A COMPARATIVE EXAMINATION OF THE DOCTOR–PATIENT PRIVILEGE IN STATE AND FEDERAL COURTS IN IOWA

ABSTRACT

Every day, Americans enter their doctors' offices and shut the doors behind them under the assumption that the things they discuss with their physician will not be divulged to the outside world. While this is generally true, there are multiple avenues by which this information can be disclosed. Oftentimes, it is through the express will of the patients, such as when they agree to allow an insurance provider or another healthcare provider access to records for purposes of furthering treatment. Another instance is when equity calls for waiver of privilege because a patient seeks to bring a lawsuit—the success of which depends entirely on the patient's medical condition. Justice and fairness counsel against recognition of a privilege in these contexts.

What may not be so commonly known, however, is that the recognition of this expectation of privacy largely depends upon the jurisdiction. State and federal courts differ widely in their approaches, such that the same information exchanged between a patient and his or her healthcare provider could be subject to privilege in one court and not in the other.

This Note calls for uniformity in the treatment of privileged communications across jurisdictions, as this ultimately facilitates communication between a patient and a healthcare provider, simplifies matters for the bar and the bench alike, and stays true to the principle of privacy so deeply rooted in our country's laws.

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I. INTRODUCTION

A. *The History of the Privilege*

The concept of confidentiality in medicine predates the common law. It finds its roots in the Hippocratic Oath, a millenniums-old principle mandating, among other things, secrecy upon those providing medical care to others.[1] The oath was a sacred belief observed by members of the Pythagorean Brotherhood.[2] Pythagorean aspirants were obliged to swear: "And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets."[3] This profound declaration crystalized into the bedrock of the relationship between doctor and patient.

1. *Historical Origins of the Privilege*

The history books are replete with past societies respecting the integrity of the doctor–patient relationship in the interest of preventing embarrassment on the part of the patient and fostering the patient's confidence in his or her medical practitioners.[4] While this oath of confidence was reverenced as the beating heart of the successful practice of medicine, pragmatism drove the need for a widely held exception: the silence could and should be broken in order to permit a physician to alert a terminally ill patient's friends and family of the terminal nature of the disease, while withholding the information from the actual patient.[5] This practice was a

1. Gerald L. Higgins, *The History of Confidentiality in Medicine: The Physician–Patient Relationship*, 35 CANADIAN FAM. PHYSICIAN 703, 921 (1989).
2. *Id.*
3. *Id.*
4. *Id.* at 922.
5. *Id.*

form of mercy on the patient consistent with prioritizing the needs of the patient and a reflection of the overall attitude of respecting the patient's dignity and autonomy.

Much like these past societies, we have, over time, faced the troubling task of determining the magnitude and scope of a doctor's duties of confidentiality. The reconciliation of this notion with the objective of transparency in litigation has been particularly troublesome for Western society. Specifically, how much respect ought the judicial system afford this principle when it acts to keep information that the public has a right to appraise secret, especially when the information is decisive—oftentimes dispositive—evidence?[6]

Today, the United States recognizes this principle generally as a collection of rights a patient has with respect to his or her physician, society, and the state.[7] And, just as in times past, we have found these rights less than absolute. U.S. jurisprudence has devoted myriad common law decisions and statutory and regulatory schemes, sometimes grounded in the amorphous legal principle of privacy, to delineate the precise contours of the promise of nondisclosure afforded to the medical patient.[8]

6. *See, e.g.*, Daniel W. Shuman, *The Origins of the Physician–Patient Privilege and Professional Secret*, 39 SW. L.J. 661, 662 (1985).

7. *Id.* at 661 n.1 (highlighting the differences between words commonly misused to convey the idea of shrouding communications in a cloak of secrecy: "Privilege, professional secret, confidentiality, secrecy, and privacy are words used to describe relationships within which certain communications are sometimes protected from disclosure. . . . Privilege is the common law term for a rule favoring privacy over probative evidence and professional secret is its civil law counterpart. Privilege and professional secret are not, however, different words describing the same thing as these doctrines differ substantially in their application. Confidentiality is the ethical duty of the professional, operating outside of the judicial setting, not to disclose confidential communications made by the patient or client. Secrecy is the expectation that a communication will not be disclosed. Privacy is the ability to control revelation of information about oneself.").

8. *See* 42 U.S.C. § 1320d-6 (2012) (establishing the elements of the offense of "[w]rongful disclosure of individually identifiable health information"); Whalen v. Roe, 429 U.S. 589, 598–600 (1977) (reaffirming that one aspect of the right of privacy "is the individual interest in avoiding disclosure of personal matters") (footnote omitted); State v. Russo, 790 A.2d 1132, 1147–48 (Conn. 2002) ("A majority of the federal Circuit Courts of Appeals have concluded this constitutionally protected right to confidentiality extends to medical information or records." (citing Herring v. Keenan, 218 F.3d 1171, 1175 (10th Cir. 2000)); Doe v. Se. Pa. Transp. Auth., 72 F.3d 1133, 1137 (3d Cir. 1995); Anderson v. Romero, 72 F.3d 518, 522 (7th Cir. 1995); Doe v. City of New York, 15 F.3d 264, 267 (2d Cir. 1994); Doe v. Attorney Gen. of the U.S., 941 F.2d 780, 795–96 (9th Cir. 1991);

B. *The Utilitarian and Deontological Approaches: Two Distinct Rationales Behind the Existence of the Privilege*

Daniel W. Shuman, a professor of law at Southern Methodist University, discusses the origins of the physician–patient privilege and identifies two distinct rationales for its existence and development over time. These rationales are referred to as the utilitarian and deontological approaches.[9] The scope of the privilege differs according to which view is applied.[10] The utilitarian approach supports a narrower view of privilege, wherein the interest of confidentiality is subordinate to the interest of full disclosure of relevant material in litigation.[11] The deontological approach places a high value on the relationship between the patient and the medical provider, "focus[ing] on the importance of societal values ensconced within a privilege, arguing that disclosure of confidences revealed in certain relationships is of itself wrong."[12] The deontologist would equate the importance of maintaining secrecy in a physician–patient relationship with other ideals we commonly associate with a democratic society, such as individualism, choice, and privacy.[13]

Neither approach is immune to criticism. Skeptics of the utilitarian approach question the efficacy of a system of privileges that is shattered merely—and often arbitrarily—through a system of pleadings and discovery that is ill-equipped to properly screen private information.[14] After all, what good is a right of privacy if it can be intruded upon by the very same parties against whom it was erected to protect? However, advocates of the utilitarian approach point to the inherent unfairness in precluding litigants from accessing all pertinent evidence relevant to their claims.

State v. Bedel, 193 N.W.2d 121, 124 (Iowa 1971).

9. Shuman, *supra* note 6, at 663–64 (citing 2 DAVID W. LOUISELL & CHRISTOPHER B. MUELLER, FEDERAL EVIDENCE § 201, at 416–17 (1978); CHARLES ALAN WRIGHT & KENNETH W. GRAHAM, FEDERAL PRACTICE AND PROCEDURE § 5422, at 670–72 (1980)).

10. *See* Shuman, *supra* note 6, at 663–64.

11. *See id.* at 663 (quoting and discussing 8 JOHN H. WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2285, at 527 (John T. McNaughton rev. ed. 1961)).

12. *Id.* at 664 (citing Daniel W. Shuman & Myron S. Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist–Patient Privilege*, 60 N.C. L. REV. 893, 906 (1982)).

13. *Id.* at 666–67.

14. *Id.* 664–67 (citing Charles L. Black, Jr., *The Marital and Physician Privileges—A Reprint of a Letter to a Congressman*, 24 DUKE L.J. 45, 49–51 (1975)).

In order for the privilege to pass muster in the utilitarian's view, a balancing test must be employed:

> (1) The communications must originate in a *confidence* that they will not be disclosed.
>
> (2) The 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 communications must be *greater than the benefit* thereby gained for the correct disposal of the litigation.[15]

Dean John Wigmore, a legal scholar with an expertise in evidentiary law and principles, perhaps not surprisingly, calls for the adoption of basic evidentiary principles favoring admissibility of relevant information.[16] Detractors of this view respond in turn by pointing to the absence of any evidence indicating that these requirements themselves facilitate an unhindered, honest exchange between the patient and the physician.[17]

The deontological view is criticized in part for conflating privacy and democracy and in part for the unchecked faith it places in the medical profession.[18] Professor Shuman openly questions the premise that a relationship exists between privacy and democracy.[19] Citing multiple texts appraising past societies' democratic structures in relation to their degrees of personal privacy, Professor Shuman concludes these sources illustrate the inconclusiveness of the evidence on this point.[20] The professor further identifies "[t]he protection of the public from incompetent physicians, the prevention of harm that the patient has threatened to third persons or the correct adjudications of child custody questions" as creating a tension against the need for privacy.[21]

15. *Id.* at 663 (quoting 8 WIGMORE, *supra* note 11, § 2285, at 527).
16. *Id.*
17. *See id.* at 664–65.
18. *See id.* at 666.
19. *Id.* at 666–67.
20. *Id.* at 666 n.18.
21. *Id.* at 667.

As this Note explores below, the federal system and the system Iowa follows seemingly track with each of these philosophies. The remainder of this Note will provide a comparative overview of both of these systems. This Note discusses why and how the privilege, as it exists in the state of Iowa, should be strengthened and expanded—shifting the focus away from Dean Wigmore's balancing test by adopting a more deontological view with an eye toward greater recognition of personal privacy.

II. THE PHYSICIAN–PATIENT PRIVILEGE UNDER FEDERAL LAW

A. *The Federal Framework*

1. *The Federal Rules of Evidence*

In federal court, patients seeking to exclude evidence on the basis of privileged information exchanged with a healthcare provider invoke the Federal Rules of Evidence. One aspect to consider is the interplay among the federal rules, the federal common law, and state statutory privilege law. At this point, a brief examination of the language of the rule is warranted.

Under Rule 501 of the Federal Rules of Evidence, "[t]he common law—as interpreted by United States courts in the light of reason and experience—governs a claim of privilege" in nondiverse actions.[22] In a civil diversity action, however, "state law governs privilege regarding a claim or defense for which state law supplies the rule of decision."[23] This rule, in its current form, is a pressure point for federal courts wrestling with assertions of privilege in diversity cases and federal question cases involving issues of state law.[24]

The advisory committee's note to Rule 501 provides some clarity. The note states that under the current iteration of Rule 501, "in criminal and Federal question civil cases, federally evolved rules on privilege should apply since it is Federal policy which is being enforced."[25] On the other hand:

> [I]n diversity cases where the litigation in question turns on a substantive question of State law, and is brought in the Federal courts because the parties reside in different States, the committee believes it

22. FED. R. EVID. 501.
23. *Id.*
24. *See id.*
25. *Id.* advisory committee's note to 1974 enactment.

> is clear that State rules of privilege should apply unless the proof is directed at a claim or defense for which Federal law supplies the rule of decision . . . .[26]

Finally, in the event that two competing privilege laws call for opposite treatment of the same item of evidence, the committee instructs "that the rule favoring reception of the evidence should be applied."[27]

Interestingly, the advisory committee's note to Rule 501 observes that the original evidentiary rules on privilege submitted to Congress looked much different than they currently do.[28] Article V, the Article within the Federal Rules of Evidence containing privileges, is now comprised of two rules, Rules 501 and 502, concerning respectively "Privilege in General," and "Attorney-Client Privilege and Work Product; Limitations on Waiver."[29] However, as originally proposed, Article V was comprised of 13 separate rules, 9 of which contemplated "specific non-constitutional privileges" that would have been binding on the federal courts.[30] This was rejected by the committee in favor of the current structure of the rules, which echoes the spirit of Rule 26 of the Federal Rules of Criminal Procedure by calling for federal courts' "application of the principles of the common law."[31] The committee's note, however, states this formulation of the rule is not intended to "disapprov[e] any recognition of . . . the enumerated privileges contained in the Supreme Court rules."[32] Whether a testimonial privilege should apply, the committee states, "should be determined on a case-by-case basis."[33] This reflects some backtracking by the committee and creates a gray area encompassing the privileges that were originally contemplated under Article V, were thereafter abolished, and now must be incorporated into federal jurisprudence in piecemeal fashion—which is likely to occur at the expense of litigants unsure of whether their claim of privilege will be recognized in their circuit.

26. *Id.*

27. *Id.*

28. *Id.*

29. FED. R. EVID. 501; FED. R. EVID. 502.

30. *See* FED. R. EVID. 501 advisory committee's note to 1974 enactment. These privileges included "required reports, lawyer–client, psychotherapist–patient, husband–wife, communications to clergymen, political vote, trade secrets, secrets of state and other official information, and identity of informer." *Id.*

31. *See id.*

32. *Id.*

33. *Id.*

2. Federal Case Law

In *Whalen v. Roe*, the Supreme Court passed over a related question in the context of a prescription-disclosure law in the state of New York. The law classified various drugs into schedules based on factors such as potential harm or medicinal value.[34] A physician prescribing certain schedules of drugs was required under the law to deliver a copy of the prescription, detailing "the prescribing physician; the dispensing pharmacy; the drug and dosage; and the name, address, and age of the patient" to the New York State Department of Health.[35]

The physicians and patients challenged the law in federal court, alleging various constitutional violations as well as an intrusion into the physician–patient relationship and a violation of the patients' privacy rights.[36] The State appealed the Southern District of New York's ruling in favor of the plaintiffs, and the Supreme Court reversed, finding no constitutional violations.[37] In a brief footnote, the Court explained its rejection of the privilege argument as being "unknown to the common law. In states where it exists by legislative enactment, [the privilege] is subject to many exceptions and to waiver for many reasons."[38] Arguably, this is dictum separate and apart from the concept of privilege because *Whalen*'s central holding ultimately was limited to disclosure of information not in the testimonial setting; however, multiple subsequent federal decisions have cited *Whalen* for the proposition that no physician–patient privilege exists under federal law.[39] To confuse matters further, those holdings do not seem to properly consider the commentary to the federal rules either: the law at issue in *Whalen* was a state law, and application of its holding to pure federal law ignores the distinction the committee sought to create.

In 1996, however, the Supreme Court decided the case of *Jaffee v. Redmond*. In *Jaffee*, the estate of a police-shooting victim brought an action for damages in federal district court under 42 U.S.C. § 1983 and a

34. Whalen v. Roe, 429 U.S. 589, 591–92 (1977).
35. *Id.* at 593.
36. *Id.* at 596.
37. *Id.* at 591.
38. *Id.* at 602 n.28 (citations omitted).
39. *See, e.g.*, Patterson v. Caterpillar, Inc., 70 F.3d 503, 506–07 (7th Cir. 1995); *In re* Grand Jury Proceedings, 867 F.2d 562, 565 (9th Cir. 1989); United States v. Bercier, 848 F.2d 917, 920 (8th Cir. 1988).

state wrongful death statute.[40] Upon learning that Redmond, the police officer, had solicited extensive counseling following the shooting, the plaintiff sought discovery of the notes prepared by Redmond's counselor during her treatment of Redmond.[41] Both the patient and the counselor invoked the psychotherapist–patient privilege to deny any obligation to divulge the contents of the counseling sessions.[42] In response, the trial court presented the jury with an adverse inference instruction.[43] The Seventh Circuit Court of Appeals reversed and remanded for a new trial, relying on the same *reason and experience* language of Rule 501 to find the existence of a psychotherapist–patient privilege under federal law.[44] The Supreme Court affirmed.[45]

Speaking for all but Justice Antonin Scalia and Chief Justice William Rehnquist, Justice John Paul Stevens began by tracing the origin of the *in the light of reason and experience* language found in the federal rules back to an older decision of the Court, which "observ[ed] that 'the common law is not immutable but flexible, and by its own principles adapts itself to varying conditions.'"[46] Rule 501 was not intended to mark the conclusion of the development of privilege law in the federal courts; on the contrary, the rule was intended to "direct[] federal courts to 'continue the evolutionary development of testimonial privileges.'"[47]

Neither was the *Jaffee* Court insensitive to the urgent need to have all relevant evidence available during litigation. The Court observed the "general rule" disfavors testimonial privileges.[48] In certain instances, however, public policy counsels against application of this general principle.[49] The psychotherapist–patient privilege exists to solidify the relationship between the two parties, and the Court recognized "[t]he mental health of our citizenry, no less than its physical health, is a public

40. Jaffee v. Redmond, 518 U.S. 1, 4–5 (1996).

41. *Id.* at 5.

42. *Id.*

43. *Id.* at 5–6.

44. *Id.* (quoting Jaffee v. Redmond, 51 F.3d 1346, 1354–55 (7th Cir. 1995), *aff'd*, 518 U.S. 1 (1996)).

45. *Id.* at 8.

46. *Id.* (quoting Funk v. United States, 290 U.S. 371, 383 (1933)).

47. *Id.* at 8–9 (quoting Trammel v. United States, 445 U.S. 40, 47 (1980)).

48. *Id.* at 9.

49. *Id.* at 11 ("[A]n asserted privilege must also 'serv[e] public ends.'" (quoting Upjohn Co. v. United States, 449 U.S. 383, 389 (1981))).

good of transcendent importance."[50] Importantly, the Court strongly disclaimed any application of a balancing-style test to determine whether the contents of the counseling sessions deserved privilege.[51] The Court looked to *Upjohn Co. v. United States*, a landmark decision in the area of attorney–client privilege law, one of the most robust privileges in existence, for the notion that "[a]n uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all."[52]

B. *Expansion of the Federal Privilege Law*

Federal privilege jurisprudence is wrought with confusion and differing applications based on the type of privilege, the nature of the claims and defenses presented, the identity of the parties, and the particular circuit where the case is brought. The holding of *Jaffee* should be extended to encompass more privileges. The reasons for such a strong respect for the psychotherapist–patient privilege apply with equal force to other privileges, in particular the general physician–patient privilege.

For instance, *Jaffee* identifies one of the reasons the courts ought to give heightened treatment to the psychotherapist–patient relationship—as opposed to the physician–patient relationship—is the risk to the patient that disclosure of the substance of the treatment by the psychotherapist "may cause embarrassment or disgrace."[53] Such a concern is not exclusive to those seeking the treatment of a psychotherapist or counselor; it is reasonable to assume that many discussions individuals hold with their physicians can present the same risks to the patients.

Jaffee plainly disagrees and places various privileged relationships into two categories: those "rooted in the imperative need for confidence and trust" and those which "can often proceed successfully" absent confidentiality and trust.[54] The Court categorized the physician–patient relationship in the latter group.[55] The Court did not pause to consider just how often, or with what degree of success, treatment can "proceed successfully" without relying on a mutual understanding of "confidence and

50. *Id.* (footnote omitted).
51. *Id.* at 17.
52. *Id.* at 17–18 (quoting *Upjohn Co.*, 449 U.S. at 393).
53. *Id.* at 10.
54. *Id.* (quoting Trammel v. United States, 445 U.S. 40, 51 (1980)).
55. *Id.* at 1.

trust."[56] In essence, the Court embedded the same balancing test it earlier strayed away from with its admonition that "uncertain[ty]" in this area "is little better than no privilege at all."[57]

However, courts in general should not be in the business of scrutinizing the relationships that exist between a physician and his or her patient in order to determine whether the object of the relationship can be successfully realized in the public eye or whether it would better function in confidence. And although the Court is correct that oftentimes treatment can be successfully accomplished without the need for the patient and the physician to communicate, this does not in turn mean that the physician–patient relationship is any less deserving of an absolute privilege. To say so would be to value the concerns of a patient suffering from mental or emotional trauma more so than a patient requiring physical treatment. This is problematic even under the language of *Jaffee* itself, which suggested both the physical and mental health of our citizenry are of equal importance.[58]

To stay true to the promise that society values our citizenry's physical and mental health equally, the federal system should move away from the slow and reactionary development of privilege law in the federal courts by proactively adjusting back to a system similar to that envisioned by the Supreme Court when it submitted Article V detailing nine separate privileges. Although this would entail a more cumbersome Article V, the benefits would include clarity moving forward for litigants and the establishment of a stronger privilege law enshrined in the black-letter language of the Federal Rules, rather than subjecting litigants to differing applications of the privilege across the circuits.

III. THE PRIVILEGE AS APPLIED IN IOWA TODAY

A. *The Nature and Purpose of the Physician–Patient Privilege as Stated by the Iowa Supreme Court and the Iowa Legislature*

1. *The Purpose of the Privilege*

As with most other state jurisdictions, the physician–patient privilege in Iowa is a creature of statute.[59] Medical patients in the state of Iowa can

56. *See id.* at 10 (quoting *Trammel*, 445 U.S. at 51).
57. *See id.* at 18 (quoting *Upjohn Co.*, 449 U.S. at 393).
58. *Id.* at 11.
59. IOWA CODE § 622.10 (2017).

avail themselves of a physician–patient privilege that has the purpose of "foster[ing] free and full communication between the physician and the patient in diagnosis or treatment of the patient's ills."[60] Such a purpose echoes the fundamentals of the utilitarian school, counseling that confidentiality must be "essential to the fulfilment of the relationship."[61] This reflects the desire of both the Iowa courts and legislature to recognize the existence of the privilege only to the extent it creates a setting conducive to the provision of medical care; the intrinsic value of privacy does not appear to serve as a basis for this privilege in Iowa.[62]

Notably, however, the Iowa Supreme Court has held, "[T]he statute creating the privilege is to be liberally construed to carry out its purpose."[63] Such a charge is a viable premise upon which to justify an expansion of the privilege; advocating for a liberal construction suggests the court is not unwilling to entertain plausible justifications for a more expansive reading of the privilege.[64]

2. *The Nature of the Privilege*

The language of the statute dictates:

> A practicing attorney, counselor, physician, surgeon, physician assistant, advanced registered nurse practitioner, mental health professional, or the stenographer or confidential clerk of any such person, who obtains information by reason of the person's employment, or a member of the clergy shall not be allowed, in giving testimony, to disclose any confidential communication properly entrusted to the person . . . to discharge the functions of the person's office according to the usual course of practice or discipline.[65]

60. State v. Bedel, 193 N.W.2d 121, 124 (Iowa 1971).

61. Shuman, *supra* note 6, at 663.

62. *See id.* at 664 (identifying the necessary assumptions that must be made in order to substantiate the utilitarian approach to privilege, which the current Iowa privilege model appears to abide by: "the patient is aware of the applicable law of privilege and considers that law before consulting with a physician, but also that the patient would avoid treatment or withhold information necessary for effective treatment in the absence of a privilege"); *see also Bedel*, 193 N.W.2d at 124.

63. *Bedel*, 193 N.W.2d at 124.

64. *See id.*

65. IOWA CODE § 622.10(1) (2017).

Similar to the federal scheme, the privilege only applies in the testimonial setting.[66] Iowa defines *testimony* as statements made "in court or during a deposition."[67] Additionally, it is well-established under Iowa precedent that a claim of physician–patient privilege must be supported by a showing of three elements: "(1) the relationship of doctor-patient; (2) the acquisition of the information or knowledge during this relationship; and (3) the necessity of the information to enable the physician to treat the patient skillfully."[68] The final element has been given great import in the Iowa decisions calling for its interpretation.[69]

While not as litigation-centric as the Wigmore requirements, these elements still require an evaluation of the content of the communications.[70] The showing of necessity under the final element is particularly troublesome to a deontologist or one who places inherent value in the notion of privacy in the treating room. The deontologist would turn the tables, requiring that the opponent of the privilege is the one burdened with a showing of necessity before the privilege is violated.[71] It is important to note that the patient may waive this privilege.[72] As it stands, waiver can occur expressly, or "by the defendant's disclosure or consent to disclosure of the privileged information."[73]

66. *See* Roosevelt Hotel L.P. v. Sweeney, 394 N.W.2d 353, 355 (Iowa 1986).

67. *Id.* (citing *In re* Burcham's Estate, 235 N.W. 764, 766 (Iowa 1931)).

68. Snethen v. State, 308 N.W.2d 11, 14 (Iowa 1981) (citing State v. Cole, 295 N.W.2d 29, 32 (Iowa 1980); State v. Nowlin, 244 N.W.2d 596, 602 (Iowa 1976); State v. Dist. Court, 218 N.W.2d 641, 643 (Iowa 1974)).

69. *Bedel*, 193 N.W.2d at 124 ("While we do not require that the physician actually see and examine the patient for privilege to exist, it is absolutely essential that the communication, alleged to be privileged, was related to the medical diagnosis or treatment of the patient.").

70. *Compare* Shuman, *supra* note 6, at 663–64, *with Bedel*, 193 N.W.2d at 124.

71. Shuman, *supra* note 6, at 665 (citing James A. Gardner, *A Re-Evaluation of the Attorney–Client Privilege (Part II)*, 8 VILL L. REV. 447, 480 (1963)) ("[S]ociety should recognize the dignity of the individual by protecting the extremely personal physician-patient relationship from unnecessary intrusions.").

72. Clay v. Woodbury County, 965 F. Supp. 2d 1055, 1058 (N.D. Iowa 2013).

73. State v. Demaray, 704 N.W.2d 60, 65 (Iowa 2005) (citations omitted) (citing several Iowa appellate decisions and an evidence treatise in support of the proposition that a defendant–patient's disclosure to law enforcement of ordinarily confidential information constitutes a waiver of any interest in confidentiality as to said information going forward in a subsequent criminal proceeding).

3. *The Patient–Litigant Exception*

The Iowa Code contemplates one major caveat to the physician–patient privilege. The privilege does not attach:

> [I]n a civil action in which the condition of the person in whose favor the prohibition is made is an element or factor of the claim or defense of the person or of any party claiming through or under the person. The evidence is admissible upon trial of the action only as it relates to the condition alleged.[74]

Courts construing this provision have opined that its "purpose . . . 'is to prevent the patient from using the privilege to suppress evidence after the patient has frustrated the purpose of the privilege by introducing evidence on his or her own medical condition.'"[75] Once a patient–litigant has made health status "an element or factor of the claim or defense," equity and fairness dictate that the opposing party should be able to evaluate all the evidence on that point such that the party may be able to adequately present a claim or defense.[76] By all accounts, this is a reasonable and necessary exception to the privilege and should always be recognized.

The Iowa Supreme Court had occasion to discuss this method of waiver in *Fagen v. Grand View University*. In that case, the plaintiff brought a tort action seeking damages stemming from the mental anguish he suffered when he was the victim of a bullying incident at a college that shattered his jaw.[77] The defendant sought production of certain mental-health records in connection with some past treatment the plaintiff received, and the plaintiff resisted, invoking Iowa's statutory privilege law.[78] The Iowa Supreme Court was asked to determine whether "a tortfeasor in a civil case is entitled to a signed patient's waiver from the injured party to obtain that party's mental health records when he or she alleges in the petition a claim for mental disability or mental distress."[79] The court reversed the trial court's order compelling the plaintiff to comply with the waiver request.[80]

74. IOWA CODE § 622.10(2) (2017).

75. *Clay*, 965 F. Supp. 2d at 1058 (quoting *In re* Marriage of Hutchinson, 588 N.W.2d 442, 447 (Iowa 1999)).

76. IOWA CODE § 622.10(2); *see Clay*, 965 F. Supp. 2d at 1059.

77. Fagen v. Grand View Univ., 861 N.W.2d 825, 828 (Iowa 2015).

78. *Id.* at 829.

79. *Id.*

80. *Id.* at 836.

The court declined to follow the absolutist path of *Jaffee*.[81] The divergence from the federal scheme is also more substantive in nature and more problematic: the *Fagen* court "adopt[ed] a protocol balancing a patient's right to privacy . . . against a tortfeasor's right to present evidence."[82] This is a marked departure from *Jaffee*, in which the United States Supreme Court disapproved of balancing tests to determine whether a privilege ought to attach.[83] The *Fagen* court looked to an earlier decision holding the physician–patient privilege is still subject to the "societal need for information, and a *compelling need for information* may override the privacy interest."[84]

This presents an interesting tension between the federal scheme and the approach taken in Iowa. Under *Jaffee*, it was the public interest in a healthy citizenry that ultimately prevailed; in Iowa, under *Fagen*, the need for information is the controlling principle.

4. *Waiver Due to the Presence of a Third Party*

Yet another exception Iowa has imposed on the physician–patient privilege is the waiver of privilege due to the presence of a third party. The idea behind this waiver is that by communicating with the physician in another's presence, the patient is impliedly asserting the communications are not intended to be confidential.

However, the presence of a third party is not a per se defeat of confidentiality. The Iowa Supreme Court has recognized at least one instance wherein the presence of a third party was not deemed to waive privilege.[85] This requires a determination of whether the third party's presence was necessary for the physician to effectuate the treatment.[86] In *State v. Deases*, two inmates were involved in a fatal altercation involving a prison shank.[87] Following the altercation, the survivor–defendant sought treatment from the prison nurse, who attended the defendant in the presence

81. *See id.* at 832.

82. *Id.* at 828.

83. *See* Jaffee v. Redmond, 518 U.S. 1, 17 (1996).

84. *Fagen*, 861 N.W.2d at 830–31 (quoting McMaster v. Iowa Bd. of Psychology Exam'rs, 509 N.W.2d 754, 759 (Iowa 1993)).

85. *See* State v. Deases, 518 N.W.2d 784, 788 (Iowa 1994).

86. *See id.* at 787.

87. *Id.* at 786.

of prison guards.[88] In the course of treatment, the nurse asked the defendant where he obtained the shank in order to determine whether the defendant had exposed himself to the risk of infection.[89] The State sought to use the defendant's reply in trial.[90] Rejecting the State's claim that privilege had been waived, the Iowa Supreme Court held:

> [T]he presence of a third person during an otherwise confidential communication does not automatically destroy privilege. If the third person is present to assist the physician in some way or the third person's presence is necessary to enable the defendant to obtain treatment, then the privilege protects confidential communications made in the presence of the third person.[91]

Specifically applying this test to the facts, the court found the prison guards "were not casual observers" but rather "were there for security."[92] The determination of whether a third party's presence is necessary under the meaning of *Deases* is subject to some degree of variability.

B. *Issues in the Application of State Privilege Law*

One can imagine, for instance, a scenario wherein an emergency healthcare responder is providing medical care to a victim of a vehicle collision at the scene of a deadly accident. Assume further that this site is populated with law enforcement, ensuring the safety of the perimeter, taking photographs, and acting pursuant to their general caretaking protocol. Does *Deases* dictate that law enforcement's presence at the accident site is necessary to the emergency responder's provision of emergency care?

The answer would seem to be yes. A case can be made that law enforcement is ensuring the safety of all those in the accident area from oncoming traffic and from hazardous debris that may be scattered in the vicinity; virtually any of the functions of law enforcement at the scene of a crash can be understood to assist all those present or, at the very least, to provide security, which is exactly what the prison guards were present for in *Deases*. The next logical inquiry is how liberally Iowa courts are willing to apply this exception.

88. *Id.* at 786–87.
89. *Id.* at 787.
90. *Id.* at 786.
91. *Id.* at 788.
92. *Id.*

Interestingly, the Iowa Supreme Court has not yet given a precise definition of what *necessary* means in this context. It is proper at this point to turn back to the *State v. Bedel* decision, wherein the supreme court endorsed a liberal construction of our privilege statute.[93] When the purpose behind the third party's presence is contested, Iowa courts should favor recognition of the privilege. This is consistent with the spirit of *Bedel*.

Taking a step back, a survey of the landscape of privileged communications under Iowa law is anything but absolute. While the patient–litigant exception undoubtedly serves an important function, its absence would compromise the integrity of the judicial system. Removing such an exception would cause uncertainty for patients in the treating room and for their attorneys thereafter.

IV. CONCLUSION

In conclusion, the physician–patient privilege today is nowhere near uniform. The federal approach to the physician–patient privilege is still currently under development, and the Supreme Court prefers it that way. At its core, though, privileges seem to be given more respect in the federal courts—once it is established that they exist to begin with, that is. In Iowa, by contrast, the legislature determines by statute whether a privileged relationship even exists, and the Iowa Supreme Court seems quite wary of its effect on the state judicial system.

Iowa should revisit *Jaffee* and its progeny and reconsider the impact a judicial balancing test conducted after the fact may have on patients' relationships with their healthcare providers. The Supreme Court got it right when it observed that a weak privilege, or one riddled with caveats, provides minimal utility. A strong, absolute privilege commands the support of the ideals of privacy and frank communication—the former being deeply ingrained in our nation's jurisprudence and the latter being a fundamental requirement of effective medical treatment recognized long before this nation's existence.

It is also worth noting that the statute creating privilege in Iowa does not distinguish between communications made to a physician and those made to a psychotherapist. Provided the elements are established, the privilege attaches. In this respect, the privilege is more robust than its federal counterpart, which places an artificial premium on communications made in

93. State v. Bedel, 193 N.W.2d 121, 124 (Iowa 1971).

furtherance of mental therapy. Uniformity between the state and federal systems on this point would do away with this problematic distinction.

In sum, patients, physicians, attorneys, and judges alike would benefit from a consistent, clear, and strong physician–patient privilege subject to waiver only by express consent or under the most compelling circumstances. Establishing protections to that effect, embodied in evidentiary rules, is the first step in the right direction.

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