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Statutory Solutions for a Common Law Defect: Advancing the Nurse Practitioner-Patient Privilege, 47 J. Marshall L. Rev. 1077 (2014)

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STATUTORY SOLUTIONS FOR A COMMON LAW DEFECT: ADVANCING THE NURSE PRACTITIONER-PATIENT PRIVILEGE

REBECCA J. PIERCE¹

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*Were there none who were discontented with what they have, the
world would never reach anything better.*²

—Florence Nightingale

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2. *Florence Nightingale Quotes*, BIOGRAPHY ONLINE, www.biographyonline.net/humanitarian/quotes/f-nightingale-quotes.html (last visited April 13, 2013).

I. INTRODUCTION

A. *The Current Problem*

Nurse practitioners are an integral part of health care in the United States. In fact, in 2012, nurse practitioners logged over 900 million patient visits.³ As a result of these staggering numbers, chances are that many Americans will receive health care at the direction of a nurse. Further, with the Affordable Care Act⁴ in place, roughly thirty-two million Americans will join the ranks of the insured.⁵ While providing healthcare access for all Americans is a necessity, it stands to tax an area of medicine already experiencing a deficit: the field of primary care medicine.⁶ In recognizing this need, part of the Affordable Care Act has already allocated \$50 million dollars to fund training of nurse practitioners to certain medical centers throughout the United States.⁷ This will help reduce the primary care deficit as well as meet the needs of new healthcare recipients.⁸

Additionally, according to the Agency for Healthcare Research and Quality, fifty-two percent of nurse practitioners in the United States practice in the area of primary care,⁹ as compared to one-third of physicians who specialize in that same field.¹⁰ With the noticeable presence of nurse practitioners providing primary care for patients, there is a glaring gap in the current federal and state laws: the lack of a nurse-patient testimonial privilege to protect confidential communications

3. NP Infographic, AM. ASSOC. OF NURSE PRACTITIONERS, www.aanp.org/images/about-nps/npgraphic.pdf (last visited May 7, 2014).

4. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 901 (2010) (codified as amended at scattered sections of the Internal Revenue Code and in 42 U.S.C.).

5. Julie A. Fairman, John W. Rowe, Susan Hassmiller, & Donna E. Shalala, *Broadening the Scope of Nursing Practice*, 364 NEW ENG. J. MED. 193, 193 (2011).

6. Emily R. Carrier, Tracy Yee, & Lucy Stark, *Matching Supply to Demand: Addressing the U.S. Primary Care Workforce Shortage*, 7 NAT'L INST. FOR HEALTH CARE REFORM POLICY ANALYSIS, Dec. 2011, at 1,1.

7. *Creating Jobs by Addressing Primary Care Workforce Needs*, U.S. DEPT OF HEALTH & HUMAN SERVS (2013), www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html.

8. INST. OF MED., THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 6 (2011), available at www.nap.edu/catalog.php?record_id=12956. (commenting on the role nurses play in filling the primary care gap).

9. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, PRIMARY CARE WORKFORCE FACTS AND STATS NO. 2, 1 (2011), available at www.ahrq.gov/research/pcwork2.pdf.

10. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, PRIMARY CARE WORKFORCE FACTS AND STATS NO. 1, 1 (2011), available at www.ahrq.gov/research/pcwork1.pdf.

between a nurse practitioner and her patient. Currently there is a split among the states whether or not such a privilege exists.¹¹

With new changes in our health care system, reason and experience speak to the necessity of the nurse-patient privilege.¹² Our laws must be flexible and address this area.¹³ This Comment advocates the necessity for a statutory nurse practitioner-patient privilege throughout the states. Part II of this Comment provides the history of the physician-patient privilege.¹⁴ Part II also delves into the scope of nurse practitioner practice and examines the current existence of the nurse-patient privilege in the United States.¹⁵ Next, Part III argues for the necessity of the nurse-patient privilege.¹⁶ Finally, Part IV proposes the steps required to extend legislation to include the nurse-patient privilege.¹⁷

II. BACKGROUND

A. *History of the Physician-Patient Privilege*

To understand the nurse-patient privilege, it is first necessary to understand the physician-patient privilege. A privilege is the “right to withhold information, the disclosure of which could otherwise be compelled.”¹⁸ The physician-patient privilege was not recognized at common law and, thus, was born out of legislation.¹⁹ It has its roots in medical ethics from the health care providers’ obligation to ensure the confidentiality of their patients’ disclosures.²⁰ However, that ethical duty does not

11. See Background, *infra* Part II.C. (providing the states which recognize a statutory nurse-patient privilege).

12. See FED. R. EVID. 501 (providing for a claim of privilege by interpreting “common law . . . in the light of reason and experience”). *Id.*

13. See *Funk v. United States*, 290 U.S. 371, 383 (1933) (deeming the common law as not “immutable but flexible”). *Id.*

14. See Background, *infra* Part II.A.

15. See Background, *infra* Part II.B.

16. See Analysis, *infra* Part III.

17. See Proposal, *infra* Part IV.

18. 1 HOOPER, LUNDY & BOOKMAN, TREATISE ON HEALTH CARE LAW § 16.02 (Matthew Bender, Rev. Ed.)(2013); see also DAVID P. LEONARD, EDWARD J. IMWINKELRIED, DAVID H. KAYE, DAVID E. BERNSTEIN & JENNIFER L. MNOOKIN, THE NEW WIGMORE: A TREATISE ON EVIDENCE § 1.1 (Richard D. Friedman, ed. 2002) (explaining a privilege is an evidentiary rule that allows an individual’s confidential communication to be shielded from compelled disclosure during litigation).

19. HOOPER et al., *supra* note 18.

20. *Id.*; see also *The Hippocratic Oath*, U.S. NAT’L LIBRARY OF MED., www.nlm.nih.gov/hmd/greek/greek_oath.html (last visited Oct. 5, 2012) (providing “Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private”). *Id.*

automatically give rise to the privilege.²¹ The ethical duty has broader implications and is not required by law but rather through a private organization.²²

The crux of the physician-patient privilege is to protect that important relationship.²³ The privilege facilitates patient comfort while speaking to his physician, and protects patient privacy interests.²⁴ It also exists to ensure that patients have confidence to completely disclose their medical information and receive the best medical treatment possible.²⁵ In spite of this, communications made to a physician do not receive automatic protection in an adjudicatory setting simply because they are confidential.²⁶ If the state recognizes the communications as important to public policy to be kept in confidence, then the legislature may create the necessary statutory protection.²⁷ Each state has its own interests based upon the needs of its citizens, which may be why state privileges differ from federally recognized privileges.²⁸

New York was the first state to enact a statute recognizing the physician-patient privilege.²⁹ Today, a majority of the states have a statutory physician-patient privilege.³⁰ That privilege does, however, come with exceptions. The communications must occur in the course of and must be for the purpose of the treatment.³¹ Also, the statute itself may limit the privilege by listing out specific exceptions.³²

21. Leonard, et al., *supra* note 18, at § 1.3.1.

22. *See id.* at § 1.3.1 (noting how ethical principles apply both in court and out of court whereas statutory privileges only apply in court).

23. Daniel W. Shuman, *The Origins of the Physician-Patient Privilege and Professional Secret*, 39 SW. L.J. 661, 676 (1985) (discussing legislative history of the first physician-patient privilege statute in the states).

24. *Giangiulio v. Ingalls Mem'l Hosp.*, 850 N.E.2d 249, 256-57 (Ill. App. Ct. 2006) (discussing the source and purpose behind the privilege in Illinois).

25. *People v. Kucharski*, 806 N.E.2d 683, 688 (Ill. App. Ct. 2004).

26. *Perry v. Fiumano*, 403 N.Y.S.2d 382, 384 (N.Y. App. Div. 1978).

27. *Id.*

28. LEONARD, et al., *supra* note 18, at § 4.3.2.

29. Shuman, *supra* note 23, at 676. *See* KENNETH BROUN ET AL., MCCORMICK ON EVIDENCE § 98, at 447 (6th ed.) (noting, in 1828, New York was the first state to depart from the common law rule).

30. HOOPER, et al., *supra* note 18, at § 16.02; *see* DAVID M. GREENWALD, ROBERT R. STAUFFER, & ERIN R. SCHRANTZ, TESTIMONIAL PRIVILEGES, ch. 7 app. (West Rev. Ed. 2012) (noting the exception of the following states; Alabama, Florida, Kentucky, Maryland, Massachusetts, Tennessee, West Virginia). These states do not have a privilege that recognize a general physician-patient privilege. *Id.*

31. HOOPER, ET AL., *supra* note 18, at § 16.02 (the privilege may extend to medical records and other documents, not simply oral communications); BROUN, ET AL., *supra* note 29, at § 99, p. 454.

32. *See* HOOPER, ET AL., *supra* note 18, at § 16.02 (revealing certain public policy and state interests that may limit the privilege); *see, e.g.*, 735 ILL. COMP. STAT. 5/8-802 (West 2013) (listing twelve exceptions to the privilege):

B. Duties and Scope of Practice of Nurse Practitioners

Nurse practitioners first originated in the 1960s to help alleviate a national physician shortage.³³ All nurse practitioners are masters or doctoral prepared, with advanced classroom and clinical training beyond their initial nursing education.³⁴ They are licensed in all states including the District of Columbia³⁵ and have a large degree of autonomy.³⁶ Each state has different educational requirements and titles for nurse practitioners resulting in a lack of uniformity across the nation.³⁷

(1) In trials for homicide when the disclosure relates directly to the fact or immediate circumstances of the homicide; (2) in actions, civil or criminal, against the physician for malpractice; (3) with the express consent of the patient, or in case of his or her death or disability, of his or her personal representative or other person authorized to sue; (4) in all actions brought by or against the patient ... wherein the patient's physical or mental condition is an issue; (5) upon an issue as to the validity of a document as a will of the patient; (6) in any criminal action where the charge is either first-degree murder by abortion, attempted abortion, or abortion; (7) in actions, civil or criminal, arising from the filing of a report in compliance with the Abused and Neglected Child Reporting Act; (8) to any department, agency, or institution who has custody of the patient; (9) in prosecutions where written blood alcohol tests are admissible pursuant to ... the Illinois Vehicle Code; (10) in prosecutions where written blood alcohol tests are admissible under ... the Boat Registration and Safety Act; (11) in criminal actions arising from the filing of a report of suspected terrorist offense, or (12) upon issuance of a subpoena pursuant to ... the Medical Practice Act ... Illinois Dental Practice Act ... Nursing Home Administrators Licensing and Disciplinary Act ... Workers' Compensation Act.

Id.; but see OR. REV. STAT. § 40.240 (2012)(providing the only exception to the privilege is the waiver of the privilege by the patient). “A licensed professional nurse shall not, *without the consent of a patient* who was cared for by such nurse, be examined in a civil action or proceeding, as to any information acquired in caring for the patient, which was necessary to enable the nurse to care for the patient.” *Id.* (emphasis added).

33. SHARON CHRISTIAN ET AL., THE CENTER FOR THE HEALTH PROFESSIONS, OVERVIEW OF NURSE PRACTITIONER SCOPES OF PRACTICE IN THE UNITED STATES – DISCUSSION 2 (2007), available at futurehealth.ucsf.edu/Content/29/200712_Overview_of_Nurse_Practitioner_Scopes_of_Practice_In_the_United_States_Discussion.pdf.

34. *Id.*; *What's an NP? Education & Training*, AM. ASSOC. OF NURSE PRACTITIONERS, www.aanp.org/all-about-nps/what-is-an-np (last visited Oct. 5, 2012).

35. *What's an NP? License & Practice Locations*, AM. ASSOC. OF NURSE PRACTITIONERS, www.aanp.org/all-about-nps/what-is-an-np (last visited Oct. 5, 2012).

36. See Christopher J. Salisbury & Monica J. Tetersell, *Comparison of the Work of a Nurse Practitioner With That of a General Practitioner*, 38 J. ROYAL COLL. OF GEN. PRACTITIONERS. 314, 314 (1988) (noting that a nurse practitioner is more autonomous than a traditional registered nurse).

37. See e.g. ALA. CODE § 34-21-81 (West 2013) (recognizing nurse

It is a growing profession; in 2011-2012, an estimated 14,000 new nurse practitioners completed their degrees.³⁸ Nurse practitioners work in a variety of healthcare settings,³⁹ with the majority working in the primary care setting.⁴⁰ It is estimated that more than sixty-four percent of nurse practitioners work in the primary care or ambulatory care setting.⁴¹ Though the scope of care varies by the licensing state, nurse practitioners have prescriptive and diagnostic authority along with referral capability.⁴² For example, they may conduct physical

practitioners as Certified Registered Nurse Practitioners (CRNP) and requiring education through a program certified by the state Board of Nursing); ALASKA ADMIN. CODE tit. 12, §§44.400, 44.465 (West 2012) (requiring at least one year of graduate education and recognizing nurse practitioners as Advanced Nurse Practitioners (ANP)); 24 DEL. ADMIN. CODE 1900-8.0 (2012) (recognizing nurse practitioners as Advanced Practice Nurses (ANP) and Nurse Practitioners (NP) and requiring graduation from a Master's degree program or from an accredited certificate program of at least one year in length); FLA. STAT. ANN. § 464.012 (West 2012) (recognizing nurse practitioners as Advanced Registered Nurse Practitioners (ARNP) and requiring a Master's degree in nursing, accredited certificate program of at least one year in length, or certification from specialty board); 225 ILL. COMP. STAT. ANN. §§ 65/50-10, 65/65-5 (West 2012) (recognizing nurse practitioners as Advance Practice Nurses (APN) or Certified Nurse Practitioners (CNP) and requiring graduate degree in an advanced practice specialty); MINN. STAT. ANN. §§ 148.171, .233,.284 (2012) (recognizing nurse practitioners as Advanced Practice Registered Nurses (APRN) and Certified Nurse Practitioner (CNP) and requiring formal advance practice nurse coursework and national certification); 49 PA. CODE §§21.251, 21.271 (2014) (requiring graduation from an accredited master's or post-master's program and recognizing nurse practitioners as Certified Registered Nurse Practitioners); VT. STAT. ANN. tit. 26, § 1611 (West 2013) (recognizing nurse practitioners as Advance Practice Registered Nurses (APRN) and requiring a degree from a graduate nursing program).

38. *NP Fact Sheet*, AM. ASSOC. OF NURSE PRACTITIONERS, available at www.aanp.org/images/documents/about-nps/npfacts.pdf (last visited Mar. 11, 2014)[hereinafter *Fact Sheet*].

39. Sharon Christian & Catherine Dower, *Scope of Practice Laws in Health Care: Rethinking the Role of Nurse Practitioners*, ISSUE BRIEF (Cal. HealthCare Found., Oakland, Cal.), Jan. 2008, at 1, available at www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20ScopeOfPracticeLawsNursePractitionersIB [hereinafter *ISSUE BRIEF*] (nurse practitioners practice in a variety of settings including, but not limited to, “pediatrics, internal medicine, anesthetics, geriatrics, and obstetrics”); see also AM. ASSOC. OF NURSE PRACTITIONERS, *supra* note 34 (click on “Services”) (explaining that nurse practitioner specialty and sub-specialty areas include: oncology, psychiatric/mental health, neurology, occupational health, orthopedics, urology, emergency medicine, gastroenterology, endocrinology, and dermatology).

40. *Fact Sheet*, *supra* note 38, at 1.

41. *The Registered Nurse Population: Initial Findings From the 2008 National Sample Survey of Registered Nurses*, U.S. DEPT OF HEALTH & HUMAN SERVS., HEALTH RES. & SERVS. ADMIN. 5-9, (Sept. 2010) available at bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyfinal.pdf.

42. *ISSUE BRIEF*, *supra* note 39, at 1.

examinations, order and interpret tests, prescribe medications, develop plans of care, and educate patients.⁴³

The varying scopes of practice are based upon each individual states' regulatory schemes.⁴⁴ Thus, every state has its own law governing nurse practitioners that has resulted in a subsequent hotchpotch of regulations regarding how nurse practitioners may practice, their educational requirements, and even their titles.⁴⁵ In general, nurse practitioner scope of practice can be divided into two categories: (1) plenary authority, which does not require physician involvement; or (2) collaboration with physician and/or supervision by a physician.⁴⁶ Currently, eighteen states allow the greatest nurse practitioner autonomy, each allowing nurse practitioners to practice without physician oversight and to prescribe drugs without any physician involvement.⁴⁷ However, more state legislation to allow nurse practitioners to deliver healthcare independent of physicians is necessary in order to meet the demands with new influx of patients into the healthcare stream.⁴⁸

Because of this autonomy, nurse practitioners operate like physicians. Additionally, state laws may expand in the future to help further sever the dependency of the nurse practitioner on the physician.⁴⁹ Accordingly, the nurse practitioner-patient privilege is a necessary and logical statute.

C. Does the Nurse-Patient Privilege Exist?

Currently, there are twelve states that identify, via statute, the existence of either a nurse practitioner- or nurse-

43. *Id.*

44. Fairman, *supra* note 5, at 194.

45. *Id.* at 2; *See generally* Susanne J. Phillips, *Twenty-Sixth Annual Legislative Update: Progress for APRN Authority to Practice*, 39 THE NURSE PRACTITIONER 29 (2014).

46. *State Practice Environment*, AM. ASSOC. OF NURSE PRACTITIONERS, www.aanp.org/legislation-regulation/state-practice-environment (click on "Download State Regulatory Map") (last visited Mar. 5, 2014) (breaking down the states into two categories of physician collaboration; the following states allow for the nurse practitioners to practice autonomously, without a requirement of physician involvement: Alaska, Washington, Oregon, Idaho, Nevada, Montana, Wyoming, North Dakota, Arizona, New Mexico, Iowa, Colorado, Maine, Rhode Island, Vermont, New Hampshire, District of Columbia, & Hawaii); *See also* Phillips, *supra* note 44, at 31 (providing a table of nurse practitioner practice authority among the states).

47. *See State Practice Environment*, *supra* note 46.

48. Andrew Villegas & Mary Agnes Carey, *Nurses' Push for Bigger Role Gets a Powerful Ally*, KAISER HEALTH NEWS (Oct. 5, 2010), www.kaiserhealthnews.org/Stories/2010/October/05/IOM-report-on-nurses.aspx?p=1.

49. *See Villegas & Carey*, *supra* note 48 (discussing the push to expand nurse practitioner practice environments).

patient privilege.⁵⁰ Another nine states extend the privilege to registered nurses who are specifically working in the mental health field.⁵¹ Communications made to nurses in those states may be protected under the statutory privilege.⁵²

50. See COLO. REV. STAT. § 13-90-107(1)(d) (2012) (including “physicians, surgeons and registered professional nurses”) *Id.*; IOWA CODE ANN. § 622.10 (West 2012) (including “physicians, surgeons, physician assistants, advanced registered nurse practitioners”) *Id.*; ME. R. EVID. 503 (2014) (including “physicians, physicians’ assistants, licensed nurse practitioners”) *Id.*; MISS. CODE ANN. § 13-1-21 (West 2013) (including “physician, osteopaths, dentist, hospital, nurse”) *Id.*; N.H. REV. STAT. ANN. §§ 326-B:35 (2014) (providing that a licensed nurses’ communication with her patient is privileged); N.Y. C.P.L.R. § 4504 (McKinney 2014) (including “a person authorized to practice medicine, registered professional nursing”) *Id.*; N.C. GEN. STAT. ANN. § 8-53.13 (West 2004) (providing for a nurse-patient privilege); OR. REV. STAT. ANN. § 40.240 (West 2013) (providing for a nurse-patient privilege); R.I. GEN. LAWS §§ 5-37.3-1 to 5-37.3-4 (2012)(including “physician, hospital, intermediate care facility or other health care facility, dentist, nurse”) *Id.*; VT. STAT. ANN. TIT. 12, § 1612 (2013) (including “a person authorized to practice medicine, chiropractic, or dentistry, a registered professional or licensed practical nurse”) *Id.*; WASH. REV. CODE ANN. §§ 5.62.010 to 5.62.030 (West 2012) (providing for a nurse-patient privilege); WIS. STAT. ANN. § 905.04 (West 2012) (including registered nurses); *E.g.*, WASH. REV. CODE § 5.62.020: (Providing the following language):

No registered nurse providing primary care or practicing under protocols, whether or not the physical presence or direct supervision of a physician is required, may be examined in a civil or criminal action as to any information acquired in attending a patient in the registered nurse's professional capacity, if the information was necessary to enable the registered nurse to act in that capacity for the patient, unless:

- (1) The patient consents to disclosure or, in the event of death or disability of the patient, his or her personal representative, heir, beneficiary, or devisee consents to disclosure; or
- (2) The information relates to the contemplation or execution of a crime in the future, or relates to the neglect or the sexual or physical abuse of a child, or of a vulnerable adult as defined in RCW 74.34.020, or to a person subject to proceedings under chapter 70.96A, 71.05, or 71.34 RCW.

Id.

51. See CAL. EVID. CODE §§ 1010(k) (including “[a] person licensed as a registered nurse . . . who possesses a master’s degree in psychiatric-mental health nursing”) *Id.*; D.C. CODE § 14-307 (2013) (including mental health profession which encompasses psychiatric nurses); FLA. STAT. § 90.503 (2006) (including “advanced registered nurse practitioners . . . whose primary scope of practice is the diagnosis or treatment of mental or emotional conditions”) *Id.*; GA. CODE § 24-5-501(2013) (including “clinical nurse specialists in psychiatric/mental health”) *Id.*; KY. R. EVID. 507 (including “registered nurse or advanced registered nurse practitioner . . . who practices psychiatric or mental health nursing”) *Id.*; MD. CODE ANN., CTS & JUD. PROC. § 9-109.1 (West 2012) (including “psychiatric-mental health nursing specialists”) *Id.*; S.C. CODE ANN. § 44-22-90 (2012) (providing for a privilege between patients and “mental health professionals, including . . . nurses”) *Id.*; N.D. R. EVID. 503 (including a registered nurse with an advanced degree in mental health or two years clinical mental health experience); TENN. CODE ANN. § 63-7-125 (2010)

For example, Vermont has a statute that recognizes the nurse-patient privilege.⁵³ This privilege was challenged in *State v. Raymond*.⁵⁴ In that case, the defendant was an emergency room patient under the care of a nurse.⁵⁵ The court noted that what the nurse heard or observed from the defendant in the course of her professional capacity could not be disclosed absent waiver by the patient.⁵⁶ The court held that the nurse could not testify as to the communications that occurred between herself and the patient, or the odor of alcohol that she observed on his breath.⁵⁷ The court reached this conclusion because of the existence of the nurse-patient privilege and the fact that the nurse was, at all times, caring for the patient in her professional capacity.⁵⁸

Additionally, the physician-patient privilege may be extended to include nurses if those nurses are deemed agents of the physician.⁵⁹ However, that privilege, based on agency principles, does not automatically extend to nurses even though they may be assisting the patient's physician.⁶⁰

In sum, there are statutes currently in the United States that recognize the nurse-patient privilege.⁶¹ The issue of disclosure

(including "registered nurses who is nationally certified as a specialist in psychiatric and mental health nursing") *Id.*; UTAH R. EVID. 506 (including "advanced practice registered nurses designated as registered psychiatric mental health nurse specialist") *Id.*

52. *State v. Raymond*, 431 A.2d 453, 455-57 (Vt. 1981).

53. *Id.*; VT. STAT. ANN. tit. 12, § 1612 (2012).

54. *Raymond*, 431 A.2d at 455-57.

55. *Id.* at 455. Defendant was involved in a motorcycle accident and suffered a head injury. He was taken, via ambulance, to the emergency room. At the hospital, the state trooper processed him for driving while intoxicated. *Id.* at 454.

56. *Id.* at 455-56 (the prosecution planned to question the nurse about her observations of the defendant while he was in the emergency room).

57. *Id.* at 456-57.

58. *Id.* at 457.

59. BROWN ET AL., *supra* note 29, at §101, p. 458; *see also* Ostrowski v. Mockridge, 65 N.W.2d 185, 190 (Minn. 1954) (allowing the physician-patient privilege to extend to nurse present at the time of the examination as the nurse was acting in the capacity as the doctors agent and the fact that the statements by the patient were heard by the nurse does not preclude them from the privilege); Branch v. Wilkinson, 256 N.W.2d 307, 312-13 (Neb. 1977) (privilege extended to nurse who obtained blood sample from patient at the direction of physician as she was agent and the physician-patient privilege applied).

60. BROWN ET AL., *supra* note 29, at §101, p. 458; *see also* Myers v. State, 310 S.E.2d 504, 505-06 (Ga. 1984) (finding statement made to nurse by patient was not protected by the physician-patient privilege because nurse was agent of hospital and not the physician albeit she took orders from the physician.); Blevins v. Clark, 740 N.E.2d 1235, 1239-40 (Ind. Ct. App. 2000) (holding plaintiff's statements to nurse were not covered under physician-patient privilege because physician's degree of control over the nurse was not sufficient).

61. *See* statutes cited, *supra* note 53 (listing statutes that confer a nurse-patient privilege).

of confidential communication between the patient and nurse has been litigated and upheld in states that recognize a statutory privilege.⁶² However, this has not always been the case when attempting to extend the physician-patient privilege to include nurses.⁶³ Therefore, instead of rolling the dice and relying on agency principles to protect confidential communications between nurses and their patients, statutory solutions must be present in all states to fill this gap.

III. ANALYSIS

Communications between nurses and patients deserve just as much privacy as communications between physicians and patients. The reasons underlying the physician-patient privilege apply with equal, if not more, force to communications between nurses and patients. For example, more patients may be receiving their primary medical care from nurse practitioners in the near future. Furthermore, the type of interpersonal relationships that develop between nurses and their patients, as well as the similarity of patient care outcomes between nurses' patients and physicians' patients magnify the need for a nurse-patient privilege. While the case law indicates various attempts to create a nurse patient privilege through common law, those attempts have proven unsuccessful. As such, this Comment proposes a different method of creating a nurse patient privilege in Part IV.

A. *Communication Encouragement*

The physician-patient relationship arises out of the necessity of encouraging people to seek medical treatment by disclosing pertinent information to their physician.⁶⁴ This in turn enables physicians to provide proper and thorough treatment.⁶⁵ However, as previously explained, many states that support a physician-patient privilege do not recognize a general nurse-patient privilege.⁶⁶ This lack of recognition is often inconsistent

62. *Raymond*, 431 A.2d at 457.

63. *Ostrowski*, 65 N.W.2d at 190; *Myers*, 310 S.E.2d at 505-06; *Blevins*, 740 N.E.2d at 1239-40.

64. See Part II.A. *supra*.

65. *Developments in the Law - Privileged Communications; IV: Medical and Counseling Privileges*, 98 HARVARD L. REV. 1530, 1532-1533 (1985) [hereinafter *Medical and Counseling Privileges*] (discussing the history behind the statutory physician-patient privilege).

66. ALASKA R. EVID. 504; ARIZ. REV. STAT. ANN. § 12-2235 (2012); ARK. R. EVID. 503; CAL. EVID. CODE § 994 (West 2012); DEL. R. EVID. 503; D.C. CODE § 14-307 (2013); HAW. REV. STAT. § 626-1, R. 504; IDAHO R. EVID. 503; 735 ILL. COMP. STAT. 5/8-802 (2012); IND. CODE § 34-46-3-1(2) (2012); MICH. COMP. LAWS § 600.2157 (2012); MO. ANN. STAT. § 491.060(5)(West 2012); MONT. CODE ANN. § 26-1-805 (2012); NEB. REV. STAT. § 27-504 (2012); NEV. REV.

with the duties of nurse practitioners in states that allow nurse practitioners to operate independently of physicians.⁶⁷ In those states, nurse practitioners are just as autonomous as physicians: many diagnose, treat, and prescribe medications for their patients. Furthermore, given the autonomy of nurse practitioners, increase in the number of nurse practitioners practicing in this area,⁶⁸ and as more people alternatively seek nurse practitioners for their primary care needs, patients are increasingly relaying private information necessary to their care to nurse practitioners.⁶⁹

Thus, the necessity of encouraging people to divulge private medical information is not limited to communications between physicians and patients, but extends to communications between nurses and patients. Nonetheless, in many states, when compelled to testify, nurses' conversations with their patients are not protected. As a result, the patient is the victim, as he bears the burden of showing that a privilege exists.⁷⁰

B. Intimate Relationships

From the time nurses are educated through completing treatment of a patient, there is a strong emphasis on every nurses' duty to develop an interpersonal relationship with their patients. As such, the intimate relationships nurses develop with their patients amplify the necessity of a nurse-patient privilege.

1. Nurse Education: An Interpersonal Approach

The nursing approach to education differs somewhat from medical doctors, and comports with a nurse-patient privilege in

STAT. § 49.215 (2012); N.J. STAT. ANN. § 2A:84A-22.2 (West 2012); N.M. R. EVID. 11-504; N.D. R. EVID. 503; OHIO REV. CODE ANN. § 2317.02 (West 2012); OKLA. STAT. TIT. 12, § 2503 (2012); 42 PA. CONS. STAT. ANN. § 5929 (West 2012); S.D. CODIFIED LAWS § 19-13-6 (Rule 503 (a)) (2012); TEX. R. EVID. 509; UTAH CODE ANN. § 78B-1-137(4) (West 2012); WYO STAT. ANN. § 1-12-101(a)(i) (2012).

67. *Compare* statutes that codify the physician-patient privilege but do not recognize the nurse-patient privilege, *supra* note 68, with *State Practice Environment*, *supra* note 46; Alaska, Arizona, Idaho, Montana, North Dakota, Wyoming, Nevada, New Mexico, Hawaii, & District of Columbia all have nurse practice acts that provide nurse practitioners autonomous practice environments, independent of physicians, yet these states do not recognize a nurse-patient privilege but do codify a physician-patient privilege).

68. *Id.* at 376. The number of nurse practitioners and physician assistants delivering primary care outnumbers that of physicians delivering the same care. *Id.* at 381.

69. INST. OF MED., *supra* note 8, at 6.

70. In *Interest of Doe*, 795 P.2d 294, 296 (Haw. App. 1990) (finding that since the patient bears the burden of proving that the privilege exists, and the mother could not prove that the nurse was under the direction of the doctor, she could not invoke the privilege).

important ways. Nurses attend not simply to physical needs, but often meeting social and spiritual needs of their patients.⁷¹ Many nurse practitioner programs also focus on client education and advocacy.⁷² As such, where M.D. programs teach physicians to focus their practice on physiological disease processes and various treatment methodologies,⁷³ one of the fundamental practices that nurses are taught to develop is a nurse-patient relationship. Such a relationship is considered a fundamental aspect of nursing practice,⁷⁴ and is built upon multiple interactions in which a series of goals are set and achieved, and through which a trusting relationship is established.⁷⁵

71. INST. OF MED., *supra* note 8, at 23.

72. See Deanna R. Tolman, *Breaking Away: The Ethical Case for Nurse Practitioner Independence*, 15 AM. J. OF NURSE PRACTITIONERS 1 (2011) (discussing the potential clash between physicians and nurse practitioners in the office setting regarding allotment times of patient visits). Typically, the medical model calls for a shorter time than nurse practitioners are comfortable with because they have been taught to focus more on patient education and to be advocates for their patients). *Id.*

73. INST. OF MED., *supra* note 8, at 72.

74. Bonnie M. Hagerty & Kathleen L. Patusky, *Reconceptualizing the Nurse-Patient Relationship*, 35 J. OF NURSING SCHOLARSHIP 145, 145 (2003).

75. *Id.*; MOSBY'S MEDICAL, NURSING, & ALLIED HEALTH DICTIONARY 1199 (6th ed. 2002) (defining the nurse-client relationship as):

A therapeutic relationship between a nurse and a client built on a series of interactions and developing over time. All interactions do not develop into relationships but may nonetheless be therapeutic. The relationship differs from a social relationship in that it is designed to meet the needs only of the client. Its structure varies with the context, the client's needs, and the goals of the nurse and the client. Its nature varies with the context, including the setting, the kind of nursing, and the needs of the client. The relationship is dynamic and uses cognitive and affective levels of interaction. It is time-limited and goal-oriented and has three phases. During the first phase, the phase of establishment, the nurse establishes the structure, purpose, timing, and context of the relationship and expresses an interest in discussing this initial structure with the client. Data collection for the nursing care plan continues, and basic goals for the relationship are stated. During the middle, developmental, phase of the relationship, the nurse and the client get to know each other better and test the structure of the relationship to be able to trust one another. The nurse is careful to assess correctly the degree of dependency that is necessary for the particular client. Plans may be devised for improved ways of coping with problems and achieving goals. The nurse is alert to the danger of losing objectivity during this phase. The last phase, termination, ideally occurs when the goals of the relationship have been accomplished, when both the client and the nurse feel a sense of resolution and satisfaction. Often this is not possible because the nurse transferred or the client discharged; in either case both may be left with a feeling of frustration.

Id.

Compare the difference between the nurse-patient relationship *with* the patient-physician relationship. The latter tends to focus on the patient's rights

rather than actual development of a meaningful relationship. *AMA Code of Medical Ethics- Fundamental Elements of the Patient-Physician Relationship*, AMERICAN MEDICAL ASSOCIATION, available at www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf (last visited Nov. 16, 2012) (providing the patient-physician relationship):

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and by fostering these rights:

- (1) The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.
- (2) The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.
- (3) The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.
- (4) The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
- (5) The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.
- (6) The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care. Physicians should advocate for patients in dealing with third parties when appropriate.

This Comment is not advocating that physicians have meaningless relationships with their patients. On the contrary, many patients implicitly trust their physicians and will not see anyone else. Physicians may form strong bonds with their patients and have a very trusting relationship. However, nurses tend to learn to focus on the patient's wants and needs at a more spiritual level. Nurses are taught to go through the nursing process and

The amount of emphasis placed on developing strong relationships between a nurse and her client during basic nursing education is an important consideration. Because a nurse will strive to develop such a trust worthy relationship, it necessarily follows that patients may divulge more confidential medical information to the nurse to enable treatment. Thus, having the nurse-patient privilege is that much more important.

2. Nurse Relationships: Trust⁷⁶

Nurses, through the nurse-patient relationship, focus not only on treating the patient's medical signs and symptoms but also focus upon the relationship between themselves and the patient. The relationship goes deeper than an impersonal meeting at the doctor's office. As such, an emphasis on a much more personal relationship requires an even higher level of trust.⁷⁷ This dichotomy between nurses and patients has even prompted scholars to surmise that the trust patients place in nurses goes beyond that of simple reliance.⁷⁸

3. Nurse Treatment: Personal Settings

Nurses treat patients in settings where those patients are likely to divulge personal information. For example, nurses not only have access to patients in offices and hospitals, but in the community as well.⁷⁹ Further, they are employed in the occupational setting, schools, retail settings, and at local health departments.⁸⁰ Nurses may also make home visits through home health care.⁸¹ Thus, they interact with patients in places where their patients feel most comfortable, and, in turn, more willing to

develop a relationship based on trust.

76. Trust is defined as "assured reliance on the character, ability, strength, or truth of someone or something." *Trust definition*, MERRIAM-WEBSTER DICTIONARY, www.merriam-webster.com/dictionary/trust (last visited Jan. 5, 2013). Members of the nursing professions have noted that characteristics of trust include: "being an expectation of something, having confidence in someone, and being involved in with relationships." Judith E. Hupcey, Janice Penrod, Janice M. Morse & Carl Mitcham, *An Exploration and Advancement of the Concept of Trust*, 36 J. OF ADVANCED NURSING 282, 285 (2001).

77. For example, the nurse-patient relationship has been further defined as a relationship based upon "mutual trust and respect." Richard L. Pullen Jr., & Tabatha Mathias, *Fostering Therapeutic Nurse-Patient Relationships*, 8 NURSING MADE INCREDIBLY EASY 4, 4 (June 2010), available at http://journals.lww.com/nursingmadeincrediblyeasy/Fulltext/2010/05000?Fostering_therapeutic_nurse_patient_relationships.1.aspx.

78. Lousie de Raeve, *Trust and Trustworthiness in Nurse-Patient Relationships*, 3 NURSING PHILOSOPHY 152, 160 (2002).

79. INST.OF MED. *supra* note 8 at 28.

80. *Id.*

81. *Id.*

let down their guard. As such, the necessity of protecting such communications is magnified.

C. Patient Care Outcomes

One study suggests that there are virtually no differences in the treatment outcomes achieved by nurse practitioners and physicians, including the ultimate outcome of safe and effective care.⁸²

In that study, patients were randomly placed with one of two providers: nurse practitioners or physicians.⁸³ After the first visit, there were no statistically significant differences between physicians and nurse practitioners in the category of satisfaction.⁸⁴ At six months, although physicians scored slightly higher in “provider attribute” satisfaction, there remained no change in overall satisfaction, and no change in communication factors.⁸⁵

The researchers noted that there was unlikely any clinical significance based upon the statistics.⁸⁶ Also, the patients own self-reported health status along with actual physiological measures did not produce any statistically significant differences in the outcomes between care from the nurse practitioner versus the physician.⁸⁷

Thus, the research suggests that in the primary care setting, nurse practitioners and physician treatment outcomes do not differ.⁸⁸ As a result, care received from a nurse practitioner is arguably just as effective as care received from a physician, and communications in such a healthcare setting are just as important and should be afforded the same protections.

D. Common Law Approaches to Extending the Physician- Patient Privilege to Nurses Have Not Worked

Why is a nurse-patient privilege even necessary? Many nurses work under the supervision of a physician, and any conversations she may have with a patient will be protected under

82. Mary O. Munding, Robert L. Kane, Elizabeth R. Lenz, Annette M. Totten, Wei-Yann Tsai, Paul D. Cleary, William T. Friedewald, Albert L. Siu, & Michael L. Shelanski, *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial*, 283 JAMA 59, 66 (2000), available at <http://jama.jamanetwork.com/article.aspx?articleid=192259>.

83. *Id.* at 60.

84. *Id.* at 64.

85. *Id.* (“provider attribute consist[ed] of patients’ ratings of the providers’ technical skill, personal manner, and time spent with the patient”). *Id.*

86. *See id.* (noting that the difference in scores based on provider attribute satisfaction was 4.22 for physicians and 4.12 for nurse practitioners).

87. *Id.*

88. *Id.* at 68.

the physician-patient privilege, either through agency theory or through statutory construction of physician-patient privilege statutes. However, as shown below, such an assertion is not always true.

1. Agency Theory Results in Inconsistent Application

The agency⁸⁹ theory has not always been extended to individuals who work under the authority of a physician. For example, in *Blevins v. Clark*, the Indiana Court of Appeals found that agency principles did not apply to statements made by labor and delivery nurses to an attorney.⁹⁰

In that case, The Blevins filed a medical negligence action against their Obstetrician, Dr. Clark, after their child died shortly after birth.⁹¹ The Blevins objected to ex parte communications between Dr. Clark's counsel and three nurses that attended to the plaintiff based on the testimonial physician-patient privilege.⁹² The court noted that Indiana extended the physician-patient privilege to individuals who work for or aid physicians on behalf of patients.⁹³ The court examined the "nature and degree of control exercised" to determine whether the nurses fell under the agency theory.⁹⁴

The court ultimately concluded that the nurses remained independent from Dr. Clark while caring for Ms. Blevins and thus did not meet the agency requirement.⁹⁵ Therefore, the nurses' statements to counsel regarding their communications with Ms. Blevins did not fall within the physician-patient privilege.⁹⁶

In contrast to *Blevins*, *Branch v. Wilkinson* extended the physician-patient privilege to include a nurse through agency theory.⁹⁷ In *Branch*, the defendant was brought to the hospital, unconscious after a motor vehicle collision.⁹⁸ The court noted that

89. See RESTATEMENT (SECOND) OF AGENCY, § 1 (1958) (defining agency as "the fiduciary relation which results from the manifestation of consent by one person to another that the other shall act on his behalf and subject to his control, and consent by the other so to act"). *Id.*

90. *Blevins v. Clark*, 740 N.E.2d 1235, 1240 (Ind. Ct. App. 2000).

91. *Id.* at 1237.

92. *Id.* at 1239.

93. *Id.* at 1239.

94. *Id.* at 1240, (quoting *In the Matter of C.P.*, 563 N.E.2d 1275, 1278 (Ind. 1990)).

95. *Id.* at 1240 (the nurses were considered to have operated independently from the physician because Dr. Clark was absent for long periods of time throughout the day).

96. *Id.*

97. *Branch*, 256 N.W.2d at 312-313.

98. *Id.* at 310-311 (the passenger's estate sued defendant under a wrongful death theory after the car the defendant was operating was involved in an accident. Defendant objected to admission of blood alcohol results based upon the physician-patient privilege).

the professional nurse, under the direction of a physician, fell under the physician-patient privilege through agency theory, and allowed the defendant to claim the privilege.⁹⁹

This inconsistent application of the agency theory appears to rest upon the individual facts of each case and how much control the physician has over the nurse. Thus, in states where nurse practitioners are relatively autonomous and do not work under the direction of a physician, agency theory will not extend the privilege from the physician to the nurse. If those states do not recognize a nurse-patient privilege then the patient's confidential communications to his nurse practitioner will not be safe from compulsion in court.

2. Statutory Construction Does Not Work

As case law suggests, judicially inventing a nurse-patient privilege through statutory construction is not an acceptable method for creating the privilege. For example, in the case *Duronslet v. Kamps*, the California Court of Appeals held that the physician-patient privilege did not extend to a nurse.¹⁰⁰ In *Duronslet*, a business partnership between Duronslet and Kamps went sour resulting in Kamps expressing threats, directed at Duronslet, through her nurse.¹⁰¹ The manager of the nurse's office then notified the police who in turn notified Duronslet of the threats, prompting her to request an emergency protective order against Kamps.¹⁰² Kamp's objection to the statement being released was based upon violation of the physician-patient privilege.¹⁰³

The court of appeals concluded that the physician-patient privilege did not apply to Kamp's statements made to the nurse.¹⁰⁴

99. *Id.* at 312-313 (the drawing of the blood alcohol sample, by the nurse, the physician's agent, fell within the scope of the physician-patient privilege); see also *State v. Henderson*, 824 S.W.2d 445, 450 (Mo. Ct. App. 1991) (noting the potential for privileged communications made to a nurse if she was working under the direction of the physician); *Cleveland v. Haffey*, 94 Ohio Misc. 2d 79, 96 (Ohio Mun. 1998) (noting privilege extended to nurse if the purpose of obtaining information was to assist the physician).

100. *Duronslet v. Kamps*, 137 Cal. Rptr.3d 756, 771 (Cal. Ct. App. 2002).

101. *Id.* at 760.

102. *Id.* at 761.

103. *Id.*

104. *Id.* at 771. The *Duronslet* court also examined case law where the physician-patient privilege extended to nurses and where it did not. *Id.* at 770-771. For example, the court made reference to the New York, Vermont, Minnesota, and Oregon statutes that specifically codified the nurse-patient privilege and then compared those statutes to the California Evidence Code which does not mention nurse in any part. The court noted that other jurisdictions had declined to extend the physician-patient privilege to nurses or other medical professionals where the statute does not specifically state that professional's title in the statute. *E.g.*, *State v. Tatro*, 635 A.2d 1204, 1206

Kamp's attorney argued that the word physician included nurses and nurse practitioners.¹⁰⁵ However the court examined the meaning of the word "physician" as defined in the code and it did not encompass nurses.¹⁰⁶ The court concluded that it could not extend the physician-patient privilege to include nurses because the California courts do not have the power to expand legislative creations.¹⁰⁷ *Duronslet* follows the proposition that because the statutory physician-patient privilege was not recognized at common law, it should be strictly construed by reading the express language of the statute.¹⁰⁸

Duronslet demonstrates the impracticality of depending on statutory construction as a vehicle for applying the nurse-patient privilege. It shows that the various other states which do not have a statutory nurse-patient privilege may be unable to extend their physician-patient privilege statute to nurses. Given the importance of such a privilege, states must find another way to ensure that communications between nurses and patients remain private.

E. The Pitfalls of the Privilege Should Not Result in a Complete Ban of the Privilege

This Comment does not argue that every form of communication between a nurse and his or her patient should be privileged. It simply argues that the states should adopt a statutory nurse-patient privilege because the physician-patient privilege cannot always be extended to patient communications with nurses.

As noted above, not all states recognize the physician-patient relationship.¹⁰⁹ However, this number has decreased over

(Vt. 1993) (holding the physician-patient privilege did not extend to a first responder who provided medical treatment); *People v. Van Le*, 239 Cal. Rptr. 858, 861 (Cal. App. Ct. 1987) (holding pharmacist did not fall under the physician-patient privilege). The court in *Duronslet* noted that the privilege should be construed to favor the patient but, nonetheless, did not find the privilege. *Duronslet*, 137 Cal. Rptr. 3d at 770-71.

105. *Duronslet*, 137 Cal. Rptr. 3d at 767.

106. *Id.* (noting "section 990 defines 'physician' as 'a person authorized, or reasonably believed by the patient to be authorized, to practice medicine in any state or nation'"). *Id.*

107. *Id.* at 771.

108. Recent Cases, *Witnesses – Confidential Relations and Privileged Communications – Relation of Nurse and Patient*, 13 IOWA L. REV. 118, 118 (1927-1928).

109. See GREENWALD, *supra* note 30. For example, the following states do not have a statutory physician-patient privilege; Alabama: ALA. R. EVID. 503 (including "psychotherapists ... licensed to practice medicine ... while regularly engaged in the diagnosis or treatment of mental or emotional conditions") *Id.*; Florida: FLA. STAT. ANN. § 90.503 (2006)(including practitioners who primarily treat mental or emotional conditions); Kentucky: KY. R. EVID. 507 (providing a

the years.¹¹⁰ But the most glaring absence of the physician-patient privilege is the reluctance to adopt by the federal courts.¹¹¹ There are reasons, adopted by some, why the physician-patient privilege is unnecessary and those reasons surely would extend to the nurse-patient privilege.¹¹²

The consensus among scholars against the privilege is similar;¹¹³ the burden of the privilege outweighs its benefits.¹¹⁴ Nonetheless, there are many valuable reasons why the privilege should exist¹¹⁵ and apply to confidential communications between

psychotherapist-patient privilege); MARYLAND: MD. CODE ANN., CTS. & JUD. PROC. § 9-109 (West 2012)(providing a patient-therapist privilege); Massachusetts: MASS. GEN. LAWS ANN. Ch. 233, §20B & Ch. 112 § 129A (West 2012) (providing a patient-psychotherapists privilege); Tennessee: TENN. CODE ANN. § 24-1-207 (2012) (including “communications between a patient and a licensed physician when practicing as a psychiatrist”) *Id.*; West Virginia: W. VA. CODE § 27-3-1 (2008) (including information obtained during treatment or evaluation of patients for mental or physical conditions).

110. See *Medical and Counseling Privileges*, *supra* note 67, at 1532 n.9 (noting in 1985 that Alabama, Connecticut, Florida, Kentucky, Maryland, Massachusetts, New Mexico, South Carolina, Tennessee, and West Virginia did not recognize a statutory physician-patient privileges). Now over 25 years later Connecticut and New Mexico have adopted the privilege.

111. See *Medical and Counseling Privileges supra* note 67, at 1533 (providing that Congress, when adopting Federal Rule of Evidence 501, chose not to list out specific privileges but rather gave discretion to the courts to adopt a privilege “in light of reason and experience,” however, the federal courts have yet to recognize the physician-patient privilege). *Id.*; *United States v. Univ. Hosp. of State Univ. of N.Y.*, 575 F. Supp. 607, 611 (E.D.N.Y. 1983) (providing that there is no general physician-patient evidentiary privilege in the federal courts). However, this Comment is not advocating for a physician-patient or nurse-patient privilege in the federal system, only for the statutory nurse-patient privilege among all the states.

112. For example, a reason in favor of the privilege is so the patient may divulge information freely to his doctor without worry that his doctor will be compelled to speak of their conversation in court. Zechariah Chafee, Jr., *Privileged Communications: Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand*, 52 YALE L. J. 607, 609 (1943). However, critics of the privilege posit that, a patient, when seeking medical care from his doctor, rarely has legal processes on his mind. *Id.* And even if a patient did have litigation on his mind, medical treatment is of such a necessity that few would abstain from receiving it to prevent certain facts from coming out in court. *Id.*

113. See, *United States ex rel. Edney v. Smith*, 425 F. Supp. 1038, 1040 (E.D.N.Y. 1976) (noting the rationale of many professors and legal scholars against the adoption of a physician-patient privilege).

114. *Id.*

115. For example, successful medical care sometimes requires prying information out of reluctant patients because there may be embarrassing secrets surrounding the illness. *Developments in the Law – Privileged Communications II. Modes of Analysis: The Theories and Justifications of Privileged Communications*, 98 HARV. L. REV. 1471, 1476 (1985). Without the privilege, the provider is confronted with a difficult choice: on the one hand he has a duty to obtain an accurate compilation of signs and symptoms regarding his patient, and has the duty to maintain confidential information he obtain from his patient private. *Id.* at 1467-77. On the other hand, he has a duty to

a physician and his patient¹¹⁶ and as Part III shows, to a nurse practitioner and patient.

IV. PROPOSAL

As demonstrated above, both agency theory and statutory construction have failed in previous cases¹¹⁷ as vehicles for implementing a nurse-patient privilege. Thus, patients have been left vulnerable to their confidential communications being exposed on the witness stand. Rather than relying on the courts to make a determination, statutory nurse-patient privileges must be codified in all the states, taking the discretion, along with the uncertainty and inconsistency that go with it, out of the courts' hands.¹¹⁸

When a nurse-patient privilege is in place, the courts have respected that statute.¹¹⁹ However, in order to have a nurse-patient privilege, the state must make the necessary statutory changes. While it would be ideal to have a federal nurse-patient privilege, that is a big hurdle to overcome as the federal system has yet to recognize even a physician-patient privilege.¹²⁰ This

speak the truth on the witness stand. *Id.* This then may lead the provider to elicit less information from the patient because he is trying to balance multiple duties. *Id.* at 1477. Unfortunately, because the provider does not press the patient as he used to, and thus fails at his duty to obtain a complete history, the effects may be compounded. *Id.* The flow of communication will be reduced thus tending to make the patient less likely to communicate with his provider. *Id.*

116. Another reason why arguably the physician-patient privilege should exist is through analogy. For example, the physician-patient privilege is analogous to the attorney-client privilege in that communications between a doctor and his patient are at minimum as important as the conversations between an attorney and his client. John Jennings, Note, *The Physician-Patient Relationship: The Permissibility of Ex Parte Communications Between Plaintiff's Treating Physicians and Defense Counsel*, 59 MO. L. REV. 441, 445-46 (1994). After all, federal law recognizes the attorney-client privilege. *Upjohn Co. v. United States*, 449 U.S. 383, 389 (1981) (noting that the "attorney-client privilege is the oldest of the privileges for confidential communications known to the common law"). *Id.*

117. *Duronselt*, 137 Cal. Rptr. 3d at 770-71. (confidential communications between nurse and patient not protected through either agency theory or statutory construction); *Myers*, 310 S.E.2d at 505-06 (statement made to nurse by patient was not protected under agency theory); *Blevins*, 740 N.E.2d at 1239-40 (holding plaintiff's statements to nurse were not covered under agency theory).

118. See NORMAN J. SINGER & J.D. SHAMBIE SINGER, 1 SUTHERLAND STATUTORY CONSTRUCTION § 1:3 (7th ed. 2012) (noting that the general public has relied upon the legislature, rather than the courts, to enact the laws and principles which individuals must adhere to).

119. See Background *supra* II.D.; *Raymond*, 431 A.2d. at 455-57 (finding a nurse-patient privilege through the Vermont nurse-patient privilege statute).

120. See *Medical and Counseling Privileges supra* note, 67 at 1533 (discussing lack of a federal physician-patient privilege); *Gilbreath v. Guadalupe Hosp. Found. Inc.*, 5 F.3d 785, 791 (5th Cir. 1993) (reaffirming that

Comment seeks only to advance the privilege among the states. This proposal discusses how to implement the privilege in the remaining states, and what obstacles may stand in the way of achieving that goal.

A. Supporting the Privilege

The fact that roughly one quarter of the states already recognize a statutory nurse-patient privilege is a promising indication that the remainder of the states may be willing to follow.¹²¹ Similar to case precedent there is the notion of statutory precedent.¹²² Once a state breaks free and goes against common law to recognize a new law, other states may follow the lead.¹²³

If other states do not fall in line, new legislative policy may be initiated in response to the requirements of the representative's constituents.¹²⁴ It is up to us as past, future, or current patients to lobby our state representatives stressing the need of the nurse-patient privilege statute set forth below.

B. Drafting the Privilege

The following is a proposed draft of a statute codifying the nurse-patient privilege. It is an example of what a state should adopt:

Privileged Communications Between Nurse Practitioners and Their Patients

(A): The Privilege: A patient, or patient's representative, has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications - information not

federal law does not recognize a physician-patient privilege); *Patterson v. Caterpillar, Inc.*, 70 F.3d 503, 506-07 (7th Cir. 1995) (noting that federal common law does not include a physician-patient privilege).

121. See statutes cited *supra* note 53 (listing statutes that confer a nurse-patient privilege).

122. SINGER *supra* note 123 at § 1:3.

123. *Id.*; Frank E. Horak, Jr., *The Common Law of Legislation*, 23 IOWA L. REV. 41, 43-44 (1937) Statutory adoption of new law is quite similar to judicial precedent. An example of this idea follows: common law required that an operator of an automobile owed a duty to his passenger to protect him from unreasonable danger of injury. Connecticut adopted a statute that changed the common law duty of care to willful or wanton conduct. *Id.* After the Connecticut statute was adopted, another twenty-three states fell in line and adopted similar statutes. *Id.* Law-makers tend to rely on established statutory models. Stefan A. Riesenfeld, *Law-Making and Legislative Precedent in American Legal History*, 33 MINN. L. REV. 103, 104 (1949).

124. SINGER, *supra* note 123 at § 1:3.

intended to be disclosed to third parties - in a civil or criminal proceeding. This privilege extends to any information acquired in treating the patient, that was necessary to assist the nurse practitioner in the nurse's professional capacity to treat the patient, and extends to persons who are participating in the diagnosis or treatment under the direction of the nurse practitioner:

(B) Exceptions: This privilege does not apply under the following circumstances:

(1) The patient or representative consents to disclosure;

(2) Communications made pursuant to a court ordered examination between a nurse practitioner and patient are not privileged;

(3) In any malpractice action against the nurse practitioner;

(4) The communication concerns the contemplation or execution of a future crime;

(5) The communication concerns the neglect or abuse of a minor;

(C) Privilege Claim: The following persons may claim the privilege on behalf of the patient:

(1) The patient;

(2) The patient's guardian;

(3) A representative of the deceased patient;

(4) The nurse practitioner on behalf of the patient.¹²⁵

125. This proposed draft of a statute was created from an amalgamation of multiple statutes, including: 735 ILL. COMP. STAT. 5/8-802 (2012); WASH. REV. CODE ANN. §§ 5.62.010 to 5.62.030; N.Y.C.P.L.R § 4504; OR. REV. STAT. § 40.240; N.H. REV. STAT. ANN. §§ 326-B:35; ME. R. EVID. 503.

This is only a suggestion of a statute recognizing the nurse-patient privilege. The individual states would be free to adopt their own versions. Since each state has their own interests in protecting its citizens, many of the above exceptions will vary vastly from state to state.¹²⁶

C. Obstacles to the Privilege

Implementing the nurse-patient privilege may face various obstacles. First, the states may be reluctant to introduce the privilege. Although there is statutory precedent in various states, this does not mean that those states without the privilege will necessarily follow.¹²⁷ After all, given how there are states that still do not recognize a general physician-patient privilege,¹²⁸ it may prove more difficult to persuade representatives in those states to implement the nurse-patient privilege.¹²⁹

To overcome this obstacle, it may be wise to lobby for the privilege and explain why the nurse-patient privilege is necessary.¹³⁰ Also, state representatives can be reminded that they do not have to use a particular statute, like the one suggested above. Rather, they can customize the statute based on their own state public policy, expanding or contracting the statute in order to fit the needs of their states.

A second obstacle to implementing the privilege is the possible intervention by medical associations. The same groups that oppose expanding the scope of care of nurse practitioners may also oppose expanding or creating a nurse-patient privilege.¹³¹ For example, the American Medical Association has continually held

126. See e.g., HOOPER, ET AL., *supra* note 18, at § 16.02 (revealing certain public policy and state interests that may limit the privilege); Statutory exceptions cited *supra* note 32 (listing all of the exceptions in the Illinois physician-patient privilege statute).

127. Horak, *supra* note 128, at 43-44.

128. See statutes cited *supra* note 115 (listing statutes that do not recognize physician-patient privilege).

129. Indeed, it is often easier for legislators to do nothing so as not to “rock the boat” because they have so many different interests to advance. INST. OF MED., *supra* note 8, at 456. To overcome this, nurses need to band together, let their voices be heard, and bring about change regarding the lack of testimonial privileges in the remaining states. *Id.* at 456.

130. See Analysis *supra* part III.A.3; Analysis *supra* Part III.B; While legislatures may be unwilling to initiate legal reform, they are at a better vantage point to make changes in the law. *Reforming the Common Law*, *supra* note 3, at 637-638. It is up to citizens or interest groups to request the change. After all, “almost no legislation originates within a legislative body.” Abbot Low Moffat, *The Legislative Process*, 24 CORNELL L. Q. 223, 224 (1939).

131. INST. OF MED. *supra* note 8, at 110. Legislators may be caught in “turf battles” and may be tired of picking sides and advocating for one group over another. *Id.* at 456-457.

the position of opposition of the states broadening the scopes of practice for all healthcare professionals other than physicians.¹³²

To overcome this obstacle, it is best to remind every medical provider why he or she is in the business of healthcare. The bottom line is that providers practice in the healthcare field to make a difference in the lives of their patients and to make sure that their patients are treated with the respect that they deserve. Additionally, the medical associations must be reminded that with the Affordable Care Act in place there may be long waits to see overworked physicians; therefore, nurse practitioners may be the only treatment provider readily available for some patients. Thus, this relationship must be protected. After all, the patient should be the primary concern and arguments or stances against the implementation of the nurse-patient privilege only hurt the patients in the long run.

V. CONCLUSION

Above all, patients want to feel comfortable in disclosing personal information to their healthcare providers. These communications are not only necessary for treatment, but may reveal certain intimate details about an individual's life that he or she does not wish anyone else to hear. Because more patients will be receiving primary care from nurse practitioners in the near future, and common law does not protect that relationship, it is necessary for the states to implement the nurse practitioner-patient privilege. This can be accomplished by urging state representatives and medical associations to petition for adopting the statute. Though there will likely be obstacles, none, however, are insurmountable.

132. INST. OF MED. *supra* note 8, at 110; In fact the American Medical Association was involved with the Scope of Practice Partnership (SOPP) who together, worked to defeat proposed legislation for scope of practice expansion in multiple states for healthcare providers including nurses. *Id.* SOPP hired a legislative attorney who helped articulate evidence to counter access to care arguments made by healthcare professionals. *Id.* Unfortunately, those same access to care arguments can be made in arguing against the nurse-patient privilege, so it may follow that there will be opposition by the same groups in implementing the nurse-patient privilege.