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### Hippocrates to HIPAA: A Foundation for a Federal Physician-Patient Privilege, 77 Temp. L. Rev. 505 (2004)

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# TEMPLE LAW REVIEW

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## ARTICLES

### HIPPOCRATES TO HIPAA: A FOUNDATION FOR A FEDERAL PHYSICIAN-PATIENT PRIVILEGE

*Ralph Ruebner and Leslie Ann Reis<sup>1</sup>*

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## INTRODUCTION

*There is no federal physician-patient privilege.*<sup>2</sup> This is the mantra that has continually been recited by federal courts for nearly thirty years.<sup>3</sup> However, recent developments in science, technology, medicine, and notions of informational privacy have given Congress and the federal courts just cause to reevaluate the validity of the continued absence of a federal physician-patient privilege. What lies at the heart of the debate is the conflict between technology and privacy. This is not a new conflict. Justice Louis D. Brandeis, in an often-quoted dissent in *Olmstead v. United States*,<sup>4</sup> noted that “[c]lauses guaranteeing to the individual protection against specific abuses of power, must have a . . . capacity of adaptation to a changing world.”<sup>5</sup> Failure to adapt to a changing world may result in “[r]ights declared in words . . . [being] lost in reality.”<sup>6</sup> The time has come to respond to a changing world and recognize a physician-patient privilege in federal court. Without such a privilege, an individual’s personal, private, and potentially damaging health information could be disclosed to the public in court proceedings,<sup>7</sup> and subsequently republished many times over, via print and electronic media including the Internet.

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2. The physician-patient privilege allows a patient to prevent his or her physician from revealing in court, as a witness, confidential information communicated to the physician during the course of professional treatment. 2 SCOTT N. STONE & ROBERT K. TAYLOR, *TESTIMONIAL PRIVILEGES*, §7.01 at 7 (2d ed. McGraw-Hill 1995). The right to assert the privilege generally belongs solely to the patient who may waive it even when the physician would rather not testify to matters revealed during the course of treatment. *Id.* at 8.

3. See *Whalen v. Roe*, 429 U.S. 589, 602 n.28 (1977) (noting that “physician-patient privilege is unknown to the common law”); *Patterson v. Caterpillar, Inc.*, 70 F.3d 503, 506-07 (7th Cir. 1995) (stating that federal common law does not recognize physician-patient privilege); *Gilbreath v. Guadalupe Hosp. Found.*, 5 F.3d 785, 791 (5th Cir. 1993) (concluding that physician-patient privilege does not exist under federal law).

4. 277 U.S. 438 (1928).

5. *Id.* at 472.

6. *Id.* at 473 (quoting *Weems v. U.S.*, 217 U.S. 349, 373 (1910)).

7. Specifically, absent a federal physician-patient privilege, physicians can be compelled by a federal court to give testimony, based on information they obtained through confidential communications with their patients – information that might be beneficial in court proceedings, but could be damaging to their patients. STONE & TAYLOR, *supra* note 2, at 7.

The virtues of physician-patient confidentiality can be traced as far back as the fourth century through the Hippocratic Oath.<sup>8</sup> The need for a physician-patient evidentiary privilege has been gaining strength for decades. The overwhelming majority of states now recognize a physician-patient privilege.<sup>9</sup> A public policy that favors confidentiality and protects the privacy of patient health information has emerged in recent years. In 1977, the United States Supreme Court observed that the Constitution protects individuals' rights to "avoid disclosure of personal matters" relating to medical information.<sup>10</sup> More recently, some federal courts have recognized an individual's right to confidentiality of medical records and medical communications,<sup>11</sup> noting that "few subject areas [are] more personal and more likely to implicate privacy interests than that of one's health"<sup>12</sup> and that medical information is "precisely the sort [of information] intended to be protected by penumbras of privacy."<sup>13</sup>

Most significant, however, is that Congress, through a broad mandate to the Department of Health and Human Services, has provided unprecedented protection to medical privacy in the form of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").<sup>14</sup> We contend that HIPAA is one major source for the foundation of a physician-patient privilege. This privilege will supply a missing link in the chain of necessary medical privacy protections. Accordingly, federal courts should now rethink their outdated view rejecting this privilege<sup>15</sup> and move to embrace the emerging physician-patient privilege in

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8. Attributed to Hippocrates, celebrated physician, circa 400 B.C. The original version of the oath states in part: "[w]hat I may see or hear in the course of the treatment of even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about." *The Hippocratic Oath: Classical Version*, NOVA ONLINE, at [http://www.pbs.org/wgbh/nova/doctors/oath\\_classical.html](http://www.pbs.org/wgbh/nova/doctors/oath_classical.html) (last visited Nov. 8, 2004). A modern version of the Hippocratic Oath, written in 1964 by Louis Lasagna, is taken by many medical students upon graduation. This modern oath states in part: "I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know." *The Hippocratic Oath: Modern Version*, NOVA ONLINE, at [http://www.pbs.org/wgbh/nova/doctors/oath\\_modern.html](http://www.pbs.org/wgbh/nova/doctors/oath_modern.html) (last visited Nov. 8, 2004).

9. See *infra* note 439 and accompanying text (listing states that have adopted physician-patient privilege).

10. *Whalen*, 429 U.S. at 599.

11. See *Norman-Bloodsaw v. Lawrence Berkeley Lab.*, 135 F.3d 1260, 1269 (9th Cir. 1998) (holding that "[t]he constitutionally protected privacy interest in avoiding disclosure of personal matters clearly encompasses medical information and its confidentiality"); *Doe v. Southeastern Penn. Transp. Auth.*, 72 F.3d 1133, 1137 (3d Cir. 1995) (holding that medical records are protected under a right to privacy); *F.E.R. v. Valdez*, 58 F.3d 1530, 1535 (10th Cir. 1995) (holding that the plaintiffs had a legitimate expectation of privacy in medical records); *Schail v. Tippecanoe County Sch. Corp.*, 864 F.2d 1309, 1322 n.19 (7th Cir. 1988) (recognizing a substantial privacy interest in confidential medical information).

12. *Norman-Bloodsaw*, 135 F.3d at 1269.

13. *Southeastern Penn. Transp. Auth.*, 72 F.3d at 1138 (citing *Eisenstadt v. Baird*, 405 U.S. 438, 450 (1972)).

14. Pub. L. No. 104-191, 110 Stat. 1936 (1996).

15. See *Hancock v. Dodson*, 958 F.2d 1367, 1373 (6th Cir. 1992) (stating that "federal courts do not recognize a federal physician-patient privilege").

federal courts.

Evidentiary privileges are exceptions to the duty of every person to present evidence, i.e., “give testimony upon all facts inquired of in a court of justice.”<sup>16</sup> Privileges promote confidential communications within certain types of special relationships – relationships that are deemed important and socially beneficial.<sup>17</sup> Privileges also promote an individual’s sense of privacy. “Recognition of evidentiary privileges for certain fundamental relationships promotes personal autonomy in the sense of decisional privacy . . . this facet of autonomy is an ultimate value.”<sup>18</sup> Even though privileges serve a valuable function, because they can prevent useful and relevant evidence from being presented in court, they are narrowly construed and new privileges are rarely recognized.

Currently, the Federal Rules of Evidence (“FRE”) do not explicitly recognize a physician-patient privilege.<sup>19</sup> However, in 1996, the Supreme Court of the United States, in *Jaffee v. Redmond*,<sup>20</sup> used the standard expressed in Rule 501 of the Federal Rules of Evidence<sup>21</sup> (“FRE 501”) to recognize a federal *psychotherapist-patient* privilege.<sup>22</sup> The analysis used in the *Jaffee* decision will serve as a model for our contention that a federal physician-patient privilege should be recognized now.

Since the *Jaffee* decision, there has been revolutionary change in science, technology, and government policy. Medical science and technology have enabled us to expose an ever-expanding wealth of information about an individual from a wide variety of medical information.<sup>23</sup> There exist evermore incentives for myriad parties to seek out and exploit information learned in confidence by physicians, often to the detriment of the patient.<sup>24</sup> Insurers, employers, creditors, and the business community have discovered that medical information is a very marketable commodity.<sup>25</sup> At the same time, there has been an exponential increase in the electronic storage and transfer of medical

16. 8 WIGMORE, EVIDENCE § 2285 (McNaughton rev. 1961).

17. EDWARD J. IMWINKELRIED, *THE NEW WIGMORE: A TREATISE ON EVIDENCE, EVIDENTIARY PRIVILEGES* 13 (2002) (citing GERALD DWORIN, *THE THEORY AND PRACTICE OF AUTONOMY* (1988)).

18. *Id.*

19. Evidence law was originally based in common law. Today, however, it is largely codified in statutes and rules of court. In 1975, the Federal Rules of Evidence was adopted by Congress to “govern proceedings in the courts of the United States.” FED. R. EVID. 101.

20. 518 U.S. 1 (1996).

21. This rule states that “the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience.” FED. R. EVID. 501.

22. *Jaffee*, 518 U.S. at 10.

23. See *infra* note 335 and accompanying text (discussing how improperly redacted medical records can yield a wide range of sensitive data).

24. See *infra* notes 153-74 and accompanying text (describing strong financial incentives for third parties to pursue and utilize personal health information).

25. See *infra* notes 154-55 and accompanying text (noting that commercial markets exist for exchange of authorized and unauthorized medical information).

information due to evolution of computer technology.<sup>26</sup> Information technology has made vast and irrevocable dissemination of this information simple and pervasive.<sup>27</sup> The combination of these factors has created an environment where physicians' disclosures of their patients' confidences can increasingly result in devastating and unexpected effects upon the patient and upon society in general.<sup>28</sup> This rapid and worrisome evolution gives ample justification to the federal courts to follow the mandate of FRE 501 to "continue the evolutionary development of testimonial privileges"<sup>29</sup> in response to changed societal conditions.

These technological advances have already spurred a legislative reassessment of what government must do to protect the privacy of individuals' information in the face of new threats. Congress's response to these concerns was HIPAA.<sup>30</sup> Congress essentially sought to reconcile two competing objectives through HIPAA: to facilitate the increased use of technology to promote health care efficiency and to protect the security, confidentiality, and integrity of medical information challenged by such technological advances.<sup>31</sup> Congress instructed the United States Department of Health and Human Services ("HHS") to promulgate uniform standards to facilitate the exchange of health information between healthcare providers and "with respect to privacy of certain health information."<sup>32</sup> HHS's original Privacy Rule, promulgated in 2000, marked an unprecedented policy of federal protection of medical information.<sup>33</sup>

HIPAA was established, in part, to provide "a set of basic national privacy standards. . . that provide all Americans with a basic level of protection and peace of mind that is essential to their full participation in their care."<sup>34</sup> Most importantly, however, the HIPAA Privacy Rule recognized that it was only

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26. See *infra* notes 118-121 and accompanying text (noting that electronic storage of medical information permits health care providers to collect larger amounts of patient data).

27. See *infra* Part I.B.2 (examining how development of computer technology and Internet has increased risk that privacy invasions can lead to disclosure of medical information to vast numbers of people).

28. Unauthorized disclosure of an individual's medical information can result in injury to that individual's reputation, embarrassment, loss of employment, loss of financial opportunities, including loans, harassment, and even violence. See generally AMITAI ETZIONI, *THE LIMITS OF PRIVACY* ch. 5 (1999) (discussing systemic violations of the privacy of medical records).

29. *Trammel v. United States*, 445 U.S. 40, 47 (1980).

30. 110 Stat. 1936. The primary purpose of HIPAA was the portability of health insurance. See *id.* (stating that purpose of HIPAA was to amend Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage for groups and individuals). The privacy concerns were really an afterthought. See also *S.C. Med. Ass'n v. Thompson*, 327 F.3d 346, 348-49 (4th Cir. 2003) (noting that the goal of HIPAA was to improve the efficiency and effectiveness of exchanging information within the health care system).

31. Standards for Privacy of Individually Identifiable Health Information Part II, 65 Fed. Reg. 82,462, 82,469 (Dec. 28, 2000) (codified at 45 C.F.R. pts 160 & 164) [hereinafter Standards for Privacy II].

32. HIPAA § 264.

33. See Standards for Privacy II, 65 Fed. Reg. at 82,464 (proclaiming that the federal rules did not protect the privacy of patient health care information until 2000).

34. *Id.* at 82,464.

creating a “framework of protection” that could later be strengthened by additional necessary state and federal action in the health privacy area to fulfill HIPAA’s broad guarantee of medical privacy.<sup>35</sup>

The necessity of strengthening this framework has come sooner than expected. The Privacy Rule’s unprecedented protection of medical privacy was dealt a serious blow on August 14, 2002 when HHS released final modifications to the Privacy Rule.<sup>36</sup> The protections that Congress intended and that HIPAA’s original Privacy Rule afforded have been weakened significantly under the Bush Administration.<sup>37</sup> Consequently, what currently exists is an unparalleled Congressional intent to protect medical privacy that was defeated by the execution of new privacy rules that fail to adequately further this intent.<sup>38</sup>

The federal judiciary has not yet fully responded to this paradox created by HIPAA and the final modifications to the Privacy Rule. However, a few federal courts have begun to jealously guard the privacy of medical information from disclosure in court in response to HIPAA’s mandate and underlying privacy policies through a new evidentiary privilege.

On February 5, 2004, in *National Abortion Federation v. Ashcroft*,<sup>39</sup> Chief Judge Charles Kocoras of the United States District Court for the Northern District of Illinois quashed a government subpoena of physicians’ abortion records that were redacted of most patient identifying information.<sup>40</sup> Citing HIPAA’s recognition of “the importance of the privacy of medical records,”<sup>41</sup> Judge Kocoras noted that, under *Jaffee* and FRE 501, reason and experience compelled the recognition of a federal physician-patient privilege in the context of abortion information.<sup>42</sup>

On March 26, 2004, the United States Court of Appeals for the Seventh Circuit, on an expedited appeal, in an opinion authored by Judge Richard Posner, affirmed Judge Kocoras’s decision. However, the court summarily and inexplicably rejected Kocoras’s finding of a new federal physician-patient privilege, noting that “[i]t is not for us – especially in so summary a proceeding as this litigation . . . to create one, whether all at once or by a process of slow but inevitable additions to the sole category recognized by *Jaffee*.”<sup>43</sup>

The need to recognize a new physician-patient privilege must remain a priority for federal courts. The increasing attention that Congress has been giving to medical privacy issues over the past decade will likely bring this issue to

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35. See *id.* (noting that HIPAA “creates a framework of protection that can be strengthened by both the federal government and by states as health information systems continue to evolve”).

36. Standards for Privacy of Individually Identifiable Health Information Part V, 67 Fed. Reg. 53,182 (Aug. 14, 2002) (codified at 45 C.F.R. pts 160 & 164) [hereinafter Standards for Privacy V].

37. See *infra* notes 74-78 and accompanying text (discussing 2002 modifications to HIPAA Privacy Rule).

38. *Id.*

39. No. 04-C-55, 2004 U.S. Dist. LEXIS 1701 (N.D. Ill. Feb. 5, 2004).

40. *Id.* at \*20.

41. *Id.* at \*6 (citing *United States v. Sutherland*, 143 F. Supp. 2d 609, 612 (W.D. Va. 2001)).

42. *Id.* at \*18-20.

43. *Northwestern Mem’l Hosp. v. Ashcroft*, 362 F.3d 923, 926 (7th Cir. 2004).



the Supreme Court sometime in the not too distant future. Both Congress and many state legislatures have recognized that an individual's right to prevent disclosure of his or her personal medical information is in imminent danger of total and irrevocable abrogation.<sup>44</sup> The overwhelming majority of states now recognize a physician-patient privilege. The federal courts have so far not followed suit. In the wake of the Bush Administration's modifications to the HIPAA Privacy Rule,<sup>45</sup> there is urgency for a federal physician-patient privilege to ensure that medical information is sufficiently protected in the context of federal litigation.

This article will examine two alternate foundations for a new federal physician-patient privilege that relies upon HIPAA as a prominent factor in each. In Part I, we will discuss HIPAA's effect on medical privacy. Part II will examine HIPAA's implicit recognition of a federal physician-patient privilege as an act of Congress. Part III will set forth a foundation for a federal physician-patient privilege using the model that the Supreme Court established in *Jaffee v. Redmond*.

In this article, we call on federal courts to apply the directive of FRE 501 and recognize a federal physician-patient privilege to govern judicial proceedings, including those arising under federal question jurisdiction of the federal courts. The ultimate nature of the proposed privilege is beyond the scope of this paper. In time, courts will fashion the contours of this privilege. Nonetheless, we must caution that in the development of this privilege, courts must be careful to maintain the confidentiality of medical information and to limit exceptions to confidentiality to rare instances when societal demands for disclosure of this information substantially outweigh the interests of privacy. Even then, exceptions should be made only in those instances where the proponent of the evidence can demonstrate that the probative value of the evidence substantially outweighs the danger of harm and embarrassment to the reputation of the patient, the holder of the privilege.

## I. PROTECTING MEDICAL PRIVACY THROUGH HIPAA AND THE PHYSICIAN-PATIENT PRIVILEGE

Medical records are beacons into our past. They reveal secrets about families. They strip us naked, as if we had been prepped for surgery. They remind us about things we would rather forget – and things that we don't want others ever to discover.

Medical records are also windows to our future. . .<sup>46</sup>

The Health Insurance Portability and Accountability Act of 1996

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44. See *infra* Parts I, III.B.5 (discussing the protection of medical privacy through HIPAA and the consensus of state legislatures of physician-patient privilege).

45. See *infra* notes 74-78 and accompanying text (discussing 2002 modifications to HIPAA Privacy Rule).

46. SIMSON GARFINKEL, DATABASE NATION: THE DEATH OF PRIVACY IN THE 21ST CENTURY 125 (Deborah Russell ed., 2000).

("HIPAA"), was initially designed to improve the portability and continuity of health insurance allowing workers and their families to remain covered when they change or lose their jobs.<sup>47</sup> Recognizing the increasing importance of protecting the privacy of health information in response to rapid evolution of science and technology, Congress included a directive to protect patient health information by establishing transaction standards for the exchange of health information. In addition, security standards and privacy standards were established for the collection, use, and disclosure of individually identifiable health information.<sup>48</sup>

The mandate to provide privacy protections for health information is contained within the administrative simplification sections of HIPAA.<sup>49</sup> This mandate directed the United States Department of Health and Human Services ("HHS") to recommend to Congress "standards with respect to the privacy of individually identifiable health information"<sup>50</sup> that addressed three broad areas of concern: (1) what are the rights of an individual who is a subject of individually identifiable health information;<sup>51</sup> (2) what procedures should be established for the exercise of such rights;<sup>52</sup> and (3) what uses and disclosures of such information should be authorized or required.<sup>53</sup> HHS responded to this mandate by setting privacy standards for a variety of disclosures including those standards that are directly on point with the authors' contentions in this article: standards for "[d]isclosures for judicial and administrative proceedings."<sup>54</sup>

HIPAA further directed HHS to promulgate final regulations concerning such standards if Congress failed to enact comprehensive health information privacy legislation before August 1999.<sup>55</sup> Congress did not meet its self-imposed deadline.<sup>56</sup> Consequently, pursuant to the statutory mandate, HHS drafted proposed regulations in November 1999.<sup>57</sup> HHS published the regulations in

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47. HIPAA, Pub. L. No. 104-191, 110 Stat. 1936 (1996).

"[T]o improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes."

*Id.*

48. *Id.* § 264(c)(1).

49. *Id.*

50. *Id.* § 264(a).

51. *Id.* § 264(b).

52. HIPAA § 264(b).

53. *Id.*

54. 45 C.F.R. § 164.512(e) (2002).

55. HIPAA § 264(c)(1).

56. See *S.C. Med. Ass'n v. Thompson*, 327 F.3d 346, 349 (4th Cir. 2003) (stating that several medical privacy bills were introduced after HHS had submitted detailed recommendations in September 1997, but that Congress did not pass any more legislation).

57. Standards for Privacy of Individually Identifiable Health Information Part IV, 64 Fed. Reg. 59,918 (proposed Nov. 3, 1999) (codified at 45 C.F.R. pts 160 & 164) [hereinafter Standards for Privacy IV].

final form on December 28, 2000.<sup>58</sup> These Privacy Rule standards significantly restricted the ability of covered entities,<sup>59</sup> including health care providers, to divulge patient medical records.<sup>60</sup>

As HHS was given a very broad mandate by Congress to recommend and ultimately promulgate the Privacy Rule, HHS's commentary on the regulations supplies the primary source for "legislative" intent behind the Privacy Rule.<sup>61</sup> The intent was clear—HHS unambiguously articulated the importance of health information privacy and the immediate need for a national health privacy framework.<sup>62</sup>

HHS commented on the inherent conflict between technology and privacy, in particular, the connection between the increasing use of interconnected electronic information systems in the health care context and the loss of health information privacy.<sup>63</sup> In doing so, HHS emphasized the fact that advances in technologies used to collect and disseminate patient health information have "reduced or eliminated many of the financial and logistical obstacles that previously served to protect the confidentiality of health information and the privacy interests of individuals."<sup>64</sup> Simply, the pervasiveness of and access to medical information in electronic form creates the likelihood that such information will be wrongfully disclosed or used in a manner that may harm the patient.<sup>65</sup> Technological advancements in information systems "may provide a reason for institutionalizing privacy protections in situations where the risk of harm did not previously justify writing such protections into law."<sup>66</sup>

An examination of HHS's commentary on the original Privacy Rule exposes the breadth and the strength of HIPAA's intended protection of

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58. Standards for Privacy II, 65 Fed. Reg. 82,462 (Dec. 28, 2000) (codified at 45 C.F.R. pts 160 & 164). The Standards for Privacy of Individually Identifiable Health Information; Final Rule, produced under the auspices of then HHS secretary, Donna Shalala, included a detailed background discussion section, a section-by-section description of the final rules and a section-by-section discussion of the comments received by HHS. *Id.*

59. 45 C.F.R. § 160.103 (2002). The HIPAA Privacy Rule defines a covered entity as "(1) A health plan. (2) A health care clearinghouse. (3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter." *Id.*

60. See *United States v. Sutherland*, 143 F. Supp. 2d 609, 612 (W.D. Va. 2001) (concluding that Congress has restricted ability of most health care providers to divulge patient medical records).

61. The authors use the preamble to the 2000 Privacy Rule (available at Standards for Privacy II, 65 Fed. Reg. 82,462) extensively in this section. HHS provided extensive information related to the state of the art of technology and governmental intent that necessitated formation of the Privacy Rule in the preamble to the 2000 Privacy Rule. There was no comparable exposition of intent following the 2002 modifications (available at Standards for Privacy V, 67 Fed. Reg. 53,182). As such, the preamble to the 2000 Privacy Rule remains the clearest statement of intent behind promulgation of the HIPAA Privacy Rule. References to any modified sections will rely on the 2002 version. As the rationale for HIPAA's privacy protections closely mirrors the rationale for the federal physician-patient privilege, HHS's research in this area is readily applicable in the present case.

62. Standards for Privacy II, 65 Fed. Reg. at 82,462.

63. *Id.* at 82,463.

64. *Id.* at 82,465.

65. *Id.* at 82,465-66.

66. *Id.*

physician-patient communications. HHS explained that patients' ability to trust that personal and often-sensitive communications with their physicians will be protected and kept confidential is "vital" to furthering HIPAA's intent.<sup>67</sup> Moreover, HHS noted that state privacy laws fail to adequately protect the privacy of the patient's health information.<sup>68</sup> The intent of the Privacy Rule was to establish "a set of basic national privacy standards . . . that provide all Americans with a basic level of protection and peace of mind that is essential to their full participation in their care."<sup>69</sup> HHS recognized that the Privacy Rule's "framework of protection" would allow both state and federal governments to further strengthen privacy protections as technologies, specifically health information systems, advance.<sup>70</sup> Thus, HIPAA was enacted with a broad and evolutionary mandate to provide strong federal protection of medical privacy.

However, with the change in administrations, so came a change in policy. In February 2001, newly appointed HHS Secretary, Tommy Thompson, re-opened the Privacy Rule for public comment.<sup>71</sup> HHS modified the Privacy Rule in 2002 in response to comments to the original Privacy Rule of 2000.<sup>72</sup> On August 14, 2002, HHS released the final modifications to the Privacy Rule.<sup>73</sup>

Although much of the original Privacy Rule was retained,<sup>74</sup> the final modifications contained several important changes.<sup>75</sup> Most significantly, the

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67. Standards for Privacy II, 65 Fed. Reg. at 82,463.

68. *Id.* at 82,463-64.

69. *Id.* at 82,464.

70. *Id.*

71. See Standards for Privacy of Individually Identifiable Health Information Part IV, 66 Fed. Reg. 12,434 (Feb. 26, 2001) (codified at 45 C.F.R. pts 160 & 164) (deferring implementation of 2000 version of statute due to procedural mistakes relating to notice and comment).

72. Standards for Privacy V, 67 Fed. Reg. 53,182 (Aug. 14, 2002) (codified at 45 C.F.R. pts 160 & 164).

73. See *id.* (modifying Privacy Rule in accordance with stated policy goals of maintaining strong privacy protection for health information and avoiding unintended administrative problems created by original incarnation of rule).

74. See *Citizens For Health v. Thompson*, No. 03-2267, 2004 U.S. Dist. LEXIS 5745, at \*20 (E.D. Pa., Apr. 2, 2004) (noting that with few exceptions the 2002 Privacy Rule was consistent with the protections of the 2000 Privacy Rule).

75. Admittedly, on their face, the modifications decreased the amount of privacy granted to protected health information because they allowed for greater dissemination of personal and private health information with a lower level of consent. See generally HEALTH & PRIVACY PROJECT, INST. FOR HEALTH CARE RESEARCH & POLICY, GEORGETOWN UNIV., SUMMARY OF HIPAA PRIVACY RULE, at 18 (2002), available at [http://www.healthprivacy.org/usr\\_doc/RegSummary2002.pdf](http://www.healthprivacy.org/usr_doc/RegSummary2002.pdf) (noting that covered entities may choose, but are not required, to elicit consent from patients to disclose health-related information and that statute neither defines consent nor provides required means for obtaining it) (last visited Nov. 8, 2004). These changes violated the strong privacy protection authorized under the statute. See also Standards for Privacy II, 65 Fed. Reg. at 82,462 (explaining importance of health information privacy). A full discussion of the effect of the modifications is beyond the scope of this article. However, this decreased level of protection does not contradict our contention that HIPAA, even under the modified rules, supports a federal physician-patient privilege for the reasons set forth in this article. In fact, this decreased level of protection, which is contrary to the policies and Congressional intent underlying the statute, is further indication that a federal physician-patient privilege is needed now more than ever.

modifications remove the regulations' former requirement of mandatory consent for uses and disclosures of protected health information for treatment, payment, or health care operations.<sup>76</sup> The 2002 Privacy Rule modifications also erode some of the patient's original protections under the 2000 Privacy Rule through liberalization of nonconsensual disclosure of health information for "marketing" of health services or products.<sup>77</sup>

Thus, while purporting to reflect "a continuing commitment . . . to strong privacy protections for medical records,"<sup>78</sup> the modifications undermined some of the privacy protections of the original 2000 Privacy Rule and arguably fail to achieve HIPAA's intended level of privacy protection for individually identifiable health information.

## A. How Does HIPAA Protect Medical Privacy?

### 1. HIPAA Protects a Broad Scope of Information

In passing HIPAA, Congress recognized that medical treatment requires the exchange of personal, sensitive information between an individual and a physician.<sup>79</sup> The Privacy Rule recognized that the patient's ability to trust that sensitive medical information will be kept private and confidential by the physician is "vital" to the physician-patient relationship.<sup>80</sup>

HIPAA explicitly mandated that every "covered entity"<sup>81</sup> must "maintain reasonable and appropriate administrative, technical and physical safeguards to ensure the integrity and confidentiality of the information."<sup>82</sup> The Privacy Rule

76. See HEALTH & PRIVACY PROJECT, *supra* note 75, at 15, 17-18 (noting that 2002 incarnation of Privacy Rule does not require consent for health-related communications).

77. See 45 C.F.R. § 164.501 (2002) (defining marketing as making a communication about a product or service that encourages purchase, or disclosure of health information by a covered entity to another entity, but excluding a communication related to patient's treatment or health plan); *id.* § 164.508(a)(3) (2002) (excluding face-to-face communications, complimentary gifts, or direct or indirect remuneration of a covered entity from a third party from definition of marketing). See also HEALTH & PRIVACY PROJECT, *supra* note 75, at 20-21 (summarizing the marketing provision in the HIPAA Privacy Rule). The 2002 Privacy Rule purports to require a patient's consent for disclosure of "protected health information" for use for "marketing" purposes. *Id.* at 15. Unlike the original Privacy Rule, however, the 2002 Privacy Rule expressly excludes any communications in any way related to health from the definition of "marketing." *Id.* at 20. This would permit disclosure (without the patient's consent or any way to "opt-out") of protected health information for such purposes as communications from pharmacies paid for by drug companies recommending that an individual switch to the drug company's product. See *id.* at 21 (giving examples of ways marketers can bypass provisions of Privacy Rule). The basic effect of this modification is to retain the requirement of a patient's consent only for communications that are not health related. *Id.* at 20-21. Anything else would be permitted without the patient's consent. See *id.* at 21 (noting that many common marketing practices are still permitted without patient's consent).

78. Standards for Privacy V, 67 Fed. Reg. at 53,183.

79. Standards for Privacy II, 65 Fed. Reg. at 82,463.

80. See *id.* (noting importance of developing trusting relationship between doctor and patient).

81. See 45 C.F.R. § 160.103 (2002) (defining "covered entity").

82. 42 U.S.C. § 1320d-2(d)(2)(A) (2000).

defines a covered entity as “a health plan, health care clearinghouse, or a health care provider who transmits any health information in electronic form” in connection with a transaction covered by the Rule.<sup>83</sup> The resultant Privacy Rule covers “protected health information”<sup>84</sup> (“PHI”), defined as health information<sup>85</sup> that is individually identifiable<sup>86</sup> and created or received by a covered entity.<sup>87</sup> This encompasses any information that “relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.”<sup>88</sup> This definition essentially covers “any health information that a patient would divulge to his or her doctor.”<sup>89</sup>

The scope of information available to a physician is extremely broad and includes personal information about the patient, such as birth date, address, education, income, employer, financial and billing information, subjective information about a patient’s mental state, employer held health information about the individual patient and his or her family and, of course, medical records.<sup>90</sup> Medical records can include diagnosis or treatment for sensitive medical conditions such as sexually transmitted diseases, contraception, abortion, substance abuse problems, mental illness, and medications that a patient may reasonably consider personal and private and wish to guard from

83. 45 C.F.R. § 160.103.

84. 45 C.F.R. § 164.501. The Privacy Rule defines *protected health information* as “individually identifiable health information: (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in electronic medium; or (iii) Transmitted or maintained in any other form or medium.” *Id.* § 160.103.

85. 45 C.F.R. § 160.103. The Privacy Rule defines *health information* as:

“any information, whether oral or recorded in any form or medium, that: (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.”

*Id.* See also HEALTH & PRIVACY PROJECT, *supra* note 75, at 5 (discussing definitions provided in Privacy Rule).

86. 45 C.F.R. § 160.103. The Privacy Rule defines *individually identifiable health information* (IIHI) as:

“information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) That identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.”

*Id.* See also HEALTH & PRIVACY PROJECT, *supra* note 75, at 5 (discussing definitions provided in Privacy Rule).

87. See 45 C.F.R. § 160.103 (defining covered entity).

88. *Id.*

89. HEALTH & PRIVACY PROJECT, *supra* note 75, at 5.

90. See *id.* (defining individually identifiable health information).

public disclosure.<sup>91</sup>

There was initially some ambiguity as to whether HIPAA applied beyond electronic transmission of health information by covered entities.<sup>92</sup> However, the Fourth Circuit, in *South Carolina Medical Ass'n v. Thompson*,<sup>93</sup> recently held that in enacting HIPAA, Congress had “expressly defined ‘health information’ to include any information, ‘whether oral or recorded in any form or medium.’”<sup>94</sup> Thus, HIPAA also covers non-electronic forms of health information as well as the non-electronic transmission of PHI.<sup>95</sup> The Fourth Circuit explained that “regulating non-electronic as well as electronic forms of health information effectuates HIPAA’s intent to promote the efficient and effective portability of health information and the protection of confidentiality.”<sup>96</sup> The court explained that if this were otherwise, there would be “perverse incentives” for health care providers to avoid computerization of medical records.<sup>97</sup> This would “utterly frustrate the purposes of HIPAA.”<sup>98</sup> Consequently, both paper and electronic records and electronic and non-electronic transmissions of PHI are covered by HIPAA.<sup>99</sup>

The allusions to “Administrative Simplification”<sup>100</sup> and “Standards for Information Transactions” contained in the text of HIPAA, therefore, should not obscure the fact that HIPAA’s scope encompasses virtually any health information that is exchanged with one’s physician.<sup>101</sup>

## 2. HIPAA Creates a Two-Tiered System of Privacy Protection

Through the Privacy Rule, HIPAA creates an absolute floor of confidentiality for medical information.<sup>102</sup> Moreover, the bulk of the Privacy Rule addresses permissive uses and disclosures<sup>103</sup> and only *requires* a covered entity to disclose PHI under two very narrow circumstances: when the patient requests access to his or her own information and when compelled by HHS for

91. LISA M. BOYLE & DAVID M. MACK, *HIPAA: A GUIDE TO HEALTH CARE PRIVACY AND SECURITY LAW 1:2* (2d supp. 2004).

92. See, e.g., *S.C. Med. Ass'n*, 327 F.3d at 353 (rejecting novel argument that HIPAA applied exclusively to electronic transmissions of protected health information).

93. 327 F.3d 346.

94. *Id.* at 353 (citing 42 U.S.C.A. § 1320d-4).

95. *Id.*

96. *Id.* at 354.

97. *Id.*

98. *S.C. Med. Ass'n*, 327 F.3d at 354.

99. *Id.*

100. Standards for Privacy V, 67 Fed. Reg. 53,182.

101. 42 U.S.C. § 1320d-2. HIPAA covers all health information exchanged with a physician provided that the physician fits the definition of “covered entity.” See 45 C.F.R. § 160.103 (defining covered entity).

102. See also HEALTH & PRIVACY PROJECT, *supra* note 75, at 5 (noting that information must be (1) health information, (2) individually identifiable, and (3) created or received by a covered entity, and that exceptions apply).

103. *Id.* at 12-16 (discussing generally applicable permissive uses and disclosures).

compliance and enforcement purposes.<sup>104</sup> Thus, Congress essentially deferred to the ethical obligations of the covered health care entities “to use their own best judgment in deciding when they will permit the use and disclosure of protected health information.”<sup>105</sup> Physicians, in particular, have a general, ethical obligation to keep the medical information of their patients confidential *unless required by law to do otherwise*.<sup>106</sup> Thus, Congress has given its full mandate to physicians to fulfill their ethical obligations of confidentiality, except where other laws may require disclosure. This means that a “covered entity” may choose not to disclose information, even if HIPAA would technically allow such disclosures. While the Privacy Rule thus establishes an absolute floor for protection of confidential health information, HIPAA implicitly defers to the covered entities’ ethical obligations with respect to any specific disclosure, thus providing an additional layer of privacy protection.

The practical effect of this dual protection of confidentiality is that patients are assured that their medical information will be generally protected from disclosure and that their medical information will further be protected by the ethical constraints of the medical profession. This is an important element to address with respect to HIPAA because the medical profession’s ethical obligations generally require confidentiality unless the patient consents to disclosure or the physician is required to disclose the information by requirements of the law.<sup>107</sup> In effect, HIPAA has given physicians the support of federal law to maintain confidentiality of their patients’ medical information.

#### *B. Why a Federal Physician-Patient Privilege is Needed Now*

Absent a federal physician-patient privilege, physicians may be compelled by a federal court to give testimony and thereby disclose protected health information obtained through confidential communications with their patients—relevant information that might be beneficial to a party in court proceedings, but could be damaging to their patients’ privacy and reputation. Admissibility of such evidence, absent a privilege, may ultimately defeat the very privacy protections Congress intended HIPAA to protect.

HIPAA demonstrates congressional awareness and recognition that medical privacy is an important right. The amount and severity of potential violations of that right are increasing over time as technology advances. HIPAA only goes so far in providing national standards for health information privacy. A federally recognized physician-patient privilege would promote the policies underlying HIPAA in two ways. First, the privilege would protect the patient’s interest in shielding the privacy of his or her medical information. Second, the privilege would enhance and preserve the physician-patient relationship—a

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104. 45 C.F.R. § 164.502(a)-(b).

105. HEALTH & PRIVACY PROJECT, *supra* note 75, at 13.

106. See *infra* notes 503-12 and accompanying text (discussing physician’s ethical rules requiring confidentiality).

107. See *infra* Part III.B.9 (discussing the medical profession’s recognition of the necessity of a physician-patient privilege).



relationship that society values as important and beneficial to the public as well as the individual patient.<sup>108</sup> Neither of these rationales was sufficient to justify recognition of the physician-patient privilege at common law.<sup>109</sup> In a less litigious society of years past, patients may have been less likely to withhold information from their physicians “for fear of later courtroom exposure, both because the possibility of litigation is less likely to be uppermost in a patient’s mind and because withholding information could jeopardize treatment.”<sup>110</sup> As we will show *infra*, these reasons are simply not applicable in today’s medical environment.

Privileges are not etched in stone. The decision in *Jaffee v. Redmond*<sup>111</sup> illustrates the need for new privileges to be recognized as the common law adapts to varying conditions such as the evolving landscape of medical privacy.

### 1. Physicians Know More About Their Patients Than Ever Before

Patients now live in a world where their physicians can know so much more about them than ever before. One particularly important example is the wealth of new information that is made available through genetic testing. Perhaps the most significant scientific development in recent times was the decoding of the human genome by the Human Genome Project.<sup>112</sup> As a result, the number of genetic tests for various diseases and conditions has expanded from a handful ten years ago to hundreds today.<sup>113</sup> These tests now range from relatively rare genetic disorders to common forms of certain breast and colon cancers.<sup>114</sup> Genetic information can also be used to predict an individual’s propensity for future illnesses and behaviors.<sup>115</sup> Thus, concerns about unauthorized disclosure and misuse of genetic information are clearly understandable:

Genetic information, which is a subset of medical information, is particularly sensitive because it reveals unique and immutable attributes. Those attributes are not just personal, but shared by family

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108. See 2 SCOTT N. STONE & ROBERT K. TAYLOR, TESTIMONIAL PRIVILEGES §7.01 at 8 (2d ed. McGraw-Hill 1995) (noting physician-patient privilege promotes protection of the patient’s interest in privacy).

109. See BARUCH A. BRODY ET AL., MEDICAL ETHICS: ANALYSIS OF THE ISSUES RAISED BY THE CODES OPINIONS AND STATEMENTS 200-02 (2001) (noting that physician-patient privilege developed statutorily in contrast to attorney-client privilege which developed out of the common law).

110. STONE & TAYLOR, *supra* note 108, at 9.

111. 518 U.S. 1 (1996).

112. See generally NATIONAL HUMAN GENOME RESEARCH INSTITUTE, ALL ABOUT THE HUMAN GENOME PROJECT (claiming that human genome project gave researchers the ability to understand genetic blueprint for human beings), at <http://www.genome.gov/10001772> (last updated Aug. 2004).

113. See COUNCIL FOR RESPONSIBLE GENETICS, GENETIC DISCRIMINATION: CRG POSITION PAPER (JAN. 2001), at [http://www.gene-watch.org/educational/genetic\\_discrimination.pdf](http://www.gene-watch.org/educational/genetic_discrimination.pdf) (noting that genetic tests are becoming increasingly utilized for routine medical diagnosis).

114. See *id.* (stating that in addition to diagnosing genetic disorders, genetic tests can screen for predispositions to other diseases).

115. See *id.* (explaining that discrimination could result from an individual being labeled on basis of expected future conduct resulting from a determined genetic predisposition).

members as well. This information has the potential to give us, and others, a frightening, or reassuring, glimpse into the future.<sup>116</sup>

While the Human Genome Project brought hopes of prolonging lives by detecting and preventing diseases at an early stage, it also brought fears that an individual's genetic information could be disseminated to and manipulated by myriad parties to the detriment of the patient. "The repercussions of genetic information falling into the wrong hands can be far ranging and include the loss of insurance or employment, having a mortgage called in or denied, or having genetic information used in child custody disputes or personal injury lawsuits."<sup>117</sup>

Also, due in part to the movement toward electronic storage of medical information, a greater amount and variety of information is being recorded by health care providers.<sup>118</sup> Physicians traditionally retained minimal written records about their patients.<sup>119</sup> Computerization of medical information has encouraged health care providers to increase the scope of the information that is collected from patients.<sup>120</sup> Medical records now include demographic information, financial information, personal, social, and lifestyle information, such as sexual orientation and addictions, as well as medical information, such as diagnoses, treatments, and family medical histories.<sup>121</sup>

## 2. Advances in Information Technology Pose New Potential Threats To Patient Privacy

Advances in information technology have posed a number of challenges to the privacy of health information. First, the increase of centralized databases of health information about patients' risks exposes far more information about the patient in the event of a breach than was previously available. The continuing development of computer technology and the Internet has vastly increased the risk that invasions of privacy can lead to disclosure of medical information to vast numbers of people.<sup>122</sup> As far back as *Whalen v. Roe*<sup>123</sup> in 1977, the Supreme Court recognized "the threat to privacy implicit in the accumulation of vast amounts of personal information in computerized data banks."<sup>124</sup> *Whalen*, while

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116. Joanne L. Hustead & Janlori Goldman, *Genetics and Privacy*, 28 AM. J. L. & MED. 285, 285 (2002).

117. Joanne L. Hustead et al., GENETICS AND PRIVACY: A PATCHWORK OF PROTECTIONS, CAL. HEALTHCARE FOUND., at 11 (Apr. 2002), available at <http://www.chcf.org/documents/ihealth/GeneticsAndPrivacy.pdf>.

118. See AMITAI ETZIONI, THE LIMITS OF PRIVACY 142 (1999) (noting that HMO-run managed care programs and health industry are increasingly compiling extensive information regarding patients' histories and treatments to determine necessity and propriety of providing requested health care).

119. *Id.* See also BOYLE & MACK, *supra* note 91, at 1:5 (noting historically physicians knew their patients' histories and had no need for extensive written records).

120. *Id.* at 1:10-11.

121. BOYLE & MACK, *supra* note 91, at 1:10-11.

122. See Standards for Privacy II, 65 Fed. Reg. at 82,465-66, (explaining how advances in computer technology eliminated safeguards that protected confidentiality of health information).

123. 429 U.S. 589 (1977).

124. *Id.* at 605.

prescient, could never have foreseen the extent to which computerized storage of information would threaten privacy.

Only a few generations ago, physicians kept few medical records on their patients at all, as there was a more personalized relationship between physician and patient.<sup>125</sup> Even in the recent past, the bulk of patients' health information was regularly stored on paper in actual health care facilities.<sup>126</sup> Clearly, this system of scattered paper records was vastly more inefficient than the computerized systems that are widely employed today.<sup>127</sup> However, the inefficient paper storage methods of medical information provided a certain degree of protection against widespread dissemination. Physical limitations to disclosure of paper records provided both actual and perceived protections of confidentiality.<sup>128</sup> "Paper records are physical. Paper records can only exist in one place at one time. And while paper records can be faxed all over town, a person must be physically holding the records in order to do so."<sup>129</sup>

The health care industry has increasingly moved to storing patients' medical information electronically. In 1996, the year in which *Jaffe* was decided, the health care industry spent an estimated ten to fifteen billion dollars on information technology.<sup>130</sup> In particular, there is an increasing reliance on health database organizations ("HDOs"), such as the Medical Information Bureau.<sup>131</sup> Essentially, these organizations store comprehensive health data on all individuals in a certain population in a centralized database.<sup>132</sup> HDOs acquire both individually identifiable and non-identifiable data from individual health records kept by physicians and hospitals, information from secondary sources such as insurance companies, government programs, public health surveillance and tracking systems, health services research, government, academics, and private surveys, and many other sources and numerous other data sources.<sup>133</sup> While electronic storage of medical information is not necessarily a new concept, there is the increasing possibility of a wide use of "patient-based longitudinal health records,"<sup>134</sup> which is essentially "a single record for every person in the

125. See Lawrence O. Gostin, *Health Information Privacy*, 80 CORNELL L. REV. 451, 489 (1995) (discussing changes in physician-patient relationships making electronic medical databases a necessity).

126. *Id.* at 457.

127. See *id.* (noting that paper records are often fragmented, inaccurate, poorly documented, duplicative, and not available when needed for patient care).

128. BOYLE & MACK, *supra* note 91, at 1:5.

129. SIMSON GARFINKEL, *DATABASE NATION: THE DEATH OF PRIVACY IN THE 21ST CENTURY* 149 (Deborah Russell ed., 2000).

130. Standards for Privacy II, 65 Fed. Reg. at 82,465 (citing NATIONAL RESEARCH COUNCIL, COMPUTER SCIENCE AND TELECOMMUNICATIONS BOARD, *FOR THE RECORD: PROTECTING ELECTRONIC HEALTH INFORMATION* (1997)).

131. See GARFINKEL, *supra* note 129, at 137 (discussing data keeping function of HDOs such as MIB).

132. See Gostin, *supra* note 125, at 463-64 (discussing the development of health databases and networks).

133. See *id.* at 464 (explaining how and where HDOs acquire their data).

134. *Id.* at 458.

United States, continually expanded from prebirth to death and accessible to a wide range of individuals and institutions for a variety of purposes.”<sup>135</sup>

It is undisputed that central electronic storage of medical information has many beneficial aspects for both patients and the health care industry, including facilitating efficient medical services to patients, speeding the processing of medical claims, and generally improving the quality of care that the patient receives.<sup>136</sup> However, electronic storage of medical information also has both the real and perceived effect of increasing access to private and comprehensive medical information. While there are safeguards to protect unauthorized dissemination of private medical information, the fact remains that records that were once locked in a file cabinet are now accessible electronically in one centralized location. Understandably, there exists at least a perception that dissemination of personal and private medical information may only require “a push of a button.”<sup>137</sup> The advent of centralized medical databases has given patients ample reason to fear that their health information may be misused.

Second, the increasing popularity of the Internet as a means of communication poses both direct and indirect challenges to the integrity of medical information.<sup>138</sup> The direct problem with increasing use of the Internet is the inherent risk that communication via computer poses to confidentiality:

Hospitals are experimenting with putting patient records on the Internet not only to improve the quality and efficiency of health care services (for example, to allow clinical information to be quickly accessed in an emergency room across town) but also to empower patients to read their own records and even to challenge the information contained in them.<sup>139</sup>

Privacy concerns abound, however; “once online, health information can be linked with other, non-health data sets – such as an individual’s credit report – to create encompassing personal dossiers.”<sup>140</sup> Moreover, Internet sites are vulnerable to intrusions. The end result is that online health information may be

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135. *Id.*

136. See Standards for Privacy II, 65 Fed. Reg. at 82,465 (noting advantages and disadvantages of using computerized databases to store medical information). See also Lawrence O. Gostin and James G. Hodge, Jr., *Personal Privacy and Common Goods: A Framework for Balancing Under the National Health Information Privacy Rule*, 86 MINN. L. REV. 1439 (2002) (discussing “health data privacy regulations” approved by President Bush on Apr. 12, 2001).

137. See Standards for Privacy II, 65 Fed. Reg. at 82,465 (explaining that easily accessible medical records eliminate obstacles that protect confidentiality and therefore strengthens argument for protecting privacy of health information). See also GARFINKEL, *supra* note 129, at 149 (citing the 1993 Harris-Equifax survey to note that “74% of physicians thought that computerized systems were ‘almost certain to weaken’ medical confidentiality, compared to 26% who thought that computers ‘could be managed to strengthen confidentiality’”).

138. See generally ETZIONI, *supra* note 118, at 139-82 (discussing how Internet facilitates access to healthcare records).

139. Charity Scott, *Is Too Much Privacy Bad For Your Health? An Introduction To The Law, Ethics, And HIPAA Rule On Medical Privacy*, 17 GA. ST. U. L. REV. 481, 485 (2000).

140. ETZIONI, *supra* note 118, at 143.

more susceptible to unauthorized and damaging disclosures.<sup>141</sup>

The indirect problem that the Internet poses to health information privacy is that the Internet is a stunningly efficient vehicle for disseminating information quickly. Thus, the consequences for any particular breach are far more dire than they have been in the past. Sensitive, private information could easily be published on the Internet and immediately accessible to anyone with a computer and Internet connection.

One example of this phenomenon is abortion information. Because of the passions and controversy associated with this issue, a number of websites devoted to both sides of this issue have been created.<sup>142</sup> If information about women who have had an abortion or physicians who have performed them is posted on the Internet (information that may have been obtained legally through disclosure in a judicial proceeding or illegally through unauthorized access to a computer database, for example), these individuals may be subjected to embarrassment, harassment or even violence by any one who discovers this information via a simple Internet search.<sup>143</sup> Without a doubt, the Internet has created a tool for dissemination of information that exponentially magnifies the damage from any particular disclosure of medical information.

In addition, physicians are also increasingly using e-mail to communicate with patients.<sup>144</sup> Even though a thorough discussion of the privacy implications of the use of e-mail in the medical environment is beyond the scope of this article, it should be noted that there is legitimate and growing concern that neither physicians nor patients realize the risks of disclosure inherent in this medium.

### 3. There is an Increasing Number of Individuals with Access to Patients' Medical Information

Another troubling consequence of technological evolution is the increasing number of individuals who can access a patient's medical information. Much of this increased access is attributable to centralized electronic storage of medical information. The rapid growth of "integrated health care delivery systems" has

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141. *Id.* at 140-44.

142. See, e.g., Catholic Information Network, *Pro-Life Internet Directory*, at <http://www.cin.org/life/proldir.html> (last visited Nov. 18, 2004) (listing 36 pro-life websites). See also *Planned Parenthood v. Am. Coalition of Life Activists*, 290 F.3d 1058, 1085-86 (9th Cir. 2002) (holding that anti-abortion activists' public disclosure of names and addresses of abortion providers was not protected under First Amendment), *cert. denied*, 539 U.S. 958 (2003).

143. See *N.W. Mem'l Hosp. v. Ashcroft*, 362 F.3d 923, 925-26 (7th Cir. 2004) (holding that HIPAA did not bar production of medical records for use in suit challenging constitutionality of Partial-Birth Abortion Ban Act). Judge Posner seems to have accepted this as a legitimate fear that women may have from disclosure and dissemination. Posner noted that "hostility to abortion has at times erupted into violence, including criminal obstruction of entry into abortion clinics, the firebombing of clinics, and the assassination of physicians who perform abortions." *Id.* at 929. Thus, women who have had abortions may be afraid that "skillful 'Googlers'" may sift through abortion records contained in a trial record and subject them to "threats, humiliation, and obloquy." *Id.*

144. *Id.*

vastly expanded the number of individuals who have access to an individual's medical information.<sup>145</sup> Statistics indicate that anywhere from 150 to as many as 400 persons may see at least some portion of a patient's medical record during the course of a single hospital stay.<sup>146</sup>

While a patient was formerly treated "one-on-one" by his or her physician, modern medicine increasingly relies upon networks of health care providers to serve a patient's specific medical needs.<sup>147</sup> The result of these "integrated health care delivery systems" is a growing number of medical professionals and others who have access to health information.<sup>148</sup> Further, as many health plan functions are outsourced, insurance administrators are often not affiliated with the physician or the health care provider.<sup>149</sup> The end result is that exponentially more individuals have access to private medical information than in the past, and the risk of exposure and dissemination of medical information is greatly magnified.<sup>150</sup>

While many disclosures of medical information are authorized, some are not. In spite of the protections provided under HIPAA, unauthorized "browsing" of electronically stored medical information by employees of health care providers can occur.<sup>151</sup> Motivations behind this browsing may include curiosity (e.g., about friends, neighbors, relatives, or celebrities), perversity (e.g., sexual interests), anger (e.g., on the part of an employee who is about to be or has recently been dismissed), or a desire for financial or political gain.<sup>152</sup>

#### 4. There are Strong Financial Incentives for Third Parties to Seek Out and Exploit Personal Medical Information for Pecuniary Gain

Strong incentives exist for myriad parties to seek out and utilize personal health information. Individually identifiable medical information, like most personally identifiable information,<sup>153</sup> is a valuable commodity.<sup>154</sup> Thus, a

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145. See Standards for Privacy II, 65 Fed. Reg. at 82,465 (stating that greater privacy protection is needed due to increasing availability of health care records).

146. See *id.* at 82,466 (citing an American Health Information Management Association report that "an average of 150 people 'from nursing staff to x-ray technicians, to billing clerks' have access to a patient's medical records during the course of a typical hospitalization"). See also Sue Blevins, *Medical Privacy Invasion?*, WASH. TIMES, July 22, 1999, at A17 (describing a report by the Congressional Research Service). See also GARFINKEL, *supra* note 129, at 131 (noting breaches of confidentiality that occur during hospital stays, such as when hospital employees are poorly trained or hold grudges against their employers).

147. See Standards for Privacy II, 65 Fed. Reg. at 82,466 (outlining how changes in health care system have made patient information more accessible).

148. See *id.* (discussing consequences of maintaining electronic medical records).

149. See *id.* (explaining that patient health records are often not protected because there is a need to share information between different entities).

150. See generally ETZIONI, *supra* note 118, at 144-48 (concluding that most privacy violations occur when employees with authorized access misuse information).

151. Scott, *supra* note 139, at 488 (explaining that one of the most pervasive abuses of privacy occurs when health care employees browse a patient's computerized medical records).

152. David L. Coleman, *Who's Guarding Medical Privacy?*, BUS. & HEALTH, at 29 (March 1999).

153. Personally identifiable information is data that in and of itself reveals a person's identity

commercial market exists for the authorized and unauthorized exchange of medical information.<sup>155</sup> Some of the more insidious uses of individually identifiable medical information include data-mining by information brokers, advertising firms, or even pharmacies and pharmaceutical companies to create customer lists for direct marketing campaigns.<sup>156</sup> This type of information has value to the news media, lawyers, employers, insurance companies, financial institutions, and many others who can use and abuse it to their advantage, often for commercial gain.<sup>157</sup>

While the threats to privacy that the above incentives pose are all serious, the example of insurers' and employers' increasing incentives to seek out patients' genetic information provides a particularly strong illustration of the increasing threat to medical privacy. Despite the dubious efficacy of genetics as a predictive tool,<sup>158</sup> there remains a realistic fear that genetic information could be used as the basis for discrimination by employers, insurance companies, and health care providers.<sup>159</sup> Even before the decoding of the human genome, the majority of the American public feared that genetic information could be used to

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such as a name, social security number, address, telephone number, etc.

154. See generally PAUL H. RUBIN & THOMAS M. LENARD, *PRIVACY AND THE COMMERCIAL USE OF PERSONAL INFORMATION* (2002) (evaluating the commercial market for personal information and whether it should be subject to regulation).

155. See Gostin, *supra* note 125, at 487 (noting that this market is motivated by both health care workers' desire to make money and by the public's desire to acquire such information, either for business or gossip).

156. See, e.g., *Weld v. Glaxo Wellcome, Inc.*, 746 N.E. 2d 522, 526 (Ma. 2001) (addressing suit in which pharmacies and drug companies used pharmacy records for marketing purposes); *Anonymous v. CVS, Corp.*, 188 Misc. 2d 616 (N.Y. 2001) (discussing lawfulness of selling patient's pharmaceutical records); Press Release, *Eli Lilly Settles Charges Concerning Security Breach*, Federal Trade Commission (Jan. 18, 2002) (reporting on settlement agreement resulting from Eli Lilly's failure to safeguard information pertaining to users of Prozac who subscribed to company's e-mail alert program), available at <http://www.ftc.gov/opa/2002/01/elililly.htm> (last visited Nov. 18, 2004); James Frederick, *Patient Privacy Lawsuit Casts Net Over Drug Makers*, DRUG STORE NEWS (Sept. 7, 1998) (reporting on a class action lawsuit against four major drug manufacturers and CVS for violating patient privacy rights through direct marketing tactics), available at [http://www.findarticles.com/p/articles/mi\\_m3374/is\\_n14\\_v20/ai\\_21147325](http://www.findarticles.com/p/articles/mi_m3374/is_n14_v20/ai_21147325).

157. See DANIEL J. SOLOVE & MARC ROTENBERG, *INFORMATION PRIVACY LAW* 263 (2003) (noting that creditors may perceive a person with a predisposition to contracting a fatal disorder as not "worth the risk of lending money to"). See also Marianne Lavelle, *Health Plan Debate Turning to Privacy: Some Call for Safeguards on Medical Disclosure. Is Federal Law Necessary?*, NAT'L L.J., May 30, 1994, at A1 (noting abuses of access to healthcare information and need to legislatively protect patient privacy). A banker who also sat on a county board gained access to patients' records and identified several people with cancer and called in their mortgages. *Id.*

158. See Paul M. Schwartz, *Privacy and the Economics of Personal Health Care Information*, 76 TEX. L. REV. 1, 20-22 (1997) (noting limited ability of genetics to predict a person's future health and behavior).

159. See *EEOC v. Woodbridge, Corp.*, 263 F.3d 812, 815 (8th Cir. 2001) (discussing an instance where an employer used neurometry tests to disqualify job applicants at risk of carpal tunnel syndrome); *EEOC v. Rockwell*, 243 F.3d 1012, 1014-15 (7th Cir. 2001) (discussing instance when an employer allegedly discriminated against employees based on genetic testing). See also COUNCIL FOR RESPONSIBLE GENETICS, *supra* note 113 (describing actual cases of genetic discrimination in the areas of employment and health insurance).

their detriment by employers and insurance companies.<sup>160</sup> The fact that the variety of available genetic tests is increasing makes the stakes even higher.

a. *Employers*

Medical information could be used in employment decisions to select prospective employees who will have greater productivity, less absenteeism, will be less of a burden on employer-funded health and life insurance, and will give the employer a greater return on employment training.<sup>161</sup> Many employers have ready access to an employee's genetic information.<sup>162</sup> The abuse of medical information by employers was not unfounded even prior to the decoding of the human genome.<sup>163</sup> Access to even more information gives an even greater incentive to employers to discriminate against employees who may have a genetic predisposition for illnesses that may lower productivity or may be perceived as high risk to incur substantial medical bills.

The physician's role in the dissemination of potentially sensitive medical information to employers is substantial and, in the past, not uncommon.<sup>164</sup> Disclosures of job-related injuries, periodic Occupational Safety and Health Administration ("OSHA") mandated examinations of employees, substance abuse tests, and much more medical information is made available to

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160. See Husted et al., *supra* note 117, at 11 (citing several recent studies and noting that 63% of people surveyed would not take genetic tests if employers or insurance companies could obtain the results and 85% believe that employers should be prohibited from obtaining genetic information about employees).

161. See *id.* (noting danger to individual's privacy resulting from failure to implement clear policies regarding use of genetic information). Note that state statutes, the ADA and other regulatory mechanisms provide some restrictions to such uses by employers. Thus, some of these uses of medical information by employers may be unlawful. See generally, Husted & Goldman, *supra* note 116 (discussing how breaches of confidentiality may deter people from seeking genetic testing).

162. Twenty percent require medical information which can be used as a source of genetic information. See Husted et al., *supra* note 117, at 19 (noting that some businesses perform genetic testing on their employees). The danger of abuse is not a fiction: The Burlington Northern & Santa Fe Railway Company was sued in 2001 for secretly testing employees for genetic predisposition to carpal tunnel syndrome. EEOC v. Burlington N. & Santa Fe Railway Co., No. 02-C-0456, 2002 WL 32155386 (E.D. Wis. May 8, 2002). This lawsuit, brought under the Americans with Disabilities Act, was settled in 2001 when the defendant agreed to stop secret genetic testing of its employees. Kristen Philipkoski, *Genetic Testing Case Settled*, WIRED NEWS (Apr. 10, 2001), available at <http://www.wired.com/news/technology/0,1282,42971,00.html>.

163. See Schwartz, *supra* note 158, at 29 (suggesting that employers often use health care information to make employment decisions). Schwartz notes that according to a 1989 survey commissioned by the Congressional Office of Technology Assessment (OTA) over one-third of Fortune 500 companies surveyed in 1995 "admitted to using the medical records of their personnel in employment-related decisions." This was a decline from previous years when this fraction reached one-half of the employers. Cancer patients lose their jobs at five times the rate of those without the disease. *Id.* See also Mark A. Rothstein, *The Law of Medical and Genetic Privacy in the Workplace*, in GENETIC SECRETS 281 (Mark A. Rothstein ed., 1997) (noting that employer's collection of medical information about employees began as early as the turn of the century).

164. See Rothstein, *supra* note 163, at 282 (observing that employers get employee medical information from both in-house medical staff and from employees' personal physicians).



employers.<sup>165</sup> While many of these disclosures have been with the consent of the patient, secondary or subsequent use of medical information can expose much more about an individual patient than initially understood when consent was given. Because objective medical information is essentially immutable, much can be derived from later retesting of information that was not particularly sensitive at time of the initial disclosure.<sup>166</sup> For example, blood samples taken to detect substance abuse could later be retested to detect genetic defects. With the rapid evolution of medical science, patients cannot really be sure that any information their physicians release about them to their employers could not later expose sensitive and damaging information. The privacy of medical information is thus increasingly at the mercy of technology.

*b. Insurance Companies*

As with employers, insurance companies face an increasing incentive to use previously unavailable genetic information.<sup>167</sup> While the expansion of genetic tests has obviously not created a higher incidence of genetic disorders, it has created the ability to identify and exclude high-risk insureds. If an insurance company can reliably identify potential clients who have an increased chance of contracting a certain disorder, the company may be able to screen out costly insureds.<sup>168</sup> One of the primary disincentives for insurance companies to pursue genetic information has been the prohibitive cost involved and because many of the disorders occur too infrequently to justify the cost of testing the entire pool.<sup>169</sup> The wider availability of genetic tests today provides a strong economic incentive for insurance companies to pursue genetic information on potential insureds.<sup>170</sup>

The incentive to use genetic information could manifest itself not only through insurance companies requiring genetic tests for coverage, but through accessing information collected by others as well.<sup>171</sup> Insurance companies can use even peripheral medical information gathered from physician-supplied medical records to collect genetic information on a potential insured.<sup>172</sup> This

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165. *Id.*

166. See George J. Annas, *Privacy Rules for DNA Databanks: Protecting Coded Future Diaries*, 270 JAMA 2346, 2346-47 (1993) (discussing effects of maintaining DNA databanks).

167. See Nancy E. Kass, *The Implications of Genetic Testing for Health and Life Insurance*, in GENETIC SECRETS 299, 303 (Mark Rothstein ed., 1997) (noting that genetic testing may become more common when "multiplexing" of genetic tests is possible).

168. See *id.* at 305 (describing dangers of permitting unlimited access to genetic test results).

169. See *id.* at 303 (explaining why insurers do not conduct routine genetic testing on insurance applicants).

170. See *id.* at 303-04 (noting that half of surveyed medical directors of life insurance reported that they would use genetic testing if the tests have "high sensitivity and specificity and general clinical acceptance").

171. See *id.* at 304-05 (noting incentives that can lead insurers to seek genetic information from applicant's physician).

172. See Kass, *supra* note 167, at 304 (noting that information contained on patient medical charts often yield genetic information). Kass gives the example of an insurance company requesting a

information may be combined with other data and predicative analysis can be applied to the detriment of the patient.

From the patient's perspective, insurer access to a wider scope of medical information can have devastating effects on the unfortunate individual who has a genetic defect, disorder, or other "problematic" medical propensities. Consequently, such an individual could be subjected to higher insurance rates or denied health or life insurance or access to any insured health services.<sup>173</sup> As an individual's genetics can expose medical information regarding one's children, these devastating outcomes could affect family members as well. The resulting disincentive to entrust full confidence in one's physician cannot be fully addressed by laws prohibiting discrimination based upon medical information.<sup>174</sup> The remedies available through tort claims or other causes of action against an employer, insurer, or other third party for wrongfully using medical information about an individual may provide little solace to the individual whose sensitive medical information has been exposed to public view or whose children have been denied health insurance.

##### 5. Patients Increasingly Engage in Privacy Protective Behavior

The privacy concerns implicated by technological advancements have changed the thought process in which a patient must undertake when deciding what and how much personal medical information to disclose to a physician. As a result, many patients are increasingly engaging in privacy-protective behavior. This behavior may include such activities as:

[S]witching doctors; paying for health care out-of-pocket; asking a doctor not to write down certain information in their record or to record a less serious or embarrassing health condition; giving inaccurate information in their medical history; or even not seeking medical care in the first place for a health problem.<sup>175</sup>

Privacy-protective behavior in patients reflects the trend toward increased public awareness and concerns regarding technology's erosion of informational privacy in general.<sup>176</sup> However, the effect that these concerns have on the physician-patient relationship is particularly counterproductive and troubling.

While a concrete number of patients who engage in privacy-protective behavior may be difficult to ascertain, statistics show that the problem is quite

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patient's medical records for a disclosed medical condition but ascertaining other genetic information peripherally from the record. *Id.*

173. *Id.* at 305-06.

174. See BOYLE & MACK, *supra* note 91, at 1:3 (noting unique sensitivity of healthcare information).

175. Scott, *supra* note 139, at 493.

176. See Standards for Privacy II, Fed. Reg. at 82,464 (discussing individuals' right to protect personal information). HHS cites a 1998 national survey that indicated that 88% of Americans were concerned about the amount of information being requested by potential employers, telemarketers, electronic marketers, insurance companies, and health care providers. *Id.* (citing Privacy and American Business, 1998 Privacy Concerns & Consumer Choice Survey).

real. An often-cited statistic indicates that one in six Americans engages in privacy-protective behavior.<sup>177</sup> Studies have documented that fears of discrimination from the disclosure of medical information is a significant factor in patients' willingness to forgo testing and to seek reimbursement from health insurers.<sup>178</sup> Studies have also shown that, even in the wake of protective federal medical privacy and state genetic discrimination laws, a substantial number of patients still believe that their health information has been improperly disclosed by a health care provider, insurance plan, government agency, or employer.<sup>179</sup>

This lack of trust in the confidentiality of health information is reflected in the 2000 Privacy Rule. Here, HHS noted that the Association of American Physicians and Surgeons reported that eighty-seven percent of its members had a patient request that information not be included in his or her records.<sup>180</sup> HHS also cited a study by the Health Privacy Working Group that concluded that patients engage in many types of privacy-protective behavior, including withholding information from doctors, providing inaccurate information, and "doctor-hop[ping] to avoid a consolidated medical record."<sup>181</sup>

The theoretical calculus that patients must make when determining what and how much information to reveal to a physician is undeniable. While it is true that most patients would not withhold information from their physicians that could compromise their physical health, some patients may choose to withhold sensitive information because they are more concerned about the possibility of social stigma from "family members, friends, neighbors, or colleagues"<sup>182</sup> and other harmful risks of disclosure, than with effective medical treatment.<sup>183</sup> However, disincentives to disclosure are not limited to sensitive

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177. See Press Release, California HealthCare Foundation, Americans Worry About the Privacy of Their Computerized Medical Records (Jan. 28, 1999) (suggesting that most Americans would like to restrict access to their medical records).

178. See Mark A. Hall & Stephen S. Rich, *Genetic Privacy Laws and Patients' Fear of Discrimination by Health Insurers: The View From Genetic Counselors*, 28 J. LAW, MED., & ETHICS 245, 246-57 (2000) (noting patients' fear that health insurers will use genetic information to deny health insurance).

179. See BOYLE & MACK, *supra* note 91, at 1:3 (citing California HealthCare Foundation, National Survey: Confidentiality of Medical Records (Jan. 1999)). *But see* 2003 Privacy Trust Survey, Executive Summary, Ponemon Institute and the CIO Institute of Carnegie Mellon University (Oct. 2003) (ranking businesses and government organizations according to "privacy trust scores"), available at <http://cioi.web.cmu.edu/research/2003PrivacyTrustSurveyExecutiveSummary.pdf>. The survey evaluated individuals' "trust" with respect to protecting the privacy of personal information and revealed that healthcare providers enjoy the highest "privacy trust scores" of the twenty-six organizations included on the survey instrument. *Id.* at 1. Grocery stores and the U.S. Department of Homeland Security received the lowest "privacy trust scores." *Id.* at 2.

180. See Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. at 82,467 (outlining steps that patients take to protect medical information).

181. *Id.* (citing Health Privacy Working Group, Best Principles for Health Privacy (July, 1999)).

182. See BOYLE & MACK, *supra* note 91, at 1:3 (noting disclosure can result in "social or psychological harm, be stigmatizing, and cause embarrassment, social isolation, or a loss of self-esteem").

183. See SOLOVE & ROTENBERG, *supra* note 157, at 263 (noting that in addition to employers and insurers, creditors may have an interest in genetic or medical information because "one who has a

information. As there are more types of medical information stored than in the past, patients may legitimately fear that even innocuous information may inferentially reveal damaging information. Depending upon who discovers the particular information (for example, spouses, friends, or employers), the harm that results from disclosure and dissemination could include severe emotional, social, or economic injury, embarrassment, humiliation, marital discord, loss of reputation, and even loss of a job or insurance.<sup>184</sup>

The evolution of medical and computer science has made patients increasingly likely to err on the side of caution with respect to disclosures to their physician when the stakes of such disclosures are unknown.<sup>185</sup> Patients confront a world where their health care providers know more about them, where the health care providers are storing this information in centralized databases, where an increasing number of individuals have access to this information, and where there are increasing financial incentives for third parties to seek out private medical information.

As technology continues to evolve, the actual dangers that patients face from disclosure of their health information may be incapable of precise identification. However, whether technology has actually made health information less secure may be beside the point if patients perceive their information as less secure. Americans are more technologically savvy than ever before.<sup>186</sup> However, the public is also confronted with news stories about abuse of information technology, electronic identity theft, and cyber-terrorism.<sup>187</sup> Patients walking into a typical physician's office will likely be cognizant of the fact that the information about them is being stored electronically and will react accordingly. While some patients may not be concerned with disclosures, others will.

In the context of the physician-patient privilege, these new reservations, whether realistic or not, threaten to do irreparable damage to the physician-

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high risk of contracting a fatal disorder may not be worth the risk of lending money to").

184. Scott, *supra* note 139, at 492 (explaining that fear of disclosure has numerous negative impacts such as impairment of doctor-patient relationship).

185. *See id.* at 485, 492-93 (noting study where 1 in 6 Americans engages in such "privacy-protecting behaviors" as switching doctors, giving inadequate medical information, and avoiding doctors altogether).

186. *See* Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. at 82,465 (noting that "[A]mericans have embraced the use of the Internet and other forms of electronic information"). The 2000 HIPAA Privacy Rule preamble cites statistics that indicate that 60% of Americans surveyed have a computer in their home, 82% reported having used a computer, 64% have used the Internet, and 58% have sent an e-mail. *Id.* at 82,466.

187. *Id.* at 82,465. According to the Federal Bureau of Investigation, cyber-terrorism "is terrorism that initiates, or threatens to initiate, the exploitation of or attack on information systems." John F. Lewis, Jr., *Fighting Terrorism in the 21<sup>st</sup> Century*, FBI Law Enforcement Bulletin No. 3, at 6 (March 1999), available at <http://www.fbi.gov/publications/leb/1999/mar99leb.pdf> (last visited Oct. 17, 2004). *See also* J. Graham, *Computer Dictionary* (updated 2001), available at [www.nystar.com/dictionary/ad.htm](http://www.nystar.com/dictionary/ad.htm) (last visited Oct. 17, 2004) (defining cyber-terrorism as "[d]eliberately interfering with the Internet or other information system with the purpose of causing widespread fear. May involve using computers to ultimately cause harm to people or their property").

patient relationship. These days, patients have a stronger motivation than ever before to jealously guard their medical information. The “mere possibility”<sup>188</sup> that extremely sensitive information could be disclosed is increasingly damaging the physician-patient relationship in the absence of a physician-patient privilege. Further, as medical science continues to evolve, this rift in the physician-patient relationship will likely become more severe. It is in this context that the need for a federal physician-patient privilege must be weighed.

### C. *What Does HIPAA Mean To The Federal Physician-Patient Privilege?*

Evidentiary privileges were disfavored at common law as being contrary to the maxim that the public has a right to “every man’s evidence.”<sup>189</sup> However, the evolution of privileges has created important exceptions to this general proposition. Federal Rule of Evidence 501 (“FRE 501”) governs the development of federal evidentiary privileges.<sup>190</sup> This rule calls for the creation of privileges by two different methods: (1) explicit recognition “by Act of Congress”<sup>191</sup>; or (2) through “principles of . . . common law . . . interpreted by the courts of the United States in the light of reason and experience.”<sup>192</sup>

HIPAA has a prominent role in establishing the physician-patient privilege by both of these means. First, HIPAA is rightly understood as an “Act of Congress” that establishes a physician-patient privilege. Second, HIPAA represents a comprehensive and strong federal policy of confidentiality of medical information that unambiguously provides the federal “reason and experience” to establish a foundation for a physician-patient privilege under FRE 501 using the model established in *Jaffee v. Redmond*.<sup>193</sup>

## II. HIPAA IS AN “ACT OF CONGRESS” THAT ESTABLISHES AN EVIDENTIARY PRIVILEGE UNDER FEDERAL RULE OF EVIDENCE 501

The sections relevant to this inquiry are section 264(c)(2) (the preemption provision) of HIPAA and section 164.512(e) of the HIPAA Privacy Rule

188. *Jaffee v. Redmond*, 518 U.S. 1, 10 (1996).

189. *Id.* at 9 (noting that, historically, exemptions from testifying were exceptional).

190. FED. R. EVID. 501. This rule reads:

Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority, the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof shall be determined in accordance with State law.

*Id.*

191. *Id.*

192. *Id.*

193. 518 U.S. 1 (1996).

(standards for disclosure in judicial proceedings).<sup>194</sup> Section 264(c)(2) provides that HIPAA's provisions "shall not supersede a *contrary* provision of State law, if the provision of State law imposes requirements, standards, or implementation specifications that are *more stringent* than the requirements, standards, or implementation specifications imposed under [HIPAA]."<sup>195</sup> A state law is "contrary" to HIPAA when "[a] covered entity would find it impossible to comply with both the State and federal requirements."<sup>196</sup> "A state privacy law is "more stringent" than a HIPAA requirement if the state law prohibits or restricts a use or disclosure in circumstances under which such use or disclosure otherwise would be permitted under HIPAA."<sup>197</sup>

HIPAA's preemption scheme is unusual, however. Generally, federal laws that contain a preemption provision will provide that the federal law, by virtue of the Supremacy Clause, trumps the state law.<sup>198</sup> HIPAA's scheme essentially reverses this. HIPAA's provisions do not preempt state law if the state privacy law is "more stringent" than HIPAA's requirements.<sup>199</sup> In fact, HIPAA itself gives effect to state privacy laws for use in both federal and state court proceedings if the state law is contrary to HIPAA and provides more stringent protections of privacy.<sup>200</sup>

This preemption scheme applies to all of HIPAA's privacy regulations, including section 164.512(e) of the Privacy Rule, which governs the standards for disclosure in federal and state judicial proceedings.<sup>201</sup> Although somewhat ambiguous on its face as to whether HIPAA's preemption provision applies to cases involving federal question jurisdiction, HHS seemed to indicate the application of this provision to federal question proceedings in the preamble to the Privacy Rule.<sup>202</sup> In addressing the concerns about "whether a subpoena in a *federal* civil action would require disclosure if a state law prohibit[ed] the release of [medical information],"<sup>203</sup> HHS responded:

Under the applicable preemption provisions of HIPAA, state laws relating to the privacy of medical information that are more stringent than the federal rules are not preempted. To the extent that an applicable state law precludes disclosure of protected health information that would otherwise be permitted under the final rule,

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194. HIPAA § 264(c)(2), 110 Stat. at 2033-34; 45 C.F.R. § 164.512(e).

195. *Id.* § 264(c)(2), 110 Stat. at 2033-34 (emphasis added).

196. 45 C.F.R. § 160.202(1).

197. *Nat'l Abortion Fed'n v. Ashcroft*, No. 04-C-55, 2004 U.S. Dist. LEXIS 1701, at \*8 (N.D. Ill. Feb. 5, 2004) (citing 45 C.F.R. § 160.202).

198. *Nat'l Abortion Fed'n*, 2004 U.S. Dist. Lexis 1701, at \*13 (citing *Wisconsin Bell, Inc. v. Bie*, 340 F.3d 441 (7th Cir. 2003)).

199. 45 C.F.R. § 160.203(b).

200. HIPAA § 264(c)(2), 110 Stat. at 2033-34.

201. 45 C.F.R. § 164.512(e).

202. *See Standards for Privacy II*, 65 Fed. Reg. at 82,677 (discussing whether state privacy laws would be applied in federal actions).

203. *Id.* (emphasis added).

state law governs.<sup>204</sup>

While HHS theoretically could have been referring solely to preemption in federal diversity jurisdiction cases, there was no such distinction made in either the text of the Privacy Rule or in HHS's commentary.<sup>205</sup> If HHS had intended for these provisions to only apply to a specific subset of federal jurisdiction, it could have clearly expressed this intention. In the absence of this expression, HHS's general language must be interpreted broadly.<sup>206</sup> Consequently, it appears that HHS intended sections 164.512(e) and 264(c)(2) to apply equally in all federal and state suits.

Thus, sections 164.512(e) and 264(c)(2) will cause state privilege laws to be applied that are "more stringent" than federal protections of medical privacy, even in the context of a federal question case.<sup>207</sup> While normally, under FRE 501, state law would govern in proceedings where state law supplies the rule of decision and federal law would govern in proceedings where federal law provides the rule of decision, this only holds true if not otherwise "provided [for] by [an] Act of Congress."<sup>208</sup> Congress explicitly provided that state privilege laws were to preempt HIPAA in all cases; state and federal, when they provided "more stringent" protections of privacy.<sup>209</sup> Essentially, HIPAA has enacted a privacy protective scheme whereby "more stringent" state laws are an integral part of the federal government's medical privacy policy. This establishes a privilege in two different ways: (1) section 164.512(e) is the general privilege that governs the use of protected health information in federal judicial proceedings; but (2) if state law happens to provide greater protections than HIPAA would, state privilege law will trump the general federal privilege in section 164.512(e) and provide the privilege that governs the nondisclosure of protected health information.<sup>210</sup>

Whether HHS and Congress intended to create an evidentiary privilege via these sections is not entirely unambiguous. In *National Abortion Federation v. Ashcroft*,<sup>211</sup> Chief Judge Charles Kocoras of the Northern District of Illinois felt these sections were rightly understood as an "Act of Congress" under FRE 501 because "[i]f the case were otherwise, Congress' directive to [HHS] to set standards and regulations 'with respect to the privacy of individually identifiable health information' . . . would be rendered meaningless."<sup>212</sup> Thus, Judge

204. *Id.*

205. HIPAA § 264(c)(2); Standards for Privacy II, 65 Fed. Reg. at 82,462.

206. See *Ehlmann v. Kaiser Found. Health Plan of Tex.*, 198 F.3d 552, 555 (5th Cir. 2000) (deferring to the canon of statutory construction that the specific rules the general, the court refused to add to the specific requirements of a federal statute).

207. See *United States ex rel. Stewart v. La. Clinic*, No. 99-1767, 2002 U.S. Dist. LEXIS 24062, at \*15-16 (E.D. La. Dec. 12, 2002) (recognizing that Louisiana privilege law would not apply to federal *qui tam* action because it was not "more stringent" under HIPAA).

208. FED. R. EVID. 501 (explaining when federal or state privilege rules should be applied).

209. HIPAA § 264(c)(2); 45 C.F.R. § 160.203(b).

210. HIPAA § 264(c)(2); 45 C.F.R. §§ 160.203(b), 164.512(e).

211. 2004 U.S. Dist. LEXIS 1701.

212. *Nat'l Abortion Fed'n*, 2004 U.S. Dist. LEXIS 1701, at \*15.

Kocoras applied “more stringent” Illinois privacy laws, including the Illinois physician-patient privilege,<sup>213</sup> to a purely federal question case.<sup>214</sup> Judge Kocoras noted that “because Illinois’ privacy protections are activated only through HIPAA’s anti-preemption provision, this is not a case of Illinois law trumping federal law but instead a case of one federal law displacing another.”<sup>215</sup> He contended that the application of the Illinois physician-patient privilege to this federal suit was “Congress’ desired outcome” in enacting HIPAA’s privacy protections for medical information.<sup>216</sup> Kocoras noted that FRE 501 specifically ratified this scheme of privacy protections because as an “Act of Congress,” HIPAA could clearly permit state laws to provide the rule of decision in a federal question case.<sup>217</sup>

On appeal, while affirming the District Court on other grounds, Judge Richard Posner of the Seventh Circuit Court of Appeals disagreed with Judge Kocoras’s reading of HIPAA.<sup>218</sup> Posner noted that “although the issue is not free from doubt,”<sup>219</sup> he believed that section 164.512(e) was simply “a procedure for obtaining authority to use medical records in litigation”<sup>220</sup> rather than an independent evidentiary privilege.<sup>221</sup> He observed that “[t]he enforcement of federal law might be hamstrung if state-law privileges more stringent than any federal privilege . . . were applicable to all federal cases.”<sup>222</sup> He added that it seemed “improbable that HHS intended to open such a can of worms” by establishing a new federal evidentiary privilege.<sup>223</sup> He advanced two justifications for this reading. First, section 164.512(e)(1)(iii)(B) requires notice to a patient be given “to permit the individual to raise an objection to the court.”<sup>224</sup> Posner noted that these objections would often be based on privileges “found elsewhere than in the regulations themselves.”<sup>225</sup> Second, he argued that the procedural character of section 164.512(e) was indicated by the fact that the “more stringent” clause applies only to “*individually identifiable* health information” rather than health information in general.<sup>226</sup>

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213. 735 ILL. COMP. STAT. 5/8-802 (2003).

214. *Nat’l Abortion Fed’n*, 2004 U.S. Dist. LEXIS 1701, at \*12.

215. *Id.* at \*16.

216. *Id.*

217. *Id.* at \*15-17.

218. *Northwestern Mem’l Hosp. v. Ashcroft*, 362 F.3d 923, 925 (7th Cir. 2004).

219. *Id.*

220. *Id.* at 926.

221. *Id.*

222. *Id.* at 925.

223. *Northwestern Mem’l Hosp.*, 362 F.3d at 925.

224. *Id.* at 926 (citing 45 C.F.R. § 164.512(e)(1)(iii)(B)).

225. *Id.*

226. *Id.* (citing 45 C.F.R. §§ 160.203(b), 164.514(a)) (emphasis added).



*A. Congress Invited HHS To Create A Privilege To Govern The Uses and Disclosures Of Protected Health Information In Judicial Proceedings*

Judge Kocoras's reading of section 164.512(e), however, is the more appropriate and correct reading. Perhaps Judge Posner felt it improper to use this case to address the complexity of the evidentiary issues because this particular appeal had been "accelerated"<sup>227</sup> and was a "summary . . . proceeding."<sup>228</sup> Contrary to Judge Posner's views, we maintain that Congress and HHS furnished a firm basis for an evidentiary privilege and that this privilege should be acknowledged and followed in all future federal court proceedings.

Congress gave HHS a mandate to set "standards with respect to the privacy of individually identifiable health information."<sup>229</sup> Congress further explained what it had in mind for the HIPAA Privacy Rule by further directing HHS to address "the *uses and disclosures* of such information that should be authorized or required."<sup>230</sup> HHS responded with the facially unambiguous section 164.512(e),<sup>231</sup> entitled "Standard: disclosures for judicial and administrative

227. *Id.* at 924.

228. *Northwestern Mem'l Hosp.*, 362 F.3d at 926.

229. HIPAA § 264(a) (emphasis added).

230. HIPAA § 264(b) (emphasis added).

231. 45 C.F.R. § 164.512(e). Section 164.512(e) reads:

e) Standard: Disclosures for judicial and administrative proceedings.

(1) Permitted disclosures. A covered entity may disclose protected health information in the course of any judicial or administrative proceeding:

(i) In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order; or

(ii) In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if:

(A) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iii) of this section, from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or

(B) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iv) of this section, from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements of paragraph e)(1)(v) of this section.

(iii) For the purposes of paragraph (e)(1)(ii)(A) of this section, a covered entity receives satisfactory assurances from a party seeking protecting health information if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The party requesting such information has made a good faith attempt to provide written notice to the individual (or, if the individual's location is unknown, to mail a notice to the individual's last known address);

(B) The notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise an objection to the court or administrative tribunal; and

(C) The time for the individual to raise objections to the court or administrative tribunal has elapsed, and:

proceedings.”<sup>232</sup> Section 164.512(e) establishes the standards that HIPAA mandates for “when a covered entity is permitted to disclose protected health information in response to requests for protected health information that are made in the course of judicial . . . proceedings.”<sup>233</sup> No distinction whatsoever is made between state and federal proceedings.

The Privacy Rule requires a court order or other privacy protective criteria to be met<sup>234</sup> before the covered entity can disclose the information for use in court.<sup>235</sup> HHS made clear that, in the event that disclosure is permitted under section 164.512(e), the covered entity may “disclose only that protected health information that is within the scope of the permitted disclosure.”<sup>236</sup> Essentially,

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- (1) No objections were filed; or
  - (2) All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.
  - (iv) For the purposes of paragraph (e)(1)(ii)(B) of this section, a covered entity receives satisfactory assurances from a party seeking protected health information, if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:
    - (A) The parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or
    - (B) The party seeking the protected health information has requested a qualified order from such court or administrative tribunal.
  - (v) For purposes of paragraph (e)(1) of this section, a qualified protective order means, with respect to protected health information requested under paragraph (e)(1)(ii) of this section, an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:
    - (A) Prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested; and
    - (B) Requires the return to the covered entity or destruction of the protected health information (including all copies made) at the end of the litigation or proceeding.
  - (vi) Notwithstanding paragraph (e)(1)(ii) of this section, a covered entity may disclose protected health information in response to lawful process described in paragraph (e)(1)(ii) of this section without receiving satisfactory assurance under paragraph (e)(1)(ii)(A) or (B) of this section, if the covered entity makes reasonable efforts to provide notice to the individual sufficient to meet the requirements of paragraph (e)(1)(iii) of this section or to seek a qualified protective order sufficient to meet the requirements of paragraph (e)(1)(iv) of this section.
  - (2) Other uses and disclosures under this section. The provisions of this paragraph do not supersede other provisions of this section that otherwise permit or restrict uses or disclosures of protected health information.

232. *Id.*

233. Standards for Privacy II, 65 Fed. Reg. at 82,529.

234. See 45 C.F.R. § 164.512(e)(1)(ii) (providing for disclosure in response to a subpoena or discovery request if satisfactory assurances that reasonable efforts have been made to give the individual whose information has been requested notice of the request or satisfactory assurances that the party seeking such information has made reasonable efforts to secure a protective order that will guard the confidentiality of the information).

235. *Id.*

236. Standards for Privacy II, 65 Fed. Reg. at 82,530.

Congress delegated authority to HHS to promulgate regulations that would set standards governing the privacy of individually identifiable health information for the use and disclosure of protected health information in judicial proceedings. The Fourth Circuit upheld the constitutionality of this broad delegation to HHS as “a statement of ‘general policy’ by Congress.”<sup>237</sup> Thus, it is clear that HHS had full authority and support from Congress to establish an evidentiary privilege. In other words, it is not at all “improbable” that HHS would have responded to Congress’ clear mandate by promulgating exactly what was asked for.

While HHS did not explicitly state that an evidentiary privilege was being created under section 164.512(e), this was the clear intent. It is difficult to imagine what else Congress could possibly have had in mind when directing HHS to promulgate “standards” governing the “uses and disclosures” of protected health information.<sup>238</sup> If, as the Seventh Circuit concluded, that this was simply a “procedure for obtaining authority to use medical records in litigation,”<sup>239</sup> it would have seemed more logical for HHS to have entitled section 512(e) “*procedures: disclosures in judicial proceedings.*” Use of *standards* implies that some qualitative judgment (a concept consistent with an evidentiary privilege rather than a procedure) is being made about the subject matter.<sup>240</sup>

Beyond speculative construction of what “standards” means, however, the most powerful evidence that an evidentiary privilege was intended is the effect of a contrary finding. If, in fact, section 512(e) were simply a *procedure* for disclosures in judicial proceedings, HHS would have neglected in the significant arena of judicial proceedings to fulfill the mandate that Congress gave HHS to develop “standards” for “uses and disclosures” of protected health information. In other words, there would be a significant gap in HIPAA’s applicability in the courtroom, thereby allowing otherwise protected health information to be disclosed to the public in court, thus defeating the policies underlying HIPAA. In the context of Congress’s clear mandate, this seems unlikely. As Judge Charles Kocoras correctly noted, such an outcome would render Congress’ mandate “meaningless.”<sup>241</sup>

#### *B. HHS Responded To Congress’ Invitation By Creating A Federal Physician-Patient Privilege*

Beyond the clear language of section 512(e), HHS has given more indications that it intended to create a federal physician-patient evidentiary privilege. First, in responding to those who “urged the Secretary to revise [section 512(e)] to state that it does not preempt or supersede existing rules and

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237. S.C. Med. Ass’n v. Thompson, 327 F.3d 346, 351 (4th Cir. 2003).

238. HIPAA § 264(a), (b)(3).

239. *Northwestern Mem’l Hosp.*, 362 F.3d at 926.

240. See BLACK’S LAW DICTIONARY 660 (8th ed. 2004) (defining standard as a “criterion for measuring acceptability, quality, or accuracy”).

241. *Nat’l Abortion Fed’n*, 2004 U.S. Dist. LEXIS 1701, at \*15.

statutes governing judicial proceedings, including rules of evidence, procedure, and discovery,”<sup>242</sup> HHS declined to include any such provision.<sup>243</sup> Instead, HHS reiterated that the Privacy Rule’s preemption provision,<sup>244</sup> which gives effect to more stringent state privilege laws under HIPAA, would continue to govern judicial disclosure.<sup>245</sup> Thus, when directly asked to state that section 164.512(e) did not establish an evidentiary privilege, HHS refused to do so.

Second, section 164.512(e), consistent with an evidentiary privilege, establishes affirmative standards for disclosure of individually identifiable health information rather than simply establishing a procedure for disclosure. Thus, Judge Posner’s dismissal of section 164.512(e) as a source of a privilege is not well founded. HHS explicitly noted that because protected health information “may be critical *evidence*,” section 164.512(e) “balance[d] the need for the information with the individual’s privacy.”<sup>246</sup> If this section were simply a procedure rather than an affirmative standard, there would not seem to be a need for any substantive balancing of interests. The standard of section 164.512(e) is essentially to further the basic principle of nondisclosure to third parties of HIPAA’s other provisions in the context of the courtroom.<sup>247</sup> In other words, section 164.512(e) requires application of the aggregate of HIPAA’s privacy protections in the context of judicial proceedings. This could be accomplished through either HIPAA’s numerous affirmative standards or, in cases where state law provides greater protection than these minimum standards, through HIPAA’s preemption provision giving effect to these state privileges instead. As HIPAA itself provides innumerable substantive protections of health information, it would have been redundant for HHS to reiterate in section 164.512(e) every single affirmative standard that applies to judicial proceedings. The source of the privilege is the HIPAA regulations themselves. It is undisputed that HIPAA provides affirmative standards for disclosure of protected health information.<sup>248</sup> Section 164.512(e) simply established that these standards apply in the context of state and federal lawsuits. In any event, this is substantive rather than procedural.

Consistent with this concept, HHS reiterated, in response to comments that section 164.512(e) should *require* rather than *permit* disclosure of protected health information, that “a presumption is established that the data contained in an individual’s medical record belongs to the individual and must be protected from disclosure to third parties.”<sup>249</sup> In response to comments suggesting “that disclosure of protected health information should be limited only to those cases

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242. Standards for Privacy II, 65 Fed. Reg. at 82,674.

243. *Id.*

244. HIPAA § 264(c)(2), 110 Stat. at 2033.

245. Standards for Privacy II, 65 Fed. Reg. at 82,674.

246. *Id.* (emphasis added).

247. *See id.* at 82,677 (noting that court order should not compromise presumption that individuals’ medical records are private).

248. *See id.* at 82,679 (describing the showing that is necessary for a covered entity to release protected health information).

249. *Id.* at 82,677.

in which the individual has consented or a court order has been issued compelling disclosure,<sup>250</sup> HHS rejected this suggestion on the grounds that state privacy laws were not even this strict.<sup>251</sup> If section 164.512(e) did not establish affirmative standards for disclosure, it would seem odd to compare the strength of its protections with state privacy law.

Third, section 164.512(e) operates identically to an evidentiary privilege. HHS noted that this new rule would not interfere with the judicial practice of requiring an individual who is a party to a proceeding and has put his or her medical condition at issue to consent to disclosure of medical information in order to prevail in the suit.<sup>252</sup> This operates similarly to the waiver of an evidentiary privilege when an individual places his or her health at issue in a lawsuit.

Fourth, Judge Posner's dismissal of the substantive character of section 164.512(e)'s protections because the "more stringent" clause applies only to "*individually identifiable* health information,"<sup>253</sup> rather than health information in general, is not fatal to the establishment of a privilege. An evidentiary privilege need not cover every conceivable communication between the holder and non-holder of the privilege. For example, the attorney-client privilege does not cover statements made by the client to the attorney, even though in confidence, if the purpose of the communication is to further crime or fraud.<sup>254</sup> Consequently, Judge Posner's summary dismissal of the presence of an evidentiary privilege under these sections is not well founded and should not be followed by other courts that consider the matter.

In sum, while the issue may not be *entirely* "free from doubt,"<sup>255</sup> it seems significantly more likely that HHS, pursuant to its broad mandate from Congress to create standards for "uses and disclosures,"<sup>256</sup> promulgated affirmative standards for disclosure of individually identifiable health information in judicial proceedings. While HHS's failure to explicitly call section 164.512(e) an evidentiary privilege leaves some room for technical disagreement, the Seventh Circuit's reading of section 164.512(e) as simply "a procedure for obtaining authority to use medical records in litigation"<sup>257</sup> is implausible and labored. This reading is not only inconsistent with HHS's explanation of section 164.512(e), but it would serve to render Congress' unambiguous mandate to HHS, to promulgate standards for "uses and disclosures," meaningless. Congress and HHS seem to have already created an evidentiary privilege through operation of HIPAA as an "Act of Congress" under FRE 501.

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250. Standards for Privacy II, 65 Fed. Reg. at 82,675.

251. *Id.*

252. *Id.* at 82,530.

253. *Northwestern Mem'l Hosp.*, 362 F.3d at 926 (emphasis added).

254. *Clark v. United States*, 289 U.S. 1, 14-16 (1933).

255. *Northwestern Mem'l Hosp.*, 362 F.3d at 925.

256. HIPAA § 264(b)(3).

257. *Northwestern Mem'l Hosp.*, 362 F.3d at 926.

### III. HIPAA ILLUSTRATES THAT A FEDERAL PHYSICIAN-PATIENT PRIVILEGE IS MANDATED BY REASON AND EXPERIENCE

Even if HIPAA cannot be read as establishing an evidentiary privilege as an “Act of Congress,” HIPAA still plays a prominent role in the foundation of a federal physician-patient privilege pursuant to FRE 501 that states: “the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of *reason and experience*.”<sup>258</sup> HIPAA provides the backdrop for finding a physician-patient privilege illustrating both the reason and experience factors required under FRE 501. HIPAA illustrates the changed medical environment (the “reason”) and the policy supporting strong and unambiguous protection of health information privacy (the “experience”) under which the federal physician-patient privilege must be evaluated. Applying the mandate of FRE 501 as interpreted by the United States Supreme Court in *Jaffee v. Redmond* to “continue the evolutionary development of testimonial privileges,”<sup>259</sup> there is ample foundation for a federal physician-patient privilege.

#### *A. How is a Privilege Recognized Under the Principles of “Reason and Experience”?*

The foundation for new evidentiary privileges was not intended to remain static.<sup>260</sup> Federal courts have a right and a responsibility to examine policies behind federal common law privileges and to alter or amend them when reason and experience so demand.<sup>261</sup> Congress intended federal courts to recognize privileges based upon changed societal conditions.<sup>262</sup> Applying this mandate of Federal Rule of Evidence 501, the United States Supreme Court recognized the existence of a psychotherapist-privilege in *Jaffee v. Redmond*.<sup>263</sup> The method used in *Jaffee* to establish the existence of a psychotherapist-patient privilege provides the model for future recognition of other federal evidentiary privileges.

The Court, in *Jaffee*, began its analysis by reiterating the intent underlying Federal Rule of Evidence 501: the law governing federal evidentiary privileges is not to be frozen at any particular period in history.<sup>264</sup> Federal courts are directed to “continue the evolutionary development of testimonial privileges”

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258. FED. R. EVID. 501 (emphasis added).

259. *Jaffee v. Redmond*, 518 U.S. 1, 9 (1996) (citing *Trammel v. United States*, 445 U.S. 40, 47 (1980)). Common law recognized the attorney-client privilege and a rule of incompetence with respect to the husband and wife relationship. This rule of incompetence later evolved to become the federally recognized marital privilege via the Supreme Court’s holding in *Trammel. Id.*

260. *See id.* at 8-9 (explaining that common law and recognition of privilege should be flexible).

261. *United States v. Allery*, 526 F.2d 1362, 1366 (8th Cir. 1975).

262. *See Jaffee*, 518 U.S. at 8 (“[T]he common law is not immutable but flexible, and by its own principles adapts itself to varying conditions.” (quoting *Wolfe v. United States*, 291 U.S. 7, 12 (1934))).

263. *Id.* at 10.

264. *Id.* at 9.

where the need for the new privilege outweighs the cost in the loss of reliable evidence that the privilege would entail.<sup>265</sup>

The *Jaffee* Court unambiguously stated that the general disfavor of testimonial privileges may be justified “by a ‘public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth.’”<sup>266</sup> In other words, if there are sufficiently important private and public interests in protecting the relationship in which certain confidential communications take place, a court may find that the communications made within that relationship should be protected from disclosure in open court. The *Jaffee* Court weighed the merits of the psychotherapist-patient relationship in this context and concluded that both “reason and experience” compelled the recognition of an absolute privilege in this relationship.<sup>267</sup>

### 1. “Reason and Experience” Under *Jaffee*

The “reason and experience” analysis used by the *Jaffee* Court looked to the logical basis for justifying recognition of a psychotherapist-patient privilege as well as the underlying policies and actions taken by state legislatures to determine that confidential communications made between patients and their psychotherapists “are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence.”<sup>268</sup> In order for a new privilege to be recognized under the *Jaffee* Court’s interpretation of FRE 501’s “reason and experience” test, several elements must be established and balanced. First, it must be shown that the new privilege advances private interests.<sup>269</sup> Second, the new privilege must also advance public interests.<sup>270</sup> Third, these private and public interests must outweigh any potential loss of evidence that flows from the new privilege.<sup>271</sup> Finally, a showing that there exists a consensus among states recognizing the privilege must be factored into the analysis.<sup>272</sup>

#### *a. An Evidentiary Privilege Must Serve Private Interests*

The *Jaffee* Court reasoned that the psychotherapist-patient privilege was “rooted in the imperative need for confidence and trust.”<sup>273</sup> It acknowledged that effective psychotherapy is dependent on an atmosphere of confidentiality

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265. *Id.* (quoting *Trammel*, 445 U.S. at 47).

266. *Id.* (quoting *Trammel*, 445 U.S. at 50).

267. *Jaffee*, 518 U.S. at 9-10.

268. *Id.* at 15.

269. *See id.* at 11 (discussing importance of serving private interests).

270. *See id.* (discussing importance of serving public ends).

271. *See id.* (noting that “the likely evidentiary benefit that would result from the denial of the privilege is modest”).

272. *See Jaffee*, 518 U.S. at 12-13 (“[W]e recognized that it is appropriate to treat a consistent body of policy determinations by state legislatures as reflecting both ‘reason’ and ‘experience.’” (citing *Funk v. United States*, 290 U.S. 371, 376-81 (1933))).

273. *Id.* at 10 (quoting *Trammel*, 445 U.S. at 51).

where a patient is willing to make a complete disclosure of facts.<sup>274</sup> As the disclosure of the inherently sensitive information related to psychotherapy could potentially cause embarrassment to the patient,<sup>275</sup> the *mere possibility* of disclosure could damage the basic structure of this relationship.<sup>276</sup> By protecting the relationship and confidential communications between patients and psychotherapists from “involuntary disclosure,” the Court held that the psychotherapist-patient privilege “thus serves important private interests.”<sup>277</sup>

*b. An Evidentiary Privilege Must Serve Public Ends*

The *Jaffee* Court reasoned that any recognized privilege must also “serve public ends.”<sup>278</sup> The Court analogized the societal benefits of establishing attorney-client privilege, which promotes the public’s interest in the observance of law and administration of justice,<sup>279</sup> and the marital privilege, which promotes the societal interest in marital harmony,<sup>280</sup> to that of the psychotherapist-patient privilege.<sup>281</sup> Under the facts of *Jaffee*, the Court observed that recognizing a psychotherapist-patient privilege would produce benefits that inure to the whole community.<sup>282</sup> The psychotherapist-patient privilege serves public ends by facilitating and encouraging the treatment of individuals with emotional or mental health problems.<sup>283</sup> Taking into account the gravity of the societal interest in mental health, the Court recognized the “transcendent” importance of the mental health of the country’s citizenry.<sup>284</sup> It is important to note in the context of this article that, in recognizing the “transcendent” importance of the mental health of the citizenry, the Court implicitly recognized that the physical health of the citizenry is of “transcendent” importance as well.<sup>285</sup>

*c. Public and Private Interests From an Evidentiary Privilege Must Outweigh the Potential Loss of Relevant Evidence*

The *Jaffee* Court balanced the possible evidentiary loss that would result from recognizing the psychotherapist-patient privilege.<sup>286</sup> The Court concluded that denying the psychotherapist-patient privilege would not result in any significant evidentiary loss because patients would likely cease sharing

274. *Id.*

275. *Id.*

276. *Id.*

277. *Jaffee*, 518 U.S. at 11.

278. *Id.* (quoting *Upjohn Co. v. United States*, 449 U.S. 383, 389 (1981)).

279. *Id.* (quoting *Upjohn*, 449 U.S. at 389).

280. *Id.* (quoting *Trammel*, 445 U.S. at 53).

281. *Id.*

282. *Jaffee*, 518 U.S. at 11.

283. *Id.*

284. *Id.*

285. *See id.* at 11 (noting that “[t]he mental health of our citizenry, no less than its physical health, is a public good of transcendent importance”).

286. *Id.*



information that could be used to their detriment.<sup>287</sup> Thus, this “unspoken ‘evidence’” would not result in any significant evidentiary loss.<sup>288</sup> Therefore, the cost of the privilege was minimal, as the privilege would protect only those communications that are generated by a reliance on confidentiality. On the balance, the public and private interests at stake outweighed any possible loss of evidence.

*d. Influence of Previous Policy Decisions Under Jaffee*

The *Jaffee* Court attached particular importance to the policy decisions of the individual states in recognizing a new privilege.<sup>289</sup> The Court observed that prior to the instant case, the legislatures of fifty states and the District of Columbia had enacted statutes recognizing some form of psychotherapist-patient privilege.<sup>290</sup> The existence of this overwhelming consensus indicated that federal recognition of this privilege was necessary as well.<sup>291</sup> The Court noted that the existence of a state privilege would have little value in encouraging candor to one’s psychotherapist if confidentiality would not be honored in federal court.<sup>292</sup> Federal court denial of an asserted privilege that is recognized by a “consensus” of states would result in the frustration of the original purpose of state legislation created to encourage confidential communications.<sup>293</sup> This potential conflict created an impermissible situation for the Supreme Court, mitigating in favor of recognizing a federal psychotherapist-patient privilege.

The *Jaffee* Court acknowledged that the primary source of modern privilege law is legislative rather than judicial action.<sup>294</sup> Legislative development of an asserted privilege would also explain the absence of federal common law with respect to any given privilege.<sup>295</sup> Although the language in Federal Rule of Evidence 501 speaks in terms of growth of privileges being “governed by the principles of the common law,”<sup>296</sup> the driving force in the establishment of new privileges is more likely to come from the legislature rather than the courts. The Court explained that legislatures (at least in the case of psychotherapy) are able to rapidly see the wisdom of and need for new privileges to meet the ever-changing needs of a society.<sup>297</sup>

Finally, the *Jaffee* Court recognized that “[t]he uniform judgment of the

287. *Jaffee*, 518 U.S. at 11-12.

288. *Id.* at 12.

289. *See id.* at 12-13 (emphasizing States’ unanimous enactment of psychotherapist privilege).

290. *Id.* at 12.

291. *See id.* at 13 (noting that consensus suggested that privilege was supported by reason and experience).

292. *Jaffee*, 518 U.S. at 13.

293. *Id.*

294. *Id.*

295. *See id.* (noting that “once a state legislature has enacted a privilege there is no longer an opportunity for common-law creation of the protection”).

296. FED. R. EVID. 501.

297. *See Jaffee*, 518 U.S. at 14 (citing quick action of state lawmakers to create unanimous acceptance).

States is reinforced by the fact that a psychotherapist privilege was among the nine specific privileges recommended by the Advisory Committee in its proposed privilege rules.<sup>298</sup> It relied on the Proposed Federal Rules of Evidence in evaluating the “experience” factor of Federal Rule of Evidence 501.<sup>299</sup> However, the *Jaffee* Court proceeded to go beyond the scope of Proposed Federal Rule of Evidence 501 to hold that communications with clinical social workers were privileged communications as well.<sup>300</sup> In this way, *Jaffee* extended the new privilege to foster a relationship that was supported by the Proposed Federal Rules of Evidence and beyond to a relationship not supported by the Proposed Federal Rules of Evidence.

## 2. Revolutionary Changes Since *Jaffee*

We would be remiss not to acknowledge the *Jaffee* Court’s dictum, which at least implicitly rejected the need for a physician-patient privilege. The Court observed that “[t]reatment by a physician for physical ailments can often proceed successfully on the basis of a physical examination, objective information supplied by the patient, and the results of diagnostic tests.”<sup>301</sup>

While the *Jaffee* Court’s characterization of the physician-patient relationship was a bit myopic, even in 1996, there have been revolutionary changes in medicine, science, technology, health care organization, and governmental policy since 1996 that confirm the need for a federal physician-patient privilege. As discussed *supra*, scientific and technological changes have altered the calculus in which patients must engage when communicating with their physicians.<sup>302</sup> There is more information collected from individuals during the course of medical diagnosis and treatment than ever before. Medical information is increasingly collected and stored electronically in centralized locations leading to greater authorized and unauthorized access by more individuals and entities than in the past. More conclusions can be drawn (both directly and inferentially) about an individual from medical information. There are more incentives for commercial and noncommercial uses for medical information today than in the past—uses that can be damaging to the privacy and reputation of the patient. Absent strong protections for medical privacy, patients may engage in privacy protective behavior when communicating with physicians. As a result, patients may decide not to disclose potentially embarrassing information to their physicians. Moreover, patients may refuse to seek treatment for certain conditions fearing that medical information may be disclosed in a manner that will ultimately harm them. These changes modify the physician-patient dynamic and call for a reevaluation by the federal courts of the

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298. *Id.*

299. *Id.* at 13-14.

300. See *Jaffee*, 518 U.S. at 15 (recognizing that reasons for applying privilege to psychiatrists and psychologists applied equally to social workers practicing psychotherapy).

301. *Id.* at 10.

302. See *supra* notes 175-88 and accompanying text (discussing patients’ privacy protective behavior).

need for a physician-patient privilege.

*B. The Jaffee Court's Interpretation of "Reason and Experience" Dictates Recognition of a Federal Physician-Patient Evidentiary Privilege*

The *Jaffee* Court distinguished the physician-patient relationship from the psychotherapist-patient relationship noting that physicians can effectively treat patients on the basis of "physical examination, objective information supplied by the patient, and the results of diagnostic tests,"<sup>303</sup> rather than requiring candor and cooperation from the patient for effective diagnosis and treatment.<sup>304</sup> This basic assumption was and remains fallacious. The veracity of this assumption was questioned even when *Jaffee* was decided in 1996.<sup>305</sup> In light of the revolutionary changes in science, technology, medicine, and governmental policy since *Jaffee*, clearly a federal physician-patient privilege is now essential to realize and maximize both individual and public health interests.

There are a number of problems in applying the *Jaffee* Court's dismissive analysis to the current state of the patient-physician relationship. First, there are facets of this relationship that do, in fact, require direct disclosure by the patient of private facts to facilitate effective diagnosis and treatment. Examples include conditions that rely on patients' subjective manifestations of symptoms, such as those involving physical pain,<sup>306</sup> or conditions having psychological or emotional components, such as depression.<sup>307</sup> As HHS stated in the 2000 Privacy Rule, "the entire health care system is built upon the willingness of individuals to share the most intimate details of their lives with their health care providers."<sup>308</sup> Such willingness is put at risk when confidential information remains unprotected.

Second, the *Jaffee* Court assumed that patients would actually consent to "diagnostic tests."<sup>309</sup> To the contrary, "[p]atients are less likely to divulge sensitive information to health professionals if they are not assured that their confidences will be respected."<sup>310</sup> If patients refuse to participate in diagnostic tests out of fear that their physicians could reveal the results,<sup>311</sup> the ability of

303. *Jaffee*, 518 U.S. at 10.

304. *Id.*

305. See Kenneth S. Broun, *Giving Codification a Second Chance-Testimonial Privileges and the Federal Rules of Evidence*, 53 HASTINGS L. J. 769, 807 (2002) (noting that the distinction between physical and mental examination is questionable).

306. See *id.* at 807 (citing James S. Lapcevic, *Pain Management*, in AMERICAN COLLEGE OF LEGAL MEDICINE, LEGAL MEDICINE ch. 37 (1998)).

307. See AMITAI ETZIONI, THE LIMITS OF PRIVACY 146 (1999) (noting that threat of disclosure of emotional problems deters patients from seeking treatment).

308. Standards for Privacy II, 65 Fed. Reg. at 82,467.

309. *Jaffee*, 518 U.S. at 10.

310. Lawrence O. Gostin, *Health Information Privacy*, 80 CORNELL L. REV. 451, 490-91 (1995).

311. As discussed *supra*, this is not simply theoretical. Studies have documented that fears of discrimination from the disclosure of medical information is a significant factor in patients' willingness to undergo testing and to seek reimbursement from health insurers. See Mark A. Hall & Stephen S. Rich, *Genetic Privacy Laws and Patients' Fear of Discrimination by Health Insurers: The View From Genetic Counselors*, 28 J. LAW, MED., & ETHICS 245, 245-57 (2000) (discussing patients' fear of losing

physicians to treat patients effectively would be hindered. In other words, a physician may not have sufficient information from which to form an accurate diagnosis. Consequently, this refusal to submit to tests can have deleterious effects on both the individual health of the patient and on public health.<sup>312</sup>

An effective physician-patient relationship depends on an atmosphere where a patient is willing to make a complete disclosure of facts and submit to all beneficial medical procedures.<sup>313</sup> Patients' fears of disclosure, dissemination, or misuse of their medical information can have a deadly effect on the physician-patient relationship.<sup>314</sup> While not all patients will allow fears of disclosure to affect their relationship with their physician, as the *Jaffee* Court properly recognized, the "mere possibility" of disclosure of sensitive information might harm a relationship that is built on trust and confidence.<sup>315</sup> In the absence of adequate legal protection for medical information, including a federal physician-patient privilege, a significant portion of the public will continue to engage in "privacy protective behavior."<sup>316</sup> Ultimately, these individuals are risking their health in response to privacy concerns. Given the public health concerns such avoidance raises, including the threat of uncontrolled pandemics,<sup>317</sup> the consequences of patients engaging in privacy protective behavior in response to the absence of a federal physician-patient privilege are ominous. As discussed *infra*, institutionalizing a federal physician-patient privilege would serve significant private and public interests.<sup>318</sup> The resultant loss of evidence in court proceedings would be minimal or nonexistent. In addition, there is a body of federal and state policy decisions that support recognition of a federal physician-patient privilege.<sup>319</sup> Thus, under the rationale of *Jaffee v. Redmond*, "reason and

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insurance coverage after undergoing genetic testing).

312. For example, if a patient forgoes medical testing or treatment for HIV/AIDS, the patient's condition may go undiagnosed and he or she may spread the infection to others. See generally Anthony L. Osterlund, *The Unequal Balancing Act Between HIV-Positive Patients and Physicians*, 25 OHIO N.U. L. REV. 149 (1999) (noting that patients do not have a duty to inform physicians of HIV status); Francoise Gilbert, *Emerging Issues in Global AIDS Policy: Preserving Privacy*, 25 WHITTIER L. REV. 273 (2003) (noting importance of safeguarding patients' personally identifiable health information and patients' protective behavior).

313. LISA M. BOYLE & DAVID M. MACK, *HIPAA: A GUIDE TO HEALTH CARE PRIVACY AND SECURITY LAW* 1:4 (2004). See also BARUCH A. BRODY ET AL., *MEDICAL ETHICS: ANALYSIS OF THE ISSUES RAISED BY THE CODES OPINIONS AND STATEMENTS* 178 (2001) (stating that a breach of confidentiality damages the patient-physician relationship).

314. See Gostin, *supra* note 310, at 491 (noting that "[t]he consequence of incomplete information is that patients may not receive adequate diagnosis and treatment of important health conditions").

315. *Jaffee*, 518 U.S. at 10.

316. See *supra* notes 175-88 and accompanying text (discussing patients' privacy protective behavior).

317. See Gilbert, *supra* note 312, at 279 (discussing domino effect that may occur if contagious diseases are not disclosed).

318. See *infra* notes 320-98 and accompanying text (discussing private and public benefit of federal physician-patient privilege).

319. See *infra* notes 431-80 and accompanying text (discussing policy choices of various states regarding physician-patient privilege and its relevance in federal judicial and legislative decision-

experience” mandate the recognition of a federal physician-patient privilege.

1. A Federal Physician-Patient Privilege Would Serve Important Private Interests

*a. Absence of a Federal Physician-Patient Privilege Harms Individual Patients' Health.*

Patients have strong disincentives to be fully open and candid with their physicians in the absence of a federal physician-patient privilege.<sup>320</sup> Obviously, patients would not desire to have information that exposes diagnosis or treatment for a sexually transmitted disease, a prior abortion, depression, or any other condition that carries a social stigma publicly disclosed. Moreover, patients have a direct disincentive to seek a constitutionally protected abortion or treatment for a communicable sexually transmitted disease if there was even a mere possibility that personally identifiable information regarding such conditions, procedures, or treatments would find its way into the public domain. One route to public disclosure is through the judicial process. The prospect that sensitive health information could be disclosed in a trial record of a federal proceeding is a legitimate concern for any patient. Patients have little or no control over how and when their confidential communications made to a physician will be exposed in federal litigation.<sup>321</sup> Thus, many 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.<sup>322</sup>

Patients may also legitimately fear that objectively non-sensitive information may provide inferences to sensitive medical conditions when combined with other available information. Medical records, for example, increasingly contain a vast amount of personal information with multiple uses.<sup>323</sup> Even when the information disclosed to a physician is not sensitive in an objective sense, the disclosure and dissemination of this information could provide a wealth of inferential information about other facets of the individual's private life. This may include demographic information (a valuable tool for consumer marketing), financial information (valuable to creditors and consumer marketing of financial services), drug, alcohol, or tobacco use (valuable to insurance providers or employers), or genetic information about the individual

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making).

320. See *supra* notes 313-18 and accompanying text (discussing patients' fear of disclosure and its effect on their behavior).

321. See *infra* notes 528-37 and accompanying text (discussing historical rule of evidence that did not recognize physician-patient privilege).

322. See, e.g., ETZIONI, *supra* note 307, at 140-48 (noting that some patients choose not to seek treatment or participate in studies to avoid disclosure).

323. See Gostin, *supra* note 310, at 490 (describing type of information that may be included in medical records).

and their family (valuable to employers and insurance providers).<sup>324</sup> In essence, information contained in medical records may be used to create a detailed profile of the individual that could be used to the individual's detriment.

Even with a strong recent federal policy on medical privacy,<sup>325</sup> in the absence of a federal physician-patient privilege, there remains the threat that medical information could be disclosed by a physician in federal court. After this initial disclosure in open court, widespread dissemination of private medical information may be only a few mouse clicks away. Public court documents are easily and instantaneously accessible via the Internet through many commercial and non-commercial sources.<sup>326</sup> Recognition of a federal physician-patient privilege would restrict disclosure of a patient's confidential medical information in federal court proceedings and thus will promote patient-physician communications necessary for effective diagnosis and treatment. Conversely, the private interests of a patient in maintaining a trusting relationship with his or her physician and in obtaining treatment are irreparably compromised in the absence of a federal physician-patient privilege. Therefore, the absence of a federal physician-patient privilege actually harms individual patients' health.

*b. Absence of a Federal Physician-Patient Privilege Harms Individual Patients' Inherent Constitutional Interest in the Privacy of Their Medical Information*

Continued refusal to acknowledge a federal physician-patient privilege compromises individuals' inherent and strong interest in protecting their constitutional rights. The United States Supreme Court recognized a constitutionally protected right to privacy in the context of medical information many years ago in *Whalen v. Roe*.<sup>327</sup> One of the constitutionally protected privacy interests that the *Whalen* Court identified was "the individual interest in avoiding disclosure of personal matters."<sup>328</sup> The Second Circuit Court of Appeals has observed, in applying *Whalen*, that "the right to confidentiality includes the right to protection regarding information about the state of one's health."<sup>329</sup> The Second Circuit further noted that "there are few matters that are quite so personal as the status of one's health, and few matters the dissemination of which one would prefer to maintain greater control over."<sup>330</sup> However, the

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324. See ETZIONI, *supra* note 307, at 146-48 (discussing the value of medical information to commercial interests).

325. See *supra* notes 30-56 and accompanying text (discussing HIPAA). See also *infra* notes 460-75 and accompanying text (discussing recent federal genetic privacy initiatives).

326. See *infra* note 335 and accompanying text (discussing potential harm to patients resulting from medical records that are used in judicial proceedings and accessible via Internet).

327. 429 U.S. 589 (1977).

328. *Whalen*, 429 U.S. at 599. See also *Nixon v. Adm'r of Gen. Servs.*, 433 U.S. 425, 457 (1977) (reaffirming the notion of constitutional protection of informational privacy concluding that President Nixon had a constitutional privacy interest in "matters of [his] personal life").

329. *Doe v. City of New York*, 15 F.3d 264, 267 (2d Cir. 1994).

330. *Id.* at 267.

constitutional right to informational privacy is not absolute.<sup>331</sup> A party seeking disclosure of this protected information must surmount a heavy burden of showing that a substantial interest outweighs this constitutionally protected privacy interest.<sup>332</sup> While this recognized privacy interest is particularly strong in the context of traditionally sensitive areas, such as abortion<sup>333</sup> and HIV/AIDS,<sup>334</sup> the sheer volume of information that could be gleaned inferentially<sup>335</sup> through judicial disclosure of a broad swath of medical information certainly implicates a patient's constitutional right to privacy of his or her medical information.

Today's technology is increasingly putting the individual's constitutional right to informational privacy at the mercy of technology.<sup>336</sup> The absence of a federal physician-patient privilege compounds this growing threat with no concomitant benefit.

The United States Supreme Court has addressed the paradox between constitutionally protected privacy and rapidly advancing technology in the Fourth Amendment context.<sup>337</sup> Lower courts have also relied on Fourth Amendment standards in measuring the constitutional protection that should be afforded to informational privacy.<sup>338</sup> The Fourth Amendment protects an

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331. See *Whalen*, 429 U.S. at 600-02 (noting disclosure of medical information to representatives of State not an automatic infringement of privacy); *Nixon*, 433 U.S. at 458, 465 (concluding that limited intrusion into personal communications was justified).

332. *Doe*, 15 F.3d at 269.

333. See *Nat'l Abortion Fed'n v. Ashcroft*, No. 04-C-55, 2004 U.S. Dist. LEXIS 1701, at \*18-19 (N.D. Ill. Feb. 5, 2004) (noting that issue of abortion is "indisputably of the most sensitive stripe" and "one of the most controversial decisions in modern life"); see also *Planned Parenthood Fed'n of Am., Inc. v. Ashcroft*, No. C-03-4872, 2004 U.S. Dist. LEXIS 3383, at \*6-7 (N.D. Cal. Mar. 5, 2004) (noting that even redacted medical records in context of abortion could not overcome strong right to informational privacy).

334. See *Doe*, 15 F.3d at 267 (noting that a constitutionally protected privacy interest is recognized in any serious medical condition "but is especially true with regard to those infected with HIV").

335. See, e.g., *Planned Parenthood*, 2004 U.S. Dist. LEXIS 3383, at \*6 (noting that medical records can contain sensitive secondary information such as marital status, types of contraception, sexual abuse or rape, or presence of sexually transmitted diseases). Furthermore, improperly redacted medical records could expose demographic information, financial information, information about disabilities, personal and social information (such as sexual orientation) as well as medical information such as diagnoses, treatments, and medical histories. BOYLE & MACK, *supra* note 313, at 1:10-1:11.

336. See *Northwestern Mem'l Hosp. v. Ashcroft*, 362 F.3d 923, 929 (7th Cir. 2004) (noting how Internet technology could be used to ascertain identities of patients from redacted medical records made available during litigation). Judge Posner noted the possibility that "persons of [the patient's] acquaintance, or skillful 'Googlers,' [individuals who collect information from the Internet]" may sift through information in patient's medical records that have been used in a judicial proceeding and identify the patient. *Id.* This could consequently result in the patient's exposure to "threats, humiliation, and obloquy" regarding the information contained therein. *Id.*

337. See generally *Kyllo v. United States*, 533 U.S. 27 (2001) (addressing whether use of thermal-imaging technology to detect growth of marijuana indoors constitutes an unreasonable search under the Fourth Amendment).

338. See, e.g., *Fraternal Order of Police, Lodge No. 5 v. City of Phila.*, 812 F.2d 105, 112-13 (3d Cir. 1987) (concluding that an inquiry must be made into individual's expectation of confidentiality in deciding whether information merits privacy protection).

individual's right to privacy when the individual manifests a subjective expectation of privacy that society accepts as objectively reasonable.<sup>339</sup> This standard is readily applicable in the medical information context.<sup>340</sup> "Patients have a right to have medical information held in confidence where they have a reasonable expectation of such confidentiality within the physician-patient relationship."<sup>341</sup> Patients have developed a reasonable expectation that their medical information will not be disclosed without their consent by their physicians.<sup>342</sup>

The United States Supreme Court's concern with the erosion of privacy in the wake of technological advancements can be traced as far back as *Olmstead v. United States*<sup>343</sup> in 1928. Here, the Court ultimately upheld the government's use of telephone wiretaps as not constituting an illegal search or seizure.<sup>344</sup> However, the often-quoted dissent of Justice Louis D. Brandeis expounded a view that would later be recognized by the majority of the Court.<sup>345</sup> Justice Brandeis, concerned with the government's newfound ability through wiretapping technology to "obtain disclosure in court of what is whispered in the closet,"<sup>346</sup> noted that "[c]lauses guaranteeing to the individual protection against specific abuses of power, must have a similar capacity of adaptation to a changing world."<sup>347</sup> "Time works changes,"<sup>348</sup> he added. As such, "our contemplation cannot be only of what has been but of what may be."<sup>349</sup> Any less may result in "[r]ights declared in words [being] lost in reality."<sup>350</sup>

The Supreme Court has sought to curb governmental encroachment on privacy caused by technological advancements. In *Kyllo v. United States*,<sup>351</sup> the Supreme Court recognized that rapid technological advancement may threaten an individual's right to privacy in the home.<sup>352</sup> In an opinion written by Justice Antonin Scalia, the Court held that the use of a technologically advanced thermal imaging device to determine relative heat emanating from a home

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339. *Katz v. United States*, 389 U.S. 347, 361 (1967) (Harlan, J., concurring).

340. See BRODY ET AL., *supra* note 313, at 174-75 (discussing relationship between privacy of medical information and Fourth Amendment).

341. *Id.* at 175.

342. See, e.g., *Alberts v. Devine*, 479 N.E.2d 113, 118-19 (Mass. 1985) (noting that patients rely on fact that physician-patient privilege is confidential (citing *MacDonald v. Clinger*, 446 N.Y.S.2d 801, 802 (N.Y. App. Div. 1982))).

343. 277 U.S. 438 (1928).

344. *Olmstead*, 277 U.S. at 466.

345. See *id.* at 471-85 (Brandeis, J., dissenting) (arguing that constitutional clauses affording individual protection must adapt to new circumstances).

346. *Id.* at 473.

347. *Id.* at 472.

348. *Id.* at 472 (quoting *Weems v. United States*, 217 U.S. 349, 373 (1910)).

349. *Olmstead*, 277 U.S. at 473 (Brandeis, J., dissenting) (quoting *Weems v. United States*, 217 U.S. 349, 373 (1910)).

350. *Id.*

351. 533 U.S. 27 (2001).

352. *Kyllo*, 533 U.S. at 33-34.



constituted an unlawful search under the Fourth Amendment.<sup>353</sup> Justice Scalia noted that “[i]t would be foolish to contend that the degree of privacy secured to citizens . . . has been entirely unaffected by the advance of technology.”<sup>354</sup> However, the power of technology to “shrink the realm of guaranteed privacy” is subject to limitations.<sup>355</sup> Justice Scalia suggested that eroding an individual’s reasonable expectation of privacy in the face of emerging technology would leave the individual’s privacy rights “at the mercy of advancing technology.”<sup>356</sup> This is an unacceptable burden for the government to put on an individual’s right to privacy. Justice Scalia sought to curb the erosive effect that technology had inflicted upon privacy.<sup>357</sup> He reasoned that it was the Court’s duty to essentially draw the line before technological advancements further eroded individuals’ expectations of privacy.<sup>358</sup>

These limitations are equally applicable in the medical privacy context. To be sure, technological advancements in health care and information technology are beneficial in many ways: improving the quality of medical treatment, making medical record keeping more efficient, and reducing the costs of medical care.<sup>359</sup> Nonetheless, these clearly beneficial capabilities of advancing technology must be balanced against the increased endangerment of the individual patient’s constitutionally protected right to informational privacy. The Supreme Court’s Fourth Amendment jurisprudence compels a reevaluation of the relative constitutional interests at stake in the medical privacy context. On the balance, a federal physician-patient privilege supports the constitutionally protected privacy rights in medical information by mitigating technological encroachment on the “realm of guaranteed privacy.”<sup>360</sup>

Technology has emerged as both a vehicle of unforeseen benefit to health and unforeseen harm to privacy. Yet, technology itself should not be reigned in. Rather, privacy protections in the face of emerging technology must be altered to ensure that patients’ rights to privacy in their medical information are not put “at the mercy of advancing technology.”<sup>361</sup> The “goal is to enhance privacy protections in ways that do not impede [technological] evolution.”<sup>362</sup> The recognition of a federal physician-patient privilege serves the goal of privacy

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353. *Id.* at 40.

354. *Id.* at 33-34.

355. *Id.* at 34.

356. *Id.* at 35.

357. *See Kylo*, 533 U.S. at 35 (noting the Court has rejected a mechanical interpretation of Fourth Amendment, which would allow an invasion of privacy as long as the surveillance involved was capturing information emanating from house).

358. *See id.* at 36 (concluding that privacy law must account for development of more sophisticated technology).

359. *See ETZIONI, supra* note 307, at 150-54 (discussing beneficial aspects of computerized medical records).

360. *See Kylo*, 533 U.S. at 34 (considering limits of technology’s ability to infringe on privacy).

361. *See id.* at 35-36 (noting that privacy law must account for development of more sophisticated technology).

362. Standards for Privacy II, 65 Fed. Reg. at 82,471.

enhancement while allowing the benefits of advancing technology to flourish.

2. A Federal Physician-Patient Privilege Would Serve Important Public Interests

a. *Absence of a Federal Physician-Patient Privilege Harms the Public Health*

There is certainly no dispute that a healthy citizenry is of utmost importance to any society. The federal physician-patient privilege could serve the “public end” of decreasing privacy protective behavior that damages the public health.<sup>363</sup> Public health can be harmed by the absence of a federal physician-patient privilege in three distinct ways. First, the physical health of the citizenry is directly implicated in the absence of a federal physician-patient privilege. Since many individuals engage in privacy protective behavior, there is the increased possibility of sick, untreated individuals circulating among the public.<sup>364</sup> If individual patients avoid medical treatment because they fear disclosure of stigmatizing medical conditions, such as sexually transmitted diseases, there is obviously an increased potential for transmission of these conditions to others.<sup>365</sup> Having more sick individuals circulating among the population may have detrimental economic effects as well. Sick individuals may be absent from work, thereby reducing economic productivity. A new privilege will serve the public by providing an incentive for sick individuals to seek necessary medical assistance.

Second, medical research suffers when individuals engage in privacy protective behaviors.<sup>366</sup> Those eligible for testing or experimental treatment may refuse to participate in research programs for fear that their medical information will be publicly disclosed<sup>367</sup>— even if that information is ostensibly de-identified. Public health is inextricably linked to ongoing medical research.<sup>368</sup> Consumers of health care services generally have a distinct incentive in facilitating medical research to improve the quality of the medical care that they receive.<sup>369</sup> The absence of a federal physician-patient privilege militates against this beneficial incentive. The sharing of medical data for research purposes advances the treatment of common conditions.<sup>370</sup> Medical advancements

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363. See *supra* Part B.5 for a discussion of the harmful effects of privacy protective behavior.

364. *Id.*

365. Because of the volume of information collected by health care providers, privacy protective behavior may not be limited to stigmatizing conditions. As such, even common ailments, such as influenza, may also remain untreated and free to spread throughout the population.

366. See ETZIONI, *supra* note 307, at 152-54 (explaining that access to medical records benefits medical research and ultimately patient health care).

367. See *id.* at 146 (noting that women have refused to participate in medical research studies out of fear that their genetic information would be disclosed).

368. See Paul Starr, *Health and the Right to Privacy*, 25 AM. J.L. & MED. 193, 194 (1999) (noting that people have an interest in both medical research and public health measures).

369. See *id.* (noting that patients have an interest in medical research and other initiatives by health care organizations to improve medical services).

370. See Gostin, *supra* note 310, at 481-82 (discussing benefits of increased medical data to medical research and public health). We do not mean to suggest that a physician-patient privilege

flourish with wider availability of objective medical data.<sup>371</sup> A ready supply of medical information enables researchers to improve medical services.<sup>372</sup> Thus, if patients are unwilling to be anything but completely candid with their physicians, not only is the health of the individual patient at risk, but the potential health benefits to society in general are compromised.

The advancement of medical science requires individual patients to cooperate with the collection and use of their de-identified medical information. For example, if patients refuse to consent to tests that reveal genetic defects, medical science will not be able to develop treatments as effectively.<sup>373</sup> Without a physician-patient privilege, the public suffers from an increased incentive for nondisclosure through unrealized benefits of medical research.

Finally, the availability of health information is necessary in recognizing and responding to public health concerns. Availability of a wide variety of health data "can help track the incidence, patterns, and trends of injury and disease in populations."<sup>374</sup> This allows for a variety of essential public health activities, such as identifying and preventing the spread of communicable diseases or infections in certain areas<sup>375</sup> and identifying risky behaviors in certain populations.<sup>376</sup> Identification and tracking of these health risks allow society to place its resources effectively in concentrated areas or populations.<sup>377</sup> If patients refuse to disclose information or submit to medical tests out of fear of disclosure, public health efforts will be hindered. Society will not be able to identify and respond to troubling health trends, such as the increasing occurrence of sexually transmitted diseases, precisely or cost-effectively.

The facilitation of general health that would flow from a federal physician-patient privilege is a "public end" of paramount importance. The public interest that a physician-patient privilege serves in the public health arena is arguably exponentially more important than even a psychotherapist-patient privilege. The *Jaffee* Court was particularly concerned with the public benefit from police officers who obtain effective counseling after traumatic events.<sup>378</sup> While that "public end" is indisputably important, the public end that the physician-patient privilege would serve is even more compelling. At stake is not only the individual health of patients, but the health of all of society. If *Jaffee* is to be a model for the creation of new evidentiary privileges, the public interests that are served by a new evidentiary privilege must look at the gravity of the "public

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would impair the confidentiality safeguards in place under other laws protecting patient identity and medical research.

371. *Id.*

372. *See id.* at 482 (noting that health information infrastructure could benefit health services).

373. *See ETZIONI, supra* note 307, at 146 (arguing that fear of disclosure can hinder medical research and endanger medical treatment).

374. Gostin, *supra* note 310, at 482-83.

375. *Id.* at 483.

376. *See id.* (giving example of "smoking among female adolescents or ethnic minorities").

377. *Id.*

378. *See Jaffee*, 518 U.S. at 11 n.10 (stating that police officers, subjected to physical and emotional danger, require confidential counseling to continue effectively safeguarding community).

end” implicated there as a litmus test for future privileges. Clearly, the “public ends” implicated by the physician-patient privilege dwarf those involved in *Jaffee*.

*b. The Physician-Patient Privilege Could Mitigate the Societal Costs of Medical Malpractice.*

The costs of medical malpractice litigation have placed a substantial financial burden on providers and consumers of health services and citizens in general.<sup>379</sup> The average payment for a malpractice claim has risen steadily over the past twenty years from \$95,000 in 1986 to \$320,000 in 2002, a growth rate more than twice the amount of general inflation.<sup>380</sup> Every year, there are approximately 15 malpractice claims for every 100 physicians.<sup>381</sup> The costs associated with medical malpractice may provide an incentive for physicians to practice “defensive medicine”— a practice that occurs when physicians “perform tests and provide treatments that they would not otherwise perform merely to protect themselves against the risk of possible litigation.”<sup>382</sup> This practice may result in substantial increases in health care costs that the public must bear.<sup>383</sup> Some insurance companies refuse to underwrite medical malpractice insurance, making insurance coverage less available and more expensive for physicians.<sup>384</sup> Malpractice insurance premiums and litigations costs can become so financially burdensome that capable physicians may be forced out of the profession.<sup>385</sup> Some physicians opt to practice without malpractice insurance altogether.<sup>386</sup> In addition, some physicians are relocating from urban settings to rural locations or

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379. See Michelle M. Mello, *Malpractice Liability and Medical Error Prevention: Strange Bedfellows?*, Paper prepared for the Council on Health Economics and Policy, Conference on Medical Malpractice in Crisis: Health Policy Options 8 (March 2003) (noting that physicians are leaving or limiting their scope of practice due to the high cost of liability insurance resulting from medical malpractice lawsuits), available at [http://www.allhealth.org/recent/audio\\_09-29-03/malpracticeAndErrors-Mello.pdf](http://www.allhealth.org/recent/audio_09-29-03/malpracticeAndErrors-Mello.pdf).

380. CONGRESSIONAL BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 3-4 (Jan. 8, 2004), available at <http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf>.

381. *Id.*

382. U.S. DEP'T OF HEALTH AND HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 4 (July 24, 2002), available at <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf>.

383. See *id.* at 7 (noting that cost of malpractice increases amount the federal government and taxpayers must pay by \$28.6-47.5 billion per year).

384. Mello, *supra* note 379, at 8.

385. See, e.g., *Nightline: A Dying Practice: What Happens When Doctors Go Out of Business* (ABC television broadcast, July 25, 2002) (reporting that some doctors cannot continue to practice medicine due to increased insurance premiums), available at LEXIS, News library, ABC News File. See also Gayle Worland, *Doctors Flee Insurance Costs*, STATE, CHI. TRIB., Mar. 12, 2004, at C1 (reporting that many doctors, particularly obstetricians, have been forced to move their practices to states with lower insurance costs).

386. See Bruce Japsen, *Doctors Risk Practicing Without Costly Insurance*, CHI. TRIB., Mar. 18, 2004, at C1 (stating that some physicians are opting to practice without insurance coverage rather than pay high premiums).

physician-friendly states, causing a doctor shortage in a number of states and major metropolitan areas.<sup>387</sup> Medical malpractice suits also burden scarce judicial resources, thus affecting all citizens' efficient access to the courts.

A federal physician-patient privilege could mitigate the societal costs of medical malpractice in two ways. First, the increased incentive for candor between patients and physicians that a physician-patient privilege promotes would facilitate thorough and efficient diagnosis and treatment. If a patient fully discloses information to his or her physician without reservation, the physician has a better chance of accurately diagnosing the patient and assigning an appropriate course of treatment.

Conversely, the absence of a federal physician-patient privilege may support the continued proliferation of medical malpractice suits. In the analogous situation of attorney-client communications, such a privilege serves public ends by "encourag[ing] full and frank communication between attorneys and their clients and thereby promot[ing] broader public interests in the observance of law and administration of justice."<sup>388</sup> One of these "broader public interests" that the attorney-client privilege serves is the furtherance of *competent* legal services.<sup>389</sup> "The [attorney-client] privilege rests on the belief that . . . full disclosure to an attorney is a necessary predicate to skillful advocacy and fully informed legal advice."<sup>390</sup> One policy justification that underlies the attorney-client privilege is that without a protective privilege, a client will not fully disclose relevant information to his or her attorney, which in turn will result in legal advice that is "predicated on half-truths."<sup>391</sup>

The benefits of facilitating the attorney's advice with all available client information is not only that the individual client benefits from optimal representation, but society benefits by avoiding the inevitable costs of incompetent professional services.<sup>392</sup> In the attorney-client dynamic, this manifests itself in reduced complaints about attorneys to professional disciplinary bodies and reduced malpractice suits against attorneys. Access to competent legal services is increased because fewer attorneys will be disciplined, disbarred or be forced from practice, thereby assuring greater access to legal

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387. See Worland, *supra* note 385, at C1 (discussing physicians' movement from Chicago to nearby states, such as Wisconsin and Indiana, that cap non-economic damages). See also *The Doctors are Leaving*, CHI. TRIB., Apr. 18, 2004, at C8 (reporting that the American Medical Association recognized Illinois as one of nineteen states suffering from a "full blown" malpractice crisis and noting that "[t]here is not a single neurosurgeon to treat head trauma cases now in Will, Grundy and Kankakee counties. . . [and] [h]igh risk obstetrics care is difficult to find Downstate").

388. See *Jaffee*, 518 U.S. at 11 (quoting *Upjohn Co. v. United States*, 449 U.S. 383, 389 (1981)).

389. See *Upjohn*, 449 U.S. at 389 (recognizing that attorney-client privilege exists so that attorneys may be fully informed and capable of providing competent legal advice).

390. *In re Dow Corning Corp.*, 261 F.3d 280, 284 (2d Cir. 2001) (quoting *Chase Manhattan Bank, N.A. v. Turner & Newall, PLC*, 964 F.2d 159, 165 (2d Cir. 1992)).

391. EDNA SELAN EPSTEIN, *THE ATTORNEY-CLIENT PRIVILEGE AND THE WORK-PRODUCT DOCTRINE* 3 (4th ed. 2001) (asserting that attorney-client privilege is necessary so that clients do not withhold information based on fear of future disclosure).

392. See *id.* at 5 (noting that attorneys can address legal matters effectively only if clients disclose what they know).

services. In addition, the amount of judicial resources that are needed to respond to attorney malpractice suits is reduced, providing financial benefit to society as well.

This justification for the attorney-client privilege can certainly be applied to the physician-patient privilege. As with the attorney-client privilege, the physician-patient privilege would facilitate effective medical care and prevent medical advice “predicated on half-truths” by encouraging full and true disclosure by the patient. More effective medical care would not only benefit the individual patient, but it would also confer enormous benefits on society through the abatement of the high costs to society of medical malpractice.

Second, the atmosphere of trust facilitated by a federal physician-patient privilege may reduce the likelihood that an injured patient will seek redress through a lawsuit. Many medical malpractice suits could be avoided if the physician-patient relationship was based on total trust and open communication.<sup>393</sup> Studies have found that the relationship between the physician and patient plays a large role in whether a patient will make a malpractice claim against his or her physician.<sup>394</sup> “Breakdowns in communication between physician and patient fuel distrust and pent up anger.”<sup>395</sup> This may result in a greater propensity for a lawsuit to be filed if there is a “bad outcome” in diagnosis or treatment. Assuming that a patient has been injured in a medical procedure, a stronger physician-patient relationship may reduce the likelihood that the patient will file a malpractice suit.

It should be noted that the physician-patient privilege in many states is subject to an exception to disclosure, which allows physicians to defend themselves against malpractice claims filed in state courts.<sup>396</sup> Clearly, this is a reasonable and necessary exception to privileged communications between patients and physicians. However, this exception is only implicated after malpractice has already occurred (or at least been implicated in a lawsuit).<sup>397</sup> At that point, an individual has already been injured and costly discovery has already been triggered. Thus, many of the benefits of reducing malpractice litigation are not implicated by permitting this exception, since the value of an

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393. See THOMAS J. BALCEZAK ET AL., YALE-NEW HAVEN MEDICAL CENTER, ISSUES IN RISK MANAGEMENT: AVOIDING MALPRACTICE, (Feb. 1998) (suggesting ways for physicians to decrease risk of malpractice lawsuits), at [http://info.med.yale.edu/caim/risk/av\\_malprac/av\\_malprac\\_2.html](http://info.med.yale.edu/caim/risk/av_malprac/av_malprac_2.html) (last visited Nov. 10, 2004).

394. See, e.g., Wendy Levinson et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553, 553 (1997) (referring to a study which found that patient dissatisfaction is a main factor in the initiation of medical malpractice suits).

395. DAN GROSZKRUGER, COOPERATIVE OF AM. PHYSICIANS, PHYSICIAN-PATIENT DIALOGUE: KEY TO AVOIDING MALPRACTICE LAWSUITS, (1999), at [http://www.cap-mpt.com/riskmanagement/physician\\_patient.html](http://www.cap-mpt.com/riskmanagement/physician_patient.html) (last visited Nov. 10, 2004).

396. See, e.g., 735 ILL. COMP. STAT. ANN. 5/8-802(2) (West 2002) (recognizing an exception to a general physician-patient privilege “in actions, civil or criminal, against the physician for malpractice”).

397. See *Petrillo v. Syntax Labs., Inc.*, 499 N.E.2d 952, 967 (1986) (finding that patient implicitly waives privilege upon filing suit against treating physician).

evidentiary privilege that fosters openness between patient and physician reduces the chance that the physician will harm the patient initially. Notwithstanding this exception, society stands to benefit from the prospect of reduced malpractice litigation through a federal physician-patient privilege.

The benefits that society could reap by reducing medical malpractice suits are substantial. Even a slight reduction of malpractice suits against physicians would, in the language of the *Jaffee* Court, "serve public ends" of the highest importance.<sup>398</sup> Health care costs could be reduced. Fewer physicians would be forced from the medical profession due to the cost of malpractice insurance. Public access to quality health care could be increased. Burdens on the judicial system could be minimized by reduced malpractice litigation. All of these crippling costs of malpractice claims could be mitigated by recognition of a federal physician-patient privilege.

### 3. Loss of Evidence Due to the Federal Physician-Patient Privilege Would Be Modest

Any potential evidentiary loss from recognizing a federal physician-patient privilege would be less significant than that which existed in *Jaffee*. First, as the Court explained in *Jaffee*, patients who believe that information will be used to their detriment will simply refuse to disclose this information.<sup>399</sup> In *Jaffe*, this meant that individuals would simply refuse to engage in "confidential conversations" with their psychotherapists.<sup>400</sup> In the context of the physician-patient relationship, conversations between patients and their physicians could be similarly "chilled."<sup>401</sup> Moreover, a patient may refuse to undergo certain diagnostic tests that could reveal potentially damaging information. This refusal would be the equivalent of the "unspoken evidence" that the *Jaffee* Court described as serving "no greater truth-seeking function than if it had been spoken and privileged."<sup>402</sup> In short, any evidentiary value that could be gleaned from medical tests could never be realized if the patient refuses to give consent to undergo the test in the first place.

Second, as with state physician-patient privileges, a federal physician-patient privilege would presumably be subject to many exceptions to nondisclosure. Illinois, for example, provides eleven statutory exceptions to nondisclosure by a physician, including one for malpractice actions against a health care provider, actions where a patient's physical or mental condition is at issue, and in homicide trials when the disclosure relates to the circumstances of the homicide.<sup>403</sup> Additionally, there are a variety of ways under the several state laws in which a patient may explicitly or implicitly waive the protection of the

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398. *Jaffee*, 518 U.S. at 11 (citing *Upjohn*, 449 U.S. at 389).

399. *See id.* at 11-12 (asserting that patients' conversations with psychotherapists would be chilled without benefit of privilege).

400. *Id.*

401. *Id.*

402. *Id.* at 12.

403. 735 ILL. COMP. STAT ANN. 5/8-802 (West 2002).

privilege.<sup>404</sup> Thus, relevant information learned within the scope of the physician-patient relationship may still be used for the purposes of litigation under a wide variety of circumstances. It would likely be no less with a federal physician-patient privilege. A federal physician-patient privilege that carefully circumscribes some exceptions would have a modest effect on the evidentiary use of relevant patient disclosures. Thus, per *Jaffee*, “the likely evidentiary benefit that would result from the denial of the privilege is modest.”<sup>405</sup>

Third, there remains the risk that, if physicians are compelled to reveal confidential patient communications in the absence of a privilege, physicians may, in accordance with their ethical duties of confidentiality, resist disclosure by concealing or modifying the content of the communications.<sup>406</sup> Under these circumstances, the evidentiary value of this evidence is inherently suspect. As the New York state legislature explained when recognizing the state physician-patient privilege:

[D]uring the struggle between legal duty on the one hand, and professional honor on the other, the latter, aided by a strong sense of the injustice and inhumanity of the rule, will, in most cases, furnish a temptation [by the physician] to the perversion or concealment of truth, too strong for human resistance.<sup>407</sup>

Finally, recognition of a physician-patient privilege may, in fact, lead to more evidence being presented in any given case. Physicians, faced with the prospect of being compelled to betray the confidences of their patients in federal court, may resist providing expert testimony in court at all. For example, if a physician foresees the prospect that his or her patients' confidential information may be used to impeach the professional opinion of an expert witness, the physician may refuse to participate in judicial proceedings. Consequently, the evidentiary benefit that would be realized through expert testimony would be lost. Providing the protections of a federal physician-patient privilege would encourage physicians to contribute to the evidentiary development in litigation, while safeguarding the physician's ethics of nondisclosure.

In sum, the evidentiary loss in recognizing the physician-patient privilege is modest. Applying *Jaffee's* balancing test for recognizing a new privilege, it is clear that the physician-patient privilege satisfies the “reason and experience” requirement of FRE 501. Recognition of a physician-patient privilege would serve private and public ends of paramount importance. The physician-patient

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404. See 2 SCOTT N. STONE & ROBERT K. TAYLOR, *TESTIMONIAL PRIVILEGES*, §7 at 29-32 (2d ed. McGraw-Hill 1995). A patient may waive the physician-patient privilege “merely by saying so, as long as this statement satisfies any general or specific state laws on waiver of rights.” *Id.* at 30. A patient may also waive the privilege impliedly through conduct. If, for example, a patient testifies as to privileged communications with his or her physician, the opposing party may ask the physician about the same communications. *Id.* at 31.

405. *Jaffee*, 518 U.S. at 11.

406. See SIMSON GARFINKEL, *DATABASE NATION: THE DEATH OF PRIVACY IN THE 21ST CENTURY* 139-40 (Deborah Russell ed., 2000) (explaining that some doctors choose to alter patients' records due to concern that some conditions may lead to increased insurance premiums for patients).

407. N.Y. REV. STAT. 737 (1836).



privilege serves private interests of “transcendent importance”<sup>408</sup> in promoting the individual health of a patient seeking medical advice from a physician. The physician-patient privilege serves public interests of paramount importance by facilitating societal access to useful medical information, potentially improving medical science, and by reducing the crippling costs of medical malpractice lawsuits. As such, it is abundantly clear that recognition of a physician-patient privilege is not only proper; it is imperative.

#### 4. HIPAA Provides Strong and Unambiguous Federal Policy that Supports Recognition of a Federal Physician-Patient Privilege Under Jaffee and Federal Rule of Evidence 501.

Since *Jaffee* was decided in 1996, there has been a drastic recognition of the incipient need for strong federal protection of medical privacy. Congress responded to the changing technological environment of the health care industry by passing HIPAA,<sup>409</sup> creating a federal floor for the protection of health information privacy and establishing a strong and unambiguous federal policy for protection of the communications between patients and their physicians.<sup>410</sup> The value of an unambiguous federal policy consistent with the protections of a physician-patient privilege cannot be overstated – HIPAA and its underlying policy provide ample “reason and experience” to sustain a federal physician-patient privilege under the test articulated in *Jaffee*.

HIPAA provides two separate means of federal “reason and experience” on which to form a foundation for a federal physician-patient privilege. HIPAA itself represents a strong federal policy of protecting medical privacy that parallels the policy that would underlie a federal physician-patient privilege. HIPAA also provides a means by which state privilege laws are given effect as federal law, thus providing further support for a federal physician-patient privilege.

##### *a. HIPAA Represents a Strong Federal Policy of Confidentiality of Health Information*

Even though the HIPAA Privacy Rule was promulgated by HHS, Congress intended to link the privacy protections of the Privacy Rule to congressional action.<sup>411</sup> For this reason, the HIPAA Privacy Rule can be read as direct congressional action to strengthen the protection of medical information. However, the privacy protections that HIPAA affords are only a “framework of protection that can be strengthened by both the federal government and by states as health information systems continue to evolve.”<sup>412</sup> Thus, HIPAA

408. See *Jaffee*, 518 U.S. at 11 (emphasizing importance of citizens’ mental health).

409. See generally HIPAA, 110 Stat. 1936 (protecting privacy of patient health information).

410. *Id.*

411. See Standards for Privacy II, 65 Fed. Reg. at 82,469 (noting that “[i]n conference, the requirement for privacy standards was moved to a separate section in the same part of HIPAA, section 264, so that Congress could link the Privacy standards to Congressional action”).

412. *Id.* at 82,464.

specifically contemplated strengthening of its medical privacy protections to ensure that its mandate is fulfilled.<sup>413</sup> A federal physician-patient privilege would provide such strengthening.

HIPAA recognizes that confidentiality of medical information is “vital” to the physician-patient relationship.<sup>414</sup> The rationale behind HIPAA’s Privacy Rule virtually mirrors the rationale for justifying a federal physician-patient privilege.<sup>415</sup> HHS noted that “[medical privacy] is necessary for the effective delivery of health care, both to individuals and populations.”<sup>416</sup> HHS also explicitly recognized that “[i]ndividuals cannot be expected to share the most intimate details of their lives unless they have confidence that such information will not be used or shared inappropriately.”<sup>417</sup> HHS specifically contemplated that patients engage in privacy protective behavior, such as withholding information from physicians, providing inaccurate information, and avoiding care altogether in the absence of adequate privacy protections.<sup>418</sup>

The Privacy Rule also acknowledges that patients’ privacy protective behavior harms society in general by restricting the ability of the medical community to use the aggregate of individuals’ medical information for medical research to “identify troubling public health trends” and to “evaluat[e] the effectiveness of various public health efforts.”<sup>419</sup> Consequently, HIPAA recognizes that the confidentiality of medical information “serves public ends” of paramount importance.

Beyond HIPAA’s parallel rationale with a recognition of a federal physician-patient privilege, the HIPAA Privacy Rule challenges *Jaffee’s* implicit rejection of the physician-patient privilege. The *Jaffee* Court implied that a physician-patient privilege was not as compelling as a psychotherapist-patient privilege because “[t]reatment by a physician for physical ailments can often proceed successfully on the basis of a physical examination, objective information supplied by the patient, and the results of diagnostic tests.”<sup>420</sup> HIPAA rejects this presumption. Instead, the Privacy Rule states that “[i]n order to receive accurate and reliable diagnosis and treatment, patients *must* provide [physicians] with accurate and detailed information about their personal health, behavior, and other aspects of their lives.”<sup>421</sup> *Jaffee’s* implicit rejection of the need for a physician-patient privilege stands at odds with the congressional mandate of HIPAA.

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413. See *id.* (asserting that goal of HIPAA was to ensure privacy and patient access to information on federal level).

414. See *id.* at 82,463 (explaining that assurance of confidential communications between patient and physician ensures that high-quality healthcare will be provided).

415. See *supra* notes 46-78 and accompanying text (discussing the rationale behind recognition of a federal physician-patient privilege).

416. Standards for Privacy II, 65 Fed. Reg. at 82,467.

417. *Id.* at 82,467-68.

418. *Id.* at 82,468.

419. *Id.* at 82,467.

420. *Jaffee*, 518 U.S. at 10.

421. Standards for Privacy II, 65 Fed. Reg. at 82,467.

In sum, HIPAA must be read as providing federal policy that parallels the justification for a physician-patient privilege and rejecting *Jaffee's* implicit dismissal of the necessity of a federal physician-patient privilege. This unambiguous support is immeasurably valuable in supplying the foundation of "reason and experience" necessary to sustain a federal physician-patient privilege under FRE 501. It should be noted that the *Jaffee* Court recognized the psychotherapist-patient privilege without the benefit of nearly as much direct federal policy supporting the protection of the privacy right at issue.<sup>422</sup>

*b. HIPAA's Preemption Provision Allows State Privilege Laws to be Applied as De Facto Federal Privacy Laws*

The significance of widespread recognition of a physician-patient privilege by the individual states also takes on new significance in the context of HIPAA. HIPAA contains a preemption provision that provides that the Act and its attendant regulations "supersede any *contrary* provision of State law."<sup>423</sup> However, HIPAA's provisions do not preempt state law if the state law is "more stringent" than HIPAA's requirements.<sup>424</sup> A state law is "contrary" to HIPAA when "a covered entity would find it impossible to comply with both the State and federal requirements."<sup>425</sup> A state privacy law is "more stringent" than HIPAA if it "prohibits or restricts a use or disclosure in circumstances under which such use or disclosure otherwise would be permitted"<sup>426</sup> under HIPAA. According to section 264(c)(2) of HIPAA, this applies to all "judicial proceedings," federal and state alike.<sup>427</sup> Thus, state privilege law will apply when it provides more stringent protections of medical privacy than federal law, even in the context of a federal question case.<sup>428</sup>

Essentially, HIPAA has enacted a privacy protective scheme whereby "more stringent" state laws are an integral part of the federal government's medical privacy policy. As the Northern District of Illinois recently stated: "because [state] privacy protections are activated only through HIPAA's anti-preemption provision, this is not a case of [state] law trumping federal law but instead a case of one federal law displacing another."<sup>429</sup> State privacy laws, including those state laws that establish a physician-patient privilege, should be read as providing the "requisite reason" and experience under *Jaffee*, despite the fact that they were initially enacted as state laws. In essence, HIPAA's scheme

422. See *Jaffee*, 518 U.S. at 13-14 (noting States' unanimous acceptance of the psychotherapist privilege).

423. 42 U.S.C. § 1320d-7(a)(1) (2004) (emphasis added).

424. 45 C.F.R. § 160.203(b) (2002).

425. *Id.* § 160.202(1).

426. *Id.*

427. *Id.*

428. See *United States ex rel. Stewart v. Louisiana Clinic*, No. 99-1767, 2002 U.S. Dist LEXIS 24062, at \*16 (E.D. La. Dec. 11, 2002) (recognizing that Louisiana privilege law would not apply to a federal *qui tam* action because it was not "more stringent" under HIPAA).

429. *Nat'l Abortion Fed'n*, 2004 U.S. Dist LEXIS 1701, at \*16.

intended for certain state privacy laws to be *de facto* federal laws in the area of federal medical privacy policy. HIPAA has essentially co-opted strict state privilege laws as an integral part of the federal medical privacy scheme.

5. Consensus of State Legislatures for Physician-Patient Privilege Provides Strong Policy for Federal Recognition of a Physician-Patient Privilege Under *Jaffee* and Federal Rule of Evidence 501

The *Jaffee* Court recognized that “the policy decisions of the States bear on the question whether federal courts should recognize a new privilege.”<sup>430</sup> The Court put strong emphasis on the existence of a “consensus” among state recognition of a privilege.<sup>431</sup> This “consensus” indicated that both “reason and experience” supported recognition of the privilege.<sup>432</sup> When *Jaffee* was decided, fifty states and the District of Columbia recognized the psychotherapist-patient privilege.<sup>433</sup> Clearly, “[t]he emphasis that the Supreme Court put on the universal state recognition of a psychotherapist-patient privilege is strong evidence that at least that Court places strong weight on issues of national conformity on the existence of a privilege.”<sup>434</sup>

The rationale behind this assertion was two-fold. First, since state legislatures are presumably aware of the need to protect the integrity of the fact-finding functions of their courts, wide-spread acceptance of a privilege by the states can provide both “reason and experience” for recognition of a new federal privilege.<sup>435</sup> This rationale takes on additional significance when read in the context of the *Jaffee* Court’s pronouncement that legislative action rather than judicial action will likely be the source of new developments in privilege law.<sup>436</sup> Second, denying a federal privilege in the face of widespread state recognition of a privilege “would frustrate the purposes of the state legislation.”<sup>437</sup> This was of particular concern in the context of confidential communications because “any State’s promise of confidentiality would have little value if the . . . privilege would not be honored in federal court.”<sup>438</sup> In other words, patients who feared disclosure of confidential information would continue to withhold information in the absence of a commensurate federal privilege even with the support of a state privilege. Consequently, the state privilege would be abrogated by the absence of a parallel federal privilege.

This rationale is equally persuasive to a physician-patient privilege. At

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430. *Jaffee*, 518 U.S. at 12-13.

431. *Id.* at 13.

432. *Id.*

433. *Id.* at 12 n.11.

434. Broun, *supra* note 305, at 805-06.

435. See *Jaffee*, 518 U.S. at 13 (noting that consensus among state courts supports conclusion that there was reason and experience to support federal recognition of privilege).

436. See *id.* (stating that common-law was no longer primary source of new developments in federal privilege law).

437. *Id.*

438. *Id.*

present, forty states and the District of Columbia recognize a physician-patient privilege.<sup>439</sup> As such, if, as *Jaffee* properly indicated, federal recognition of new privileges is to be a reflection of a general state of the law in the nation, the argument for a federal physician-patient privilege is strong.<sup>440</sup> There exists a situation akin to that in *Jaffee* where state legislatures have “rapidly recognized the wisdom of the rule”<sup>441</sup> as the nature of the physician-patient relationship has evolved. It would be prudent for the federal judiciary to recognize the wisdom of this rule as well.

Most of the state physician-patient privilege rules mirror the rationale set forth by New York in 1828 for recognizing a physician-patient privilege.<sup>442</sup> It was asserted that the physician-patient privilege was necessary ‘to protect the health of the patient and provide effective medical care.’<sup>443</sup> If communications

439. The following states have adopted a physician-patient privilege: Alaska, ALASKA R. EVID. 504; Arizona, ARIZ. REV. STAT. ANN. § 12-2235 (West 2003); Arkansas, ARK. CODE ANN. § 16-41-101, R. 503 (Michie 1999); California, CAL. EVID. CODE §§ 990-1007 (West 1995); Colorado, COLO. REV. STAT. § 13-90-107(d) (2003); Delaware, DEL. UNIF. R. EVID. 503; District of Columbia, D.C. CODE ANN. § 14-307 (2001); Georgia, GA. CODE ANN. § 24-9-40 (1995); Hawaii, HAW. R. EVID. 504; Idaho, IDAHO CODE § 9-203.4 (Michie 2004); Illinois, 735 ILL. COMP. STAT. ANN. § 5/8-802 (2004); Indiana, IND. CODE ANN. § 34-46-3-1 (West 2004); Iowa, IOWA CODE ANN. § 622.10 (West 1999); Kansas, KAN. STAT. ANN. § 60-427 (Supp. 2004); Louisiana, LA. CODE EVID. ART. 510 (West 2004); Maine, ME. R. EVID. 503; Michigan, MICH. COMP. LAWS ANN. § 600.2157 (West 2000); Minnesota, MINN. STAT. ANN. § 595.02(1)(d) (West 2000); Mississippi, MISS. CODE ANN. § 13-1-21 (1999); Missouri, MO. ANN. STAT. § 491.060(5) (West 1996); Montana, MONT. CODE ANN. § 26-1-805 (2000); Nebraska, NEB. REV. STAT. § 27-504 (1995); Nevada, NEV. REV. STAT. ANN. §§ 49.215-245 (Michie 2002); New Hampshire, N.H. REV. STAT. ANN. § 329:26 (1995); New Jersey, N.J. STAT. ANN. § 2A:84A-22.2 (West 1976); New York, N.Y. C.P.L.R. 4504(a) (McKinney 1992); North Carolina, N.C. GEN. STAT. § 8-53 (2003); North Dakota, N.D. R. EVID. 503; Ohio, OHIO REV. CODE ANN. § 2317.02(B) (Anderson 2001); Oklahoma, OKLA. STAT. ANN. tit. 12, § 2503 (1993); Oregon, OR. REV. STAT. ANN. § 40.235 (Butterworth 1988); Pennsylvania, PA. CONS. STAT. ANN. tit. 42, § 5929 (West 1982); Rhode Island, R.I. CODE R. § 5-37.3-4 (2002); South Dakota, S.D. CODIFIED LAWS §§ 19-13-6 to -11 (Michie 1987); Texas, TEX. R. EVID. 509 (West 2004); Utah, UTAH CODE ANN. § 78-24-8(4) (2002); Vermont, VT. STAT. ANN. tit. 12, § 1612(a) (2002); Virginia, VA. CODE ANN. § 8.01-399 (Michie 2000); Washington, WASH. REV. CODE ANN. § 5.60.060(4) (West 1995); Wisconsin, WIS. STAT. ANN. § 905.04 (West Supp. 2000); Wyoming, WYO. STAT. ANN. § 1-12-101(a)(i) (Michie 2003).

440. See Broun, *supra* note 305, at 807 (noting that federal rules are, to some extent, representative of general state of State law).

441. *Jaffee*, 518 U.S. at 14.

442. Robert A. Wade, Note, *The Ohio Physician-Patient Privilege: Modified, Revised, and Defined*, 49 OHIO ST. L.J. 1147, 1148 (1989) (citing N.Y. REV. STAT. 406, § 73 (1828)).

443. *Id.* (citing N.Y. REV. STAT. 737 (1836)). The revisers of the statute stated:

The ground on which communications to counsel are privileged, is the supposed necessity of a full knowledge of the facts, to advise correctly, and to prepare for the proper defense or prosecution of a suit. But surely the necessity of consulting a medical adviser, when life itself may be in jeopardy, is still stronger. And unless such consultations are privileged, men will be incidentally punished by being obliged to suffer the consequences of injuries without relief from the medical art, and without conviction of any offence. Besides, in such cases, during the struggle between legal duty on the one hand, and professional honor on the other, the latter, aided by a strong sense of the injustice and inhumanity of the rule, will, in most cases, furnish a temptation to the perversion or concealment of truth, too strong for human resistance.

*Id.* (quoting N.Y. REV. STAT. 737 (1836))

between patient and physician were not privileged, patients would often refuse to seek medical treatment.<sup>444</sup> Further, if physicians were compelled to reveal confidential patient communications, physicians might, in accordance with their ethical duties of confidentiality, resist disclosure by concealing or modifying the content of those communications.<sup>445</sup> This reasoning is equally compelling for a federal privilege. Many of the state privilege laws also mirror the recognition of a physician-patient privilege set forth in Uniform Rule of Evidence 503.<sup>446</sup>

While the scope of a physician-patient privilege may differ from state to state,<sup>447</sup> *Jaffee* recognized that the force of states' decisions to enact a new privilege outweighs any limited variations in the scope that the privilege protects

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444. *Id.*

445. See *infra* notes 509-17 and accompanying text (discussing the medical profession's ethical rules regarding confidentiality).

446. Rule 503 provides as follows:

Rule 503-Physician and Psychotherapist-Patient Privilege (a) Definitions. As used in this rule: (1) A "patient" is a person who consults or is examined or interviewed by a [physician or] psychotherapist. [(2) A "physician" is a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be.] (3) A "psychotherapist" is (i) a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition, including alcohol or drug addiction, or, (ii) a person licensed or certified as a psychologist under the laws of any state or nation, while similarly engaged. (4) A communication is "confidential" if not intended to be disclosed to third persons, except persons present to further the interest of the patient in the consultation, examination, or interview, persons reasonably believed necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the [physician or] psychotherapist, including members of the patient's family. (b) General Rule of Privilege. A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment of his [physical,] mental or emotional condition, including alcohol or drug addiction, among himself, [physician or] psychotherapist, and persons who are participating in the diagnosis or treatment under the direction of the [physician or] psychotherapist, including members of the patient's family. (c) Who May Claim the Privilege. The privilege may be claimed by the patient, his guardian or conservator, or the personal representative of a deceased patient. The person who was the [physician or] psychotherapist at the time of the communication is presumed to have authority to claim the privilege but only on behalf of the patient. (d) Exceptions. (1) Proceedings for hospitalization. There is no privilege under this rule for communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization. (2) Examination by order of court. If the court orders an examination of the [physical,] mental[,] or emotional condition of a patient, whether a party or a witness, communications made in the course thereof are not privileged under this rule with respect to the particular purpose for which the examination is ordered unless the court orders otherwise. (3) Condition an element of claim or defense. There is no privilege under this rule as to a communication relevant to an issue of the [physical,] mental[,] or emotional condition of the patient in any proceeding in which he relies upon the condition as an element of his claim or defense or, after the patient's death, in any proceeding in which any party relies upon the condition as an element of his claim or defense.

UNIF. R. EVID. 503.

447. See *supra* note 439 (listing the various physician-patient privilege statutes). See also BOYLE & MACK, *supra* note 313, at 2:5.

from state to state.<sup>448</sup> As such, the strength of the overwhelming recognition of the physician-patient privilege is undiminished by the variations of the privilege between the states.

The failure of federal courts to explicitly recognize a federal physician-patient privilege undermines the promise of confidentiality that the overwhelming majority of the states have made to their citizens. As recognized in *Jaffee*, this creates the threat of an impermissible abrogation of state law.<sup>449</sup> The destruction that incomplete protection in the area of privacy can inflict upon individuals' privacy rights has been noted in other contexts<sup>450</sup> and specifically by the *Jaffee* Court.<sup>451</sup> Other compelling reasons also exist for consistency of state and federal law in this area, such as preventing forum shopping by litigants. Clearly, federal recognition of the physician-patient privilege is strongly supported by a consensus among the states on a physician-patient privilege.

#### 6. Consistent Federal Medical Privacy Policy in the Context of Genetic Nondiscrimination Provides "Reason and Experience"

Federal actions taken since the 1996 *Jaffee* decision have illustrated an evolutionary policy to protect medical privacy in response to technological advancement. As discussed below, the need for even greater protection of medical information than HIPAA provides has been recognized by the Clinton Administration and Congress. Thus, federal governmental policy favors the development of medical privacy protections through recognition of a federal physician-patient privilege.

President Clinton signed Executive Order 13145 on February 8, 2000.<sup>452</sup> In doing so, he recognized the threat that technology, specifically the decoding of the human genome, posed to the privacy of individuals' medical information.<sup>453</sup> Executive Order 13145 prohibits federal government agencies from obtaining genetic information from employees or job applicants and from using genetic information in hiring and promotion decisions.<sup>454</sup> President Clinton, citing Justice Brandeis, noted that "technological advances would require us to be ever-vigilant in protecting what [Brandeis] said was civilization's most valued right, the fundamental right to privacy."<sup>455</sup> President Clinton noted that "powerful ways of technological change threaten to erode our sacred walls of

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448. *Jaffee*, 518 U.S. at 14 n.13.

449. *Id.* at 13-14.

450. See *Mapp v. Ohio*, 367 U.S. 643, 660 (1961) (noting that "[t]he ignoble shortcut . . . left open to the State [by inapplicability of the exclusionary rule] tends to destroy the entire system of constitutional restraints on which the liberties of the people rest").

451. *Jaffee*, 518 U.S. at 13.

452. Exec. Order No. 13145, 3 C.F.R. § 235 (2001).

453. See also *supra* notes 112-17 and accompanying text (discussing genetic privacy).

454. NAT'L HUMAN GENOME RESEARCH INST., FED. GOV'T POL'Y ON GENETIC DISCRIMINATION IN INS. AND EMP., at <http://www.genome.gov/11510229> (last visited Oct. 20, 2004).

455. NAT'L HUMAN GENOME RESEARCH INST., PRESIDENT CLINTON'S COMMENTS ON THE SIGNING OF EXECUTIVE ORDER 13145 (Feb. 8, 2000), at <http://www.genome.gov/10002346> (last visited Nov. 12, 2004).

privacy in ways we could not have envisioned a generation ago.”<sup>456</sup> President Clinton announced that the government now had new responsibilities to ensure that technology did not “pry open the protective doors of privacy.”<sup>457</sup> To ensure this was done, President Clinton asserted, the government needed to go further than HIPAA to protect medical information.<sup>458</sup> Thus, President Clinton gave a mandate to further develop privacy protections in the face of technological threats to medical information.

The 108th Congress has continued to develop and expand privacy policy as well, introducing dozens of medical privacy related bills.<sup>459</sup> For example, on October 14, 2003, the United States Senate passed the Genetic Information Nondiscrimination Act of 2003<sup>460</sup> by a vote of 95-0.<sup>461</sup> This bill would prohibit health insurance plans from denying enrollment or basing insurance premiums on the basis of genetic information, prohibits disclosures or collection of genetic information for underwriting purposes, and prohibits the use of genetic information in employment decisions.<sup>462</sup> This bill would follow the HIPAA model by setting another federal floor for medical privacy by providing basic protections of medical information while deferring to more stringent state and federal measures.<sup>463</sup>

Despite the Bush Administration’s weakening of privacy protections under

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456. *Id.*

457. *Id.*

458. *See id.* (noting that “the health insurance portability law . . . was an important first step, but we must go further”).

459. *See* Thomas: Legislative Information on the Internet, LIBRARY OF CONGRESS WEB SITE, [at http://thomas.loc.gov](http://thomas.loc.gov) (last visited May 9, 2004) (providing searchable database of Congressional bills). *See, e.g.*, Stop Taking Our Health Privacy Act of 2003, H.R. 1709, 108th Cong. (2003) (restoring “standards to protect the privacy of individually identifiable health information”); Medical Independence, Privacy, and Innovation Act of 2003, H.R. 2544, 108th Cong. (2003) (intending “to improve the quality, availability, diversity, personal privacy, and innovation of health care in the United States”); Patient Safety and Quality Improvement Act of 2004, H.R. 663, 108th Cong. (2003) (attempting “to provide for the improvement of patient safety and to reduce the incidence of events that adversely affect patient safety”); Defense of Privacy Act, H.R. 338, 108th Cong. (2003) (requiring that “agencies, in promulgating rules, take into consideration the impact of such rules on the privacy of individuals”); Patient Privacy Act, H.R. 1699, 108th Cong. (2003) (repealing sections 1173(b) and 1177(a)(1) of the Social Security Act); Equal Rights and Equal Dignity for Americans Act of 2003, S. 16., 108th Cong. (2003) (authorizing Attorney General, upon request, to provide assistance with investigation or prosecution of violent and hate based crimes); Health Information for Quality Improvement Act, S. 2003, 108th Cong. (2003) (intending to “promote higher quality health care and better health by strengthening health information, its infrastructure, and its use by clinicians and consumers”); Better HEALTH Act of 2003, S. 1374, 108th Cong. (2003) (enhancing patient access to care through direct assistance); Health Care Coverage Expansion and Quality Improvement Act of 2003, S. 10, 108th Cong. (2003) (attempting to improve managed care by increasing access to information and care).

460. S. 1053, 108th Cong. (2003).

461. NAT’L HUMAN GENOME RESEARCH INST., *supra* note 454.

462. *See* ELECTRONIC PRIVACY INFO. CENTER, MEDICAL PRIVACY: GENETIC INFORMATION (detailing impact of Genetic Information Nondiscrimination Act of 2003), [at http://www.epic.org/privacy/medical/](http://www.epic.org/privacy/medical/) (last visited Dec. 28, 2004).

463. *Id.*



the modified HIPAA Privacy Rule,<sup>464</sup> there has nevertheless been recognition by the current administration that privacy protections must continue to be developed. In 2001, President Bush “called on Congress to enact reasonable legislation to prohibit genetic discrimination in employment and health insurance.”<sup>465</sup> A White House press release noted that there is “growing concern that employers and insurance companies will use genetic information to discriminate by denying jobs or insurance coverage to individuals who have predictive genetic markers for certain diseases.”<sup>466</sup> Moreover, the White House acknowledged that “[t]here is also a concern that current laws have not kept pace with the issues raised by the scientific and technological progress of genetics.”<sup>467</sup> While the Bush Administration’s policies have thus far failed to further develop necessary medical privacy protections, they have nonetheless supported the notion that privacy protections must be periodically altered to respond to technological change.

Current federal government policy promotes the evolution of protections of medical privacy. A federal physician-patient privilege would complement this policy. Consequently, the evolutionary mandate of Federal Rule of Evidence 501 and *Jaffee* should be applied with this developing governmental policy as strong support for the evolutionary protection of medical privacy.

#### 7. Consistent State Genetic Nondiscrimination Legislation Provides Additional “Reason and Experience”

In establishing a new privilege, the *Jaffee* Court observed “the policy decisions of the States bear on the question whether federal courts should recognize a new privilege.”<sup>468</sup> *Jaffee* further noted that “it is appropriate to treat a consistent body of policy determinations by state legislatures as reflecting both ‘reason’ and ‘experience.’”<sup>469</sup> In the present case, there is a consistent trend of increased medical privacy protection in the arena of genetic discrimination. State genetic discrimination laws provide extensive “experience” on which to base the federal physician-patient privilege.

At present, forty-one states have enacted legislation on genetic discrimination in health insurance and thirty-one states have enacted legislation on genetic discrimination in the workplace.<sup>470</sup> Nearly all of these laws have been

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464. See *supra* notes 73-78 and accompanying text (discussing 2002 modifications to HIPAA Privacy Rule).

465. White House News Release, Today’s Presidential Action (June 2001) (summarizing President’s call for legislative action to prevent genetic discrimination), available at <http://www.whitehouse.gov/news/releases/2001/06/20010623-2.html> (last visited Dec. 28, 2004).

466. *Id.*

467. *Id.*

468. *Jaffee*, 518 U.S. at 12-13.

469. *Id.* at 13.

470. See NAT’L HUMAN GENOME RESEARCH INST., POLICY AND LEGIS. DATABASE (providing searchable database of federal and state laws pertaining to “privacy of genetic information/confidentiality; informed consent; insurance and employment discrimination; genetic testing and counseling; and commercialization and patenting”), at <http://www.genome.gov/>

passed since *Jaffee* was decided and HIPAA was passed.<sup>471</sup> They were enacted in response to concerns about technology's erosion of privacy, specifically the privacy of genetic information, and their underlying policies parallel the rationale supporting recognition of a federal physician-patient privilege.<sup>472</sup> These laws provide a wide variety of increased protections of medical information,<sup>473</sup> including prohibitions on the release of the results of a genetic test without consent,<sup>474</sup> provisions that define genetic information as confidential and privileged,<sup>475</sup> prohibitions on disclosing genetic information (even in response to a subpoena) backed up by penalties,<sup>476</sup> provisions that make genetic testing and information inadmissible as evidence and not discoverable,<sup>477</sup> and provisions providing for a private cause of action for unauthorized disclosure.<sup>478</sup>

In sum, it is clear that state legislatures have, on a broad scale, recognized the need to expand the protection of medical information in the face of advancing technology. *Jaffee* explicitly ratified the use of this "consistent body of policy determinations by state legislatures"<sup>479</sup> as *both* reason and experience for the purpose of recognizing new privileges under FRE 501.

## 8. Judicial Recognition of Privilege

The *Jaffee* Court noted that "[i]t is of no consequence that recognition of the privilege in the vast majority of States is the product of legislative action rather than judicial decision."<sup>480</sup> The Court explained that "[a]lthough common-law rulings may once have been the primary source of new developments in federal privilege law, that is no longer the case."<sup>481</sup> In evaluating "reason and experience" under *Jaffee*, recognition of new privileges will likely be based more heavily on legislative actions rather than judicial actions. Even so, there has

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PolicyEthics/LegDatabase/pubsearch.cfm (last visited Dec. 28, 2004).

471. See *id.* (providing dates of laws' passage).

472. See *id.* (providing summary of federal and state laws dealing with genetic discrimination). See also NAT'L HUMAN GENOME RESEARCH INST., GENETIC DISCRIMINATION IN HEALTH INS. OR EMP. (providing links to other sources on genetic nondiscrimination legislation), at <http://www.genome.gov/11510227> (last visited Nov. 12 2004).

473. See NAT'L HUMAN GENOME RESEARCH INST., *supra* note 470 (outlining types of protection varying state laws provide).

474. E.g., ARIZ. REV. STAT. ANN. § 12-2802(A)(2) (West 2003) (requiring written authorization for release of genetic testing information).

475. E.g., *id.* § 12-2802(A) (stating that information derived from genetic testing is confidential and privileged).

476. E.g., DEL. CODE ANN. tit. 16, §§1224(a), 1227 (2003) (prohibiting disclosure of genetic information in response to subpoena and establishing penalties for violation of statute).

477. E.g., Genetic Information Privacy Act, 410 ILL. COMP. STAT. ANN. 513/15 (West 2003) (prohibiting discovery or admission of genetic testing and information derived from genetic testing in any legal proceeding except in specifically identified circumstances).

478. E.g., *id.* at 513/40 (authorizing private cause of action for unauthorized disclosure of genetic testing information).

479. *Jaffee*, 518 U.S. at 13.

480. *Id.*

481. *Id.*

been judicial recognition of a federal physician-patient privilege that mitigates in favor of creating this new privilege.

In 2001, a magistrate for the United States District Court for the District of Colorado in a federal question case involving the Federal Employers' Liability Act rejected the plaintiff's sole argument that allowing the defendants to conduct informal interviews with the plaintiff's treating physician would violate a federal physician-patient privilege.<sup>482</sup> The plaintiff argued that section 1320d2-(d)(2) of HIPAA should be recognized as codifying a federal physician-patient privilege.<sup>483</sup> In rejecting this argument, the magistrate reiterated that there was no federal physician-patient privilege.<sup>484</sup> This order was appealed to District Court Judge Richard P. Matsch, who announced that "the Magistrate Judge's orders resulted from an *error of law* in denying the existence of a physician-patient privilege."<sup>485</sup> Judge Matsch further stated that "[t]he privilege is recognized,"<sup>486</sup> although the privilege had been waived under the facts of the case.<sup>487</sup>

More recently, in *National Abortion Federation v. Ashcroft*,<sup>488</sup> the Northern District of Illinois recognized a federal physician-patient privilege in matters relating to abortion.<sup>489</sup> In a case challenging the constitutionality of the Partial Birth Abortion Ban Act of 2003 ("PBABA"),<sup>490</sup> the government subpoenaed the medical records from treating physicians of women who had received the banned type of abortion procedure.<sup>491</sup> Chief Judge Charles Kocoras applied *Jaffee* and FRE 501's evolutionary mandate and concluded that the intrusion on a woman's privacy from possible release of confidential medical information outweighed the loss of evidence to the government through a process that recognizes a federal physician-patient privilege.<sup>492</sup> The government's subpoena was quashed and the privilege was recognized.<sup>493</sup> The District Court's order was affirmed by the Seventh Circuit Court of Appeals on other grounds.<sup>494</sup>

In the related case challenging the PBABA, *Planned Parenthood Federation of America v. Ashcroft*,<sup>495</sup> District Court Judge Phyllis Hamilton of the Northern District of California denied the government's motions to compel production of

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482. *Lovato v. Burlington N. & Santa Fe R.R. Co.*, No. 00-M-2584, 2001 U.S. Dist LEXIS 7924, at \*4-5 (D. Colo. May 4, 2001).

483. *Id.* at \*5.

484. *Id.* at \*4-5.

485. *Id.* at \*1 (emphasis added).

486. *Id.*

487. *Lovato*, 2001 U.S. Dist. LEXIS 9002, at \*1.

488. No. 04-C-55, 2004 U.S. Dist. LEXIS 1701 (N.D. Ill., Feb. 6, 2004).

489. *Id.* at \*19-20.

490. 18 U.S.C. § 1531 (2003).

491. *Nat'l Abortion Fed'n*, 2004 U.S. Dist. LEXIS 1701, at \*3-5.

492. *Id.* at \*18-20.

493. *Id.* at \*20.

494. *Northwestern Mem'l Hosp.*, 362 F.3d at 932-33.

495. No. C 03-4872 PJH, 2004 U.S. Dist. LEXIS 3383 (N.D. Cal., Mar. 5, 2004), *injunction granted*, 320 F. Supp. 2d 957.

abortion records.<sup>496</sup> Judge Hamilton explained that, even if the records sought were redacted of certain “objectively identifying information,”<sup>497</sup> such as names, addresses, and birth dates, the remaining records contained information of “an extremely personal and intimate nature,”<sup>498</sup> such as contraception, sexual abuse or rape, marital status, or presence of sexually transmitted diseases.<sup>499</sup> Most significant for the purposes of privilege, Judge Hamilton noted that disclosure of these medical records would “have a chilling effect on communications between patients and providers.”<sup>500</sup> Thus, Judge Hamilton articulated one of the most compelling justifications for recognizing the new physician-patient privilege: open communications between a patient and his or her physician in a confidential relationship.<sup>501</sup>

Following the trend of increased federal protection of medical privacy, these three federal cases show a willingness on the part of federal judges to recognize a federal physician-patient privilege.

#### 9. The Medical Profession’s National Recognition of the Need for a Physician-Patient Privilege

The doctrine of doctor-patient confidentiality is deeply rooted within the medical profession. The Hippocratic Oath can be traced back to the fourth century B.C.<sup>502</sup> It states in part: “[w]hat I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.”<sup>503</sup> Historically, the privacy of a patient’s medical information was protected by the professional responsibilities of the treating physician.<sup>504</sup> Confidentiality has been a definitive characteristic of the physician-patient relationship for centuries.<sup>505</sup> Confidentiality in the physician-patient relationship is “a situation in which information is disclosed within a trusting relationship on the agreement that it will not be divulged to a third person without the prior consent of the source of the information.”<sup>506</sup> The canon of confidentiality has been recognized by many medical professional groups.<sup>507</sup>

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496. *Planned Parenthood Fed’n of Am.*, 2004 U.S. Dist. LEXIS 3383, at \*7.

497. *Id.* at \*6.

498. *Id.*

499. *Id.*

500. *Id.* at \*6.

501. *See Jaffee*, 518 U.S. at 10-11 (noting that protecting willingness of patients to confide in psychotherapist serves both public and private interests).

502. *See supra* note 8 for a discussion of the origins of the Hippocratic Oath and the relevant text regarding doctor patient confidentiality.

503. *Id.*

504. BOYLE & MACK, *supra* note 313, at 1:4.

505. *See* BRODY, ET AL., *supra* note 313, at 170 (discussing origins of physician-patient confidentiality and its importance in modern medicine).

506. *Id.* at 171.

507. *See id.* at 179-87 (listing medical groups that have issued statements regarding confidentiality).

Most significantly, the American Medical Association provides:

The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.<sup>508</sup>

This ethical mandate is typical of the ethical codes of nearly all health care professions: physicians, nurses, dentists and dental hygienists, mental health professionals, social workers, pharmacists, and chiropractors.<sup>509</sup> These codes usually refer to privacy or confidentiality as a “core value” or a “fundamental tenet” and usually make respect for privacy a central principle of the health professions.<sup>510</sup>

*Jaffee* relied extensively on the judgments of professional associations in recognizing the psychotherapist-patient privilege.<sup>511</sup> Such widespread recognition of the need for confidentiality in the physician-patient relationship by those in the best position to judge the effect of a lack of candor between patients and physicians provides powerful “reason and experience” for recognizing a federal physician-patient privilege.

#### 10. Absence of a Federal Physician-Patient Privilege by the Advisory Committee is Not Fatal to Recognition of a New Privilege

Concededly, while the American Law Institute included a physician-patient privilege in Uniform Rule of Evidence 503,<sup>512</sup> the Advisory Committee for the Federal Rules of Evidence did not include a physician-patient privilege.<sup>513</sup> We note that *Jaffee* relied, in part, on the inclusion of a proposed psychotherapist-patient privilege by the Advisory Committee in recognizing this new privilege under FRE 501.<sup>514</sup> Nonetheless, the absence of the physician-patient privilege

508. BARRY R. FURROW ET AL., HEALTH LAW 148 (2d ed. 2000).

509. See generally CODES OF PROFESSIONAL RESPONSIBILITY: ETHICS STANDARDS IN BUSINESS, HEALTH, AND LAW (Rena A. Gorlin ed., 4th ed. 1999) (containing codes of ethics stressing importance of confidentiality for various health care professions).

510. See, e.g., *id.* at 312 (noting American College of Physicians' description of confidentiality as a fundamental tenant of medicine).

511. See *Jaffee*, 518 U.S. at 10 n.9 (relying on amici curiae brief by American Psychiatric Association and American Psychological Association). See also *id.* at 13 n.12 (relying upon ethical principles of psychologists and social workers in asserting that “any State’s promise of confidentiality would have little value if the patient were aware that the privilege would not be honored in federal court”).

512. See *supra* note 446 for the text of Uniform Rule of Evidence 503.

513. See *supra* note 19 and accompanying text (noting that Federal Rules of Evidence do not recognize physician-patient privilege).

514. See *Jaffee*, 518 U.S. at 14-15 (noting that States’ support for psychotherapist-patient privilege is reinforced by inclusion of privilege in recommendations to Advisory Committee).

from the proposed rules does not diminish the compelling argument in favor of its adoption under FRE 501.

First, privileges are always recognized on a “case-by-case basis.”<sup>515</sup> While the original proposed rules could be a guide to recognizing new privileges, they are not dispositive.<sup>516</sup> Thus, the specific circumstances under which the psychotherapist-patient privilege was adopted are not necessarily universally applicable to all new privileges. Second, *Jaffee* itself, in recognizing privileged communications to social workers as well as psychotherapists, went beyond the scope of proposed Federal Rule of Evidence 504.<sup>517</sup> Courts should not be limited by the proposed rules of privileges. For example, the United States Supreme Court, in *Trammel v. United States*,<sup>518</sup> held that the testifying spouse alone has the sole right to determine whether she would offer adverse testimony,<sup>519</sup> rejecting the view of the Advisory Committee’s proposed rule that gave the criminal defendant the right to bar a spouse’s adverse testimony.<sup>520</sup> Thus, the absence of a physician-patient privilege in the proposed Federal Rules of Evidence should not diminish the courts’ willingness to recognize this new privilege.

#### 11. The Pre-*Jaffee* “Wigmore” Test for Establishing Evidentiary Privileges

Putting the recent *Jaffee* decision aside, it should be noted that even under the time-honored, traditional, and less flexible “Wigmore”<sup>521</sup> test for establishing new privileges, a physician-patient privilege should be recognized at this point in time. This traditional test applies four fundamental factors:

- (1) The communications 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*.
- (4) The *injury* that would inure to the relation by the disclosure of the communication must be *greater than the benefit* thereby gained for the correct disposal of litigation.<sup>522</sup>

515. *Id.* at 8 (quoting S. REP. NO. 93-1277, p. 13 (1974)).

516. See *In re Grand Jury Investigation*, 918 F.2d 374, 380 (3d Cir. 1990) (noting only that “the proposed rules provide a useful *reference point* and *offer guidance* in defining the existence and scope of evidentiary privileges in the federal courts”) (emphasis added).

517. See *supra* notes 298-300 and accompanying text (discussing how *Jaffee* went beyond scope of proposed Federal Rule of Evidence 504).

518. 445 U.S. 40 (1980).

519. *Trammel*, 445 U.S. at 53.

520. FED. R. EVID. 505(b) (proposed 1973).

521. Noted scholar and legal educator John Henry Wigmore wrote the seminal treatise on Evidence (1904 and 1940).

522. 8 JOHN HENRY WIGMORE, 8 EVIDENCE IN TRIALS AT COMMON LAW § 2285 (John T. McNaughton rev., Little, Brown & Co. 1961) (1904). This long-established test pre-dates the FRE and *Jaffee*. Wigmore first discussed this test in *Evidence in Trials at Common Law* (Little Brown 1940).

According to Wigmore, if any one of the above conditions is not met, the asserted privilege is left without support and cannot be adopted.<sup>523</sup> Applying this test to the physician-patient privilege, Wigmore found that the only condition arguably met was the third one.<sup>524</sup> The first condition was not satisfied because communications between physician and patient in the early 1900's were not considered confidential.<sup>525</sup> Wigmore asserted that out of the thousands of communications made every day by patients to physicians "[i]n only a few instances . . . is the fact communicated to a physician confidential in any real sense . . . [b]arring the facts of venereal disease and criminal abortion, there is hardly a fact in the categories of medicine in which the patient himself attempts to preserve any real secrecy."<sup>526</sup>

The second condition was equally absent at the time Wigmore considered the physician-client privilege because privacy-protective behavior was not commonplace.<sup>527</sup> It was inconceivable that patients would be "deterred from seeking medical help because of the possibility of disclosure in court."<sup>528</sup>

The fourth condition was also not demonstrated in Wigmore's view because any injury to the physician-patient relationship stemming from disclosure of medical information was insubstantial.

In the first place, there is nothing in the world, by the nature of the injury, for the physician to disclose which any person would ordinarily care to keep private from his neighbors . . . furthermore, the few topics – such as venereal disease and abortion – upon which secrecy might be seriously desired by the patient come into litigation ordinarily in such issues . . . that for these very facts common sense and justice demand that the desire for secrecy shall not be listened to.<sup>529</sup>

Therefore, according to Wigmore, a physician-patient privilege could not be sustained.

This was the prevailing view pre-*Jaffee*.<sup>530</sup> Obviously, much has changed in the last half-century. Wigmore's arguments no longer hold true. For all the reasons we have advanced throughout this article, we believe each 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. Thus, even under the traditional, pre-*Jaffee* test, there is ample support for the recognition of a federal physician-patient privilege.

523. WIGMORE, *supra* note 522, at § 2285.

524. *Id.* at § 2380a.

525. *See id.* (noting there are few instances where communications between physician and patient are confidential).

526. *Id.*

527. *Id.* at § 2380a.

528. WIGMORE, *supra* note 522, at § 2380a.

529. *Id.* at § 2380a(4).

530. *See supra* notes 19-22 and accompanying text for a discussion of how the Supreme Court's recognition of a psychotherapist-patient privilege in *Jaffee* demonstrates that there should also be a physician-patient privilege.

## IV. CONCLUSION

The drafters of Federal Rule of Evidence Article V, Rule 501 wisely decided to forego codifying specific evidentiary privileges in favor of a more flexible tool for creating evidentiary privileges. The flexible mandate of FRE 501 that allows federal courts to recognize new evidentiary privileges based on “reason and experience” provides evidentiary privileges room to evolve as the law and society change. A more appropriate situation to apply this evolutionary mandate does not exist than in the case of a federal physician-patient privilege. Our society has witnessed unimaginable and dramatic technological achievements over the past few decades. While advances in medicine and technology present the possibility of untold benefits to society, they also pose untold threats—real, not imaginary threats—to personal privacy.

Congress recognized these threats in passing the Health Insurance Portability and Accountability Act of 1996.<sup>531</sup> It is certainly plausible that Congress and HHS intended to protect medical privacy by crafting a new federal physician-patient privilege. Both the language and underlying policies of HIPAA support this conclusion. HIPAA has signaled an unprecedented and unambiguous congressional intent to protect health information in the face of rapidly emerging technology. However, protections for medical privacy under the HIPAA Privacy Rule do not go far enough. Recognition of a federal physician-patient privilege is necessary to close the gap that, absent the privilege, would permit an individual’s personal, private, and potentially damaging medical information to be disclosed in court proceedings and redistributed to the public many times over and thus defeating the very purpose of HIPAA.

The challenge to implement the policy of medical privacy also belongs to the federal courts. They, in turn, should apply the mandate and process of FRE 501 to craft a new physician-patient privilege for use in federal court. FRE 501 requires courts to assess new privileges in light of “reason and experience” looking to the logical basis for justifying recognition of a federal physician-patient privilege as well as the underlying policies and actions taken by state and federal legislatures. Together, HIPAA and the vast record of “reason and experience” give a solid foundation for the physician-patient privilege. The boundaries of such a privilege remain to be marked by the courts. However, the need to recognize a federal physician-patient privilege is imperative.

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531. See *supra* notes 23-34 and accompanying text for a discussion of the increase in threats to privacy and Congress’ response in HIPAA.



