effect on July 1, 1983, will extend application of the privileged communications statute to other health care providers, such as pharmacists." (citing Act of Mar. 9, 1983, 1983 Miss. Laws ch. 327)); Rogers v. State, 255 P.3d 1264, 1267 (Nev. 2011) ("Over the years, the [Nevada] Legislature has expanded the definition of 'doctor' for purposes of the doctor-patient privilege from the narrow Nevada-licensed 'physician or surgeon' definition . . . to encompass any person licensed under the laws of any state or nation to practice medicine, dentistry, or osteopathy, or who is employed as a psychiatric social worker." (citing NEV. STAT. § 49.215(2))).

[219] *See* H.R. 216, 131st Gen. Assemb., Reg. Sess. (Ohio 2016) (codified at OHIO REV. STAT. ANN. § 2317.02(B)). The terms "advanced practice nurse" and "nurse practitioner" are occasionally used interchangeably. *See* Battaglia, *supra* note 195, at 1132 n. 31. However, "[t]he term 'advanced practice nurse' is actually an umbrella term which covers a wide variety of nursing distinctions, namely [nurse practitioners], clinical nurse specialists, nurse midwives, and nurse anesthetists[.]" *Id.*

[220] 72 N.E. 245 (Ohio 1947); *see supra* notes 152–158 and accompanying text.

[221] *See, e.g.,* State v. McKinnon, 525 N.E.2d 821, 823 (Ohio Ct. App. 1987) ("Comments made to a nurse in the performance of her duties are not privileged unless the nurse is also a physician or nurse." (citing Weis v. Weis, 72 N.E.2d 245, 252 (Ohio 1947)); *see also* Knecht v. Vandalia Med. Ctr., 470 N.E.2d 230, 232 (Ohio Ct. App. 1984) ("It has been held that the provisions against testifying in [the physician-patient privilege] statute do not apply to a nurse." (citing Weis v. Weis, 72 N.E.2d 245 (Ohio 1947)).

[222] *See generally* Doe v. White, 647 N.E.2d 198, 202 (Ohio Ct. App. 1994) ("[I]t is presumed that the legislature is fully aware of any prior judicial interpretation of an existing statute when enacting an amendment."), *leave to appeal denied*, 645 N.E.2d 1259 (Ohio 1995).

[223] *See, e.g.*, State v. Odenbrett, 349 N.W.2d 265, 268 n.3 (Minn. 1984). "The current language of our physician-patient privilege was enacted in 1919 . . . Since then, in more recent years, the psychologist and registered nurse privileges have been added." *Id. See also* Keshecki v. St. Vincent's Med. Ctr., 785 N.Y.S.2d 300, 302 (Sup. Ct. 2004). "The physician/patient confidentiality privilege has been codified for over one hundred and seventy-five years. The confidentiality statute has been extended to other health care providers to include dentists, podiatrists, chiropractors and nurses . . ." *Id.* (footnote omitted).

surgeon" could not be examined without the patient's consent "as to any information acquired in attending the patient, which was necessary to enable him to prescribe or act for the patient."[224] Construing this language narrowly,[225] the Colorado Supreme Court held that the statute did "not include a nurse or medical technician."[226] The Colorado legislature subsequently amended the statute,[227] presumably in response to this interpretation,[228] "to include within the statutory privilege communications made to a registered professional nurse."[229]

C. Relatively Few State Legislatures Have Recognized Nurse-Patient Privilege

The occasional enactment of nurse-patient privilege statutes has led some commentators to predict that the privilege eventually will be recognized on a much

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[224] *See* COLO. REV. STAT. ANN. § 154-1-7(5) (1963), *quoted in* Quinn, *supra* note 95, at 350.

[225] *See* People v. Covington, 19 P.3d 15, 19 (Colo. 2001) ("Because the physician-patient privilege is statutory, courts should construe it narrowly."); People v. Garrison, 109 P.3d 1009, 1014 (Colo. Ct. App. 2004) ("The patient physician privilege is a statutory creation in derogation of the common law. A statute in derogation of the common law must be strictly construed to limit its application to the clear intent of the General Assembly.") (citation omitted).

[226] Block v. People, 240 P.2d 512, 514 (Colo. 1951), *superseded in part by statute*, Ch. 173, § 1, 1983 Colo. Sess. Laws 636-37, *as recognized in* People v. Deadmond, 683 P.2d 763, 769 n.7 (Colo. 1984). One commentator explained the reasoning underlying this interpretation of the privilege in the following terms:

> [I]nformation given by a patient to his chiropractor or dentist, in the course of treatment, is often considered by the patient to be as confidential as information given to his physician. Under many circumstances, the same can be said of information given to a chiropodist, optometrist or nurse. However, to extend the privilege statute to those professions merely because of the confidential nature of the relationship engendered by these professions would constitute a rather blatant disregard of the express "physician or surgeon" provision of the statute.

Quinn, *supra* note 95, at 352.

[227] *See generally* COLO. REV. STAT. § 13-90-107(1)(d). Like their counterparts in other jurisdictions, the Colorado courts typically leave modifications of the state's privilege statutes to the legislature. *See, e.g.*, Sherman v. Dist. Ct., 637 P.2d 378, 384 (Colo. 1981). "In view of the selective approach which the General Assembly has adopted in creation of privileges relating to physicians and hospitals, and the general policy of our rules favoring liberal discovery, we conclude that it would not be appropriate to expand the area of privilege absent legislative action." *Id.*

[228] *See* Union Pac. R.R. Co. v. Martin, 209 P.3d 185, 188-89 (Colo. 2009). "[W]here an existing statute has already undergone construction by a final judicial authority, further legislative amendment necessarily reflects the legislature's understanding of that construction, or perhaps simply disagreement with how [the statute] is being (or fear of how it is likely to be) interpreted by other courts." *Id.*

[229] Clark v. Dist. Ct., 668 P.2d 3, 8 n.4 (Colo. 1983) (discussing COLO. REV. STAT. § 13-90-107(1)(d)); *see also* Cochran, *supra* note 48, at 193. "The scope of the doctor-patient privilege varies from state to state . . .. In some states the privilege is limited to doctor-patient only . . . [I]n other states, nurses are included (e.g., in Colorado)." *Id.*

broader scale.[230] However, the nearly universally recognized authority of state legislatures to create new evidentiary privileges and expand existing ones[231] has been an impediment to any judicial recognition of the privilege.[232] This phenomenon has prompted one proponent of the privilege to assert that "[r]ather than relying on the courts to make a determination, statutory nurse-patient privileges must be codified in all the states, taking the discretion, along with the uncertainty and inconsistency that go with it, out of the courts' hands."[233]

There is certainly some force to this argument.[234] Indeed, some states have abandoned the concept of common law privileges altogether,[235] making the adoption of

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[230] *See, e.g.*, Pierce, *supra* note 14, at 1097. "The fact that roughly one quarter of the states already recognize a statutory nurse-patient privilege is a promising indication that the remainder of the states may be willing to follow." *Id.* *See also* O'Sullivan, *supra* note 45, at 950.

> Because the main purpose of the privileged communication statutes is to inspire confidence in the patient to encourage making a full account of symptoms and conditions so that they may be properly care[d] for or cured by treatment, and since the trend to provide primary care to clients by nurses continues throughout this country, I believe the states will eventually recognize the nurse clinician-patient privilege as they have the physician-patient privilege.

Id.

[231] *See, e.g.*, Bedell v. Williams, 386 S.W.3d 493, 505 (Ark. 2012). "This court has specifically given the General Assembly the power to enact statutes regarding testimonial privilege." *Id.* (citing ARK. R. EVID. 501)). *See also* D.C. v. S.A., 670 N.E.2d 1136, 1141 (Ill. App. Ct. 1996), *rev'd on other grounds*, 687 N.E.2d 1032 (Ill. 1997) ("[N]o one can dispute that the legislature has the power, through the enactment of evidentiary privileges, to inhibit the truth-seeking process to protect certain relationships."), *rev'd on other grounds*, 687 N.E.2d 1032 (Ill. 1997); Terre Haute Reg'l Hosp., Inc. v. Trueblood, 600 N.E.2d 1358, 1360 (Ind. 1992) ("Indiana generally recognizes that privileges are statutory in nature and that it is within the power of the legislature to create them."); Commonwealth v. Chauvin, 316 S.W.3d 279, 284 (Ky. 2010) ("Kentucky rules allow for the creation of statutory privileges."); State v. Almonte, 644 A.2d 295, 298 (R.I. 1994) ("We do not doubt the power of the legislature to create a privilege as a matter of substantive law."). *But see* Breen v. State Taxation & Revenue Dep't, 287 P.3d 379, 386 (N.M. Ct. App. 2012) ("In New Mexico . . . legislated privileges are generally regarded as an unconstitutional intrusion into judicial rule-making.").

[232] *See, e.g.*, People v. Ackerson, 566 N.Y.S.2d 833, 833 (Monroe Cty. Ct. 1991) (declining to "judicially extend" the protection of New York's physician-patient privilege to other health care providers because the legislature had "shown a willingness to be explicit in creating and extending evidentiary privileges"); State v. Ross, 947 P.2d 1290, 1293 (Wash. Ct. App. 1997) (declining to expand physician-patient privilege, as legislature may extend literal language of the statute).

[233] Pierce, *supra* note 14, at 1096.

[234] *See* Montebello Rose Co. v. Agric. Labor Relations Bd., 173 Cal. Rptr. 856, 876 (Ct. App. 1981) ("The creation of a privilege is a legislative matter."); People *ex rel.* Birkett v. City of Chi., 705 N.E.2d 48, 53 (Ill. 1998) (asserting that "the creation of a new privilege is presumptively a legislative task"); J. Tyson Covey, Note, *Making Form Follow Function: Considerations in Creating and Applying a Statutory Parent-Child Privilege*, 1990 U. ILL. L. REV. 879, 899 ("[S]tatutory enactment of a . . . privilege is preferable to case-by-case development of a common law privilege because statutes can be general, create consistency, and be tailored to achieve specific goals.").

a nurse-patient privilege – or any other previously unrecognized evidentiary privilege – entirely dependent upon legislative action.[236] Even in states where the courts retain the authority to create privileges,[237] they typically defer the recognition of any new privilege to the legislature.[238]

Unfortunately, state legislatures have shown relatively little enthusiasm for the nurse-patient privilege.[239] The Tennessee legislature enacted a statute in 1995 that protects a patient's confidential communications with a nurse specializing in "psychiatric and mental health nursing,"[240] but it has never extended the protection of a comparable privilege to nurses generally.[241] Numerous other state legislatures have refused or failed

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[235] *See, e.g.*, McNair v. NCAA, 183 Cal. Rptr. 3d 490, 498 (Ct. App. 2015) ("[T]he California Legislature has abolished common law privileges and precluded courts from creating new nonstatutory privileges as a matter of judicial policy."); Citizens Commc'ns Co. v. Att'y Gen., 931 A.2d 503, 506 (Me. 2007) (noting that Maine has "eliminated all common law privileges" (construing ME. R. EVID. 501)); *see also* Reichhold Chems., Inc. v. Textron, Inc., 157 F.R.D. 522, 528 (N.D. Fla. 1994) ("Florida courts are forbidden from adopting new privileges by judicial decision."); State v. Migliorino, 489 N.W.2d 678, 682 (Wis. Ct. App. 1992) ("Testimonial privileges in Wisconsin may not be created by judicial decision . . . .").

[236] *See, e.g.*, Marshall v. Anderson, 459 So.2d 384, 387 (Fla. Dist. Ct. App. 1984) (discussing a statute that "abolishes all common-law privileges in Florida and makes the creation of privileges dependent upon legislative action or pursuant to the Supreme Court's rule-making power" (quoting FLA. STAT. § 90.501 Law Revision Council Note)); Scroggins v. Uniden Corp. of Am., 506 N.E.2d 83, 86 (Ind. Ct. App. 1987) ("Research has not produced a single privilege in Indiana that is not statutory . . . . All privileges are statutory and the creation thereof is [within] the sole power of the legislature."); Sessoms v. Allstate Ins. Co., 624 So.2d 516, 523 (Miss. 1993) (McRae, J., dissenting) ("Only the legislature has the power to bestow the privilege of confidence on records or communications.").

[237] *See, e.g.*, Ill. Educ. Labor Relations Bd. v. Homer Cmty. Consol. Sch. Dist., 547 N.E.2d 182, 185 (Ill. 1989) ("[T]his court will recognize a privilege to protect communications in certain rare instances . . . ."); Babets v. Sec'y of Exec. Office of Human Servs., 526 N.E.2d 1261, 1264 (Mass. 1988) ("Although this court has the power to create a privilege, it is a power that we have exercised sparingly . . . ."); State v. Darden, 41 P.3d 1189, 1196 (Wash. 2002) ("Although most evidentiary privileges in Washington are statutory, this court does have the power to recognize a privilege when doing so is clearly warranted.").

[238] *See, e.g.*, *Babets*, 526 N.E.2d at 1264 ("We have consistently concluded that the creation of . . . privileges ordinarily is better left to the Legislature."); People v. Dixon, 411 N.W.2d 760, 763 (Mich. Ct. App. 1987) ("[W]e note that the exclusion of evidence by evidentiary privileges is largely governed by statute. Accordingly, we believe that the recognition of a new privilege is best deferred to the Legislature.") (citation omitted); *In re* Gail D., 525 A.2d 337, 339 (N.J. Super. Ct. App. Div. 1987) ("[T]he recognition of a privilege not . . . firmly embedded in the common-law has usually been the subject of judicial restraint and deferral to the Legislature.").

[239] *See* Morse, *supra* note 18, at 745 (noting that "only a few states have . . . create[d] a statutory [nurse-patient] privilege"); Pierce, *supra* note 14, at 1099 (recognizing that state legislatures "may be reluctant to introduce the privilege").

[240] *See* S. 902, 99th Gen. Assemb., Reg. Sess. § 1(a) (Tenn. 1995) (codified at TENN. CODE ANN. § 63-7-125(a)).

[241] *See* Smith, *supra* note 15, at 28 ("Tennessee nurses attempted to introduce a statute of privileged communication for nurses. . . . The bill was withdrawn without being passed." (discussing sub silentio H.B. 1117, 96th Gen. Assemb., Reg. Sess. (Tenn. 1989))). In fact, "no testimonial privilege protecting *doctor*-patient communications has ever been . . . declared by Tennessee statute." Alsip v. Johnson City Med. Ctr., 197 S.W.3d 722, 725 (Tenn. 2006)

to enact a broadly applicable nurse-patient privilege,[242] although a few have joined their Tennessee counterpart in recognizing a privilege protecting a patient's confidential communications with a nurse providing mental health care.[243]

Even in states with nurse-patient privilege statutes,[244] near-herculean efforts occasionally have been required in order to get those statutes enacted.[245] In short, while legislatures may "create privileges involving professionals beyond the usual privileges for lawyers, doctors, and psychiatrists fairly regularly,"[246] nurses must "continually fight and lobby for the right to practice their profession,"[247] including for the critical ability to maintain the confidentiality of their patients' private health-related communications.[248]

(emphasis altered), *superseded by statute on other grounds*, TENN. CODE ANN. § 29-26-121(f). However, there is a Tennessee statute protecting a patient's confidential communications with a physician who is "practicing as a psychiatrist in the course of and in connection with a therapeutic counseling relationship." TENN. CODE ANN. § 24-1-207(a).

[242] *See, e.g.*, Darnell v. State, 674 N.E.2d 19, 20 (Ind. Ct. App. 1996) (noting that "the [Indiana] legislature has not expressly created a provision to protect communications between a nurse and a patient"); Myers v. State, 310 S.E.2d 504, 505 (Ga. 1984) ("Georgia has no statute making a patient's statement to his nurse privileged."); Furci, *supra* note 87, at 241 ("The New Jersey statute, enacted in 1968, recognizes a limited privilege for information obtained by physicians during the course of treating their patients. . . . [T]here is no specific privilege extended to the nurse-patient relationship.").

[243] *See* Pierce, *supra* note 14, at 1084 n.51 (identifying "nine states [that] extend [a] privilege to registered nurses who are specifically working in the mental health field"). For example, Minnesota's legislature enacted a privilege that applies to a "registered nurse . . . engaged in a psychological or social assessment or treatment of an individual at the individual's request." State v. Expose, 849 N.W.2d 427, 432 (Minn. Ct. App. 2014) (quoting MINN. STAT. § 595.02 subd. 1(g)), *aff'd as modified*, 872 N.W.2d 252 (Minn. 2015). *See also* Sheets v. Commonwealth, 495 S.W.3d 654, 670 n.6 (Ky. 2016) (noting that Kentucky's psychotherapist-patient privilege applies "to confidential communications made for the purpose of diagnosis or treatment by . . . a licensed registered nurse or advanced registered nurse who practices psychiatric or mental-health nursing" (citing KY. R. EVID. 507(a)(2)(D)).

[244] *See generally Developments in the Law – Privileged Communications, supra* note 52, at 1533-34 (observing that "a few state statutes include . . . registered nurses" among the persons protected by an evidentiary privilege).

[245] *See, e.g.*, Stern, *supra* note 53, at 24 (discussing, *sub silentio*, H.R. 126, 1990 Reg. Sess. Ch. 300 (Md. 1990) (codified at MD. CODE ANN., CTS. & JUD. PRAC. § 9-109.1)). "Following three attempts in the Maryland General Assembly, a bill was finally passed in April 1990 that provides for privileged communication for clients of psychiatric/mental health nursing specialists." *Id.*

[246] *See* Covey, *supra* note 234, at 898; *see, e.g.*, Runyon v. Smith, 730 A.2d 881, 888 (N.J. Super. Ct. App. Div. 1999) ("In enacting the psychologist-patient privilege and other professional-client privileges, the Legislature changed the policy of this State."); *see also* Deborah A. Ausburn, Note, *Circling the Wagons: Informational Privacy and Family Testimonial Privileges,* 20 GA. L. REV. 173, 174 (1985) (asserting "[p]rivileges for professional relationships have multiplied"); Marianne E. Scott, Comment, *Parent-Child Testimonial Privilege: Preserving and Protecting the Fundamental Right to Family Privacy*, 52 U. CIN. L. REV. 901, 902 (1983) (discussing "the expansion of professional testimonial privileges.").

[247] *See* Zand, *supra* note 197, at 261-62; *cf.* Linda H. Aiken & William M. Sage, *Staffing National Health Care Reform: A Role for Advanced Practice Nurses*, 26 AKRON L. REV. 187, 199 (1992) (asserting legal, financial and professional barriers operate "to prevent advanced practice nurses from being utilized to their full potential.").

[248] *See* Stern, *supra* note 53, at 24 (asserting nurses must "use their political clout to develop and implement a national strategy for protecting the confidential communication of clients" and

D. Possible Explanations for the Infrequent Legislative Recognition of Nurse-Patient Privilege

Some states' privilege statutes may not encompass nurses simply because the nursing profession "had scarcely come into being" at the time the statutes were enacted,[249] and would-be reformers often have difficulty persuading legislators to amend existing statutes to reflect changing societal conditions.[250] One commentator described the phenomenon this way:

> [T]he legislative process writ large is generally characterized by inertia. Change requires not only the identification and analysis of problems and potential solutions, but, even more importantly in the political arena, a coalescence of support sufficient to enact a measure. Given the usual context within [which] legislators must act – a context reflecting multiple agendas and interests, as well as finite political or suasion capital – it is often easier to "let things be" than to marshal the forces required for change.[251]

In other jurisdictions the lack of a nurse-patient privilege may be at least partly the result of opposition from the American Medical Association ("AMA")[252] and other

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"promote their right to statutory privileged communication"); Pierce, *supra* note 14, at 1099 ("Implementing the nurse-patient privilege may face various obstacles. . . . Although there is statutory precedent in various states, this does not mean that those states without the privilege will necessarily follow.").

[249] *See* Culver v. Union Pac. R.R. Co., 199 N.W. 794, 797 (Neb. 1924); *see also* DEMARCO ET AL., *supra* note 18, at 211 ("The reason that in most states information disclosed to a nurse is not protected by the right of confidentiality may be related to the fact that only relatively recently have nurses been considered professionals in their own right, with their own standard of care.").

[250] *See* Yoli v. Yoli, 285 N.Y.S.2d 470, 474 (Spec. Term Kings Cty. 1967) (observing "often much legislative inertia must be overcome to bring about an amendment: the legislature has to relearn the problem; and new, pressing matters may crowd out for years a consideration of an existing statute" (quoting JEROME FRANK, COURTS ON TRIAL: MYTH AND REALITY IN AMERICAN JUSTICE 307 (1949))); *see also* Justin Driver, *Constitutional Outliers*, 81 U. CHI. L. REV. 929, 958 n.145 (2014) ("[S]tatutes are 'hard to amend or repeal' and '[c]onsequently, a statute may stay on the books indefinitely even though it has become out of step with current public policy[.]'" (quoting DANIEL A. FARBER & PHILIP P. FRICKEY, LAW AND PUBLIC CHOICE: A CRITICAL INTRODUCTION 106 (1991)).

[251] Barbara J. Safriet, *Federal Options for Maximizing the Value of Advanced Practice Nurses in Providing Quality, Cost-Effective Health Care*, *in* INST. OF MED., THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 443, 456 (2011).

[252] *See* Oregon v. Azar, 389 F. Supp. 3d 898, 916 (D. Or. 2019). The AMA is the largest professional medical organization in the country. *Id.* Physicians' lobbying efforts and their "presence in the political arena allows them to be successful in their pursuit." Robert A. Wade, Note, *The Ohio Physician-Patient Privilege: Modified, Revised, and Defined*, 49 OHIO ST. L.J. 1147, 1151 n.32 (1989). Many state medical associations also have "significant lobbying influence." A.J. Barbarito, Note, *The Nurse Will See You Now: Expanding the Scope of Practice for Advanced Practice Registered Nurses*, 40 SETON HALL LEGIS. J. 127, 144 (2015). See Note, *The American Medical Association: Power, Purpose, and Politics in Organized Medicine*, 63 YALE L.J. 938 (1954) for a somewhat dated scholarly examination of the AMA's political influence.

professional physicians' organizations.[253] Motivated in part by their members' economic interests,[254] these organizations have consistently – and often successfully[255] – opposed the expansion of legally authorized nursing practice.[256] This opposition presumably encompasses resistance to the recognition of an evidentiary privilege that would enhance the professional status of nurses,[257] who increasingly compete with physicians not only in the provision of primary health care services,[258] but in other more specialized practice areas as well.[259]

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[253] *See* Pierce, *supra* note 14, at 1099 ("[An] obstacle to implementing the privilege is the possible intervention by medical associations."); *cf.* Mary Beck, *Improving America's Health Care: Authorizing Independent Prescriptive Privileges for Advanced Practice Nurses*, 29 U.S.F. L. REV. 951, 976 (1995) ("Organized medicine's anticompetitive policies are . . . reflected in the legislative stances adopted by some state medical associations.").

[254] *See* James L.J. Nuzzo, *Independent Prescribing Authority of Advanced Practice Nurses: A Threat to the Public Health?*, 53 FOOD & DRUG L.J. 35, 38 (1998) (asserting "doctors' legitimate desire to protect patients' welfare is intermingled extensively with physicians' economic self-interest."); Ritter & Hansen-Turton, *supra* note 202, at 22 ("Financial self-interest and concerns about competition may play a role in physicians' opposition to increased clinical independence for nurse practitioners."); Zand, *supra* note 197, at 272 ("Publicly, the AMA takes [the] position . . . that [nurse practitioners] lack the appropriate education to properly medically supervise patients. However, financial self-interest and competition clearly play a role.").

[255] *See* Randall G. Holcombe, *Eliminating Scope of Practice and Licensing Laws to Improve Health Care*, 31 J.L. MED. & ETHICS 236, 243 (2003) (noting laws regulating the scope of nursing practice "restrict the allowable activities of nurses, so they are less effective competition for physicians."); *see also* Tricia Owsley, *The Paradox of Nursing Regulation: Politics or Patient Safety?*, 34 J. LEGAL MED. 483, 499 (2013):

> Legislators unfamiliar with nursing practice are confronted with what can be very technical changes when issues regarding nursing and medicine arise. This process may exacerbate the power differentials seen in lobbying efforts as physicians, with traditionally more lobbying resources and established networks, may continue to have more influence when they express concerns about technical proposals to lay lawmakers.

Id.

[256] *See* David A. Hyman & Charles Silver, *And Such Small Portions: Limited Performance Agreements and the Cost/Quality/Access Trade-Off*, 11 GEO. J. LEGAL ETHICS 959, 976 (1998) (noting that "the medical profession has long opposed advanced practice nursing"); *see also* Ritter & Hansen-Turton, *supra* note 202, at 22 ("The American Medical Association ('AMA') and representatives from state medical societies and specialty organizations have been the most vocal opponents to the expansion of the nurse practitioner role."); *see also* Pierce, *supra* note 14, at 1100 n.132 (stating that the AMA has "worked to defeat proposed legislation for scope of practice expansion in multiple states for healthcare providers including nurses").

[257] *See* Pierce, *supra* note 14, at 1099 ("The same groups that oppose expanding the scope of care of nurse practitioners may also oppose expanding or creating a nurse-patient privilege."); *cf.* Amanda H. Frost, *Updating the Marital Privileges: A Witness-Centered Rationale*, 14 WIS. WOMEN'S L.J. 1, 19 (1999) ("[P]rofessional privileges enhance the status of . . . groups with . . . political clout to get them enacted into law."); *see generally* Brian Domb, Note, *I Shot the Sheriff, But Only My Analyst Knows: Shrinking the Psychotherapist-Patient Privilege*, 5 J.L. & HEALTH 209, 211 (1991) (noting that "modern commentators have described the evidentiary privileges as originating from competing professional jealousies.").

[258] *See* Tine Hansen-Turton et al., *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1235, 1237 (2010) ("Since the early 1970's, nurse practitioners have assumed a prominent place in primary health care across the country, providing medical care and treatment independent of a physician's

VIII. The Courts' Potential Role in Recognizing Nurse-Patient Privilege

A. The Courts' Institutional Authority to Recognize New Privileges

Legislatures are policy-making institutions susceptible to the influence of powerful special interest groups,[260] and there is little reason to expect the legislative recognition of evidentiary privileges to be free from that influence.[261] Thus, it should come as no surprise that the lobbying efforts of the AMA and other powerful professional organizations have played, and are likely to continue to play,[262] a significant role in the development of statutory privilege law.[263]

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supervision."); Julie A. Muroff, *Retail Health Care: Taking Stock of State Responsibilities*, 30 J. LEGAL MED. 151, 163 (2009) (discussing "ability of nurse practitioners to compete against physicians . . . in conventional primary care settings").

[259] *See, e.g.*, Wicker v. Union Cty. Gen. Hosp., 673 F. Supp. 177, 179 (N.D. Miss. 1987) ("[N]urse anesthetists, physician anesthesiologists . . . may administer anesthesia. Nurse anesthetists compete with such other providers."); Brenda J. Glaser-Abrams, Comment, *Hospital Privileges for Nurse-Midwives: An Examination under Antitrust Law*, 33 AM. U. L. REV. 959, 960 (1984) ("In providing . . . services, nurse-midwives compete with physicians who provide obstetrical services to the same population.").

[260] *See, e.g.*, MacDonald v. City Hosp., Inc., 715 S.E.2d 405, 430 (W. Va. 2011) (Wilson, J., dissenting) (describing an instance where a state legislature "succumbed to tremendous pressure from the medical profession"); *see also* Shands Teaching Hosp. & Clinics v. Smith, 480 So. 2d 1366, 1373 (Fla. Dist. Ct. App. 1985) (*approved*, 497 So. 2d 644 (Fla. 1986)) ("[L]egislative process is . . . exposed to pressures from interested persons and organizations encouraging responsiveness to the community.").

[261] *See In re* Grand Jury Subpoena, 722 N.E.2d 450, 456 n.13 (Mass. 2000) ("In a society with egalitarian pretensions, the creation and justification of a privilege . . . is essentially a political question; i.e., it is an allocation of the power as between the various components of the society." (quoting Timothy J. Flynn, Comment, *The Parent-Child Testimonial Privilege: A Survey of Its Acceptance by the Courts*, 19 LINCOLN L. REV. 123, 127 (1991))); Charles Nesson, *Modes of Analysis: The Theories and Justifications of Privileged Communications*, 98 HARV. L. REV. 1471, 1494 (1985) ("The . . . majority of new privileges have been created by statute, a process that . . . requires the exercise of political power.") (footnote omitted).

[262] *See* Christopher D. Jones, *Recent Development, Jaffee v. Redmond: The Supreme Court Adopts a Testimonial Privilege for Psychotherapists and Extends the Privilege to Licensed Social Workers*, 23 J. CONTEMP. L. 252, 266 (1997) ("Well-organized and well-financed interests could have some substantial influence on the creation of future testimonial privileges.").

[263] *See, e.g.,* Dru Brenner-Beck, *"Shrinking" the Right to Everyman's Evidence: Jaffee in the Military*, 45 A. F. L. REV. 201, 207 (1998) ("American common law courts refused to recognize a general doctor-patient privilege. In response to intense lobbying by the American Medical Association, state legislatures rapidly moved into this void, creating statutory privileges protecting the doctor-patient relationship."); Wade, *supra* note 252, at 1151 ("[One] basis for the [physician-patient] privilege lies in the degree of influence that the medical profession wields in the various state legislatures. Physicians lobby for the privilege, and their presence in the political arena allows them to be successful in their pursuit."); *see also* Jones, *supra* note 262, at 266 ("Well-organized and well-financed interests could have some substantial influence on the creation of future testimonial privileges.").

Nevertheless, the medical profession's presumed opposition to any broader recognition of the nurse-patient privilege is regrettable,[264] and the profession's disproportionate influence in the legislative arena casts doubt on the view – widely held by both courts and commentators[265] – that legislatures are better suited than courts to balance the competing policy interests involved in the recognition and development of evidentiary privileges.[266] In contrast to legislatures,[267] courts are relatively insulated from the lobbying efforts of the AMA[268] and other organizations "concerned about the special interests of their professions,"[269] and therefore may be a more inviting forum for those seeking broader recognition of the nurse-patient privilege.[270] As one court explained:

> Certain fundamental differences between courts and legislatures must be recognized. For profound and historical reasons, courts have been

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[264] *See* Pierce, *supra* note 14, at 1100 ("[A]rguments . . . against the implementation of the nurse-patient privilege only hurt . . . patients in the long run."); *cf.* Barbarito, *supra* note 252, at 128-29 (questioning whether physicians who oppose expanding the nursing practice "have patients' best interests in mind").

[265] *See, e.g.*, Cruey v. Gannett Co., 76 Cal. Rptr. 2d 670, 678 (Ct. App. 1998) ("[O]ur Supreme Court has made clear that creation or expansion of existing statutory privileges involve matters of public policy more appropriately deferred to legislative judgment." (citing Slaughter v. Friedman, 649 P.2d 886 (Cal. 1982))); People v. Sanders, 457 N.E.2d 1241, 1245 (Ill. 1983) ("The expansion of existing privileges and acceptance of new ones involves a balancing of public policies which should be left to the legislature."); Anne Bowen Poulin, *The Psychotherapist-Patient Privilege After* Jaffee v. Redmond: *Where Do We Go From Here?*, 70 WASH. U. L.Q. 1341, 1341 (1998) ("Privilege law is particularly suited for statutory treatment; it embodies policy choices and details of application that are best addressed by the legislature.").

[266] *See* Moses v. Albert Einstein Med. Ctr., 25 Phila. Cty. Rep. 389, 406 n.69 (Pa. C.P. 1993) ("[L]egislators have on occasion been unduly influenced by powerful groups seeking the prestige and convenience of a professionally-based privilege." (quoting 1 JOHN W. STRONG, MCCORMICK ON EVIDENCE § 75, at 282 (4th ed. 1992))); Morse, *supra* note 18, at 751 ("[L]egislatures provide a forum for the necessary balancing of societal values concerning privileges. However, . . . legislatures have been influenced by special interest groups and politics in the past."); Jones, *supra* note 262, at 260 ("[S]tatutory privileges may be more the result of the lobbying efforts of organized interest groups than an objective search for a balance between social policy and truth.").

[267] *See generally* Milner v. Apfel, 148 F.3d 812, 814 (7th Cir. 1998) (noting that the "conditions under which legislatures operate . . . include interest-group pressures"); Nat'l Ass'n of Social Workers v. Harwood, 69 F.3d 622, 645 (1st Cir. 1995) (Lynch, J., dissenting) ("Lobbying aims at influencing the votes of legislators; it attempts to affect the outcome of the political processes.").

[268] *See, e.g.*, Carhart v. Stenberg, 972 F. Supp. 507, 525 n.27 (D. Neb. 1997) ("The political statements of the AMA (or any other professional group) are irrelevant to our decision."); *see also* Raymond F. Miller, Comment, *Creating Evidentiary Privileges: An Argument for the Judicial Approach*, 31 CONN. L. REV. 771, 788 (1999) ("[T]he judiciary is more insulated from the pressures of the medical lobby than the legislature.").

[269] Kenneth S. Broun, *Giving Codification a Second Chance—Testimonial Privileges and the Federal Rules of Evidence*, 53 HASTINGS L.J. 769, 770 (2002); *see also* Braswell v. Haywood Reg'l Med. Ctr., 352 F. Supp. 2d 639, 649 (W.D.N.C. 2005) (noting the "insulation from political influence . . . typically found in judicial bodies"); Morse, *supra* note 18, at 757 ("[C]ourts, unlike legislatures, are . . . less sensitive to political pressures.").

[270] *See generally* Miller, *supra* note 268, at 788-89 ("[T]he judicial recognition of evidentiary privileges is superior to legislative action. The judiciary is more insulated from powerful political lobbies and thus can be more objective than the necessarily partisan legislature.").

> substantially protected from outside pressures, providing an atmosphere in which relatively pure, disinterested legal decisions can be made. . . . Somewhat isolated from the political process, courts can more easily ignore current waves of political passion and focus on fundamental questions.[271]

This premise is embodied in the federal law of evidence,[272] which favors the judicial development of evidentiary privileges.[273] Specifically, in enacting Rule 501 of the Federal Rules of Evidence[274] Congress delegated to the courts the primary responsibility for creating new federal privileges and modifying existing ones.[275] In doing so, Congress

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[271] Shands Teaching Hosp. & Clinics v. Smith, 480 So. 2d 1366, 1373 (Fla. Dist. Ct. App. 1985), *approved*, 497 So.2d 644 (Fla. 1986); *cf.* Elizabeth Kimberly (Kyhm) Penfil, *In the Light of Reason and Experience: Should Federal Evidence Law Protect Confidential Communications Between Same-Sex Partners?*, 88 MARQ. L. REV. 815, 825 (2005):

> Scholars, too, have recognized that the judiciary, because it can better explain the rationales for privileges, because it minimizes the influence of politically powerful groups who lobby for privileges, and because it can create more flexible privileges than those enacted via legislation, is in a better position than the legislature to develop evidence law.

Id. (citing Miller, s*upra* note 268, at 781-92).

[272] *See generally* FED. R. EVID. 501. Deferring the recognition of testimonial privileges to the legislature is primarily a state law phenomenon; virtually all federal privileges "are the product of common law development." Stidham v. Clark, 74 S.W.3d 719, 723 (Ky. 2002); *see also* Marshall v. Anderson, 459 So.2d 384, 386 n.7 (Fla. Dist. Ct. App. 1984) ("[V]irtually the entire federal law of privilege is based upon the common law rather than either rule or statute.").

[273] *See Hartsock* v. Goodyear Dunlap Tires N. Am. Ltd., 813 S.E.2d 696, 699 (S.C. 2018) (quoting Baldridge v. Shapiro, 455 U.S. 345, 360 (1982)). There is no question that "'a privilege may be created by statute' as deemed appropriate by Congress." *Id. See also* Mia Anna Mazza, Comment, *The New Evidentiary Privilege for Environmental Audit Reports: Making the Worst of a Bad Situation*, 23 ECOLOGY L.Q. 79, 115 (1996) (observing that "the federal legislature, like many state legislatures, is allowed to create statutory privileges"). Nevertheless, Congress "has preferred to leave to the courts questions of which privileges to recognize." *In re* Sealed Case, 676 F.2d 793, 807 n.45 (D.C. Cir. 1982). *Cf.* Davisson, *supra* note 69, at 695 n.72 ("States have slowly progressed to statutory privileges in the majority of scenarios. However, the federal courts . . . maintain a common law approach to the enforcement of existing privileges and the creation of new privileges.").

[274] FED. R. EVID. 501. Congress enacted the federal rule in 1975 in lieu of adopting a series of enumerated privileges the Supreme Court had proposed. *See In re* Grand Jury Subpoena, Judith Miller, 397 F.3d 964, 978 (D.C. Cir. 2005), *superseded*, 438 F.3d 1141 (D.C. Cir. 2006) (Sentelle, J., concurring); *In re* Grand Jury No. 91-1, 795 F. Supp. 1057, 1058 (D. Colo. 1992). See Edward J. Imwinkelried, *Draft Article V of the Federal Rules of Evidence on Privileges, One of the Most Influential Pieces of Legislation Never Enacted: The Strength of the Ingroup Loyalty of the Federal Judiciary*, 58 ALA. L. REV. 41 (2006) for a comprehensive discussion of the rule's enactment and the continuing influence of the enumerated privileges that Congress declined to adopt.

[275] *See* FED. R. EVID. 501. The rule states, in relevant part, that unless otherwise provided by the United States Constitution, a federal statute, or a Supreme Court rule, the "common law – as interpreted by United States courts in the light of reason and experience – governs a claim of privilege" in federal question cases. *Id. See also In re* Grand Jury Subpoena Dated Nov. 14, 1989, 728 F. Supp. 368, 370 (W.D. Pa. 1990) ("Th[e] rule grants to the federal judiciary the

envisioned the type of case-by-case development of federal privilege law that is "central to common-law adjudication,"[276] while largely avoiding the interest group politics that might influence its own recognition and development of evidentiary privileges.[277]

Several states have adopted similar rules,[278] which generally empower the courts in those jurisdictions "to develop common law rules governing . . . privilege."[279] Arizona courts have the authority to recognize new evidentiary privileges under that state's version of Rule 501[280] when doing so would promote "sufficiently important interests to outweigh the need for probative evidence."[281] In this regard, the Arizona Supreme Court has noted its agreement with the principles governing the creation of

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responsibility of developing recognized privileges and formulating new privileges by resorting to the principles of common law interpreted 'in the light of reason and experience.'" (quoting FED. R. EVID. 501)).

[276] *See* Wachtel v. Health Net, Inc., 482 F.3d 225, 230 (3d Cir. 2007); *see also In re* Witness Before Special Grand Jury 2000-2, 288 F.3d 289, 291 (7th Cir. 2002) ("Rule 501 manifests a congressional desire to grant courts the flexibility to determine privileges on a case-by-case basis . . . .").

[277] *See* Mila Sohoni, *The Power to Privilege*, 163 U. PA. L. REV. 487, 494 (2015).

> By . . . letting common law decisionmaking by federal courts set the content of federal privilege law, Congress was able to avoid the difficult task of drafting a set of statutory privilege rules that would please the many powerful interest groups with a stake in the shape of federal privilege law.

Id. *See* Jones, *supra* note 262, at 266 ("Rule 501 itself appears to provide privilege law with insulation from outside political pressure by requiring that new privileges be interpreted [under] the principles of the common law.") (internal quotation marks omitted).

[278] *See, e.g.*, Chesapeake & Ohio Ry. Co. v. Kirwan, 120 F.R.D. 660, 664 (S.D. W. Va. 1988) ("Rule 501, W.Va.R.Ev., in similar fashion to its federal counterpart, provides that . . . privilege 'shall be governed by the principles of the common law except as modified by the Constitution of the United States or West Virginia, statute or court rule.'"); Combined Commc'ns Corp., Inc. v. Pub. Serv. Co. of Colo., 865 P.2d 893, 897 (Colo. App. 1993).

> The federal rules . . . provide that any testimonial privilege "shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in light of reason and experience." The comparable state rule . . . contains a somewhat similar provision.

Combined Commc'ns Corp., Inc., 865 P.2d at 897 (quoting FED. R. EVID. 501)).

[279] *See* Note, *Inadvertent Disclosure of Documents Subject to the Attorney-Client Privilege*, 82 MICH. L. REV. 598, 598 n.1 (1983); *see also* Babets v. Sec'y of Exec. Office of Human Servs., 526 N.E.2d 1261, 1265 n.7 (Mass. 1988) ("In at least ten . . . States, common law jurisdiction in this area has been expressly sanctioned by statute or rule of court.").

[280] *See* Andrew B. Mazoff, *A Common Thread to Weave a Patchwork: Advocating for Testamentary Exception Rules,* 3 PHX. L. REV. 729, 752 n.166 (2010) (identifying Arizona as among the states that have "adopted their own versions of Federal Rule 501").

[281] City of Tucson v. Superior Ct. *ex rel.* Cty. Of Pima, 809 P.2d 428, 432 (Ariz. 1991) (quoting Univ. of Penn. v. E.E.O.C., 493 U.S. 182, 189 (1990)). Under Arizona's version of Rule 501, evidentiary privileges can be created by statute or judicial decision. *See* State v. Carver, 258 P.3d 256, 262 n.9 (Ariz. Ct. App. 2011) (citing, *inter alia*, ARIZ. R. EVID. 501). In this respect, the Arizona rule "is very similar to Rule 501 of the Federal Rules of Evidence." *City of Tucson*, 809 P.2d at 430.

evidentiary privileges announced in *University of Pennsylvania v. EEOC*,[282] where the United States Supreme Court concluded that the federal rule, and thus, by implication, its Arizona counterpart,[283] reflects an intent "to provide the courts with flexibility to develop rules of privilege on a case-by-case basis."[284]

B. Practical Prospects for the Judicial Recognition of a Nurse-Patient Privilege

So what are the realistic prospects for the judicial recognition of a nurse-patient privilege,[285] or for judicially interpreting the physician-patient privilege broadly enough to encompass nurse patient communications?[286] Addressing this question, the author of Arizona's principal evidence law treatise, Morris Udall,[287] argued that a patient's confidential communications with a nurse acting as a "necessary assistant" to a physician should be privileged.[288] Although Udall acknowledged that the recognition of such a privilege might require legislative action,[289] as the Ninth Circuit and a number of other

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[282] 493 U.S. 182 (1990).

[283] *See City of Tucson*, 809 P.2d at 430 ("United States Supreme Court interpretations of the federal version of Rule 501 are persuasive, but not binding on us, in interpreting Arizona's version.").

[284] *Id.* at 430, 431 (quoting *Univ. of Pa.*, 493 U.S. at 189); *cf.* Breen v. State Taxation & Revenue Dep't, 287 P.3d 379, 393 (N.M. Ct. App. 2012) (Sutin, J., concurring) ("In the federal system, 'Rule 501 manifests a congressional desire not to freeze the law of privilege but rather to provide the courts with flexibility to develop rules of privilege on a case by case basis.' The policy should be no different in the New Mexico courts." (quoting *Univ. of Pa.*, 493 U.S. at 189)) (bracketing omitted).

[285] *See* Pierce, *supra* note 14, at 1093 ("[C]ase law suggests . . . judicially inventing a nurse-patient privilege through statutory construction is not an acceptable method for creating the privilege.").

[286] *See, e.g.*, Taylor v. Reo Motors, Inc., 275 F.2d 699, 702-03 (10th Cir. 1960) ("The Kansas courts have not spoken on the divided question whether an attending nurse comes within the statutory privilege expressly applicable to physicians."); State v. Bounds, 258 P.2d 751, 753 (Idaho 1953) ("We expressly do not decide whether the privilege extends to nurses present with the physician as his immediate and necessary technical agents and assistants in giving medical care and attention . . . .").

[287] *See* Leonard P. Stark, Note, *The Presidential Primary and Caucus Schedule: A Role for Federal Regulation*, 15 YALE L. & POL'Y REV. 331, 380 (1996). Udall was a highly respected Arizona congressman and unsuccessful candidate for the Democratic presidential nomination in 1976. *Id.* However, "as a lawyer before he moved to the national political scene," Udall also "wrote a treatise on the Arizona law of evidence." Charles E. Ares, *Tribute To Morris K. Udall*, 23 ARIZ. ST. L.J. 723, 723 (1991) (discussing UDALL, *supra* note 7). That treatise has been described as "a bible for Arizona trial lawyers." *Id.* at 723 n.2.

[288] *See* UDALL, *supra* note 7 § 93, at 145 n.57.

[289] *See id.* The Arizona Court of Appeals has stated that because the physician-patient privilege was created by statute, "the boundaries of the privilege can also be statutorily altered." *See* State *ex rel.* Romley v. Gaines, 67 P.3d 734, 738 (Ariz. Ct. App. 2003). *See also* Bartlett v. Superior Ct., 722 P.2d 346, 351 (Ariz. Ct. App. 1986) (alluding to the Arizona legislature's authority "to expand [a] privilege").

courts have held,[290] he suggested that it also might be accomplished through a "liberal interpretation" of Arizona's existing physician-patient privilege.[291]

Udall's optimism might be warranted,[292] despite the judiciary's traditional reluctance "to expand or create new privileges in the absence of compelling reasons."[293] In *Tucson Medical Center v. Rowles*,[294] the Arizona Court of Appeals judicially extended the protection of the state's statutory physician-patient privilege to encompass information contained in a patient's hospital records,[295] even though those records typically reflect the patient's communications with hospital nurses.[296] In reaching this result,[297] the court specifically asserted that it was not bound by the Ninth Circuit's analysis in *Southwest*

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[290] *See* DEWITT, *supra* note 85, at 92 ("Several courts have pointed out that if public policy demands that the privilege of the physician should be extended to nurses and other attendants who are not physicians, the change should be made by the legislature, not by judicial construction.").

[291] *See* UDALL, *supra* note 7 § 93, at 145 n.57.

[292] *See* Sims v. Charlotte Liberty Mut. Ins. Co., 125 S.E.2d 326, 330 (N.C. 1962) ("In some jurisdictions the privilege statutes are strictly construed on the theory that they are in derogation of the common law; in others the courts say that the statutes are remedial and consequently should be liberally construed."); Leonard William Copple, Comment, *Physician-Patient Privilege: A Need to Revise the Arizona Law*, 6 ARIZ. L. REV. 292, 294 (1965) ("Logically, [physician-patient privilege] statutes should be strictly construed since they are in derogation of the common law; however, some states grant them a liberal construction on the basis of the public policy under which they were enacted.") (footnote omitted).

[293] *See* Dixon v. Rutgers, State Univ. of N.J., 521 A.2d 1315, 1317 (N.J. Super. Ct. App. Div. 1987); *see also* United States *ex rel.* Riley v. Franzen, 653 F.2d 1153, 1160 (7th Cir. 1981) ("[C]ourts have been reluctant to create new privileges, preferring to leave such matters to the legislature despite any policy reasons supporting recognition of a particular privilege.").

[294] 520 P.2d 518 (Ariz. Ct. App. 1974).

[295] *See* State v. Morales, 824 P.2d 756, 759 (Ariz. Ct. App. 1991) ("[I]t is well established in Arizona that a person's medical records and oral communications to physicians are protected by the physician-patient privilege." (citing *Tucson Med. Ctr.* and State v. Santeyan, 664 P.2d 652 (Ariz. 1983))); *cf. Sims*, 125 S.E.2d at 331 ("*A fortiori*, if [a] physician is incompetent personally to testify to information obtained, entries made by him or under his direction pertaining to the same matter are inadmissible as evidence.").

[296] *See* Johnston v. Miami Valley Hosp., 572 N.E.2d 169, 171 (Ohio Ct. App. 1989) ("Since nurses often spend more time than physicians with hospital patients, their notes often comprise the bulk of the hospital record."). Other courts have concluded that the fact that medical records contain nurses' notes does not prevent those records from falling within the protection of the physician-patient privilege. *See, e.g.*, House v. SwedishAmerican Hosp., 564 N.E.2d 922, 927 (Ill. App. Ct. 1990) ("The nurses' notes present in this case were placed in the patient's medical record and were intended to be used by the physicians in rendering medical treatment to the patient. Thus, these notes were . . . protected under the physician-patient privilege."). *See also* State v. Shirley, 731 S.W.2d 49, 53 (Mo. Ct. App. 1987) (Maus, J., concurring) ("The physician-patient privilege extends to hospital records. The records in such cases obviously include information disclosed to nurses employed by the hospital.") (citations omitted).

[297] *See Rowles*, 520 P.2d at 524 n.1. More than 20 years after the Arizona Court of Appeals recognized a common law hospital records privilege in the *Tucson Medical Center* case, the Arizona legislature enacted a privilege protecting the confidentiality of "all medical records and . . . the information contained in medical records." Carondelet Health Network v. Miller, 212 P.3d 952, 957 n.1 (Ariz. Ct. App. 2009) (quoting ARIZ. REV. STAT. § 12-2292.A). Significantly, this statutory privilege has been interpreted to protect "parties that provide medical services and nursing services, rather than protecting only physicians." O'Neill, *supra* note 163, at 322.

Metals Co,[298] which suggests that if presented with the opportunity, Arizona state courts might recognize the nurse-patient privilege.[299]

IX. Adoption of a Nurse-Patient Privilege Depends on the Existence of a Physician-Patient Privilege

A. The Physician-Patient Privilege Is Not Universally Recognized

Given the similarities in the services provided by nurses and physicians in today's health care environment,[300] there is no longer any persuasive reason – if there ever was one[301] – for refusing to extend the protection of the physician-patient privilege to a patient's confidential communications with a nurse.[302] There is, on the other hand, a great deal to be said for treating nurses and physicians similarly insofar as the

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[298] *See Rowles*, 520 P.2d at 524 n.1. ("We have been cited to a 1925 federal case holding that the physician-patient privilege . . . should be strictly construed and that since nurses are not specifically mentioned in the statute, information they possess is not privileged. This decision is not binding upon us and has been criticized." (discussing Sw. Metals Co. v. Gomez, 4 F.2d 215 (9th Cir. 1925), and UDALL, *supra* note 7 § 93, at 145 n.57)).

[299] *See* State v. Zeitner, 436 P.3d 484, 491 (Ariz. 2019) (citing *Tucson Med. Ctr.*, 520 P.2d at 521) (noting that "Arizona courts have expanded the physician-patient privilege beyond its original testimonial protections"); *cf.* Johnson v. O'Connor, 327 P.3d 218, 225 (Ariz. Ct. App. 2014) (acknowledging the importance of "the physician-patient and *related* privileges") (emphasis added)*; see generally,* Lyrissa Barnett Lidsky, *Prying, Spying, and Lying: Intrusive Newsgathering and What the Law Should Do About It*, 73 TUL. L. REV. 173, 246 (1998) ("Throughout the history of the common law, judges have created privileges to protect important societal interests.").

[300] *See* Berthiaume v. Caron, 142 F.3d 12, 16 (1st Cir. 1998) ("Like doctors, nurses are a part of the medical profession and are entrusted with patient care, where reliance is normally placed on the competence of the nurse or doctor."); Reimann v. Frank, 397 F. Supp. 2d 1059, 1078 (W.D. Wis. 2005) (asserting that "nurse practitioners are akin to licensed physicians in their ability to diagnose and manage illnesses"); Ritter & Hansen-Turton, *supra* note 202, at 21 ("Like physicians, nurse practitioners now provide primary care in a broad range of settings.").

[301] *See* Fraijo v. Hartland Hosp., 160 Cal. Rptr. 246, 252 (Ct. App. 1979) ("While nurses traditionally have followed the instructions of attendant physicians, doctors realistically have long relied on nurses to exercise independent judgment in many situations."). The expansion of the nurse's role in the provision of health care is not a particularly recent development. *See* Phyllis Coleman & Ronald A. Shellow, *Extending Physician's Standard of Care to Non-Physician Prescribers: The Rx for Protecting Patients*, 35 IDAHO L. REV. 37, 59 (1998) ("Nurses began seeking expansion of their scope of practice around 1965."); Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. REG. 417, 444 (1992) (describing "[s]everal events in the mid-1960s [that] set the stage for an expansion of nursing generally, and advanced practice nursing in particular").

[302] *See* Hermanson v. Multi-Care Health Sys., Inc., 448 P.3d 153, 164 (Wash. Ct. App. 2019) (finding "no reasoned distinction . . . between the physician-patient privilege and . . . the nurse-patient privilege"), *review granted*, 456 P.3d 399 (Wash. 2020); *cf.* Nat'l Family Planning & Reprod. Health Ass'n v. Sullivan, No. 92-935 (CRR), 1992 U.S. Dist. LEXIS 7043, at *4 (D.D.C. May 28, 1992) (questioning whether "there exists a rational basis to conclude that the doctor-patient privilege inheres to communications made to physicians and not communications made to nurse practitioners"), *aff'd*, 979 F.2d 227 (D.C. Cir. 1992).

confidentiality of their communications with patients is concerned.[303] Thus, in states that recognize the physician-patient privilege, or that may do so in the future,[304] a compelling argument can be made for interpreting the privilege to encompass a patient's confidential communications with a nurse:

> Clearly, the limited scope of most of the present statutes is inconsistent with the social judgment upon which the statutes are based. Nurses . . . often play essential roles in the treatment process. If communications made to such persons are not privileged on the same basis as communications to physicians, there is a real danger of disclosure of information which the physician-patient privilege is designed to keep secret.[305]

However, neither Congress nor the federal courts have recognized the physician-patient privilege,[306] and several states also do not recognize the privilege.[307] In these jurisdictions,[308] there is no existing statutory or common law privilege for the

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[303] *See* Pierce, *supra* note 14, at 1095-96 ("[T]here are many valuable reasons why [a] privilege should exist and apply to confidential communications between a physician and his patient and . . . a nurse practitioner and patient.") (footnotes omitted).

[304] *See, e.g.*, Laural C. Alexander, Comment, *Should Alabama Adopt a Physician-Patient Evidence Privilege?*, 45 ALA. L. REV. 261, 273 (1993) ("Alabama should recognize the importance of protecting the confidentiality of physician-patient communications by enacting a physician-patient privilege statute."); *see also,* McCormick v. England, 494 S.E.2d 431, 435 (S.C. Ct. App. 1997) ("The modern trend recognizes that the confidentiality of the physician-patient relationship is an interest worth protecting." (citing Vickery, *supra* note 57)); *see generally,* State v. Almonte, 644 A.2d 295, 301 (R.I. 1994) (Lederberg, J., dissenting) ("[A]s of 1989, 'no state [had] withdrawn the [physician-patient] privilege after adopting it. In fact, the number of states recognizing the privilege has gradually grown.'" (quoting Wade, *supra* note 252, at 1151 n.34)).

[305] *Legal Protection of the Confidential Nature of the Physician-Patient Relationship*, 52 COLUM. L. REV. 383, 393 (1952); *see also,* DEMARCO ET AL., *supra* note 18, at 228 ("[T]he rules of confidentiality for physicians and nurses vary in important ways. The difference is surprising – even alarming – and suggests that advocacy is needed to render the same information confidential if it's disclosed to a physician or to a nurse.").

[306] *See* Griffin v. Sanders, 914 F. Supp. 2d 864, 869 (E.D. Mich. 2012) ("The physician-patient privilege does not exist under common law and Congress has not codified such a privilege."); Hutton v. City of Martinez, 219 F.R.D. 164, 166 (N.D. Cal. 2003) ("The physician-patient privilege is not recognized by federal common law, federal statute, or the U.S. Constitution."); Benally v. United States, 216 F.R.D. 478, 479 (D. Ariz. 2003) ("There is no physician-patient privilege under federal statutes, rules or common law.").

[307] *See* Kurdek v. W. Orange Bd. of Educ., 536 A.2d 332, 335 (N.J. Super. Ct. Law Div. 1987) ("In fact, the common law rule of no privilege still applies in . . . several states in this country."); David A. Schlueter, *The Parent-Child Privilege: A Response to Calls for Adoption*, 19 ST. MARY'S L.J. 35, 40 (1987) ("The disparity among privileges recognized by courts is exemplified by the fact that not all jurisdictions have adopted the physician-patient privilege.").

[308] *See* Hardy v. Riser, 309 F. Supp. 1234 (N.D. Miss. 1970). Even in states that recognize the physician-patient privilege, its status may be uncertain. *Id.* at 1237 (asserting that the privilege "has long been criticized by leading publicists and has been the subject of heated debate in Mississippi") (footnote omitted). *See also* Anker v. Brodnitz, 413 N.Y.S.2d 582, 584 (Sup. Ct. 1979) (observing that the courts in some states "have severely questioned the value of the physician-patient privilege . . . ."). *See generally* Alexander, *supra* note 304, at 261 ("Even in states which do recognize a physician-patient privilege, debate continues over whether the privilege should be retained . . . .").

courts to interpret broadly enough to encompass confidential communications between nurses and their patients.[309] There also is very little likelihood that the courts or legislatures in jurisdictions with no physician-patient privilege would adopt an independent nurse-patient privilege.[310] As one proponent of the latter privilege observed: "While it would be ideal to have a federal nurse-patient privilege, that is a big hurdle to overcome as the federal system has yet to recognize even a physician-patient privilege."[311]

B. Evaluating the Physician-Patient Privilege Under the Wigmore Test

Although the issue occasionally arises in state court proceedings,[312] the potential recognition of a common law physician-patient privilege is typically discussed in federal cases,[313] where unlike in most state court cases,[314] no statutory physician-patient

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[309] *See* Cross v. Huff, 67 S.E.2d 124, 127 (Ga. 1951) (asserting that "courts can not construe that which does not exist"); State v. Quested, 352 P.3d 553, 566 (Kan. 2015) ("With no statute to construe . . . statutory construction . . . plays no part.").

[310] *See* State v. Bounds, 258 P.2d 751, 753 (Idaho 1953) ("[I]f the testimony of [a] physician is not privileged, obviously the testimony of . . . nurses would not be privileged."); Pierce, *supra* note 14, at 1099 ("[G]iven how there are states that still do not recognize a general physician-patient privilege, it may prove . . . difficult to persuade representatives in those states to implement the nurse-patient privilege.").

[311] *See* Pierce, *supra* note 14, at 1096; *see also* Korff v. City of Phoenix, No. CV-13-02317-PHX-ESW, 2015 U.S. Dist. LEXIS 86546, at *6 (D. Ariz. July 2, 2015) (stating that "no physician-patient privilege exists in federal law between [a patient] and his medical doctors, doctors of osteopathic medicine, physicians, physician assistants, nurses, nurse practitioners, or pharmacists . . . .").

[312] *See, e.g.*, Edelstein v. Dep't Pub. Health & Addiction Servs., 692 A.2d 803, 805 (Conn. 1997) ("Although the plaintiff . . . urges us to recognize a common law privilege for communications between a patient and physician, we decline to do so . . . ."); Quarles v. Sutherland, 389 S.W.2d 249, 250 (Tenn. 1965) ("The basic issue which we must decide in this case is whether communications between physician and patient are by law privileged communications . . . ."); *cf.* Allred v. State, 554 P.2d 411, 418 (Alaska 1976) ("[W]e recognize a common law privilege, belonging to the patient, which protects communications made to psychotherapists in the course of treatment.").

[313] *See* Heilman v. Waldron, 287 F.R.D. 467, 473 (D. Minn. 2012) ("Federal courts have consistently refused to recognize a federal physician-patient privilege . . . ."); *cf.* Stacey A. Garber, Note, *The Clergy Privilege and Alcoholics Anonymous*, 31 CAP. U. L. REV. 917, 924 (2003) ("As the law of privilege has evolved, the judiciary has been the primary force in defining and establishing privileges for the federal system, and the state legislatures have been the primary body establishing and defining privileges in the state system."). See Stephen Aaron Silver, Note, *Beyond* Jaffee v. Redmond*: Should the Federal Courts Recognize a Right to Physician-Patient Confidentiality?*, 58 OHIO ST. L.J. 1809 (1998) for an academic discussion of the potential recognition of a federal common law physician-patient privilege.

[314] *See, e.g.*, Doe v. Md. Bd. Soc. Work Exam'rs, 862 A.2d 996, 1006 (Md. 2004) (describing a physician who invoked "the physician-patient privilege, as set forth by a state statute"); Moore v. Grandview Hosp., 495 N.E.2d 934, 935 (Ohio 1986) (holding that the admissibility of a treating physician's testimony was "governed by [a] statutory physician-patient privilege"); *see also* Gonzenbach v. Ruddy, 645 S.W.2d 27, 28 (Mo. Ct. App. 1982) ("We must look to the physician-patient privilege statute for guidance. For the most part, courts in other jurisdictions have followed the dictates of their particular statutes.").

privilege ordinarily applies.[315] Several federal courts have refused to recognize the privilege on the ground that it does not satisfy the four-part test for the recognition of evidentiary privileges originally propounded by Professor John Henry Wigmore,[316] and subsequently adopted and applied by many state and federal courts.[317] In order to be privileged under that test:

> (1) The communications [at issue] must originate in a *confidence* that they will not be disclosed; (2) This element of *confidentiality must be essential* to the full and satisfactory maintenance of the relation between the parties; (3) The *relation* must be one which in the opinion of the community ought to be sedulously fostered; and (4) The *injury* that would inure to the relation by the disclosure of the communications must be *greater than the benefit* thereby gained for the correct disposal of litigation.[318]

Courts that refuse to recognize the physician-patient privilege on this basis typically hold that the privilege satisfies only one or two[319] of the four prongs of the Wigmore test,[320] specifically the requirement that the relationship at issue be one that

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[315] *See In re* Grand Jury Subpoena, 197 F. Supp. 2d 512, 514 (E.D. Va. 2002) (noting that "no federal statute creates a physician-patient privilege"); *cf.* Green v. Fulton, 157 F.R.D. 136, 139 (D. Me. 1994) ("Though a state statute might create an evidentiary privilege that is cognizable in state court, that statute does not bind a federal court sitting in that state deciding a federal question."); United States v. Univ. Hosp., 575 F. Supp. 607, 611 (E.D.N.Y. 1983) ("There is . . . no doctor-patient evidentiary privilege in a federal court proceeding except with respect to an element of a claim or defense as to which state law supplies the rule of decision."), *aff'd*, 729 F.2d 144 (2d Cir. 1984).

[316] *See* Ellen S. Soffin, Note, *The Case for a Federal Psychotherapist-Patient Privilege that Protects Patient Identity*, 1985 DUKE L.J. 1217, 1224 (1985) (stating that "federal courts have held that the physician-patient relationship fails to meet Wigmore's standard"). *See generally* John Dawson, *Compelled Production of Medical Records*, 43 MCGILL L.J. 25, 32 (1998) ("In the common law, a claim that a confidential communication between a patient and a physician is inadmissible, and therefore to be excluded, is determined by reference to Wigmore's four criteria for the establishment of case-by-case privileges.").

[317] *See In re* Contempt of Wright, 700 P.2d 40, 48 (Idaho 1985) (Bistline, J., concurring) ("Many courts and commentators have accepted Wigmore's test as the proper method for determining if a proposed privilege ought to be recognized."); Douglas v. Windham Superior Ct., 597 A.2d 774, 777 (Vt. 1991) (citing WIGMORE, *supra* note 79, § 2285, at 527) ("Most courts have created a testimonial privilege only when the conditions meet the four-part test for recognition set forth in Dean Wigmore's treatise."). *See generally* Nicole Hallett, *From the Picket Line to the Courtroom: A Labor Organizing Privilege to Protect Workers*, 39 N.Y.U. REV. L. & SOC. CHANGE 475, 496 (2015) ("The Wigmore test remains the gold standard for courts today when they consider whether to recognize new evidentiary privileges.").

[318] Hansen v. Allen Mem'l Hosp., 141 F.R.D. 115, 122 n.13 (S.D. Iowa 1992) (citing, *inter alia*, WIGMORE, *supra* note 79, § 2285, at 527). See Edward J. Imwinkelried, *The New Wigmore: An Essay on Rethinking the Foundation of Evidentiary Privileges*, 83 B.U. L. REV. 315 (2003) for a critique of Wigmore's approach to the recognition of privileges.

[319] *See* Jessica G. Weiner, Comment, "*And the Wisdom to Know the Difference": Confidentiality vs. Privilege in the Self-Help Setting*, 144 U. PA. L. REV. 243, 280 n.200 (1995) ("[C]ritics argue that the doctor-patient privilege should not obtain under the . . . second and fourth prong.").

[320] *See, e.g.*, United States v. Kan. City Lutheran Home & Hosp. Ass'n, 297 F. Supp. 239, 243 (W.D. Mo. 1969) (citing WIGMORE, *supra* note 79, § 2380a, at 831-32) (asserting that "the physician-patient privilege does not meet the four conditions required for recognition of a

society should foster or encourage.[321] These courts often assume that adoption of the privilege would result in the exclusion of too much relevant and in some cases crucial[322] evidence,[323] and therefore conclude that the privilege does not satisfy the critical fourth prong of the test in particular.[324]

Wigmore himself opposed recognition of the physician-patient privilege on this basis.[325] He argued that under the balancing of interests contemplated by the fourth prong of his test,[326] a refusal to recognize the privilege would cause "less harm . . . to the

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privileged communication"); *see also* State v. Aucoin, 362 So.2d 503, 505 (La. 1978) (citing WIGMORE, *supra* note 79, § 2380a) (asserting that the privilege "has been severely criticized, because it arguably meets only one of the four traditional tests").

[321] *See Aucoin*, 362 So.2d at 505 (citing WIGMORE, *supra* note 79, § 2380a) ("Obviously, the physician-patient relationship should be fostered; but it is doubtful whether most physician-patient communications are truly intended to be kept in confidence, or whether people would stop going to doctors if they feared disclosure."); *cf. In re* Grand Jury Subpoena Dated Nov. 18 v. United States, No. 94-CV-0947E(M), 1995 U.S. Dist. LEXIS 2388, at *9 (W.D.N.Y. Feb. 24, 1995) (declining to recognize the privilege despite acknowledging that "society might have an interest in fostering the physician-patient relationship").

[322] *See, e.g.*, People v. Johnson, 314 N.W.2d 631, 634 (Mich. Ct. App. 1981) ("Without the doctor's testimony, convictions for forgeries of prescriptions would be well-nigh impossible. The privilege is to be used for preserving legitimate confidential communications, not for suppressing the truth."); *see also* State v. Betts, 384 P.2d 198, 205 (Or. 1963) ("A physician attending a [criminal] defendant is frequently the sole or most competent source of very relevant evidence.").

[323] *See, e.g.*, *Grand Jury Subpoena Dated Nov. 18*, 1995 U.S. Dist. LEXIS 2388, at *10-11 (finding that "the fourth Wigmore consideration" was not met because recognition of the privilege "might, in effect, accomplish nothing but the secreting of criminal activity"); *see also* State v. Boysaw, 532 N.E.2d 154, 157 (Ohio Ct. App. 1987) ("Recently courts have begun questioning the applicability of the physician-patient privilege . . . on the grounds that the privilege operates to exclude relevant evidence at trial."). *But see Development in the Law – Privileged Communication*, 98 HARV. L. REV. 1629, 1632 n.15 (1985) (emphasis added) (citing WIGMORE, supra note 79, § 2285, at 527) ("Wigmore's fourth condition for recognizing a privilege, that the societal benefits from the privilege outweigh any resulting loss of evidence to society . . . *assumes* that recognition of a privilege shields relevant information from the courts.").

[324] *See, e.g.*, Hague v. Williams, 181 A.2d 345, 348 (N.J. 1962) (noting that the New Jersey courts regarded Wigmore's fourth condition "as being unfulfilled" in the case of the physician-patient privilege). *See generally In re* Grand Jury Proc., 103 F.3d 1140, 1152 (3d Cir. 1997) (noting that "Wigmore's four-factor formula requires satisfaction of all four factors in order to establish a privilege").

[325] *See Kan. City Lutheran Home & Hosp. Ass'n*, 297 F. Supp. at 243 (noting Wigmore's own "detailed discussion supporting the reasons why the physician-patient privilege does not meet the four conditions required for recognition of a privileged communication" (discussing WIGMORE, *supra* note 79, § 2380a, at 831-32)); Hague, *supra* note 54, at 567 n.11 (citing WIGMORE, *supra* note 79 § 2380a, at 829-30) ("Wigmore has stated that the physician-patient privilege meets but one of his four conditions – that the relationship should be fostered by society.").

[326] *See In re* Hampers, 651 F.2d 19, 23 (1st Cir. 1981) ("Wigmore's fourth inquiry is whether 'the injury that would inure to the relation by the disclosure of the communications would be greater than the benefit thereby gained for the correct disposal of litigation.'" (quoting Am. Civil. Liberties Union of Miss. v. Finch, 638 F.2d 1336, 1344 (5th Cir. 1981))) (bracketing and emphasis omitted); *cf.* Three Juveniles v. Commonwealth, 455 N.E.2d 1203, 1207 (Mass. 1983) ("In the last analysis, the question comes down to a balancing of the public's interest in obtaining every

physician-patient relationship" than the injury that would be done "to the judicial process in providing a privilege for the relationship."[327] The Kansas Supreme Court quoted Wigmore's initial articulation of this view in *Flack v. Brewster*,[328] a case decided not long after he formulated his test: "That the relation of physician and patient should be fostered, no one will deny. But that the injury to the relation is greater than the injury to justice – the final canon to be satisfied – must most emphatically be denied. The injury is decidedly in the contrary direction."[329]

If Wigmore's view of the physician-patient privilege is correct,[330] his analysis obviously militates against recognition of the nurse-patient privilege as well.[331] However, Wigmore offered no empirical support for his view,[332] and several modern commentators have concluded that the physician-patient privilege satisfies the test he

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person's testimony against public policy considerations in favor of erecting a testimonial privilege in the circumstances.").

[327] State *ex rel.* Allen v. Bedell, 454 S.E.2d 77, 86 n.12 (W. Va. 1994) (Cleckley, J., concurring) (citing WIGMORE, *supra* 79 §§ 2380-2391); *see also* Charles D. Weiss, Comment, *AIDS: Balancing the Physician's Duty to Warn and Confidentiality Concerns*, 38 EMORY L.J. 279, 286-87 (1989) ("In the early 1900's, Professor Wigmore set forth a detailed criticism of the traditionally accepted rationale for the physician-patient privilege. . . . Wigmore asserted that the expected benefit to justice from disclosure would far outweigh any potential injury to the patient." (citing WIGMORE, *supra* 79 § 2380a)).

[328] 190 P. 616 (Kan. 1920).

[329] *Id.* at 617 (quoting 4 JOHN HENRY WIGMORE, A TREATISE ON THE SYSTEM OF EVIDENCE IN TRIALS AT COMMON LAW § 2380 (1904)). Wigmore's view was also quoted with approval several years earlier, albeit in dissent, in *Noelle v. Hoquiam Lumber & Shingle Co.*, 92 P. 372, 375-76 (Wash. 1907) (Root, J., dissenting).

[330] *See generally* Koump v. Smith, 250 N.E.2d 857, 861 (N.Y. 1969).

> Over the years . . . the privilege has been severely criticized by leading commentators on the law of evidence, primarily on the ground that the privilege suppresses the truth, resulting in an injury to justice far more substantial than the injury expected to result to the doctor-patient privilege [sic] as a result of disclosure.

Id. (citations omitted).

[331] *See* Pierce, *supra* 14, at 1095 ("There are reasons . . . why the physician-patient privilege is unnecessary and those reasons surely would extend to the nurse-patient privilege."); *cf.* Storer Commc'ns, Inc. v. Giovan (*In re* Grand Jury Proceedings), 810 F.2d 580, 584 (6th Cir. 1987) (discussing "the warnings of Professor John Henry Wigmore and other commentators against obstructing the search for truth by the creation of additional testimonial privileges"); Anthony L. Fargo & Paul McAdoo, *Common Law or Shield Law? How Rule 501 Could Solve the Journalist's Privilege Problem*, 33 WM. MITCHELL L. REV. 1347, 1363 (2007) ("Wigmore, after stating his four part test for the recognition of privileges, . . . expressed a disdain for *most privileges* created by statute or common law as impediments to the discovery of truth through litigation." (citing WIGMORE, *supra* 79 § 2286)) (emphasis added).

[332] *See* Kenneth S. Broun, *The Medical Privilege in the Federal Courts – Should It Matter Whether Your Ego or Your Elbow Hurts?*, 38 LOY. L.A. L. REV. 657, 684 (2004) ("Although Wigmore offered no empirical data to support his assumptions, he found none to be necessary, noting that '[t]hese facts are well enough known.'" (quoting WIGMORE, *supra* 79 § 2380a, at 829)); *cf. Developments in the Law – Privileged Communications, supra* 52, at 1666 ("One can never prove that costs outweigh benefits or vice-versa with regard to a particular privilege: such arguments inevitably degenerate into simple unsupported assertions.").

formulated.[333] In fact, it is far from clear that the physician-patient privilege impedes the judicial search for truth to the extent Wigmore and other critics of the privilege[334] apparently assumed.[335] As the Supreme Court observed when it recognized the related psychotherapist-patient privilege:[336] "Without a privilege, much of the desirable evidence to which litigants . . . seek access – for example, admissions against interest by a party – is unlikely to come into being. This unspoken 'evidence' will therefore serve no greater truth-seeking function than if it had been spoken and privileged."[337]

In some cases, the application of an evidentiary privilege might even advance the search for truth by excluding unreliable or even perjured testimony,[338] the giving of

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[333] *See, e.g.*, Ralph Ruebner & Leslie Ann Reis, *Hippocrates to HIPAA: A Foundation for a Federal Physician-Patient Privilege*, 77 TEMP. L. REV. 505, 574 (2004) ("Obviously, much has changed in the last half-century. Wigmore's arguments no longer hold true. . . . [E]ach and every one of the four Wigmore conditions is met by today's physician-patient relationship and the importance that relationship has to the individual patient and society in general."); Mary Claire Johnson, Note, *"I Will Not Divulge": How to Resolve the "Mass of Legal Confusion" Surrounding the Physician-Patient Relationship in West Virginia*, 110 W. VA. L. REV. 1231, 1253 (2008) ("With the spread of sexually transmitted disease, the growth of easy access to patient files, and the growing importance of the right to privacy, all of Wigmore's arguments seem to collapse, and each of the four criteria that he created can be satisfied.").

[334] *See* Lowe's of Roanoke, Inc. v. Jefferson Std. Life Ins. Co., 219 F. Supp. 181, 187 (S.D.N.Y. 1963) (asserting that "a considerable body of opinion . . . holds that the privilege serves only to obstruct justice by preventing the physician from disclosing the truth"); Johnson v. Trujillo, 977 P.2d 152, 156 (Colo. 1999) ("[C]ourts and commentators have criticized the physician-patient privilege for suppressing the truth and have argued that the resulting harm to justice is far more substantial than the harm that disclosure would cause to the physician-patient relationship.").

[335] *See* Robert R. Summerhays, *The Problematic Expansion of the* Garner v. Wolfenbarger *Exception to the Corporate Attorney-Client Privilege*, 31 TULSA L.J. 275, 280 n.17 (1995) ("Some commentators have questioned whether the costs identified by Wigmore should be given much weight. . . . These commentators argue that the evidence lost through the [recognition of a] privilege might not exist without the privilege.") (discussing the attorney-client privilege).

[336] *See generally* Doe v. Oberweis Dairy, 456 F.3d 704, 718 (7th Cir. 2006) (noting that the psychotherapist-patient privilege is "intended like the closely related doctor-patient privilege to avoid deterring people from seeking treatment"); Ginsberg v. Fifth Ct. of App., 686 S.W.2d 105, 107 (Tex. 1985) (discussing the psychotherapist-patient privilege and "the related physician-patient privilege"). For a discussion of the relationship between the two privileges, see Broun, *supra* note 332.

[337] *See* Jaffee v. Redmond, 518 U.S. 1, 12 (1996); *see also Developments in the Law – Privileged Communications, supra* note 52, at 1477 ("Because at least some evidence presumably exists only because a privilege encouraged its creation, the unavailability of such evidence cannot properly be deemed a cost of having the privilege.") (footnote omitted). Ironically, this view has been attributed to Wigmore himself. *See, e.g.*, Edward J. Imwinkelried, *Questioning the Behavioral Assumption Underlying Wigmorean Absolutism in the Law of Evidentiary Privileges*, 65 U. PITT. L. REV. 145, 149 (2003) ("Wigmore reasoned that on balance, suppressing privileged information did not impair judicial fact-finding because, but for the privilege, the evidence would not have come into existence.").

[338] *See* Rancho Publ'ns v. Super. Ct., 81 Cal. Rptr. 2d 274, 280 n.6 (Ct. App. 1999) ("More than 40 years ago, another commentator observed that privileges may promote truth seeking by avoiding conflicts of interest that could lead to perjury." (citing David W. Louisell, *Confidentiality, Conformity and Confusion: Privileges in Federal Court Today*, 31 TUL. L. REV. 101, 114-15 (1956))); *Developments in the Law – Privileged Communications, supra* note 52, at 1478 n.42 ("Even though privileges may not

which certainly tends to undermine the truth-seeking process.[339] One commentator explained this in the following terms:

> [I]t is unclear how often and how truthfully the type of witnesses who normally claim the protection of a privilege would testify if compelled to do so. Indeed, privileges seem to protect exactly those relations most likely to produce an outright refusal to testify. Even if members of these relations did not actually refuse to testify altogether, the testimony extracted from them would probably be considerably less reliable than the testimony of the average witness. Such unreliable testimony might even *decrease* the likelihood of correctly resolving litigation.[340]

Significantly, the New York legislature based its enactment of the nation's first statutory physician-patient privilege in part on the assumption that physicians forced to reveal their patients' confidences might not testify truthfully,[341] thereby undermining the truth-seeking process no less than would be the case if they were permitted to withhold that information on the basis of a privilege.[342] Other state legislatures contemplating the recognition of a physician-patient privilege appear to have reached the same conclusion.[343]

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be *designed* to protect the reliability of evidence, they do have the *effect* of screening out testimony that carries a higher likelihood of unreliability than most testimony.") (citation omitted).

[339] *See* Cedars-Sinai Med. Ctr. v. Super. Ct., 954 P.2d 511, 516 (Cal. 1998) ("Perjury . . . undermines the search for truth and fairness by creating a false picture of the evidence before the trier of fact."); John L. Watts, *To Tell the Truth: A* Qui Tam *Action for Perjury in a Civil Proceeding is Necessary to Protect the Integrity of the Civil Judicial System*, 79 TEMP. L. REV. 773, 820 (2006) ("Perjury undermines the fundamental truth-seeking process of the courts and the integrity and legitimacy of the judicial process.").

[340] *Developments in the Law – Privileged Communications, supra* note 52, at 1478 (footnotes omitted).

[341] *See* Dillenbeck v. Hess, 536 N.E.2d 1126, 1130 (N.Y. 1989) (noting that New York's codification of the physician-patient privilege was based in part upon a fear that "physicians would alter or conceal the truth when forced, in the absence of any privilege, to choose between their legal duty to testify and their professional obligation to honor their patients' confidences" (citing, *inter alia*, EDITH L. FISCH, FISCH ON NEW YORK EVIDENCE § 541 (2d ed 1977))); People v. Austin, 93 N.E. 57, 59 (N.Y. 1910) ("The revisers, in their notes, . . . say: '. . . [D]uring the struggle between legal duty on the one hand, and professional honor on the other, the latter . . . will, in most cases, furnish a temptation to the perversion or concealment of the truth, too strong for human resistance.'" (quoting *Extracts from the Original Reports of the Revisers*, REVISED STATUTES OF THE STATE OF NEW YORK (1836))).

[342] *See* Paul Rosenzweig, *Truth, Privileges, Perjury, and the Criminal Law*, 7 TEX. REV. L. & POL. 153, 165 (2002).

> [J]ust as the assertion of privilege impedes the search for truth, so too does perjury. . . . The difference is that the assertion of a privilege is a means of impeding the search for truth in a lawful manner, while perjury is an unlawful effort to the same end.

Id.

[343] *See* Wade, *supra* note 252, at 1148 (observing that "most states that have adopted the physician-patient privilege have embraced the same reasoning asserted by New York"); *cf. Developments in the Law – Privileged Communications, supra* note 52, at 1499 ("[P]rivilege holders seem

In any event, the argument that the recognition of a physician-patient privilege or a comparable nurse-patient privilege would be an impediment to truth-seeking is a relatively unpersuasive reason for refusing to recognize such a privilege,[344] in part because all evidentiary privileges are subject to criticism on this ground.[345] Indeed, it is apparent that relatively few state legislatures contemplating the recognition of a physician-patient privilege actually have been persuaded by the argument.[346] As one court explained:

> Wigmore in his treatise on evidence recognized no privilege between doctor and patient. . . . Some states have weighed the "need to know" by the doctor in order to be better equipped to treat his patient against the search for truth involved in all trials. *Usually where the legislature has created a confidential relationship, it has been in recognition of the doctor's paramount need at the expense of the public's right to know*.[347]

C. Impact of the Legislative Recognition of a Physician-Patient Privilege

Whatever its merit, the argument that a particular evidentiary privilege does not satisfy the Wigmore test is purely academic in states that have adopted the privilege by statute,[348] as Wigmore himself presumably would acknowledge.[349] The Arizona

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to constitute those groups most likely to respond to a court order by lying or by refusing to testify. They are bound by strong loyalties or oaths of confidentiality, often supported by professional codes of ethics and the threat of professional sanctions.") (footnote omitted).

[344] *See* Raymond C. Ruppert, Note, *The Accountant-Client Privilege Under the New Federal Rules of Evidence – New Stature and New Problems*, 28 OKLA. L. REV. 637, 647-48 (1975) ("The . . . argument against [a] privilege – that privileges are an exception to the court's right to know all the relevant facts – can be made against all privilege laws. Yet privilege laws exist because the law recognizes that some communications must be made in the aura of confidentiality.").

[345] *See* United States v. Textron, Inc., 577 F.3d 21, 31 (1st Cir. 2009) (noting that "all privileges limit access to the truth in aid of other objectives"); *In re* Sealed Case, 676 F.2d 793, 806 (D.C. Cir. 1982) ("Each of the recognized privileges protects a substantial individual interest or a relationship in which society has an interest, at the expense of the public interest in the search for truth."); People v. Knuckles, 650 N.E.2d 974, 979 (Ill. 1995) ("Testimonial privileges are, by their nature, inconsistent with the search for truth.").

[346] *See, e.g.*, *Dillenbeck*, 536 N.E.2d at 1131 ("Although the physician-patient privilege has been criticized by commentators . . ., the privilege remains rooted in both the statutory law and public policy of New York State."); State v. Betts, 384 P.2d 198, 204-05 (Or. 1963) ("[W]igmore . . . attacks the [physician-patient] privilege in either civil or criminal proceedings. Because of the Oregon statute there is no question, however, that in this jurisdiction the privilege exists in civil proceedings.").

[347] Gilmore v. State, 333 S.E.2d 210, 211 (Ga. Ct. App. 1985) (emphasis added); *see also* Brunton v. Kruger, 32 N.E.3d 567, 578 (Ill. 2015) ("The existence of a statutory privilege of any kind necessarily means that the legislature has determined that public policy trumps the truth-seeking function of litigation in certain circumstances.").

[348] *See, e.g.*, State v. Wilson, 26 P.3d 1161, 1166 (Ariz. Ct. App. 2001) ("[B]ecause our legislature has established a physician-patient privilege, we find unpersuasive the . . . contention that [the] 'four [Wigmore] conditions must be met before a privilege can be legally recognized.'" (quoting Ulibarri v. Superior Ct., 909 P.2d 449, 456 (Ariz. Ct. App. 1995) , *review denied*, 924 P.2d 109 (Ariz. 1996))); *cf.* State v. Donovan, 30 A.2d 421, 426 (N.J. 1943) (rejecting a challenge to a statutory

legislature has created a number of privileges that were not recognized at common law,[350] including the physician-patient privilege.[351] In doing so, it is presumed to have "considered and accounted for the various policy concerns that underlie the four [Wigmore] conditions."[352] The same presumption should apply in other states where the physician-patient privilege has been adopted by statute.[353] As one commentator noted: "Although Wigmore's criteria for the adoption of common law privileges do not bind statutory privileges, legislatures presumably would look to the same issues in determining whether privileges should be granted."[354]

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privilege criticized by Professor Wigmore because it is the privilege of the legislature to decide public policy).

[349] *See* Firschein v. Lafayette Coll., 7 Pa. D. & C.3d 243, 248 (Ct. C.P. Northampton Cty. 1978) ("The creation of a privilege as a legislative prerogative is recognized by Wigmore himself."). *But cf.* Davison v. St. Paul Fire & Marine Ins. Co., 248 N.W.2d 433, 440-41 (Wis. 1977) ("Although setting forth the prerequisites for the granting of a privilege, Wigmore does not indicate whether the court of the legislature is the proper body to grant such privilege.").

[350] *See, e.g.*, Grubaugh v. Blomo, 359 P.3d 1008, 1012 (Ariz. Ct. App. 2015) ("[A]rizona's mediation process privilege has no common law origin. It was created entirely by the legislature." (discussing ARIZ. REV. STAT. § 12-2238.B)); *see also* Johnson v. O'Connor, 327 P.3d 218, 225 (Ariz. Ct. App. 2014) (noting that Arizona's psychologist-client privilege is a professional privilege created by statute (construing ARIZ. REV. STAT. ANN. § 32-2085(A))); *see also* Ulibarri v. Superior Ct., 909 P.2d 449, 454 (Ariz. Ct. App. 1995) ("The marital communications privilege and the professional communications privileges are all created by statute . . . ."), *review denied sub nom.* Ulibarri v. Hancock, 924 P.2d 109 (Ariz. 1996). *See generally* Kim E. Williamson, Note, *Confidentiality of Sexual Assault Victim – Counselor Communication: A Proposed Model Statute*, 26 ARIZ. L. REV. 461, 470 (1984) ("Almost all privileges existing in Arizona today have been statutorily enacted.").

[351] *See* Martin v. Reinstein, 987 P.2d 779, 806 (Ariz. Ct. App. 1999) ("The physician-patient privilege . . . is a creature of statute."); *cf. Wilson*, 26 P.3d at 1166 (noting Arizona's extensive statutory scheme relating to the physician-patient privilege").

[352] *Wilson*, 26 P.3d at 1167 (discussing ARIZ. REV. STAT. § 13-4062.4); *see also* Humana Hosp. Desert Valley v. Superior Ct., 742 P.2d 1382, 1387 (Ariz. Ct. App. 1987) ("The legislature has determined that a peer review privilege is necessary to encourage the free flow of information essential for effective peer review. Like other statutory privileges, the hospital peer review privilege meets the four traditional [Wigmore] criteria for privileged communications . . .").

[353] *See* Boyd Isherwood, Note, *The Psychologist-Patient Privilege: Time for a Change in Kansas, or Is It All in Our Heads?*, 37 WASHBURN L.J. 659, 669-70 n.73 (1998) ("Legislatures and courts have accepted Wigmore's four essential criteria for privilege justification; virtually every privilege statute enacted since the mid-1960's has been evaluated according to Wigmore's criteria."); *see* Molly E. Slaughter, Casenote, *Misuse of the Psychotherapist-Patient Privilege in* Weissbeck v. Hess: *A Step Backward in the Prohibition of Sexual Exploitation of a Patient by a Psychotherapist*, 41 S.D. L. REV. 574, 597 (1996) ("Professor Wigmore's requirements have been widely accepted and applied by courts, and have become the cornerstone for statutory privilege law in the United States.").

[354] Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit – Is It Time for a Change?*, 25 AM. J.L. & MED. 7, 50 (1999). *But see* Myrna S. Raeder, *The Social Worker's Privilege, Victim's Rights, and Contextualized Truth*, 49 HASTINGS L. J. 991, 991 (1998) ("states enact statutory privileges by responding to political pressure with no thought to Wigmore's classic formulation"). *See generally* Thomas J. Reed, *The Futile Fifth Step: Compulsory Disclosure of Confidential Communications Among Alcoholics Anonymous Members*, 70 ST. JOHN'S L. REV. 693, 716 n.108 (1996) ("Of course, the legislature may pass statutes granting confidential communications privileges to professionals which the courts must follow, even if they fail to meet Wigmore's criteria.").

While the Arizona legislature and the legislatures of most other states have not yet enacted nurse-patient privilege statutes,[355] the legislative presumption that the physician-patient privilege satisfies the Wigmore test should extend by analogy to the nurse-patient privilege.[356] As one pair of commentators noted, while "scholars have often criticized the privileged relationships created by the legislatures,"[357] the legislatures of the majority of states have enacted physician-patient privilege statutes,[358] and "[s]ome states have privileged communication laws involving . . . nurses."[359] The legislatures, and arguably the courts,[360] of these latter states have at least implicitly concluded that the nurse-patient and physician-patient relationships are equally deserving of the protection of an evidentiary privilege.[361]

X. Public Policy Favors Recognition of Nurse-Patient Privilege

A. Nurse-Patient Privilege Would Promote Candor in the Nurse-Patient Relationship

Whether intentional or not,[362] the failure of a majority of states to recognize a nurse-patient privilege operates to perpetuate the paternalism and gender stereotyping that have long plagued the health care field,[363] where females dominate the nursing

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[355] *See* DEMARCO ET AL., *supra* note 18, at 210 ("The majority of states . . . do not currently recognize a nurse-patient privilege, conditional or otherwise."); Winters, *supra* note 53, at 233 ("Nurses in some states are not included in the state statutes of parties entitled to privileged communications, which protects that party from the disclosure of confidential information obtained from a patient.").

[356] *See generally* Wright, *supra* note 18, at 82 ("The nurse-patient relationship meets Wigmore's criteria for establishing privilege.").

[357] SAMUEL KNAPP & LEON VANDECREEK, PRIVILEGED COMMUNICATIONS IN THE MENTAL HEALTH PROFESSIONS 4 (1987).

[358] *See id.*; *cf.* People v. Allen, 784 N.E.2d 393, 395 (Ill. App. Ct.) (stating that "most states have adopted some form of the [physician-patient] privilege"), *leave to appeal denied*, 792 N.E.2d 308 (Ill. 2003).

[359] KNAPP & VANDECREEK, *supra* note 357, at 4.

[360] *See, e.g.*, Poornima L. Ravishankar, Comment, *Planned Parenthood Is Not a Bank: Closing the Clinic Doors to the Fourth Amendment Third Party Doctrine*, 34 SETON HALL L. REV. 1093, 1105 (2004). "New York . . . provides a wide range of statutory protections for privileged communications. Confidential information is privileged not only in the instance of physicians . . . and nurses, but also for psychologists and social workers. *These statutory protections are reinforced by New York common law*." *Id.* (emphasis added and footnotes omitted).

[361] *See generally* Pierce, *supra* note 14, at 1086. "Communications between nurses and patients deserve just as much privacy as communications between physicians and patients. The reasons underlying the physician-patient privilege apply with equal, if not more, force to communications between nurses and patients." *Id.*

[362] *See generally* Julie F. Kay, Note, *If Men Could Get Pregnant: An Equal Protection Model For Federal Funding of Abortion Under a National Health Care Plan*, 60 BROOK. L. REV. 349, 383 (1994). "The danger exists that gender stereotypes are so ingrained that legislators do not recognize that such assumptions form the basis of a policy." *Id.*

[363] *See generally* Daley v. St. Agnes Hosp., Inc., 490 F. Supp. 1309, 1314 (E.D. Pa. 1980) (referring to "traditional views of the female nursing role as a menial one"); Camille S. Williams, *Women, Equality, and the Federal Marriage Amendment*, 20 BYU J. PUB. L. 487, 507 (2006) (asserting that "the

profession,[364] but at least until relatively recently,[365] have been all but excluded from the medical profession.[366] One commentator lamented this phenomenon in the following terms:

> Modern nursing originated at a time when Victorian ideals dictated that the role of women was to serve men's needs and convenience. Nursing's development continued to be greatly influenced by the attitudes that women were less independent, less capable of initiative, and less creative than men, and thus needed masculine guidance.[367]

However, the absence of a widely recognized nurse-patient privilege does not merely diminish the professional status of nurses;[368] it poses a threat to the health of their patients.[369] Nurses often must obtain sensitive and potentially embarrassing information from their patients in order to treat them effectively.[370] Just as the

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male-dominated occupation of physician has more prestige than the female-dominated occupation of nursing").

[364] *See* Beck-Wilson v. Principi, 441 F.3d 353, 356 (6th Cir. 2006) (discussing "the historically female-dominated profession of nursing"); *Daley*, 490 F. Supp. at 1311 (noting that "the nursing profession is traditionally overwhelmingly female"); Andrew I. Gavil & Tara Isa Koslov, *A Flexible Health Care Workforce Requires a Flexible Regulatory Environment: Promoting Health Care Competition Through Regulatory Reform*, 91 WASH. L. REV. 147, 170 n.56 (2016). "Even today, gender biases persist; according to one respected source, over eighty percent of professional active nurses in the United States are female." *Id.*

[365] *See* Sobel v. Yeshiva Univ., 566 F. Supp. 1166, 1169 n.8 (S.D.N.Y. 1983) (referring to "the increased entrance of women into the medical profession in recent years"), *rev'd and remanded for reconsideration on other grounds*, 797 F.2d 1478 (2d Cir. 1986). *But see* Nancy K. Kubasek, *Legislative Approaches to Reducing the Hegemony of the Priestly Model of Medicine*, 4 MICH. J. GENDER & L. 375, 379 (1997). "While there has been an increase in medical school admissions for women in recent years, women's numbers in the medical profession are still sparse vis-à-vis their proportion of the entire population." *Id.*

[366] *See* Gavil & Koslov, *supra* note 364, at 170 n.56 ("[T]he existing hierarchy of health care professionals likely is tied to historical gender roles, whereby most physicians were male and most nurses were female."); Thomas Koenig & Michael Rustad, *His and Her Tort Reform: Gender Injustice in Disguise*, 70 WASH. L. REV. 1, 61 (1995) ("Stereotypes of the medical profession are so powerful that doctors are automatically perceived to be male and nurses to be female.").

[367] Armstrong, *supra* note 191, at 582 n.37 (quoting JO ANN ASHLEY, HOSPITALS, PATERNALISM, AND THE ROLE OF THE NURSE 75-76 (1976)); *see also* Deborah A. Calloway, *Equal Employment and Third Party Privacy Interests: An Analytical Framework for Reconciling Competing Rights*, 54 FORDHAM L. REV. 327, 361 n.169 (1985) ("Nursing . . . has been one of the most stereotyped occupations 'because of its congruence with the traditional female role.'" (quoting Myron D. Fottler, *Attitudes of Female Nurses Toward the Male Nurse: A Study of Occupational Segregation*, 17 J. HEALTH & SOC. BEHAVIOR 98, 99 (1976))).

[368] *See* Wright, *supra* note 18, at 82 ("Nursing's status as a profession is minimized without nurse-client privilege."); *Cf.* Stern, *supra* note 53, at 23 ("Issues of trust and self-disclosure are paramount in the nurse-patient relationship. If these are adversely affected by the absence of statutory privilege, the relationship may be jeopardized.").

[369] *See* Pierce, *supra* note 14, at 1087 ("[I]n many states, when compelled to testify, nurses conversations with their patients are not protected. As a result, the patient is the victim . . . .").

[370] *See, e.g.*, Med. Lab. Mgmt. Consultants v. Am. Broad. Cos., 306 F.3d 808, 816 (9th Cir. 2002) (discussing a "patient's communications with [a] nurse [that] were intensely private and personal"); *see also* Orna Rabinovich-Einy, *Deconstructing Dispute Classifications: Avoiding the Shadow of*

assurance of confidentiality provided by the recognition of a nurse-patient privilege might prompt a patient to "divulge more confidential medical information to the nurse to enable treatment,"[371] the lack of such assurance is likely to cause some patients to withhold important information about their health.[372] This undoubtedly results in less favorable treatment outcomes in some cases.[373] Indeed, the recognition of any health care provider privilege is premised largely on this assumption.[374]

B. Nurse-Patient Privilege Would Benefit Lower Income Patients

Broader recognition of the nurse-patient privilege might be particularly beneficial to lower income patients.[375] Finding it difficult to afford the more costly health care services provided by physicians,[376] lower income patients are increasingly

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the Law in Dispute System Design in Healthcare, 12 CARDOZO J. CONFLICT RESOL. 55, 72 (2010) (asserting that "nurses need to obtain full and accurate information from patients").

[371] Pierce, *supra* note 14, at 1090; *see also* DEMARCO ET AL., *supra* note 18, at 211 (stating that "the trust between a nurse and a patient is potentially enhanced by nurse-patient privilege").

[372] *See* Long v. Am. Red Cross, 145 F.R.D. 658, 668 (S.D. Ohio 1993) (discussing the "assumption that people will be less likely to disclose fully their . . . medical problems to a professional if they know that such information can be freely disclosed to third parties"); Laburre v. E. Jefferson Gen. Hosp., 555 So.2d 1381, 1383 (La. 1990) ("The threat of disclosure of patient confidences may deter patients from revealing information that could result in humiliation, embarrassment, or disgrace to the patient or that could be the basis for the patient's legal liability."); Gostin, *supra* note 58, at 490-91 ("Patients are less likely to divulge sensitive information to health professionals if they are not assured that their confidences will be respected.").

[373] *See generally* Richard Delgado, Comment, *Underprivileged Communications: Extension of the Psychotherapist-Patient Privilege to Patients of Psychiatric Social Workers*, 61 CALIF. L. REV. 1050, 1053 (1973) ("The absence of privilege not only jeopardizes the possibility of effective treatment for the patient; it can also deter others from seeking attention.").

[374] *See* Moss v. State, 925 So.2d 1185, 1191 (La. 2006):

> The principal purpose of the health care provider-patient privilege is to encourage full disclosure by the patient of his or her condition in order to ensure proper diagnosis and treatment. To obtain this end, the privilege seeks to secure the patient from disclosure, in court, of potentially humiliating, embarrassing or disgraceful information, or information that could be the basis for the patient's legal liability.

Id. (citation omitted).

[375] *See* Goodman, *supra* note 20, at 429 (concluding that the "current standard for judging whether a physician-patient communication was made confidentially undermines the interests of those from lower socio-economic classes"). *See generally* Morse, *supra* note 18, at 744 ("[P]rofessions with the money and clients to establish a strong lobby are the professions that receive privileges. Professionals with poorer clients do not have the money nor the political clout to lobby for privileges.") (footnote omitted).

[376] *See* McCoy v. Health Net, Inc., 569 F. Supp. 2d 448, 466 (D.N.J. 2008) ("A procedure performed by a highly skilled physician is likely to be more expensive than one performed by a . . . nurse practitioner . . . ."); *see also* Aaron Edlin & Rebecca Haw, *Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny?*, 162 U. PA. L. REV. 1093, 1108 (2014) ("[N]urse practitioners' education costs less than that of medical doctors, and nurse practitioners' fees reflect those cost savings.").

looking to nurse practitioners for their health care needs.[377] These patients are often called upon to reveal the type of sensitive information about their health that might be essential to the provision of effective treatment,[378] and that would be protected by an evidentiary privilege in most states if it was revealed to a physician.[379]

In fact, access to physician care may be virtually nonexistent in some impoverished rural and inner city areas,[380] leaving treatment by nurse practitioners as the only viable option for many individuals residing in those areas.[381] Patients in other situations may face similar challenges.[382] As one commentator observed: "Access

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[377] *See* Ridge v. Colvin, No. 1:13-cv-02063-AC, 2015 U.S. Dist. LEXIS 83438, at *19 (D. Or. June 9, 2015) ("It is not uncommon for individuals to seek treatment from a nurse practitioner, who is often an economical and efficient means of obtaining certain medical treatment."), *adopted*, 1:13-cv-02063-AC, 2015 U.S. Dist. LEXIS 81899 (D. Or. June 24, 2015); *see also* Parker v. Comm'r of Soc. Sec., No. 6:12-cv-00029, 2013 U.S. Dist. LEXIS 120224, at *13 (W.D. Va. Aug. 2, 2013) ("[N]urse practitioners play a significant role in the provision of health care in this country, particularly to low-income persons."), *adopted*, 2013 U.S. Dist. LEXIS 119847 (W.D. Va. Aug. 23, 2013); *see also* Richardson v. Astrue, No. SKG-10-614, 2011 U.S. Dist. LEXIS 98932, at *23 n.5 (D. Md. Aug. 31, 2011) ("[N]urse practitioners play a critical and increasingly large role in [the] provision of health care, especially among the low-income populations.").

[378] *See* Pierce, *supra* note 14, at 1087 ("[A]s more people . . . seek nurse practitioners for their primary care needs, patients are increasingly relaying private information necessary to their care to nurse practitioners."); Wright, *supra* note 18, at 82 ("Nurses often seek information from patients that is sensitive, delicate, and intimate.").

[379] *See generally* DEMARCO ET AL., *supra* note 18, at 210 ("[I]t is regrettable that in most states the information provided to a nurse is not protected in the way that the same information would be protected if conveyed to a physician.").

[380] *See generally* Singer v. Dep't Health & Human Servs., 641 F. Supp. 2d 1219, 1220 (D. Utah 2009) (noting that "in inner cities and remote rural areas . . . residents lack adequate access to health care."); *see also* Fisher v. Bown, 659 F. Supp. 784, 785 (D. Or. 1987) (referring to "the shortage of health resources in the area of primary health care services for urban and rural medically underserved populations in the United States"); *see also* Coleman & Shellow, *supra* note 301, at 55 ("Certain rural Americans have long lacked access to medical treatment. The number of underserved people in inner-city areas has also increased.") (footnote omitted); *see also* Kay, *supra* note 362, at 404 (asserting that "physician shortages in areas of rural and urban poverty severely limit health care access for low-income people.").

[381] *See, e.g.*, Rinaldi v. Berryhill, No. 2:16-CV-1403-RBH, 2017 U.S. Dist. LEXIS 147305, at *15 (D.S.C. Sept. 12, 2017) ("Plaintiff argues that her location in a small, rural town limits her access to medical care, and she was assigned a certified nurse practitioner as her primary care provider for this reason."); *see also* Groover v. Johnston, 625 S.E.2d 406, 409 (Ga. Ct. App. 2005) (discussing "the health care needs of indigent and rural Georgians, where an insufficient number of practicing physicians made expanded nurse care necessary."). *See generally* Linda F. Heffernan, *Regulation of Advanced Practice Nursing in Health Care Reform*, J. HEALTH & HOSP. L., Mar./Apr. 1995, 73, 75 (stating that nurse practitioners "have been credited with improving the geographic distribution of care because many are willing to practice in underserved inner city and rural areas.").

[382] *See, e.g.*, Drinan, *supra* note 44, at 1339-40 ("[W]hen patients go 'to the doctor' for, say, a common cold, they may not even see a physician; in many cases, nurse practitioners serve as primary care providers."); *see also* Alexander M. Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, 36 CASE W. RES. L. REV. 708, 740-41 (1986) ("Compared to people who are insured, people not covered by any form of private or public health insurance . . . are more likely to face substantial obstacles in obtaining adequate care, particularly for chronic or other nonemergency conditions.").

problems are not limited to residents of rural or inner-city communities, nor are they limited to the very poor, but even extend to low or middle income families."[383] As well-intentioned as its actions may have been,[384] Congress's enactment of the Affordable Care Act[385] appears to have exacerbated rather than alleviated these problems.[386]

C. The Analogy to the Social Worker-Client Privilege

The inequity inherent in many states' existing privilege laws is illustrated by the analysis in *Jaffee v. Redmond*,[387] where the Supreme Court recognized a federal common law psychotherapist-patient privilege[388] and extended its protection to a client's

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[383] *See* Capron, *supra* note 382, at 740.

[384] *See* Brittany Hynes, Comment, *Section 1332 State Innovation Waivers: Waiving Goodbye to Cooperative Federalism and Hello to Collaborative Federalism*, 27 U. MIAMI BUS. L. REV. 329, 331 (2019) ("The politically controversial Patient Protection and Affordable Care Act . . . was designed to 'improve access to and the delivery of health care services for all individuals, particularly low income, underserved, minority and rural populations.'"); *see also* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 5001, 124 Stat. 119, 588 (2010); *cf.* Sabeena Bali, Comment, *The Economic Advantage of Preventative Health Care in Prisons*, 57 SANTA CLARA L. REV. 453, 462 (2017) (asserting that enactment of the Affordable Care Act was motivated in part by the "lack of access to health care for many Americans.").

[385] *See* The Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010) (The "Affordable Care Act" actually consists of two separate pieces of federal legislation). *see also* The Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010); Eden Foods, Inc. v. Sebelius, 733 F.3d 626, 627 (6th Cir. 2013), *vacated and remanded*, 573 U.S. 956 (2014); *see also* Sara Rosenbaum, *Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System*, 7 J. HEALTH & BIOMEDICAL L. 1 (2011) (summarizes the applicable legislation).

[386] *See* Pierce, *supra* note 14, at 1100. "[W]ith the Affordable Care Act in place there may be long waits to see overworked physicians; therefore, nurse practitioners may be the only treatment provider available for some patients." *Id. Cf.* Hana Sahdev, Note, *Can I Skype My Doctor? Limited Medicare Coverage Hinders Telemedicine's Potential to Improve Health Care Access*, 57 B.C.L. REV. 1813, 1823 (2016). Asserting that a "shortage of primary care physicians in the United States . . . hinders access to care," and that the problem has been "exacerbated" by the expanded access to health insurance coverage available under the Affordable Care Act. *Id.*

[387] 518 U.S. 1 (1996).

[388] *See* Parsons v. Weber Cty., 151 F.R.D. 130, 132 (D. Utah 1993). Prior to *Jaffee* there was "a significant split in the federal courts on whether a psychotherapist/patient privilege exists under federal law." *Id. See also* Smith v. United States, 193 F.R.D. 201, 209 n.30 (D. Del. 2000) (suggesting in *Jaffee* that privileges may sometime have exceptions and exception are case-by-case). The *Jaffee* Court resolved this split by formally recognizing the privilege "as a matter of federal common law." *Id. See also* Kinsella v. Kinsella, 696 A.2d 556, 566 (N.J. 1997) (citing *Jaffee*, 518 U.S. at 12 & n.11). The *Jaffee* decision also brought federal law more closely into accord with the privilege laws of the various states, in that the psychotherapist-patient privilege was "statutorily recognized in some form by all fifty states and the District of Columbia" at the time *Jaffee* was decided. *Id. See generally* George C. Harris, *The Dangerous Patient Exception to the Psychotherapist-Patient Privilege: The* Tarasoff *Duty and the* Jaffee *Footnote*, 74 WASH. L. REV. 33, 33 (1999). "Beginning in the 1960s and culminating with the U.S. Supreme Court's 1996 decision in *Jaffee v. Redmond*, every U.S. jurisdiction has recognized some form of evidentiary privilege for statements made by a patient to a psychotherapist for the purpose of obtaining treatment." *Id.*

confidential therapeutic communications with a licensed social worker.[389] Explaining this uncharacteristically broad interpretation of the privilege,[390] the *Jaffee* Court noted that social workers' clients "often include the poor and those of modest means who could not afford the assistance of a psychiatrist or psychologist, but whose counseling sessions serve the same public goals."[391] Given this fact, the Court concluded that "drawing a distinction between the counseling provided by costly psychotherapists and that provided by more readily accessible social workers serves no discernible public purpose."[392]

This is persuasive reasoning,[393] foreshadowed by several commentators[394] and, at least inferentially, adopted by many state legislatures,[395] and in at least one pre-*Jaffee*

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[389] *See* Student 1 v. Williams, 206 F.R.D. 306, 307 (S.D. Ala. 2002). Observing that the *Jaffee* Court "established a federal psychotherapist privilege applicable to licensed psychiatrists, licensed psychologists and licensed social workers." *Id. See generally* W. Joseph Nielsen, Note, *The Psychotherapist-Patient Privilege as Adopted in the Federal Courts Includes Not Only All Communications to Licensed Psychiatrists and Psychologists, But Also All Communications to Licensed Social Workers in the Course of Psychotherapy*, 27 SETON HALL L. REV. 1123 (1997) (discussing the privileges established by the *Jaffee* court).

[390] *See generally* United States v. Bolander, 722 F.3d 199, 222 (4th Cir. 2013). "Like all testimonial or evidentiary privileges, the psychotherapist-patient privilege must be strictly construed." *Id.* Catharina J.H. Dubbelday, Comment, *The Psychotherapist-Client Testimonial Privilege: Defining the Professional Involved*, 34 EMORY L.J. 777, 811 (1985) ("The psychotherapist-client privilege . . . is often construed narrowly as being in derogation of the common law.").

[391] *See Jaffee*, 518 U.S. at 16; *see also* Alex Koch, Note, *Internal Corporate Investigations: The Waiver of Attorney-Client Privilege and Work-Product Protection Through Voluntary Disclosures to the Government*, 34 AM. CRIM. L. REV. 347, 367 (1997). "[S]ocial workers provide the only affordable mental health counseling for many people" *Id.*; *see generally* Mary Kearny Stroube, Comment, *The Psychotherapist-Patient Privilege: Are Some Patients More Privileged Than Others*?, 10 PAC. L.J. 801, 818 (1979) "[I]ndividuals who exist near the poverty level . . . are more apt to receive treatment by a mental health professional other than a psychiatrist or psychologist." *Id.*

[392] *See Jaffee*, 518 U.S. at 17 (quoting Jaffee v. Redmond, 51 F.3d 1346, 1358 n.19 (7th Cir. 1995), *aff'd*, 518 U.S. 1 (1996)); *cf.* Stroube, *supra* note 391, at 824. "If society continues to value the psychotherapeutic relationship by giving it legal recognition in the form of the psychotherapist-patient privilege, . . . disparate protection for clients makes little sense." *Id.*

[393] *See* Farrell v. Regola, 150 A.3d 87, 99 n.3 (Pa. Super. Ct. 2016) (characterizing the *Jaffee* Court's "reasons for extending the privilege to clinical social workers" as "compelling"), *leave to appeal denied*, 168 A.3d 1259 (Pa. 2017); *cf.* Ralph Slovenko, *Psychotherapist-Patient Testimonial Privilege: A Picture of Misguided Hope*, 23 CATH. U.L. REV. 649, 664 (1974).

> Social workers . . . are called the "poor man's psychiatrist." Their clients are referred to as "patients." Since it is the therapeutic function . . . the law on privilege is theoretically designed to protect, there is little justification for extending privileged status to one group and denying it to another that is fundamentally accomplishing the same thing.

Id.

[394] *See, e.g.*, Bruce J. Winick, *The Psychotherapist-Patient Privilege: A Therapeutic Jurisprudence View*, 50 U. MIAMI L. REV. 249, 264 (1996). "Recognizing a privilege that extends . . . to psychiatrists and psychologists, but not to psychiatric social workers, would in effect create a second-class professional relationship for people lacking the financial means to hire the more expensive psychiatrist or psychologist." *Id. See also* Stroube, *supra* note 391, at 819. Asserting that the

federal court decision.[396] Its application to the analogous relationship between physicians[397] and nurses seems obvious.[398] Indeed, the force of the *Jaffee* Court's reasoning is particularly compelling in the case of psychiatric nurses,[399] who may provide

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psychotherapist-patient privilege should "provide equal protection for all classes of persons claiming the privilege." *Id.*

[395] *See In re* Madison, 687 F. Supp. 2d 103, 122 (E.D.N.Y. 2009) (quoting Jaffee, 518 U.S. 1, 16-17 (1996) (emphasis omitted). In extending the protection of the privilege to social workers, the *Jaffee* Court "relied, in part, on the fact that the 'vast majority of States explicitly extend a testimonial privilege to licensed social workers'" by statute. *Id. But see, e.g.*, State v. Curtis, 597 A.2d 770, 772 (Vt. 1991). "The Vermont legislature has not created a social worker privilege." *Id. See generally* Philip W. Savrin, Note, *The Social Worker-Client Privilege Statutes: Underlying Justifications and Practical Operations*, 6 PROB. L.J. 243 (1985) (discussing the pre-*Jaffee* state legislative environment).

[396] *See In re* Production of Records to Grand Jury, 618 F. Supp. 440, 441 (D. Mass. 1985) ("[T]his court recognizes as a matter of federal evidentiary law, a qualified privilege for . . . communications made to a social worker in his or her professional capacity . . . insofar as the communication relates to the care and treatment of the patient."). *But cf. State v. Driscoll*, 193 N.W.2d 851, 856 (Wis. 1972) ("[T]he creation of privileged communication in this . . . area should be left to the legislature. We think public policy is not so definitely compelling or clear or the area so limited that we should grant testimonial confidentiality by court decision to social workers.") (footnote omitted)

[397] *See* Michael B. Bressman & Fernando R. Laguarda, *Jaffee v. Redmond: Towards Recognition of a Federal Counselor-Battered Woman Privilege*, 30 CREIGHTON L. REV. 319, 330 (1997). In recognizing the psychotherapist-patient privilege as a matter of federal common law, the *Jaffee* Court is generally assumed to have "evaluated the privilege under the Wigmore test." *Id. Cf.* Jennifer Sawyer Klein, Note, *"I'm Your Therapist, You Can Tell Me Anything": The Supreme Court Confirms the Psychotherapist-Patient Privilege in Jaffee v. Redmond*, 47 DEPAUL L. REV. 701, 731 (1998) ("Although the majority did not directly cite to this test in its opinion, much of the reasoning seems to derive from the basic principles of the test."). This assumption prompted one commentator to argue that the federal courts also should recognize the physician-patient privilege because "each of the Wigmore factors for recognizing common law privileges applies equally well to the physician-patient relationship as to the psychotherapist-patient relationship." Goodman, *supra* note 20, at 432. See Stephen Aaron Silver, Note, *Beyond Jaffee v. Redmond: Should the Federal Courts Recognize a Right to Physician-Patient Confidentiality?*, 58 OHIO ST. L.J. 1809 (1998) for a discussion of *Jaffee*'s potential impact on the physician-patient privilege.

[398] *See* Merrily S. Archer, Recent Development, *All Aboard the Bandwagon!: The Uncertain Scope of the Federal Psychotherapist-Client Privilege in the Aftermath of Jaffee v. Redmond,* 52 J. URB. & CONTEMP. L. 355, 362 (1997) (noting that "nothing in the Court's analysis indicates that the privilege could not also extend to . . . registered nurses"); *cf. In re* C.P., 543 N.E.2d 410, 412 (Ind. Ct. App. 1989), *aff'd*, 563 N.E.2d 1275 (Ind. 1990) (recognizing "an analogy between a nurse/physician working relationship and a social worker/psychiatrist working relationship," as both nurses and social workers "gather patient information and indeed treat patients in their own right").

[399] *See, e.g.,* TENN. CODE ANN. § 63-7-125(a). In Tennessee, for example, the legislature enacted a statute protecting "confidential communications between a client and a registered nurse who is nationally certified as a specialist in psychiatric and mental health nursing and who is practicing in that specialty," reasoning that those communications are "equivalent to the confidential communications between a patient and a licensed physician practicing as a psychiatrist." *Id. See also In re* Amendments to Fla. Evidence Code, 960 So.2d 762, 763 (Fla. 2007) ("In 2006, the [Florida] Legislature amended Section 90.503, Florida Statutes, to broaden the psychotherapist-patient privilege by adding to the list of those who will be deemed 'psychotherapists' certain certified registered nurses whose primary practice is the diagnosis or treatment of mental or emotional conditions." (citing ch. 2006-204, § 1, Laws of Fla.)).

affordable mental health care to patients,[400] and thus – like licensed social workers[401] – can be considered psychotherapists themselves.[402] As one commentator explained:

> [S]ociety has an interest in encouraging people to make full disclosures to nurses and social workers as well as to doctors and psychiatrists . . . [T]hose who are interested in facilitating the admission of relevant evidence should re-examine the privilege rules with an eye towards developing a more balanced approach that eliminates the discriminatory effects of the current structure.[403]

In short, by encouraging patients to be more forthcoming about their medical conditions,[404] thereby enabling nurses to more fully and effectively practice their profession,[405] the recognition of a nurse-patient privilege would be of particular benefit to lower income patients and those who for other reasons may have only limited access

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[400] *See generally State v. Edourd*, 854 N.W.2d 421, 459 (Iowa 2014), *overruled in part on other grounds by Alcala v. Marriott Int'l, Inc.*, 880 N.W.2d 699, 708 & n.3 (Iowa 2016) (Hecht, J., concurring in part and dissenting in part) ("[N]urses . . . fill specialized, technical roles in the realm of psychiatric care, and perform highly specialized functions in providing professional mental health services for clients and patients.").

[401] *See State v. Smith*, 809 So.2d 556, 564 (La. Ct. App. 2002) ("Psychotherapist is defined as including a licensed social worker." (citing LA. CODE EVID. ANN. art. 510(A)(4)(c))); *State v. A.S.* (*In re* A.S.), 982 P.2d 1156, 1169 (Wash. 1999) ("The [Washington] statute defining certified social workers includes . . . psychotherapy within a social worker's scope of practice.").

[402] *See, e.g.,* Commonwealth. v. Brandwein, 760 N.E.2d 724, 728 n.6 (Mass. 2002) ("The term 'psychotherapist' includes a registered nurse who has been authorized to practice as a 'psychiatric nurse mental health clinic specialist.'" (quoting MASS. GEN. LAWS ch. 233, § 20B)); *see also* Catherine M. Baytion, Comment, *Toward Uniform Application of a Federal Psychotherapist-Patient Privilege*, 70 WASH. L. REV. 153, 153 n.3 (1995) (observing that "psychiatric nurses . . . arguably perform the same functions as psychotherapists").

[403] Kit Kinports, *Evidence Engendered*, 1991 U. ILL. L. REV. 413, 442; *see also* KNAPP & VANDECREEK, *supra* note 357, at 60 (advocating the recognition of a privilege whereby "the function of psychotherapy is protected for several types of mental health professionals with different kinds of professional training"). Some states have already taken steps to remedy these inequities. In New York, for example, "communications between a patient and his doctors, nurses, psychologists, and social workers are privileged." *In re* Miccoli v. W.T., 31 N.Y.S.3d 806, 809 (Sup. Ct. 2016); *see also Hermanson v. MultiCare Health Sys., Inc.*, 448 P.3d 153, 164 (Wash. Ct. App. 2019) ("Similar to the physician-patient privilege, the [Washington] legislature has provided statutory social worker-patient and nurse-patient privileges."), *review granted*, 456 P.3d 399 (Wash. 2020).

[404] *See In re* Vioxx Prods. Liab. Litig., 230 F.R.D. 473, 477 (E.D. La. 2005) (observing that an assurance of confidentiality "invites patients to provide information about [their] ailments with greater candor"); Robert M. Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C. L. REV. 255, 257 (1984) (noting that "the assurance of confidentially encourages patients to be candid . . . and candor is essential to effective diagnosis and medical management of the patient's ailments" (quoting *Privacy of Medical Records: Hearings on H.R. 2979 and H.R. 3444 Before the Government Information and Individual Rights Subcomm. of the House Comm. on Government Operations*, 96th Cong.. 1st Sess. 1129 (1979) (Statement of James H. Sammons, M.D., Executive Vice President, American Medical Association))).

[405] *See, e.g.*, Smith, *supra* note 15, at 29 ("The education and expertise acquired by clinical nurse specialists cannot be fully utilized without privileged communication.").

to physicians.[406] Conversely, refusing to extend the protection of an evidentiary privilege to patients who require, or simply prefer,[407] the more accessible and affordable health care services provided by nurses is both inequitable and unwise.[408]

XI. Conclusion

The physician-patient privilege is premised in part on the assumption that patients might withhold sensitive information about their medical conditions, such as those stemming from past sexual history or substance abuse,[409] or even elect not to seek treatment,[410] if there is a risk that the information would subsequently be revealed in court.[411] Although Professor Wigmore questioned the validity of this assumption,[412] his

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[406] *See* Don W. King, *U.S. Health Care Reform: Comprehensive Insurance or Affordable Care?*, 7 J.L. ECON. & POL'Y 439, 479 (2011) ("Allowing nurse practitioners to utilize full extent of training makes care available to low-income persons."); Smith, *supra* note 15, at 29 (asserting that "[w]ith privilege, clinical nurse specialists can extend the services provided to . . . those in need").

[407] *See* Patrick Groshong, Note, *And Curb This Cruel Devil of His Will: The Griffin Health Bill and Collaborative Practice Between Physicians and Nurses*, 62 UMKC L. REV. 925, 934 (1994).

> Many patients claim they are happier with advanced nurse practitioners than physicians because the nurse practitioner is more likely to take the time to talk with the patient and ask the patient questions. The reason for this preference is simple – the nurse practitioner is a more holistic health care provider than the physician.

Id.

[408] *See* Hallett, *supra* note 317, at 500-01 (asserting professional privileges might be expanded to . . . nurses whom low-income individuals are more likely to contact); Betty F. Lay, Note, *Healer-Patient Privilege: Extending the Physician-Patient Privilege to Alternative Health Practitioners in California*, 48 HASTINGS L.J. 633, 636 (1997) (explaining patients are increasingly entering into physician-patient relationships with alternative healthcare providers raises concerns of fairness).

[409] *See* Furci, *supra* note 87, at 250 (observing disclosure of diagnosis of a sexually transmitted disease would engender anguish and embarrassment); Ruebner & Reis, *supra* note 333, at 548 (noting that patients would not want information that exposes diagnosis or treatment for a stigmatized condition publicly disclosed.); Smith, *supra* note 23, at 547 (noting "treatment for venereal disease or drug abuse" is medical information many people consider sensitive).

[410] *See* Erin B. Bernstein, *Health Privacy in Public Spaces*, 66 ALA. L. REV. 989, 1011 (2015) (explaining that fearing disclosure of health information, patients may critical information or forego treatment altogether); Ruebner & Reis*, supra* note 333, at 548. "[M]any patients may choose to not discuss sensitive medical conditions with their physicians, or worse, avoid treatment for such conditions, rather than risking the stigma, embarrassment, or opprobrium to which they may be subjected if the information finds its way into the public domain." *Id.*

[411] *See* Prudential Ins. Co. v. Kozlowski, 279 N.W. 300, 301-02 (Wis. 1938).

> [P]atients may be afflicted with diseases or have vicious or uncleanly habits necessary for a physician to know in order to treat them properly, disclosure of which would subject them to humiliation, shame, or disgrace, and which they might refrain from disclosing to a physician if the physician could be compelled to disclose them on the witness stand.

Id. See also Johnson, *supra* note 333, at 1252. "Patients will withhold information if they understand that it may be revealed on the witness stand, or if they fear that too many people are

opposition to the physician-patient privilege has not carried the day,[413] and even he acknowledged the existence of "some justification for the privilege in sex-related medical evidence."[414]

In any event, Arizona's physician-patient privilege statutes embody this assumption,[415] which has no less application to the relationship between nurses and patients than it does to the relationship between physicians and patients.[416] Given the

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seeing their medical records." *Id.* (footnote omitted). *See also* Weiss, *supra* note 327, at 286-87. "The standard justification [for the physician-patient privilege] accepted by the courts has been that the privilege would encourage full and complete disclosure of potentially embarrassing information by patients – information which would assist physicians in providing effective treatment." *Id.*

[412] *See* Green v. Superior Ct., 33 Cal. Rptr. 604, 606 (Ct. App. 1963). "Dean Wigmore opines that few communications by a patient to a doctor are intended to be confidential and that even where they are the patient is not deterred from making them by the possibility of their disclosure." *Id.* (citing 8 WIGMORE, *supra* note 79, § 2380a, at 829). *See also* Weiss, *supra* note 327, at 287. "Wigmore argued that patients hardly ever have an interest in preserving the secrecy of their communications. Even if they did, their interest in treatment would supersede the interest in secrecy, causing them to seek medical care regardless of the existence of any privilege." *Id.* (citing WIGMORE, *supra* note 79, § 2380a).

[413] *See* Alvin O Boucher, *Implied Waiver of Physician-Patient Privilege in North Dakota Medical Malpractice and Personal Injury Litigation*, 83 N.D. L. REV. 855, 861 (2007). "Despite the arguments advanced by Wigmore against the privilege, its existence was established by statute in most states . . .. It is now a generally accepted evidentiary premise resulting in expectations of medical privacy by the public." *Id.* (footnote omitted). *See also* Note, *Medical Jurisprudence—Privileged Communications Between Physician and Patient—State Regulation and Right to Privacy*, 39 TENN. L. REV. 515, 521 (1972). "The physician-patient privilege has won at least limited recognition in a majority of the states, despite disparaging treatment by Dean Wigmore and others." *Id.* (footnote omitted).

[414] *See* Howard v. Des Moines Register & Tribune Co., 283 N.W.2d 289, 305 (Iowa 1979) (Larson, J., dissenting) (citing WIGMORE, *supra* note 79, § 2380a, at 830). *Cf.* Weiss, *supra* note 327, at 287. "Although Professor Wigmore's arguments might apply in the context of common ailments or broken limbs, they are thoroughly unconvincing in a consideration of a highly stigmatized disease such as AIDS." *Id.*

[415] *See* Carondelet Health Network v. Miller, 212 P.3d 952, 954 (Ariz. Ct. App. 2009).

> The physician-patient privilege, codified in Arizona at A.R.S. §§ 12-2235 and 12-2292, exists to foster a patient's "full and frank disclosure of medical history and symptoms" to his or her physician in order to facilitate the best possible medical treatment. The privilege reflects a societal judgment that people should feel free "to seek treatment undeterred by fear that a private physical condition will become a matter of public discussion.

Id. (quoting Lewin v. Jackson, 492 P.2d 406, 410 (Ariz. 1972), and JOSEPH M. LIVERMORE ET AL., ARIZONA LAW OF EVIDENCE § 501.1, at 123 (4th ed. 2000)) (footnote omitted).

[416] *See* State v. Evans, 454 P.2d 976, 978 (Ariz. 1969) ("The obvious policy underlying the physician-patient privilege is that patients should be encouraged to make full and frank disclosures *to those who are attending them*.") (emphasis added); Winn, *supra* note 168, at 622 ("[N]urses and other health care providers have long known that fear of disclosure of health information may cause people to withhold information, to lie, or to avoid treatment altogether."). *cf.* Cochran, *supra* note 48, at 190 ("Gaining a patient's trust and confidence is essential to the nurse-patient relationship. If patients were to be secretive with their health care providers, all

increasing convergence of the two professions,[417] the lack of a privilege protecting confidential communications between nurses and patients represents a "glaring gap" in Arizona's and many other states' existing privilege laws.[418] The Arizona legislature, or if presented with the opportunity the Arizona courts,[419] should act expeditiously to rectify this omission,[420] as should the legislatures and courts in other states where the nurse-patient privilege is not currently recognized.[421]

concerned could be at a serious disadvantage.") *See generally* Pugach v. Borja, 670 N.Y.S.2d 718, 721 (Sup. Ct. 1998) (stating that trust "is critical to the nurse-patient relationship"). *Id.*

[417] *See* Sermchief v. Gonzales, 660 S.W.2d 683, 688 (Mo. 1983) (referring to the "thin and elusive line that separates the practice of medicine and the practice of professional nursing in modern day delivery of health services").

[418] *See* Pierce, *supra* note 14, at 1078-79; *cf.* Goodman, *supra* note 20, at 423 (asserting that "courts [that] decline to cover nurses . . . leave a large gap in protection for patients' private medical information").

[419] *See* William L. Carney & George B. Shepard, *The Mystery of Delaware Law's Continuing Success*, 2009 U. ILL. L. REV. 1, 68. One of the disadvantages of common law policymaking is that courts "must await a case suitable to announce new rules, while legislators can act once the phenomenon appears anywhere." *Id. Cf.* Corrin N. Hatala, Note, *Shielding the Fourth Estate: Why the Iowa Legislature Should Protect Journalists from Subpoena-Compelled Testimony by Enacting a Shield Statute*, 63 DRAKE L. REV. 1177, 1196 (2015) (asserting that legislatures contemplating the enactment of a statutory evidentiary privilege "can address a wider array of situations, especially ones that are easily foreseeable, rather than waiting for litigants to bring a case or claim . . . a court may adjudicate").

[420] *See* State v. Carver, 258 P.3d 256, 262 n.9 (Ariz. Ct. App. 2011) (observing that in Arizona "privileges are created by statute or common law"); *cf.* Diehl v. State, 698 S.W.2d 712, 718 (Tex. App. 1985) (Levy, J., dissenting) ("Creation of . . . a testimonial privilege represents a determination – *either judicial or legislative* – that fostering certain relationships outweighs the potential benefit to the judicial system of compelled disclosure.") (emphasis added).

[421] *See* Pierce, *supra* note 14, at 1100 ("Because more patients will be receiving primary care from nurse practitioners in the near future, and common law does not protect that relationship, it is necessary for the states to implement the nurse practitioner-patient privilege.").