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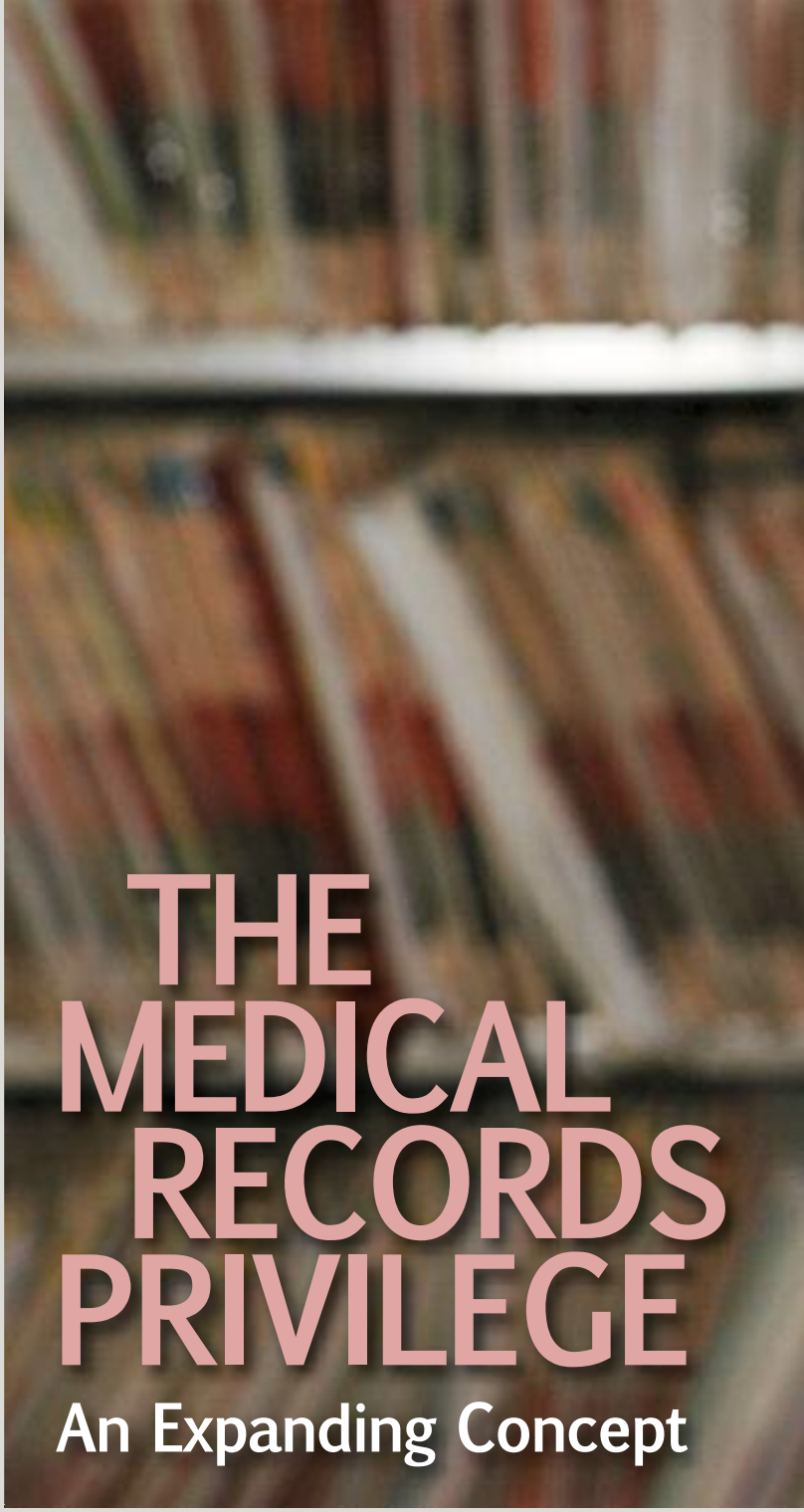

THE MEDICAL RECORDS PRIVILEGE

An Expanding Concept

There is a new privilege in town—or at least it has been hiding in plain view.

In 1995, the Arizona Legislature created what has recently been identified as the Medical Records Privilege.[1] Although the Medical Records Disclosure Act generally was recognized as a means to streamline the litigation and nonlitigation disclosure of medical records, very few attorneys and, apparently, virtually no legal writers recognized that the insertion of the term "privilege" created a whole new privilege that went well beyond the traditional categories of physician–patient, psychologist–client, and hospital peer review. In *Catrone v. Miles*,[2] the Arizona Court of Appeals recognized the privilege for the first time and identified it as the "medical records privilege."

Recognition of a medical records privilege is important because it expands the number of health care professions for whom an express privilege has been established—from 6 to 20. It defines the privilege based equally upon the nature and format of the communication, as well as the relationship between the health care professional and patient.

It establishes a new privilege paradigm by shifting the focus from the confidential communication between two persons in a protected relationship to the nature of recorded communication. This conceptual shift allows the Legislature to regulate more generally the duties that attach to privileged communications.

This article describes the new privilege, discusses differences with the existing patient privileges, and explores how the laws affecting privileged communications may develop in the future.

Far More Professionals Covered

In the context of a comprehensive act to simplify the disclosure of medical records, the Arizona Legislature started with a seemingly straightforward proposition: "Unless otherwise provided by law, all medical records and the information contained in medical records are privileged and confidential."[3]

Because Arizona's physician–patient privilege dates back to territorial days,[4] the statement appears to be no more than a confirmation of statutory and common law. Interestingly, this is the only reference to privilege in the Act. The greatly expanded scope of the privilege comes from the definition of medical records and the number of professions that can create these records.

A.R.S. § 12-2291(5) defines a medical record as a record about any communication concerning a patient's physical or mental condition that is maintained for diagnosis and treatment. Again, the definition is not controversial, but it is an expansion from the original statutory privilege that focused on "any communication made by [the] patient" or "knowledge obtained by personal examination of the patient."[5]

The major expansion in the privilege comes from the definition of "health care provider." Rather than limiting the definition to those professions that already had an established privilege (*e.g.*, physicians, psychologists and behavioral health professionals), the law expands the definition—and reach of the privilege—to any person licensed under Title 32 who maintains or creates patient records.[6]

More Than An Expansion

Initially, one might suppose that a "medical records privilege" is at most an expansion of the physician–patient privilege to professionals who work with physicians and patients. This assumption would be incorrect for several reasons.

First, the physician–patient privilege, like all privileges, must be strictly construed. For instance, more than 75 years ago the Ninth Circuit held that communications to a nurse assisting a physician

were not privileged because the physician–patient privilege statute did not include nurses.[7] This statutory construction principle still applies.

The *Catrone*[8] court found that special education records, which clearly relate to the physical and mental health condition of a student, are not privileged unless the professional who created the records was licensed under Title 32. Specifically, the court held that the records of school psychologists and speech therapists are not privileged because neither profession is required to be licensed under Title 32.

When the Medical Records Disclosure law was enacted in 1995, the definition of health care provider was limited to seven identified professions from Title 32. In 1997, the definition of "health care provider" was expanded to include *any* Title 32 licensee who creates medical records.[9] By changing the definition of "health care provider," the Legislature made a policy decision to greatly expand the number of professions from which a privilege may be claimed.

For instance, Title 32 lists at least 32 different professions, ranging from architects, acupuncturists and athletic trainers to physicians, security guards and veterinarians. Obviously, some professions never deal with patients (*e.g.*, real estate agents, driving trainers and private investigators), many spend all of their time in patient care (*e.g.*, dentists, nurses and radiology technologists), and the work of others may or may not involve diagnosis and treatment (*e.g.*, funeral directors, barbers and cosmetologists).

The expanded scope of the privilege occurred without notice or

comment. For instance, a primary treatise on evidence, ARIZONA LAW OF EVIDENCE (2000), does not mention A.R.S. § 12-2292 in its extensive discussion of the physician–patient privilege or in the section on miscellaneous privileges.

Likewise, the more recent ARIZONA TRIAL HANDBOOK (2007-08) omits any discussion of it despite a practical, detailed review of all testimonial privileges. (In the spirit of full disclosure, the author must acknowledge that the text he co-authored on mental health professionals also omits any reference to it.[10]) This was an easy privilege statute to overlook and, until the *Catrone* court labeled it as the medical records privilege, it could have been argued that the reference to privilege in a statute governing disclosure of records was not intended to establish a whole new privilege.

Evolving rationales for privilege increasingly stress a rights-based argument that is normative rather than empirical.

Other Privilege Changes in the Offing?

The traditional rationale for a privilege is that if a person could not be assured that conversations with his doctor were protected from arbitrary disclosure, the patient would be less willing to seek needed medical care.[11] However, rationales are changing.

Evolving rationales for privilege increasingly stress an independent basis for privilege that recognizes the privacy interest of a person to obtain health services without fear of embarrassment or discrimination.[12] This is a rights-based argument that is normative rather than empirical. This distinction can be crucial, particularly in determining whether requirements attach to assertion of the privilege.

For instance, if a patient's statements to a physician could be overheard by a third person, the privilege might not apply, because it can be assumed that the patient did not care whether his communications were kept confidential.[13] Likewise, a person's failure to protect privileged communications from inadvertent disclosure could result in waiver of the privilege.[14] Generally, a waiver of a specific privileged communication in any context prevents assertion of the privilege for that communication in any other forum.

These attacks on privilege have much less force if the basis for the privilege is the right to keep medical records private unless waiver is made or implied in a particular circumstance. As with other statutory and constitutional rights, a single waiver does not mean waiver in all other contexts, even where the subject matter is the same. It remains to be seen, however, whether courts will depart markedly from prior caselaw on waiver because a rationale underlying health care privileges has shifted from confidential communications to privacy interests.

Whatever the courts decide about the contours of privilege application and waiver, the medical records privilege is further confirmation of the shift to statutes as the principal source of privilege law. Moreover, there are several indications that changing the focus from profession-specific privileges to a general records privilege will allow the Arizona Legislature to more easily regulate privileges and to use them as a tool for other purposes, such as the creation or elimination of negligence claims.

As an example, the Legislature codified the duty of health care professionals to maintain medical records, including a continuing duty upon retirement or sale of the professional's practice unless the person is an employee.[15] Different retention periods are specified for adults versus children. It also granted immunity to professionals for medical record disclosure that complies with the law.[16]

The application of privilege law to emerging technologies can be accomplished with a single cross-reference rather than amendments to multiple profession-specific privilege statutes. Telemedicine is specifically protected by the medical records privilege.[17] As hard-copy records move to a digital-only format, we can expect the privilege law to be applied to it in a uniform, consistent basis. That is, it will not be necessary to ask whether the communication was made in private, whether the patient had an expectation of privacy, or whether an inadvertent data disclosure also resulted in waiver of the privilege.

Conclusion

The medical records privilege represents a subtle but far-reaching conceptual change to how the privileges for health care providers are addressed in the courts. At a minimum, there are many more professions that can now claim communications about their patients are protected by privilege law. Express or implied waiver of the privilege must be analyzed with an eye on statutory disclosure provisions. The scope of waiver may be more limited. Finally, we have a new label that likely will have the effect of broadening how we generally think about privilege.

endnotes

1. Laws 1995, Ch. 225, Medical Records – Disclosure.
2. 160 P.3d 1204, 1208, ¶ 10 (Ariz. Ct. App. 2007).
3. A.R.S. § 12-2292(A).
4. Civ. Code 1901, § 2535.
5. A.R.S. § 12-2235.
6. The actual statutory definitions are somewhat circular in that a medical record is one prepared by a health care provider and a health care provider is a person who maintains medical records. Presumably, the additional descriptors in both definitions resolve this circularity on a common sense basis.
7. *Southwest Metals Co. v. Gomez,* 4 F.2d 215, 218 (9th Cir. 1925).
8. 160 P.3d 1024 (Ariz. Ct. App. 2007).
9. Laws 1997, Chap. 267, § 1.
10. MICHAEL OWEN MILLER, BRUCE D. SALES & JAVIER B. DELGADO, LAW AND MENTAL HEALTH PROFESSIONALS: ARIZONA (2003).
11. JOHN WIGMORE, WIGMORE ON EVIDENCE § 2380(a) (1961).
12. EDWARD J. IMWINKELRIED, THE NEW WIGMORE: EVIDENTIARY PRIVILEGES § 1.1 (2002).
13. *Southwest Metals Co.,* 4 F.2d at 217.
14. *See e.g., Gomez v. Vernon,* 255 F.3d 1118, 1131-32, (9th Cir. 2001); *Suburban Sew 'N Sweep, Inc. v. Swiss-Bernina, Inc.,* 91 F.R.D. 254, 258 (N.D. Ill. 1981) (privilege "is not easily invoked and is easily destroyed").
15. A.R.S. § 12-2297.
16. *Id.* § 12-2296.
17. *Id.* § 36-3602(B).