We Might Be On (to) Something, but Who Knows? A Fresh Look at the Pharmacist-Patient Privilege

Michael Moberly

Follow this and additional works at: https://digitalcommons.law.umaryland.edu/jhclp

Recommended Citation
Michael Moberly, We Might Be On (to) Something, but Who Knows? A Fresh Look at the Pharmacist-Patient Privilege, 27 J. Health Care L. & Pol’y (2024).
Available at: https://digitalcommons.law.umaryland.edu/jhclp/vol27/iss2/3

This Article is brought to you for free and open access by the Academic Journals at DigitalCommons@UM Carey Law. It has been accepted for inclusion in Journal of Health Care Law and Policy by an authorized editor of DigitalCommons@UM Carey Law. For more information, please contact smccarty@law.umaryland.edu.
WE MIGHT BE ON (TO) SOMETHING, 
BUT WHO KNOWS? 
A FRESH LOOK AT THE 
PHARMACIST-PATIENT PRIVILEGE

MICHAEL D. MOBERLY*

Abstract

This Article will advocate for broader recognition of the pharmacist-patient evidentiary privilege that currently exists in only a handful of states. The Article will discuss the lack of common law support for the privilege, as well as its recent legislative adoption in a few states. The Article also will examine the privilege’s similarity to the widely recognized physician-patient privilege, arguing that confidentiality is as essential to the relationship between patients and their pharmacists as it is to the relationship between patients and their doctors. Because complete confidentiality in these relationships is only assured if they are protected by an evidentiary privilege, the Article will conclude that states that recognize the physician-patient privilege also should recognize a comparable pharmacist-patient privilege.

* B.B.A., J.D., University of Iowa; Attorney, Clark Hill, Phoenix, Arizona. The views expressed in this article are those of the author and do not necessarily reflect the official views of Clark Hill.
INTRODUCTION

The American justice system is designed to ascertain the truth underlying litigated disputes. To that end, courts have long held that the public, and therefore private litigants, are presumptively entitled to “every person’s evidence.” When called upon, all potential witnesses possess a corresponding obligation to appear and provide testimony. These corollary principles are based on the proposition that full disclosure of the facts in a judicial proceeding is most likely to reveal the truth and ultimately lead to a just result.

Despite the importance of the courts’ truth-seeking function, American law recognizes a number of evidentiary “privileges.” Most of these privileges

1. See Tasby v. United States, 504 F.2d 332, 336 (8th Cir. 1974) (“The foundation of our adversary system is the search to elicit the truth from witnesses concerning factual occurrences.”); In re Miller, 584 S.E.2d 772, 785 (N.C. 2003) (stating that “the primary goal of our adversarial system of justice is to ascertain the truth in any legal proceeding”).


4. See Shannon ex rel. Shannon v. Hansen, 469 N.W.2d 412, 415 (Iowa 1991) (discussing “the fundamental principle that ordinarily a private litigant is entitled to discover and use every person’s evidence”).

5. See United States v. Hively, 202 F. Supp. 2d 886, 889 (E.D. Ark. 2002) (“The general principle obligating all witnesses to appear and provide relevant testimony is well established in the law.”); Schlossberg v. Jersey City Sewerage Auth., 104 A.2d 662, 669 (N.J. 1954) (“[T]he duty owed by every witness . . . to aid in the quest for truth in the administration of justice makes it compulsory that he appear and produce documentary evidence in his possession and, if required, to testify concerning it.”).

6. See State v. Gilbert, 326 N.W.2d 744, 746 (Wis. 1982) (discussing principle that public has a right to every person’s evidence “and its corollary—that each person has a duty to testify”); cf. Berst v. Chipman, 653 P.2d 107, 114 (Kan. 1982) (“It is an oft-quoted doctrine that the public has a right to every man’s evidence; there is a general duty to give what information one is capable of . . . .” (citing 8 JOHN HENRY Wigmore, EVIDENCE IN TRIALS AT COMMON LAW § 2192, at 70 (McNaughton rev. ed. 1961))).

7. See In re Selser, 105 A.2d 395, 401 (N.J. 1954) (“[T]he fundamental theory of our judicial system [is] that the fullest disclosure of the facts will best lead to the truth and ultimately to the triumph of justice.”); Glenn v. Plante, 676 N.W.2d 413, 419 (Wis. 2004) (“At its core, the adversary system is based upon the proposition that an examination of all of the persons possessing relevant information, which will lead to the discovery of all of the relevant facts, will produce a just result.”).

8. See Physicians Healthsource, Inc. v. Allscripts Health Sols., Inc., 254 F. Supp. 3d 1007, 1024 (N.D. Ill. 2017) (indicating that “the truth seeking process is perhaps the court’s most important function” (citing Cassidy v. Cassidy, 923 F.2d 856 (7th Cir. 1991))); Gaumond v. Trinity Repertory Co., 909 A.2d 512, 516–17 (R.I. 2006) (stating that “the primary function of the judicial process indisputably is truth-seeking”). But see Morrison v. State, 845 S.W.2d 882, 884 (Tex. Crim. App. 1992) (“While we recognize that the search for truth is an integral part of the adversary process, other equally prominent features characterize our system.”).

9. See Sultan v. State Bd. of Examiners of Practicing Psychs., 468 S.E.2d 443, 446 (N.C. Ct. App. 1996) (“An evidentiary privilege is a law that permits a person to prevent a court from requiring revelation
protect the confidentiality of communications between laypersons and professionals. 10 When applicable, 11 evidentiary privileges enable (and sometimes require) 12 potential witnesses to refuse to testify or produce other evidence in judicial proceedings. 13 Thus, privileges operate as exceptions to the public’s right to every person’s evidence. 14 Rather than furthering the justice of relational communications.” (quoting Daniel W. Shuman & Myron S. Weiner, The Privilege Study: An Empirical Examination of the Psychotherapist–Patient Privilege, 60 N.C. L. REV. 893, 912 (1982)); cf. Borgwardt v. Redlin, 538 N.W.2d 581, 584 (Wis. Ct. App. 1995) (stating that “parties in litigation are entitled to every person’s evidence, except when a person from whom evidence is sought has a privilege not to give evidence”). See generally Int’l Union, UAW v. Honeywell Int’l, Inc., 300 F.R.D. 323, 328 n.3 (E.D. Mich. 2014) (“[T]ruth-seeking is not the only interest or principle at stake in litigation; if it was, there would be no need for any privileges, the very purpose of which is to protect against the disclosure of information notwithstanding its relevance.”).

10. See, e.g., Morrison v. Century Eng’g., 434 N.W.2d 874, 876 n.2 (Iowa 1989) (“Section 622.10 [of the Iowa Code] establishes a general evidentiary privilege for confidential communications within various professional relationships, including that of physician-patient.”); see also Lowy v. PeaceHealth, 280 P.3d 1078, 1086 (Wash. 2012) (stating that “the attorney-client, physician-patient, and clergy-penitent privileges are all founded on the premise that the relationship is so important that the law is willing to sacrifice its pursuit for the truth”). See generally Coulter v. Rosenblum, 682 A.2d 838, 840 (Pa. Super. Ct. 1996) (recognizing “the crucial role that uninhibited speech, fostered by privilege, plays in professional relationships”).


12. The person entitled to assert a privilege, commonly referred to as the “holder” of the privilege, is not necessarily or perhaps even typically the person from whom testimony or other evidence is sought. See In re Sealed Case, 754 F.2d 395, 399 (D.C. Cir. 1985) (discussing “cases where the person subpoenaed is not the holder of a privilege”). A potential witness who is not the privilege holder cannot disclose information protected by the privilege if the privilege holder objects to the disclosure. See Hartsock v. Good year Dunlop Tires N. Am. Ltd., 813 S.E.2d 696, 703 (S.C. 2018) (Few, J., dissenting) (“[T]he concept of ‘privilege’ places the determination of whether to produce information in the hands of the holder of the privilege.”).

13. See In re Kevork, 634 F. Supp. 1002, 1006 (C.D. Cal. 1985) (“The traditional definition of an evidentiary privilege is a rule giving a person a right, inter alia, to refuse to disclose information, or to prevent someone else from disclosing the information, to a tribunal that would otherwise be entitled to demand and make use of that information in performing its assigned function.” (citing 23 CHARLES ALAN WRIGHT & KENNETH W. GRAHAM, FEDERAL PRACTICE AND PROCEDURE § 5422, at 667 (1977)), aff’d, 788 F.2d 566 (9th Cir. 1986); State v. Britley, 251 A.2d 442, 446 (N.J. 1969) (observing that privileges “enable a person to prevent another from testifying against him or . . . permit him to decline to testify himself”).

14. See D.C. v. S.A., 687 N.E.2d 1032, 1038 (Ill. 1997) (“[P]rivileges are an exception to the general rule that the public has a right to every person’s evidence.”), State v. Schmidt, 884 N.W.2d 510, 520 (Wis. Ct. App. 2016) (“A fundamental tenet of our legal system is that the public has a right to every person’s evidence . . . . Privileges are therefore the exception, not the rule.”).
system’s search for truth, privileges are intended to foster communications deemed essential to the proper functioning of protected relationships. In other words, unlike other evidence rules designed to facilitate the judicial search for truth, privileges “further public policies and protect primary conduct extrinsic to the judicial process.”

The physician-patient privilege, recognized in most states (but not under federal law), enables patients to prevent their treating physicians from testifying to or otherwise revealing confidential information about patient

15. See D.C., 687 N.E.2d at 1038 (“Privileges which protect certain matters from disclosure are not designed to promote the truth-seeking process, but rather to protect some outside interest other than the ascertainment of truth at trial.”); State v. Serrano, 210 P.3d 892, 900 n.6 (Or. 2009) (“[E]videntiary privileges . . . are distinguishable from most other evidentiary rules in that they are designed to limit the search for truth rather than facilitate its discovery.”).

16. See Commonwealth v. Chauvin, 316 S.W.3d 279, 302 (Ky. 2010) (Abramson, J., dissenting) (asserting that privileges are intended “to protect certain relationships that depend, if their full benefits are to be realized, on frank and unfettered communication”); Serrano, 210 P.3d at 900 n.6 (“Generally speaking, the purpose of the evidentiary privileges is to encourage open communication between the persons in the protected relationship, which theoretically, in turn, strengthens that relationship and encourages participation in such relationships.”); Richard M. Mosk & Tom Ginsburg, Evidentiary Privileges in International Arbitration, 50 INT’L & COMPARE. L.Q. 345, 350 (2001) (“[A]ll professional privileges have the same rationale—to encourage open communications between professionals and those with whom they have a professional relationship.”).

17. See, e.g., State ex rel. State Highway Dep’t v. 62.96247 Acres of Land, 193 A.2d 799, 806 (Del. Super. Ct. 1963) (“There are many exclusionary rules of evidence that are intended to withhold evidence which is regarded as unreliable or regarded as prejudicial or misleading, but rules of privileged communications have no such purpose.”); People v. Sanders, 457 N.E.2d 1241, 1245 (Ill. 1983) (noting that evidentiary privileges “are distinct from evidentiary rules, such as the protection against hearsay testimony, which promote [the truth-seeking] function by insuring the quality of the evidence which is presented”).


19. See, e.g., Crawford ex rel. Goodyear v. Care Concepts, Inc., 625 N.W.2d 876, 881 n.4 (Wis. 2001) (“In this opinion, the privilege will be referred to as the physician-patient privilege, as it is widely known.”). The privilege “is also known as the doctor-patient and the patient-physician privilege.” David B. Canning, Comment, Privileged Communications in Ohio and What’s New on the Horizon: Ohio House Bill 52 Accountant-Client Privilege, 31 AKRON L. REV. 505, 522 n.58 (1998).

health. Like other evidentiary privileges, this physician-patient privilege is not intended to facilitate the judicial search for truth. The privilege instead is intended to encourage patients to make complete and candid disclosures of their medical conditions to their physicians (and at least in some states, to other health care professionals) so physicians can properly diagnose and treat those conditions.

The physician-patient privilege is premised on the assumption that patients would be less forthcoming if the information they disclose to their health care providers might be revealed in subsequent judicial proceedings. As one court explained:

The rationale of this privilege is to promote health by encouraging a patient to fully and freely disclose all relevant information which may assist the physician in treating the patient. If the patient feared that such information could be revealed by the treating doctor, the patient


22. See Diaz v. Eighth Jud. Dist. Ct., 993 P.2d 50, 57 (Nev. 2000) (“Privileges relating to confidential communications, such as those between attorney and client, between doctor and patient, and between spouses, . . . are not designed or intended to assist the fact-finding process or to uphold its integrity.”).


24. See, e.g., State v. Post, 541 N.W.2d 115, 134 (Wis. 1995) (asserting that Wisconsin’s physician-patient privilege “prevents the use in court of confidential communications by a patient to any treatment provider” (construing Wis. Stat. § 905.04(2))); see also Duronslet v. Kamps, 137 Cal. Rptr. 3d 756, 770 (Ct. App. 2012) (“In some states, the physician-patient privilege specifically includes . . . other medical personnel.”).

25. See Miller v. Miller, 161 So. 3d 690, 694 (La. Ct. App. 2014) (“The primary purpose of the privilege is to encourage patients to fully disclose their problems, symptoms, concerns, and reasons for seeking treatment to allow the health care provider to make accurate diagnoses and provide proper treatment.”). Because the privilege is intended to enable patients to obtain proper diagnosis and treatment, it does not prevent disclosure of an individual’s communications with a non-treating physician. See, e.g., State v. Cross, 132 P.3d 80, 95 (Wash. 2006) (“Examinations that are not done for the purpose of providing treatment but instead solely for forensic purposes are ‘not within the statutory prohibitions of the doctor-patient privilege.’” (quoting State v. Sullivan, 373 P.2d 474, 479 (Wash. 1962))), abrogated on other grounds by State v. Gregory, 427 P.3d 621 (Wash. 2018).

26. See Long v. Am. Red Cross, 145 F.R.D. 658, 668 (S.D. Ohio 1993) (“[C]ertain privileges, like the attorney-client or physician-patient privilege, rest upon an assumption that people will be less likely to disclose fully their legal or medical problems to a professional if they know that such information can be freely disclosed to third parties.”); Rodriguez v. N.Y.C. Transit Auth., 574 N.Y.S.2d 505, 506 (Sup. Ct. 1991) (“It is clear, and all the cases so state, that the physician-patient privilege was created because of the belief that fear of embarrassment or disgrace flowing from communication made to a physician would deter people from seeking medical help and securing adequate diagnosis and treatment.”).
might refrain from, or be inhibited from, disclosing relevant information.27

Like physicians and many other health care professionals,28 pharmacists frequently play a pivotal role in a patient’s medical treatment.29 Thus, patients often must share with their pharmacists,30 if only through the presentation of a physician’s prescription,31 sensitive information about their health.32 Protecting the confidentiality of this information is a fundamental tenet of the pharmacy profession,33 and it would seem to be a logical corollary to, if not a component of, the physician-patient privilege.34 However, courts and legislatures show

27. Huzjak v. United States, 118 F.R.D. 61, 63 (N.D. Ohio 1987) (citation omitted); see also Prudential Ins. Co. of Am. v. Kozlowski, 276 N.W. 300, 301–02 (Wis. 1937) (“Patients may be afflicted with diseases or have vicious or uncleanly habits necessary for a physician to know in order to treat them properly. . . . which they might refrain from disclosing to a physician if the physician could be compelled to disclose them on the witness stand.”).

28. See, e.g., Clark v. United Emergency Animal Clinic, Inc., 390 F.3d 1124, 1127 (9th Cir. 2004) (noting that “physicians, podiatrists, optometrists, and dentists . . . prevent, diagnose, and treat diseases, disorders, and injuries”); see also Beach v. Lopham, 578 S.E.2d 402, 405 (Ga. 2003) (discussing an “assumption that physicians, nurses, and other medical professionals exercise due care and skill in their treatment of a patient”).


30. An individual to whom a pharmacist dispenses medication is not invariably characterized as the pharmacist’s patient. See, e.g., Suarez v. Pierard, 663 N.E.2d 1039, 1042 (Ill. App. Ct. 1996) (asserting that function of a pharmacist “is essentially that of providing a product to a customer, not providing . . . health services to a patient”). However, “a person for whom a medication has been prescribed” can be considered “a patient of the dispensing pharmacist . . . as well as the prescribing health care provider.” Landay v. Rite Aid, 40 A.3d 1280, 1284 (Pa. Super. Ct. 2012), rev’d on other grounds, 104 A.3d 1272 (Pa. 2014). Accordingly, this Article generally uses the terms “patient” and “pharmacist-patient privilege.” Cf. Correa v. Schoeck, 98 N.E.3d 191, 199 (Mass. 2018) (discussing “statutes and regulations [that] refer to those obtaining prescriptions as ‘patients’ rather than ‘customers’”).


33. See Robert A. Buurk & Louis D. Vottero, Ethical Responsibility in Pharmacy Practice 93 (2d ed. 2002) (“Of all the values associated with pharmacy practice, patient confidentiality is the most easily identified and the most prevalent.”).

34. See, e.g., Ladner v. Ladner, 436 So. 2d 1366, 1373 n.3 (Miss. 1983) (discussing legislation extending Mississippi’s physician-patient privilege “to other health care providers, such as pharmacists”
relatively little interest in protecting the relationship between patients and pharmacists,\(^{35}\) apparently because they perceive confidentiality as less essential to that relationship than to the relationship between patients and physicians.\(^{36}\)

This Article will challenge that perception\(^{37}\) and propose the adoption of a pharmacist-patient privilege throughout the states.\(^{38}\) Part I of the Article will discuss the English common law origin of American privilege law and how English and American courts do not recognize a privilege protecting communications between patients and pharmacists.\(^{39}\) Part II will examine the pharmacist’s ethical duty to maintain the confidentiality of patient information.\(^{40}\) Part III will examine cases where courts considered extending the protection of state statutory physician-patient privileges to pharmacists.\(^{41}\) Part IV will explore the potential legislative enactment of a pharmacist-patient privilege.\(^{42}\) Part V will evaluate the privilege’s potential value in the provision of health care\(^{43}\) and Part


35. See, e.g., Kohari v. Jessie, No. 2:13-CV-09072, 2014 WL 1338558, at *3 (S.D. W. Va. Apr. 3, 2014) (“[T]he State of West Virginia has not codified a pharmacist/patient privilege, nor have West Virginia courts recognized such a privilege.”); In re John Doe, Inc., 466 N.Y.S.2d 202, 204 (Sup. Ct. 1983) (“[T]here is no physician-patient privilege which encompasses pharmacists in their trade, and the legislature has not been disposed to create a new category of confidentiality applicable to pharmacists.”); see also Sharon R. Schawbel, Comment, Are You Taking Any Prescription Medication?: A Case Comment on Weld v. CVS Pharmacy, Inc., 35 NEW ENG. L. REV. 909, 963 (2001) (footnote omitted) (“Historically, the holdings have been varied with regard to a pharmacist-patient privilege, and many courts are reluctant to recognize it.”).

36. See Brenda Jones Quick, The Cost of the Omnibus Budget Reconciliation Act of 1990, 2 J. PHARMACY & L. 145, 161 (1994) (“[A]ttempts to suppress pharmaceutical records from evidence have not been successful. In almost all cases the courts have ruled against the party seeking to exclude the records from evidence, finding that they are not entitled to the same protection as the records of physicians . . . .”); Schawbel, supra note 35, at 961 (“[A]lmost all efforts to keep pharmaceutical records out of evidence have failed because the courts have found that these records are not entitled to the same confidentiality protections as those maintained by doctors.”).

37. See Fanean v. Rite Aid Corp. of Del., Inc., 984 A.2d 812, 824 (Del. Super. Ct. 2009) (holding that “a physician-patient relationship, for the purposes of confidentiality, is undertaken by the pharmacist when he or she accepts a patient”); Weld v. CVS Pharmacy, Inc., 10 Mass. L. Rptr. 217, 219 (Super. Ct. 1999) (stating that physicians and pharmacists “share an analogous relationship . . . in so far as private medical information is concerned,” and both therefore owe their patients “a duty of confidentiality”).

38. See Kimberly Craft & Angela McBride, Pharmacist-Patient Privilege, Confidentiality, and Legally-Mandated Counseling: A Legal Review, 38 J. AM. PHARM. ASS’N 374, 377 (1998) (“To protect patients’ privacy and afford them a necessary degree of comfort, the pharmacist-patient relationship, and counseling occurring within that relationship, must be granted nationwide, privileged status.”).

39. See infra Part I.
40. See infra Part II.
41. See infra Part III.
42. See infra Part IV.
43. See infra Part V.
VI will summarize judicial and scholarly debate over the privilege’s likely impact. Part VII will consider the importance of existing state physician-patient privilege statutes upon which a pharmacist-patient privilege could be modeled. The Article ultimately will conclude that jurisdictions that lack this protection should adopt a pharmacist-patient privilege as a matter of policy.

I. THERE IS NO COMMON LAW PHARMACIST-PATIENT PRIVILEGE

Privilege doctrine came to this country as part of the common law, transported here by English colonists and adopted by most American states—Louisiana is the lone exception—when they formed or subsequently joined the American colonies by Great Britain. Despite Louisiana’s civil law heritage, the courts of that state “adopted common-law procedure, [and] most of the common-law rules of evidence.”

See infra Part VI.

45. See infra Part VII.

46. See infra Conclusion.


48. See State v. Hawkins, 604 A.2d 489, 495 (Md. 1992) (“When the English colonists crossed the sea to America they brought with them the common law of England, and that law was generally recognized in the rule of the colonies by Great Britain.”); McKennon v. Winn, 33 P. 582, 584 (Okla. 1893) (“The English-speaking people brought the common law to America with them, in the first settlement of the colonies . . . .”). For a scholarly discussion of the common law’s application in colonial America, see generally William B. Stoebeck, Reception of English Common Law in the American Colonies, 10 WM. & MARY L. REV. 393 (1968).


50. See Haines v. Liggett Group Inc., 975 F.2d 81, 93 (3d Cir. 1992) (describing Louisiana as “the sole civil law jurisdiction in this country”); Bouis v. Aetna Cas. & Sur. Co., 98 F. Supp. 176, 177 (W.D. La. 1951) (discussing common law “as understood and inherited from England in states other than Louisiana”). Despite Louisiana’s civil law heritage, the courts of that state “adopted common-law procedure, [and] most of the common-law rules of evidence.” Jean-Louis Baudouin, The Impact of the Common Law on the Civilian Systems of Louisiana and Quebec, in THE ROLE OF JUDICIAL DECISIONS AND DOCTRINE IN CIVIL LAW AND IN MIXED JURISDICTIONS 1, 8 (Joseph Dainow ed., 1974). Thus, for example, “in analyzing the attorney-client privilege, Louisiana courts have relied on common law authorities.” State v. Montgomery, 499 So. 2d 709, 711 (La. Ct. App. 1986); see also State v. Taylor, 642 So. 2d 160, 163 (La. 1994) (“The spousal witness privilege in Louisiana has a long history and can be traced to the common law.”)

51. See Elwood v. City of New York, 450 F. Supp. 846, 866 (S.D.N.Y. 1978) (“Most of the original states adopted the common law of England as received and applied in their jurisdiction under colonial rule.”), rev’d on other grounds sub nom. Badgley v. City of New York, 606 F.2d 358 (2d Cir. 1979); State
the Union. The concept of a common law privilege arose in England in response to the courts’ authority to compel witnesses to testify. Although this authority did not exist until the sixteenth century, as all witness testimony was voluntary (or effectively prohibited) prior to that time, the authority to compel


52. See, e.g., Ex parte Beville, 50 So. 685, 687 (Fla. 1909) (“The common law as it existed in England prior to 1776 is in force in this state by statute”); Quarles v. Sutherland, 389 S.W.2d 249, 250 (Tenn. 1965) (“The common law of England, as it stood at and before the separation of the colonies, has been adopted by the State of Tennessee, being derived from North Carolina, out of which state the State of Tennessee was carved.”); Sands v. Whitnall Sch. Dist., 754 N.W.2d 439, 469 (Wis. 2008) (Prosser, J., dissenting) (stating that “pre-statehood common law, including the common law of evidentiary privileges, continues as part of the law of Wisconsin” (construing Wis. Const. art. XIV, § 13)); see also Johnson v. Union Pac. Coal Co., 76 P. 1089, 1092 (Utah 1904) (“The lex non scripta, or common law, of England, was brought over to the American colonies by our ancestors, and was adopted by them so far as applicable to their new conditions, and has been adopted by most of the states in the Union . . . .”).

53. See Howe v. Detroit Free Press, Inc., 487 N.W.2d 374, 386 (Mich. 1992) (Boyle, J., concurring in part and dissenting in part) (“At common law, the rules of privilege were developed as a protection against the court’s power to compel testimony.”); Appel, supra note 34, at 2 (“The origins of testimonial privileges at common law are directly connected to the creation of rules that compelled the appearance of witnesses at trial . . . . Only after the general principle of compulsory testimony was established did such privileges become necessary.”); Kevin Hopkins, Blood, Sweat, and Tears: Toward a New Paradigm for Protecting Donor Privilege, 7 VA. J. SOC. POL’Y & L. 141, 175 (2000) (footnote omitted) (“Evidentiary privileges originated with the imposition of compulsory process in Elizabethan England. The concept arose when reliance on witnesses led to the establishment of a universal duty to testify.”).

54. See Sorrells v. Cole, 141 S.E.2d 193, 198 n.4 (Ga. Ct. App. 1965) (“It was not until the late sixteenth century that compulsory process was available in the common law courts of England to compel the attendance of disinterested witnesses.”); In re Marshall, 805 N.W.2d 145, 151 (Iowa 2011) (“Common law in the fifteenth century did not recognize the right to compel a witness to testify in criminal proceedings. Over time, however, the common law evolved to the point where witnesses had a duty to testify and could be compelled to do so.”).


56. See Gecas, 120 F.3d at 1441 (stating that “all nonparty witness testimony was voluntary until the mid-sixteenth century”); Appel, supra note 34, at 2 (discussing Perjury Act, 1562, 5 Eliz. 9 §§ 1-6 (Eng.)) (“Prior to the passage of the Perjury Act of 1562, privileges were superfluous, as unwilling witnesses could simply refuse to appear in court.”); Stephen Landsman, A Brief Survey of the Development of the Adversary System, 44 OHIO ST. L.J. 713, 726 (1983) (“Through the fifteenth century . . . voluntary testimony was viewed with suspicion, and witnesses could not be compelled to testify against their will.”); Booth, supra note 55, at 1176 (“The witness was not welcomed in court or required to testify before 1562.”).
witness testimony was nevertheless part of the common law transported to the American colonies and ultimately adopted by the states.

However, apart from an early version of the attorney-client privilege, English common law recognized very few evidentiary privileges. No privilege protecting confidential communications between patients and pharmacists existed under the common law. Indeed, neither the English, nor the American

57. See Gecas, 120 F.3d at 1451 (“Just as in England, colonial courts could . . . compel the attendance of . . . witnesses for examination.”); Commonwealth ex rel. Chidsey v. Mallen, 63 A.2d 49, 52 n.4 (Pa. 1949) (citations omitted) (“Testimony was compelled in England and in the Colonies before our constitutions were adopted.”).

58. See Garland v. Torre, 259 F.2d 545, 549 (2d Cir. 1958) (“[A]t the foundation of the Republic the obligation of a witness to testify and the correlative right of a litigant to enlist judicial compulsion of testimony were recognized as incidents of the judicial power of the United States.”); United States v. Collins, 603 F. Supp. 301, 303 (S.D. Fla. 1985) (discussing “inclusion by the Framers of the right to compulsory process in the Bill of Rights”); Milton Hirsch, “The Voice of Adjuration”: The Sixth Amendment Right to Compulsory Process Fifty Years After United States ex rel. Touhy v. Ragen, 30 F.L.A. St. U. L. REV. 81, 85 (2002) (footnote omitted) (“Although a relative latecomer to the common law, the compulsory process power was well-recognized in early America, earning a place in the national Constitution as well as the constitutions of most states.”).

59. See United Jersey Bank v. Wolosoff, 483 A.2d 821, 825 (N.J. Super. Ct. App. Div. 1984) (“The attorney-client privilege is deeply embedded in our jurisprudence and formed a part of the common law of England prior to the birth of this country.”). The original common law privilege differed from its modern American counterpart in at least one important respect. See In re Grand Jury Proceedings, 87 F.3d 377, 381 n.5 (9th Cir. 1996) (citation omitted) (“The original justification for the privilege was to preserve the ‘honor’ of the attorney as a professional gentleman. Later, to survive the onslaught that befell the other privileges founded on that rationale, the privilege reinvented itself as existing for the benefit of the client.”); Lonnie T. Brown, Reconsidering the Corporate Attorney-Client Privilege: A Response to the Compelled-Voluntary Waiver Paradox, 34 Hofstra L. REV. 897, 913–14 (2006) (“Unlike the modern American edition, under which the privilege belongs to the client, the privilege in England originally belonged to the lawyer.”). For a scholarly examination of the English privilege, see generally Richard S. Pike, The English Law of Legal Professional Privilege: A Guide for American Attorneys, 4 LOY. CHI. INT’L L. REV. 51 (2006).


61. See In re Adoption of Embick, 506 A.2d 455, 459 (Pa. Super. Ct. 1986) (“At common law the attorney-client relationship was the only professional association protected by an evidentiary privilege.”). A nonprofessional privilege protecting confidential communications between spouses also “has ancient origins rooted in the common law.” Commonwealth v. Spetzer, 813 A.2d 707, 717–18 (Pa. 2002); see also Tabor v. Commonwealth, 625 S.W.2d 571, 572 (Ky. 1982) (“At common law . . . confidential communications made to an attorney in his professional character are privileged; likewise privileged are confidential communications between husband and wife.”). However, the common law heritage of the spousal communications privilege is more difficult to trace than that of the attorney-client privilege. See, e.g., State v. Pratt, 153 N.W.2d 18, 20 (Wis. 1967) (asserting that “[w]hile some early legal scholars conceived and articulated the policies supporting the privilege for marital communications, the privilege itself ‘was nonexistent in early common law.’”). In any event, “[E]very case has addressed whether the pharmacist-patient privilege existed at common law,” and none have held that it did. Berger, supra note 31, at 143.
courts, recognize a privilege “even for communications between physician and patient.”62 In states where the physician-patient privilege does exist,63 the privilege is invariably a creature of statute64—a fact that may surprise many who advocate for a comparable pharmacist-patient privilege.65

Thus, like the physician-patient privilege ultimately adopted by statute in most American states66 (but still not recognized in England67 or under American common law),68 the recognition of a pharmacist-patient privilege would be in

62. State v. Shaw, 289 S.E.2d 325, 329 (N.C. 1982); see also State ex rel. Husgen v. Stussie, 617 S.W.2d 414, 415 (Mo. Ct. App. 1981) (“The physician-patient privilege has never been recognized in England nor at common law in the United States.”); State v. Dyal, 478 A.2d 390, 393 (N.J. 1984) (“No physician-patient privilege existed at common law . . . throughout the United States, or in England.”). One possible explanation for the lack of a physician-patient privilege at common law “is that in the 16th and 17th centuries in England, medicine was simply a trade, not a profession of high calling, and thus physicians were to be treated like all other witnesses.” Holbrook v. Weyerhaeuser Co., 822 P.2d 271, 278 (Wash. 1992) (Utter, J., dissenting) (citing Daniel W. Shuman, The Origins of the Physician-Patient Privilege and Professional Secret, 39 SW. L.J. 661, 673 (1985)); see also Terry D. Ragsdale, Comment, The Constitutional Right to Privacy and the Psychotherapist-Patient Privilege as Limitations on the National Transportation Safety Board’s Right to Investigate Air Traffic Accidents, 57 J. AIR L. & COM. 469, 483 n.78 (1991) (“The reluctance of pre-1776 English courts to recognize a physician-patient privilege may have stemmed in part from the relatively unreliable nature of medical science; in fact, the medical ‘profession’ was more akin to a trade, not considered worthy of an attorney’s professional respect.”).

63. See State v. Almonte, 644 A.2d 295, 301 (R.I. 1994) (Lederberg, J., dissenting) (noting that “forty-three states and the District of Columbia have enacted physician-patient privileges”); cf. Werner v. Kliwer, 710 P.2d 1250, 1254 (Kan. 1985) (citation omitted) (“While at common law there was no physician-patient privilege, most states . . . have adopted such a privilege by statute.”).

64. See In re Grand Jury Subpoena John Doe No. A01-209, 197 F. Supp. 2d 512, 514 (E.D. Va. 2002) (footnote omitted) (“[T]here was no physician-patient privilege at common law. In the states where the privilege exists, it is created by statute.”); In re Schulman v. N.Y.C Health & Hosps. Corp., 342 N.E.2d 501, 502 n.1 (N.Y. 1975) (stating that “the physician-patient privilege is wholly a creature of statute, unknown to the common law”).

65. See Berger, supra note 31, at 142 (“Pharmacists are . . . surprised to find that even the physician-patient privilege does not exist at common law and only exists in states that have provided for the privilege by statute.”); Daniel J. Capra, The Federal Law of Privileges, Litig., Fall 1989, at 32, 36 (asserting that lack of a common law physician-patient privilege is “surprising to lawyers and nonlawyers alike”).


derogation of the common law.\textsuperscript{69} That fact does not necessarily preclude its modern recognition,\textsuperscript{70} even as a common law concept.\textsuperscript{71} Nevertheless, those advocating for recognition of the privilege face a formidable challenge,\textsuperscript{72} and at least in this country,\textsuperscript{73} recognition of the privilege remains the exception rather than the rule.\textsuperscript{74}

\textsuperscript{69} See Cepeda v. Cohane, 233 F. Supp. 465, 473 (S.D.N.Y. 1964) (observing that “the recognition of a privilege is in derogation of the common law”); People v. Ackerson, 566 N.Y.S.2d 833, 833 (Cnty. Ct. Monroe Cnty.1991) (stating that privileges that “did not exist at common law . . . are in derogation of common law”); Magney v. Truc Pham, 466 P.3d 1077, 1082 (Wash. 2020) (noting that “when a privilege is . . . not a privilege found within the common law, it is considered to be in derogation of—that is, an exemption from—the common law”).

\textsuperscript{70} See, e.g., Sweasy v. King’s Daughters Mem’l Hosp., 771 S.W.2d 812, 816 (Ky. 1989) (noting that Kentucky legislature “has in some instances created a confidentiality privilege by statute where none exists at common law”). By way of analogy, the physician-patient privilege “owes its existence . . . to legislative enactment in derogation of the common law.” In re N.Y.C. Health & Hosps. Corp. v. N.Y. State Comm’n of Corr., 969 N.E.2d 765, 768 (N.Y. 2012); see also State v. Pelley, 828 N.E.2d 915, 920 (Ind. 2005) (“Like the physician/patient privilege, the statutorily created counselor/client privilege is also in derogation of common law.”).

\textsuperscript{71} See, e.g., In re Grand Jury, 103 F.3d 1140, 1148 (3d Cir. 1997) (describing a court that “recognized a common-law privilege . . . in derogation of the prevailing jurisprudence” (discussing In re Agosto, 553 F. Supp. 1298 (D. Nev. 1983))); see also In re Pittsburgh Action Against Rape, 428 A.2d 126, 136 (Pa. 1981) (Larsen, J., dissenting) (“[T]here can be no serious doubt that courts have the common law authority to judicially create testimonial privileges.”).


\textsuperscript{73} The lack of pharmacist-patient privilege under English or American common law contrasts with the situation prevailing in other countries. See, e.g., Eisai v. Dr. Reddy’s Lab’ys, Inc., 406 F. Supp. 2d 341, 344 (S.D.N.Y. 2004) (observing that “Japanese law . . . extends a privilege to, for example, pharmacists and midwives”); Richard S. Frase, \textit{The Search for the Whole Truth About American and European Criminal Justice}, 3 \textit{BUFF. CRIM. L. REV.} 785, 822–23 (2000) (“Germany recognizes more categories of privileges, not only spouses but also fiancées and relatives; not only doctors, attorneys and clergy, but also dentists, pharmacists, drug counselors, midwives, tax advisors, public accountants, journalists, and employees of certain of these professions.”).

\textsuperscript{74} See Craft & McBride, supra note 38, at 375 (“Currently, the majority of states do not recognize oral communications, confidential or otherwise, between pharmacist and patient as privileged.”); Kit Kinports, \textit{The “Privilege” in the Privilege Doctrine: A Feminist Analysis of the Evidentiary Privileges for Confidential Communications}, in \textit{FEMINIST PERSPECTIVES ON EVIDENCE} 79, 91–92 (Mary Childs & Louise Ellison eds., Routledge 2016) (2000) (“[J]urisdictions that have adopted the doctor-patient privilege tend to confine it to . . . those with [medical] degrees. A few state statutes protect . . . pharmacists, . . . but they are in the clear minority.”).
II. THE PHARMACIST’S ETHICAL DUTY OF CONFIDENTIALITY

Pharmacists have a professional ethical obligation, and arguably, a corresponding contractual obligation, to maintain the confidentiality of information regarding the health of their patients. Although this ethical obligation may serve as an important precursor to the judicial or legislative adoption of a pharmacist-patient privilege, the common law never incorporated this obligation. Even when codified, which is rare, an ethical duty of

75. For a comprehensive discussion of pharmacists’ ethical obligations to their patients, see generally Buerki & Vottero, supra note 33.


77. See Langford v. Rite Aid of Ala., Inc., 231 F.3d 1308, 1314 (11th Cir. 2000) (“Pharmacists owe duties to their patients ranging from diligence in recommending medication to confidentiality in maintaining [a] patient’s records . . . .”); Craft & McBride, supra note 38, at 374 (asserting that “pharmacists are ethically bound to maintain confidentiality”); Betty M. Ng, Note, Universal Health Identifier: Invasion of Privacy or Medical Advancement?, 26 Rutgers Comput. & Tech. L.J. 331, 352–53 (2000) (stating that “pharmacists have an ethical duty to keep patient information confidential”). For an extended academic discussion of this ethical obligation, see generally Eugene Y. Mar, Pharmaceuticals: Duty to Maintain Confidentiality of Customers’ Records, 29 J.L. Med. & Ethics 229 (2001).


79. See Weld v. CVS Pharmacy, Inc., 1 Mass. L. Rptr. 217, 219 (Super. Ct. 1999) (“This Court is not aware of any case which holds that pharmacists owe their customers a duty of confidentiality . . . .”); Washburn, 695 A.2d at 501 n.10 (stating that a pharmacist’s obligation “to hold . . . prescription drug information confidential” does not arise “from the common law”); Evans v. Rite Aid Corp., 478 S.E.2d 846, 848 (S.C. 1996) (“There is no common law duty of confidentiality for pharmacists. No South Carolina case has ever recognized such a duty, nor are we aware of any other jurisdiction that has done so.”). See generally Soldano v. O’Daniels, 190 Cal. Rptr. 310, 313 (Ct. App. 1983) (stating that “the common law does not attempt to enforce all moral, ethical, or humanitarian duties” (quoting Francis H. Bohlen, The Moral Duty to Aid Others as a Basis of Tort Liability (pt. 2), 56 U. Pa. L. Rev. 316, 334 (1908))).

80. See, e.g., Alaska Stat. § 08.80.315 (“Information maintained by a pharmacist in the patient’s records or that is communicated to the patient as a result of patient counseling is confidential . . . .”); Ind. Code § 25-26-13-15(a) (“A pharmacist shall hold in strictest confidence all prescriptions, drug orders, records, and patient information.”); 247 Mass. Code Regs. § 9.01(19) (“A pharmacist shall maintain patient confidentiality at all times.”); Roe v. Cheyenne Mountain Conf. Resort, Inc., 124 F.3d 1221, 1237 (10th Cir. 1997) (“The Colorado Board of Pharmacy regulations protect the privacy interest of patients by prohibiting disclosure of any order for prescriptions, illness suffered by a patient, etc.”).

81. See, e.g., Evans, 478 S.E.2d at 848 (“Although the Code of Ethics of the American Pharmaceutical Association may be a potential source of guidance . . . it does not create for pharmacists a
confidentiality “is not the equivalent of an evidentiary privilege.”82 Such a duty may prohibit the disclosure of patient information in nonjudicial settings.83 However, unlike a privilege,84 a duty of confidentiality does not limit a court’s “inherent power to compel the production of evidence and the appearance of witnesses.”85

Thus, like doctors in those jurisdictions that do not recognize the physician-patient privilege,86 pharmacists called to testify in states that merely treat the pharmacist-patient relationship as confidential (or that have not addressed the statutory duty of confidentiality.”); see also Berger, supra note 31, at 142 (“[E]xcept for a few states which have enacted legislation to provide for such, there is no legally protected pharmacist-patient confidentiality.”).


83. See, e.g., Canfield v. Sandock, 563 N.E.2d 526, 529 (Ind. 1991) (“[T]he ethical rules of the medical profession . . . prohibit disclosure of confidential information in non-judicial settings.”); see also United States v. Carlson, 946 F. Supp. 2d 1115, 1126 (D. Or. 2013) (“[T]he very concept of ‘privileged information’ is intrinsically linked to court proceedings: the disclosure of the same information outside of the courtroom . . . is most accurately described as a breach of confidentiality, not as a violation of privilege.”); Shuman, supra note 62, at 661 n.1 (“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.”).


86. See, e.g., Stidham v. Clark, 74 S.W.3d 719, 730 (Ky. 2002) (Keller, J., concurring) (“[T]here is no physician-patient privilege in Kentucky that would shield information obtained through the physician-patient relationship from testimonial disclosure . . . . Accordingly, physicians remain subject to [a] ‘general obligation to testify,’ and no privilege exists to prevent disclosure of confidential patient confidences or information in the judicial forum.” (quoting KY. R. EVID. 501)); Wichansky v. Wichansky, 313 A.2d 222, 224 (N.J. Super. Ct. App. Div. 1973) (stating that because “no physician-patient privilege existed in New Jersey” a physician “could be required to testify as to his treatment of [a patient]”). See generally Alberts v. Devine, 479 N.E.2d 113, 119 (Mass. 1985) (“The principle that society is entitled to every person’s evidence in order that the truth may be discovered may require a physician to testify in court about information obtained from a patient in the course of treatment.”).
issue)\(^{87}\) can be compelled to reveal private information about their patients’ health.\(^{88}\) Pharmacists summoned to testify in those states are thus presented with a conflict “between the exercise of [their] ethical obligations of confidentiality, and the general legal requirement of testifying in a court of law.”\(^{89}\) In some instances, a pharmacist might attempt to minimize this conflict by testifying untruthfully.\(^{90}\) The presentation of such misleading evidence presumably would undermine the courts’ truth-seeking function at least as much as the application of a pharmacist-patient privilege to exclude evidence.\(^{91}\)

While intended to serve essentially the same purpose as a privilege,\(^{92}\) a pharmacist’s ethical obligation to maintain patient confidentiality is not likely to

---

87. See, e.g., Evans v. Rite Aid Corp., 478 S.E.2d 846, 847 (S.C. 1996) (“The provisions in S.C. Code Ann. § 40-43-10 et seq. regulate the licensing and practice of pharmacists; however, these provisions do not set forth, explicitly or implicitly, a duty of confidentiality.”); see also Craft & McBride, supra note 38, at 374 (“Statutes are largely silent on the issue of pharmacist-patient communications, particularly oral communications.”).

88. See Ex parte Frye, 98 N.E.2d 798, 803 (Ohio 1951) (“In the absence of a privilege . . . not to disclose available information, a witness may not refuse to testify to pertinent facts in a judicial proceeding . . . no matter how confidential may be the character of the communication itself or the relationship between the parties thereto.”); Dillenbeck v. Hess, 536 N.E.2d 1126, 1129 (N.Y. 1989) (noting that in absence of a privilege, confidential communications enjoy “no protection against disclosure in a legal proceeding, however unethical such disclosure may be when occurring outside the courtroom”); State ex rel. Allen, 454 S.E.2d at 85 n.10 (Cleckley, J., concurring) (“In the absence of a privilege, a person called as a witness can normally be compelled to disclose confidential communications, regardless of any professional standard of confidentiality and regardless of what personal assurances or contractual commitments were given to the communicants.”) (quoting CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE § 5.2, at 336 (1994))).

89. Vacco, supra note 34, at 407; see also Joanne C. Brant, Ethical Issues and Trouble Spots, 4 J. PHARMACY & L. 25, 37 (1995) (“A pharmacist’s obligations when confronted with a court order for production of records must be contrasted with his or her duty of confidentiality.”). See generally Root v. State Bd. of Pharmacy, 659 A.2d 626, 630 (Pa. Commw. Ct. 1995) (“Whenever a professional in possession of confidential information is served with a subpoena, a conflict naturally arises between one’s duty to the courts and one’s duty of confidentiality towards one’s client.”).

90. See Dillenbeck, 536 N.E.2d at 1130 (indicating that witnesses might “alter or conceal the truth when forced, in the absence of any privilege, to choose between their legal duty to testify and their professional obligation to honor their patients’ confidences”). Conversely, the “[r]efusal by a professional to testify in the absence of a privilege may result in a charge of contempt of court against the professional.” State v. Lynch, 885 N.W.2d 89, 96 (Wis. 2016) (quoting Catharina J.H. Dubbelday, Comment, The Psychotherapist-Client Testimonial Privilege: Defining the Professional Involved, 34 EMORY L.J. 777, 781 (1985)); see also Lewis v. Roderick, 617 A.2d 119, 121 (R.I. 1992) (discussing “the underlying pressures either of divulging patient confidences or of refusing to testify”).

91. Compare United States v. Lea, 249 F.3d 632, 641 (7th Cir. 2001) (observing that “the cost of [a] privilege is a reduction in truthful disclosure”), with State v. Brunette, 501 A.2d 419, 423 (Me. 1985) (observing that “the truth-seeking function of the trial process itself is unacceptably compromised” by “false testimony”). See generally Paul Rosenzweig, Truth, Privileges, Perjury, and the Criminal Law, 7 TEX. REV. L. & POL’Y 153, 165 (2002) (“Just as the assertion of privilege impedes the search for truth, so too does perjury. . . . The difference is that the assertion of a privilege is a means of impeding the search for truth in a lawful manner, while perjury is an unlawful effort to the same end.”).

92. See Seaton v. Mayberg, 610 F.3d 530, 539 (9th Cir. 2010) (asserting that “[c]onfidentiality of communications . . . and the evidentiary privilege to prevent disclosure” are both intended to enable patients “to disclose what may be highly personal or embarrassing conditions . . . so that they may obtain
create the level of patient trust necessary to elicit the full and frank disclosure of a patient’s medical condition when seeking treatment.93 Such confidentiality can be assured (and the pharmacist’s ethical dilemma avoided)94 only if, when called to testify in a judicial proceeding,95 a pharmacist can invoke an evidentiary privilege on the patient’s behalf.96 As a pair of commentators who favor the recognition of such a privilege observed, “[p]rivilege grants a much higher standard of legal protection . . . than does confidentiality.”97

93. See In re McCann, 422 S.W.3d 701, 713 n.11 (Tex. Crim. App. 2013) (“Of course, a professional who is called to testify in judicial proceedings cannot lawfully refuse to do so based exclusively on a duty of confidentiality in the absence of any recognized privilege. Unless a privilege exists as well, the court can properly require the professional’s testimony.”) (quoting Robert A. Pikowsky, Privilege and Confidentiality of Attorney-Client Communication Via E-mail, 51 BAYLOR L. REV. 483, 490–91 (1999)); Canning, supra note 19, at 549 n.137 (“The fact that . . . [professionals] can protect their clients’ confidential information from disclosure through ethical obligations is not enough; there is a difference between an ethical duty of confidentiality and [a] privilege as far as protection of the client goes.”).

94. See Canning, supra note 19, at 550 n.137 (“[A] privilege would . . . protect certain client communications from any disclosure whatsoever without client consent. This . . . avoids unneeded conflict regarding having to disclose information in court that would normally be disallowed per the profession’s ethical standards.”).

95. See, e.g., Green v. Superior Ct., 33 Cal. Rptr. 604, 604 (Dist. Ct. App. 1963) (“Counsel caused subpoenas duces tecum to be issued to petitioners who are pharmacists, to appear at the trial bringing with them their prescription records.”); State v. Bell, 432 S.E.2d 532, 534 (W. Va. 1993) (describing a “pharmacist [who] received a subpoena to testify at trial”).

96. See State ex rel. Grimm v. Ashmanskas, 690 P.2d 1063, 1065 (Or. 1984) (stating that a “privilege is necessary to secure the patient from disclosure in court of potentially embarrassing private details concerning health and bodily condition”); State ex rel. Allen v. Bedell, 454 S.E.2d 77, 85 (W. Va. 1994) (Cleckley, J., concurring) (“When a disclosure of information is sought and it is required by law or compelled by court order, usually only a privilege will protect against disclosure.”); Deborah Paruch, The Psychotherapist-Patient Privilege in the Family Court: An Exemplar of Disharmony Between Social Policy Goals, Professional Ethics, and the Current State of the Law, 29 N. ILL. U. L. REV. 499, 520 (2009) (“Absolute confidentiality . . . can only be assured if an evidentiary privilege applies alongside a professional duty of confidentiality.”).

97. Craft & McBride, supra note 38, at 375. But cf. State ex rel. Allen, 454 S.E.2d at 85 n.10 (Cleckley, J., concurring) (“In some respects the duty of confidentiality provides greater protection for privacy than an evidentiary privilege. A privilege applies only when testimony is sought in a legal proceeding, whereas the duty of confidentiality applies to prevent disclosure of secrets in extra judicial settings as well.”) (quoting MUELLER & KIRKPATRICK, supra note 88 § 5.2, at 335)).
III. EXTENDING THE PROTECTION OF THE PHYSICIAN-PATIENT PRIVILEGE TO PHARMACISTS

A. Cases Construing the Physician-Patient Privilege Narrowly

No state or federal court has ever recognized a common law physician-patient privilege, let alone a pharmacist-patient privilege. However, most state legislatures have enacted physician-patient privilege statutes, which could be interpreted expansively to protect confidential communications between patients and their pharmacists. As one court explained, “statutory interpretation is a different matter from judicial creation of a broad privilege in the face of conflicting public policy considerations.”

A few cases consider this possibility. However, courts generally are more concerned with the search for truth than with the interests served by expanding


101. See Vacco, supra note 34, at 412 (stating that “several cases . . . have suggested or at least considered expanding the physician-patient privilege to include pharmacists”); cf. Schawbel, supra note 35, at 964 (“The personal nature of prescription records and other private information obtained and kept by pharmacists justifies the expansion of the physician-patient privilege to include pharmacists.”). But see Borngne ex rel. Hyter v. Chattanooga-Hamilton Cnty. Hosp. Auth., 671 S.W.3d 476, 501 (Tenn. 2023) (Campbell, J., concurring) (“It is hard to see how any new privilege could truly ‘grow out of’ an existing one.” (quoting Cardwell v. Bechtol, 724 S.W.2d 739, 744 (Tenn. 1987))).

102. Sherman v. Dist. Ct., 637 P.2d 378, 384 (Colo. 1981); see also Eli Lilly & Co. v. Marshall, 850 S.W.2d 155, 162 (Tex. 1993) (Doggett, J., dissenting) (stating that “most jurisdictions exercise judicial restraint by interpreting statutes rather than enacting new privileges”). But see Branzburg v. Pound, 461 S.W.2d 345, 347 (Ky. Ct. App. 1971) (“It is elementary that a privilege that did not exist at common law cannot be asserted under a statute unless it is clear that the statute was intended to grant the privilege.”), aff’ d sub nom. Branzburg v. Hayes, 408 U.S. 665 (1972).

the scope of an existing privilege, resulting in courts often narrowly construing privilege statutes. Consequently, most courts considering the issue ultimately refused to extend existing statutory protections from compelled testimonial disclosure to pharmacists.

In *Green v. Superior Court*, for example, the husband’s counsel in a divorce action served subpoenas on the wife’s pharmacists demanding that they appear and testify about her prescription medications. The pharmacists appeared in response to the subpoenas but refused to answer questions about the wife’s prescriptions. Invoking California’s statutory physician-patient privilege, the pharmacists argued that “information as to the nature and

104. See People v. Dixon, 411 N.W.2d 760, 763 (Mich. Ct. App. 1987) (“As privileges do not further the ascertainment of truth but, rather, permit the concealment of relevant, reliable information, courts have been reluctant to expand or create new privileges in the absence of compelling reasons.”); Smith, supra note 60, at 91 (“Privilege law often reflects a struggle between legislatures and courts, in which the latter take a narrow view of the codified privileges established by the former. . . . Judges resented and resisted restrictions on their authority to make evidentiary rulings, particularly where the restrictions resulted in the exclusion of evidence that was quite often plainly relevant to the issues before the court.”).

105. See, e.g., Blevins v. Clark, 740 N.E.2d 1235, 1239 (Ind. Ct. App. 2000) (“Because the physician-patient privilege is in derogation of the common law and impedes the search for truth, it is to be strictly construed.”), transfer denied, 753 N.E.2d 16 (2001); see also Lowy v. PeaceHealth, 280 P.3d 1078, 1088 (Wash. 2012) (“Statutory privileges in derogation of both common law and constitutional principles favoring broad discovery in the pursuit of truth must be narrowly construed.”).

106. See John Doe, 466 N.Y.S.2d at 204 (asserting that “the relevant case law does not extend the right of confidentiality, so as to attach to a pharmacist, nor does it equate the pharmacist with a physician”); Berger, supra note 31, at 142 (“In a few states in which the statutory physician-patient privilege exists, attempts have been made by pharmacists to bring their records within the purview of some of those statutes in order to exclude[] patient prescription records in various Court proceedings. These attempts have been mostly unsuccessful.”); Mowery, supra note 99, at 713 (“Most states . . . recognize some form of a physician-patient privilege, which protects patient information. . . . In most states, this privilege is limited solely to physicians and is not extended to pharmacists.”).


108. See id. at 604; cf. Washburn v. Rite Aid Corp., 695 A.2d 495, 500 (R.I. 1997) (observing that a patient’s “prescription-drug history may well have been subject to discovery in her divorce litigation and ultimate disclosure pursuant to compulsory legal process”).

109. A privilege does not provide its holder with the right to ignore a subpoena, but only to assert the privilege in response to specific questions or document requests. See *In re Certain Complaints Under Investigation*, 783 F.2d 1488, 1518 (11th Cir. 1986) (“It is well settled that a witness whose testimony is subpoenaed cannot simply refuse to appear altogether on grounds of privilege, but rather must appear, testify, and invoke the privilege in response to particular questions.”).

110. See *Green*, 33 Cal. Rptr. at 604 (noting that pharmacists “appeared but refused to testify as to the nature of the drugs dispensed and as to their strength”).

111. CAL. CIV. PROC. CODE § 1881(4) (1965), superseded by CAL. EVID. CODE §§ 990-1007. New York and California have been described as “the first states to enact statutes codifying the physician-patient privilege in 1828 and 1878, respectively.” Elinor Lynn Hart, Comment, *The Illinois Mental Health and Developmental Disabilities Act: Lest We Forget the Search for the Truth*, 41 Loy. U. Cmt. L.J. 885, 892 n.47 (2010). However, Missouri actually “was the second state to establish this privilege by statute,” in 1835. *State ex rel. Husgen v. Stasse*, 617 S.W.2d 414, 415 (Mo. Ct. App. 1981); see also Mathis v. Hilderbrand, 416 P.2d 8, 8 (Alaska 1966) (“New York was the first state to establish the privilege by statute in 1828, followed by Missouri in 1835 and in time by approximately two-thirds of the states.”) (citing 8 Wigmore, supra note 6, § 2380)).
strength of the drugs dispensed by a pharmacist on prescription by a licensed physician is as much a part of the physician-patient privilege as would be the testimony of the physician himself.”  

Although there is little precedential support for this argument, it is a relatively compelling one, and the absence of supporting precedent is not necessarily fatal to a claim of privilege. Indeed, the Green court recognized that knowledge of the medications patients are taking, which obviously is reflected in patient prescription records, often reveals the conditions for which they are treated. For example, certain drugs are used exclusively for the treatment of the human immunodeficiency virus (“HIV”). A patient who is prescribed one of those drugs is clearly receiving the medication to treat an HIV diagnosis. This is precisely the type of information many patients undoubtedly

112. Green, 33 Cal. Rptr. at 605; cf. Ryan Knox, Fourth Amendment Protections of Prescription Drug Monitoring Programs: Patient Privacy in the Opioid Crisis, 46 AM. J.L. & MED. 375, 402 (2020) (“Distinguishing between disclosing the fact that someone is taking a specific prescription and disclosing the medical condition that specific prescription drug treats would be nonsensical.”).

113. See Green, 33 Cal. Rptr. at 605 (“[P]etitioners cite no case bringing the pharmacist within the physician-patient privilege in any . . . jurisdiction.”); cf. Brant, supra note 89, at 29 (“Only a few states permit pharmacists to invoke the physician-patient privilege in a judicial proceeding.”).

114. See, e.g., Meier v. Awaad, 832 N.W.2d 251, 262 (Mich. Ct. App. 2013) (“[T]he statutory physician-patient privilege operates to bar disclosure even when the disclosure is not sought directly from a physician or surgeon but rather from a third party who obtained protected information from a doctor.”); see also Rite Aid of N.J., Inc. v. Bd. of Pharmacy, 304 A.2d 754, 757 (N.J. Super. Ct. 1973) (observing that “the physician-patient privilege that protects the confidentiality of medical prescriptions . . . must be guarded by pharmacists”).


117. See Green, 33 Cal. Rptr. at 605 (observing that “use of some drugs is exclusively for the treatment or cure of specific ailments” and “in such cases knowledge of the drug dispensed would reveal the patient’s confidentially-communicated information to the doctor”); cf. Ricco Jones, 24 F.4th at 738 (observing that “prescription drug records contain intimate and private details because it may be possible to determine a person’s illnesses from looking at such records”).


119. See Anonymous v. CVS Corp., 728 N.Y.S.2d 333, 342 (Sup. Ct. 2001) (“Even if the pharmacist’s medical profile does not expressly state the medical condition of an HIV or AIDS positive customer, the type of drug prescribed often identifies the nature of the customer’s illness.”). The same is true of medications prescribed for other medical conditions. See Lewis v. Superior Ct., 397 P.3d 1011, 1023 (Cal.
would prefer to keep private—and that should receive protection from disclosure in judicial proceedings regardless of whether the information is sought from a physician or a pharmacist. As the court in another California case observed, the “whole purpose of the privilege is to preclude the humiliation of the patient that might follow disclosure of his ailments.”

The Green court nevertheless rejected the pharmacists’ argument. The court recognized that as in many other states, pharmacists in California are “required to treat the contents and effect of a prescription and the nature of the patient’s illness as being confidential.” However, the court also noted that the “[e]xistence of a confidential relationship does not ipso facto cause

2017) (Liu, J., concurring) (noting that many drugs “are approved only for the treatment of specific and often sensitive medical conditions or symptoms”).

120. See Doe v. City of New York, 15 F.3d 264, 265 (2d Cir. 1994) (describing an individual whose “HIV status was an intensely personal matter which he did not share even with his family, his friends, or his colleagues at work”); see also Se. Pa. Transp. Auth., 72 F.3d at 1138 (“It is now possible from looking at an individual’s prescription records to determine that person’s illnesses . . . . This information is precisely the sort intended to be protected by penumbras of privacy.”); Lewis, 397 P.3d at 1024 (Liu, J., concurring) (“Patients retain a reasonable expectation of privacy in prescription drug records that can reveal their medical conditions.”).

121. See, e.g., Johnstown Trib. Publ’g Co. v. Ross, 871 A.2d 324, 329 (Pa. Commw. Ct. 2005) (referring to “sensitive, and arguably privileged, information related to [a patient’s] medical history, such as whether he or she was HIV-positive”), abrogated on other grounds by Penn Jersey Advance, Inc. v. Grim, 962 A.2d 632, 634–37 (Pa. 2009); see also Doe v. Delie, 257 F.3d 309, 331 (3d Cir. 2001) (Nyguard, J., concurring in part and dissenting in part) (recognizing “importance of respecting the medical privacy of HIV carriers”); Anonymous, 728 N.Y.S.2d at 342 (noting that “pharmacists who fill or refill prescriptions of HIV positive or AIDS infected customers possess confidential information”).

122. City of San Francisco v. Superior Ct., 231 P.2d 26, 28 (Cal. 1951); see also State ex rel. Grimm v. Ashmanskas, 690 F.3d 1063, 1065 (Or. 1984) (“[T]he privilege is necessary to secure the patient from disclosure in court of potentially embarrassing private details concerning health and bodily condition.”); cf. Roe v. Ingraham, 403 F. Supp. 931, 937 (S.D.N.Y. 1975) (“An individual’s physical ills and disabilities, the medication he takes, [and] the frequency of his medical consultation are among the most sensitive of personal and psychological sensibilities. . . . Generally one is wont to feel that this [information] is nobody’s business but his doctor’s and his pharmacist’s.”), rev’d on other grounds sub nom. Whalen v. Roe, 429 U.S. 589 (1977).

123. See Green v. Superior Ct., 33 Cal. Rptr. 604, 608 (Dist. Ct. App. 1963) (“[E]ven were we inclined to extend the language of [the physician-patient privilege statute] to create a privilege in a prescription-dispensing druggist generally, which we are by no means disposed to do, we still could not reasonably do so under the facts of this case.”).

124. See, e.g., Commonwealth v. Slaton, 556 A.2d 1343, 1356 (Pa. Super. Ct. 1989) (Kelly, J., concurring in part and dissenting in part) (“[P]harmacists are charged with a duty to exercise great care to preserve the legitimate privacy expectations of their clients regarding the information contained in the prescription file.”), aff’d, 608 A.2d 5 (Pa. 1992); see also Washburn v. Rite Aid Corp., 695 A.2d 495, 500 (R.I. 1997) (stating that prescription records “contain information that might be extremely embarrassing or damaging to [a patient] if it were to be disclosed,” and thus, are “presumptively private and confidential”).

125. Green, 33 Cal. Rptr. at 605 (discussing CAL. CODE REGS. tit. 16, § 1764 (1963)); see also Lewis, 397 P.3d at 1023 (Liu, J., concurring) (“[P]atients have a legally recognized privacy interest in their prescription records.”); Med. Bd. v. Chiarottino, 170 Cal. Rptr. 3d 540, 546–47 (Ct. App. 2014) (observing that patients “have a right to privacy in their medical information” that “would appear to extend to prescription records”).
communications between the confidants to be privileged.”126 Because California’s physician-patient privilege statute did not list pharmacists among the health care professionals entitled to its protection,127 the court held that the wife’s pharmacists could be compelled to testify about her prescriptions.128 Quoting from a prior decision in Samish v. Superior Court,129 the Green court explained that “[u]nless the statute expressly extends the privilege to specific persons or classes, the law will not justify such individuals in refusing to disclose facts . . . which would otherwise be competent evidence in a particular proceeding.”130

Courts in other states reached essentially the same conclusion.131 In Ladner v. Ladner,132 for example, the Mississippi Supreme Court refused to extend Mississippi’s physician-patient privilege to encompass confidential communications between patients and pharmacists.133 Because the privilege

126. Green, 33 Cal. Rptr. at 605; see also Dep’t of Motor Vehicles v. Superior Ct., 122 Cal. Rptr. 2d 504, 509 (Ct. App. 2002) (“Characterizing information as confidential . . . is not the equivalent of establishing a privilege in a legal proceeding.”); White v. Superior Ct., 126 Cal. Rptr. 2d 207, 210 (App. Dep’t Super. Ct. 2002) (“[T]here is a distinction between information that is confidential and information that is privileged.”). For a scholarly examination of this aspect of California law, see generally Fred. C. Zacharias, Privilege and Confidentiality in California, 28 U.C. DAVIS L. REV. 367 (1995).

127. See Green, 33 Cal. Rptr. at 605 (noting that California’s physician-patient privilege statute “does not expressly mention a pharmacist dispensing a doctor’s prescription as falling within the privileged class”); cf. Frederick v. Fed. Life Ins. Co., 57 P.2d 235, 238 (Cal. Dist. Ct. App. 1936) (“At common law, communications between physician and patient were not privileged, and we must look to the statute to determine the extent of the privilege which has been provided.”).

128. See Green, 33 Cal. Rptr. at 604, 608 (upholding trial court’s order holding pharmacists in contempt for “refus[ing] to testify as to the drugs dispensed and as to their strength”); cf. James H. Feldman & Carolyn Sievers Reed, Silences in the Storm: Testimonial Privileges in Matrimonial Disputes, 21 FAM. L.Q. 189, 214 (1987) (“[U]nless pharmacists are explicitly protected under the physician-patient privilege statute or some similar statutory provision, a party can successfully subpoena a pharmacist and his or her records.”).

129. 83 P.2d 305 (Cal. Dist. Ct. App. 1938). In Samish, a grand jury witness argued that copies of his income tax returns were privileged under state and federal statutes permitting the use of such returns only “for taxation purposes.” Id. at 309. The court held that the witness must produce copies of the returns because the statutes he relied on “specifically limit[ed] the application of the privilege to the [government] officers having custody of the original documents.” Id.

130. Green, 33 Cal. Rptr. at 607 (quoting Samish, 83 P.2d at 310); see also In re Lifschutz, 467 P.2d 557, 560 n.3 (Cal. 1970) (observing that protection of physician-patient privilege “only applied to medical practitioners who fell within the terms of the various state statutes”).

131. See, e.g., Carr-Hoagland v. Patterson, 96 N.Y.S.3d 774, 776 (holding that “pharmacy records are not protected by the physician-patient privilege”), reargument denied, 99 N.Y.S.3d 894 (App. Div. 2019); In re Miner’s Will, 133 N.Y.S.2d 27, 28 (Sup. Ct. 1954) (“Communications to a druggist and prescriptions given him by his customer are not confidential communications protected from disclosure by [a privilege] and such communications and prescriptions, under proper circumstances, may be received in evidence.”); see also Lipsy v. State, 318 S.E.2d 184, 187 (Ga. Ct. App. 1984) (“[T]he mere fact that a communication is made in confidence is generally considered insufficient to entitle it to a privilege unless the parties bear to each other one of the specific relations recognized as privileged by statute.”).

132. 436 So. 2d 1366 (Miss. 1983).

133. See id. at 1372–73 (construing MISS. CODE ANN. § 13-1-21 (1972)); see also Feldman & Reed, supra note 128, at 214–15 (“The [Ladner] court held that the pharmacist’s testimony was properly
operates to exclude relevant and material evidence,\textsuperscript{134} the court held that a statute embodying the privilege “must be limited to its express language and clear purpose.”\textsuperscript{135} Much like the California statute at issue in \textit{Green},\textsuperscript{136} Mississippi’s privilege statute applied only to “communications made to a physician or surgeon by a patient under his charge or by one seeking professional advice.”\textsuperscript{137} Applying the analysis in prior cases in which it refused to extend the protection of the statute “to include persons not within its terms,”\textsuperscript{138} the \textit{Ladner} court held that the privilege did not protect a patient’s communications with a health care professional other than a physician or surgeon.\textsuperscript{139}

Many other states’ physician-patient privilege statutes only protect a patient’s communications with a physician or surgeon.\textsuperscript{140} As in \textit{Ladner} and

\begin{itemize}
\item Admitted . . . because the physician-patient privilege did not extend protection to pharmacist-patient interactions.
\end{itemize}

\textsuperscript{134} \textit{See} Gulf, Mobile & N. R.R. Co. v. Willis, 157 So. 899, 901 (Miss. 1934) (noting that physician-patient privilege “has the effect of preventing facts from being disclosed which would often be material to the administration of justice”), \textit{suggestion of error overruled}, 158 So. 551 (Miss. 1935).

\textsuperscript{135} \textit{Ladner}, 436 So. 2d at 1373; cf. \textit{Cepeda} v. \textit{Cohane}, 233 F. Supp. 465, 473 (S.D.N.Y. 1964) (“[T]he recognition of a privilege . . . suppresses otherwise relevant and important evidence, and, accordingly, in the absence of specific statutory language creating it, should not be extended to cover other situations not specifically included in the actual terminology of the statute.”). \textit{See generally} \textit{Babcock} v. Bridgeport Hosp., 742 A.2d 322, 341 (Conn. 1999) (“[A]lthough a statutory privilege must be applied to effectuate its purpose, it is to be applied cautiously and with circumspection because it impedes the truth-seeking function of the adjudicative process.”).

\textsuperscript{136} The \textit{Green} court noted that the original version of California’s statutory physician-patient privilege, which protected a patient’s communications with licensed physicians and surgeons, had “not been materially altered throughout the years except to limit the privilege to civil cases.” \textit{Green} v. \textit{Superior Court}, 33 Cal. Rptr. 604, 606 (Dist. Ct. App. 1965) (citing \textit{CAL. CIV. PROC. CODE} § 1881(4) (1965), \textit{superseded by CAL. EVID. CODE §§ 990-1007); see also City of \textit{San Francisco} v. \textit{Superior Ct.}, 231 P.2d 26, 28 (Cal. 1951) (emphasis added) (“The statute reads: ‘A licensed physician or surgeon cannot, without the consent of his patient, be examined in a civil action, as to any information acquired in attending the patient, which was necessary to enable him to \textit{prescribe or act} for the patient.’”) (quoting \textit{CAL. CIV. PROC. CODE} § 1881(4))).

\textsuperscript{137} \textit{Ladner}, 436 So. 2d at 1373 (quoting \textit{MISS. CODE ANN.} § 13-1-21 (1972)); \textit{see also} \textit{Huff} v. \textit{Polik}, 408 So. 2d 1368, 1369 (Miss. 1982) (“[T]he statute . . . clearly makes privileged only communications made to a physician or surgeon by a patient.”) (discussing \textit{MISS. CODE ANN.} § 13-1-21 (1972))). The statute at issue in \textit{Ladner} has been amended and now extends to pharmacists and certain other health care professionals who are not physicians or surgeons. \textit{See MISS. CODE ANN.} § 13-1-21(1) (2001) (“All communications made to a physician, osteopath, dentist, hospital, nurse, pharmacist, podiatrist, optometrist or chiropractor by a patient under his charge or by one seeking professional advice are hereby declared to be privileged . . . .”).

\textsuperscript{138} \textit{Powell} v. \textit{J.J. Newman Lumber Co.}, 165 So. 299, 302 (Miss. 1936) (discussing \textit{Gulf, Mobile}); \textit{see also}, e.g., \textit{S.H. Kress & Co. v. Sharp}, 126 So. 650, 653 (Miss. 1930) (“Chiropractors are not physicians . . . and they are not therefore within the privilege of physicians . . . .”).

\textsuperscript{139} \textit{See} \textit{Ladner}, 436 So. 2d at 1373 (citations omitted) (“[T]he [privilege] statute . . . has the effect of preventing facts from being disclosed which would often be material to the case. This Court has frequently employed such reasoning in denying the statute’s application to professionals who are not physicians or surgeons.”).

\textsuperscript{140} \textit{See}, e.g., \textit{State v. Beaty}, 762 P.2d 519, 526 (Ariz. 1988) (stating that for Arizona’s physician-patient privilege statute to apply “the witness must be a physician or surgeon”); \textit{Griggs v. Griggs}, 707 S.W.2d 488, 490 (Mo. Ct. App. 1986) (“The physician-patient privilege of \textsection{491.060(5)} applies only to a


Green, courts in those states typically interpret these statutes narrowly.\footnote{Twisdale v. Snow, 325 F.3d 950, 953 (7th Cir. 2003) (discussing "the limitations of literalism as a mode of interpretation"); Pottharst v. Small Bus. Admin., 329 F. Supp. 1142, 1145 (E.D. La. 1971) ("The law reports are full of cases deploring excessive literalism in statutory interpretation.")} While pharmacists and other nonphysician health care professionals may have confidentiality obligations comparable to those of physicians and surgeons,\footnote{Sparks v. Donovan, 884 So. 2d 1276, 1280 (La. Ct. App. 2004) (noting plaintiff’s argument that "a duty of confidentiality is owed by health care providers, including pharmacists, to their patients"); Charity Scott, Is Too Much Privacy Bad for Your Health? An Introduction to the Law, Ethics, and HIPAA Rule on Medical Privacy, 17 GA. ST. U. L. REV. 481, 493 (2000) ("The professional codes of nearly every health care profession (for example, the ethics codes for physicians, nurses, dentists and dental hygienists, mental health professionals, social workers, pharmacists, and chiropractors) . . . all explicitly require respect for the principles of privacy and confidentiality.")} "extend[ing] the privilege statute to those professions merely because of the confidential nature of the relationship . . . would constitute a rather blatant disregard of the express ‘physician or surgeon’ provision of the statute."\footnote{Deutschmann v. Third Ave. R.R. Co., 84 N.Y.S. 887, 893–94 (App. Div. 1903) (holding that New York’s statutory privilege “relates to the physician alone” and “does not extend to a druggist who fills [a] physician’s prescriptions”); see also Taylor v. REO Motors, Inc., 275 F.2d 699, 703 (10th Cir. 1960) (“One well considered view is that . . . since [a physician-patient privilege] statute excludes otherwise admissible testimony, it should be limited by its terms to persons named therein, i.e., physicians and surgeons.”).}

The courts’ strict interpretation of these privilege statutes is not simply a mechanical application of literalism.\footnote{Pottharst v. Small Bus. Admin., 329 F. Supp. 1142, 1145 (E.D. La. 1971) ("The law reports are full of cases deploring excessive literalism in statutory interpretation.")} The analysis in cases such as Green and Ladner also reflects an underlying dissatisfaction with the physician-patient physician. Section 334.021, RS Mo 1978 provides that the term ‘physician’ . . . means [licensed] physicians and surgeons . . . ”; see also CLINTON DEWITT, PRIVILEGED COMMUNICATIONS BETWEEN PHYSICIAN AND PATIENT 80 (1958) (“In most of the statutes, the words ‘physician’ and ‘surgeon’ are used to designate the persons whose disclosures of information acquired in their professional capacity are prohibited.”); Developments in the Law—Privileged Communications, 98 HARV. L. REV. 1450, 1533 (1985) (asserting that physician-patient privilege statutes “most often use the general terms ‘physician’ or ‘physician or surgeon’ to denote the individuals covered”).

141. See, e.g., State v. Howland, 658 P.2d 699, 703 (10th Cir. 1960) ("Counsel argues that New Mexico’s patient privilege statute “applies only to physicians and surgeons and not to psychologists” (construing ARIZ. REV. STAT. 13–4062(4))); Deutschmann v. Third Ave. R.R. Co., 84 N.Y.S. 887, 893–94 (App. Div. 1903) (holding that New York’s statutory privilege “relates to the physician alone” and “does not extend to a druggist who fills [a] physician’s prescriptions”); see also Taylor v. REO Motors, Inc., 275 F.2d 699, 703 (10th Cir. 1960) (“One well considered view is that . . . since [a physician-patient privilege] statute excludes otherwise admissible testimony, it should be limited by its terms to persons named therein, i.e., physicians and surgeons.”).

142. See Sparks v. Donovan, 884 So. 2d 1276, 1280 (La. Ct. App. 2004) (noting plaintiff’s argument that “a duty of confidentiality is owed by health care providers, including pharmacists, to their patients”); Charity Scott, Is Too Much Privacy Bad for Your Health? An Introduction to the Law, Ethics, and HIPAA Rule on Medical Privacy, 17 GA. ST. U. L. REV. 481, 493 (2000) ("The professional codes of nearly every health care profession (for example, the ethics codes for physicians, nurses, dentists and dental hygienists, mental health professionals, social workers, pharmacists, and chiropractors) . . . all explicitly require respect for the principles of privacy and confidentiality.")

143. Joseph R. Quinn, The Physician-Patient Privilege in Colorado, 37 U. COLO. L. REV. 349, 352 (1965); cf. 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, 611 (1943) (stating that a “licensed physician or surgeon” may fall within terms of a privilege statute while pharmacists are “left out in the cold”).

144. See generally Twisdale v. Snow, 325 F.3d 950, 953 (7th Cir. 2003) (discussing "the limitations of literalism as a mode of interpretation"); Pottharst v. Small Bus. Admin., 329 F. Supp. 1142, 1145 (E.D. La. 1971) ("The law reports are full of cases deploring excessive literalism in statutory interpretation.").
privilege, and indeed with evidentiary privileges in general. As the court in *Prudential Insurance Co. of America v. Kozlowski* observed, a physician-patient privilege statute “must, of course, be complied with as to physicians and surgeons, because it expresses a public policy declared by the legislature.” Nevertheless, privileges “must coexist in a judicial system seeking to find the truth, serve the interests of justice, and have all relevant information available for consideration by the fact-finder.” It is primarily for this reason that courts strictly construe privilege statutes, often holding that they only protect those professionals specifically named therein.

As the *Prudential Insurance* court explained when interpreting Wisconsin’s physician-patient privilege statute,

---

145. See B. Abbott Goldberg, *The Physician-Patient Privilege – An Impediment to Public Health*, 16 Pac. L.J. 787, 791 (1985) (“[In view of the . . . questionable basis of the privilege, any broadening of the present scope of the privilege ought to be opposed.”) (quoting 6 CAL. REVISION COMM’N REP. 407 (1964))); cf. Johnson v. Trujillo, 977 P.2d 152, 156 (Colo. 1999) (noting defendant’s observation that “courts and commentators have criticized the physician-patient privilege for suppressing the truth and have argued that the resulting harm to justice is far more substantial than the harm that disclosure would cause to the physician-patient relationship”); Rodriguez v. N.Y.C. Transit Auth., 574 N.Y.S.2d 505, 506 (Sup. Ct. 1991) (citations omitted) (“While upholding the physician-patient privilege, many commentators have criticized it as an unnecessary impediment to the search for truth and justice. Additionally, many courts have indicated a similar conclusion.”).

146. See United States v. Frank, 869 F.2d 1177, 1179 (8th Cir. 1989) (“We recognize that privileges are disfavored because they impede the search for truth.”); Guerrier v. State, 811 So. 2d 852, 854 (Fla. Dist. Ct. App. 2002) (“The reason for the common law’s reluctance to embrace testimonial privileges is rooted in the general precept that privileged communications are an exception to the rule that all relevant evidence is admissible.”).

147. 276 N.W. 300 (Wis. 1937).

148. Id. at 302; see also State v. Staat, 192 N.W.2d 192, 196 (Minn. 1971) (“Despite persistent academic and judicial criticism of this evidentiary privilege as an impediment to the ascertainment of truth, it is nevertheless our duty to enforce it to the full extent reasonably necessary for the attainment of the longstanding legislative policy for which it was created . . . .”).

149. Crawford *ex rel. Goodyear v. Care Concepts, Inc.*, 625 N.W.2d 876, 881 (Wis. 2001); *see also* Page v. Va. State Bd. of Elections, 15 F. Supp. 3d 657, 660 (E.D. Va. 2014) (“Testimonial and evidentiary privileges exist against the backdrop of the general principle that all reasonable and reliable measures should be employed to ascertain the truth of a disputed matter.”).

150. *See, e.g.*, Stigliano *ex rel. Stigliano v. Connaught Labs., Inc.*, 658 A.2d 715, 718 (N.J. 1995) (citations omitted) (“Because privileges undermine the search for truth . . . courts construe them strictly. So here, we strictly construe the physician-patient privilege.”); *see also* Samish v. Superior Ct., 83 P.2d 305, 310 (Cal. Dist. Ct. App. 1938) (“Since the protection against privileged communications often leads to a suppression of the truth and to a defeat of justice, the tendency of courts is toward a strict construction of such statutes.”).

151. *See, e.g.*, Geisberger v. Willuhn, 390 N.E.2d 945, 947 (Ill. App. Ct. 1979) (“In a number of cases, for example, the privilege has been denied to nurses on the theory that it . . . should be particularly confined to those expressly named.”); *see also* Weis v. Weis, 72 N.E.2d 245, 252 (Ohio 1947) (stating that a “privileged-communication statute . . . must be strictly construed and must be held to afford protection only to those relationships specifically named in the statute”).

152. Wis. Stat. § 325.21 (1961). Similar to the statutes at issue in *Green and Ladner*, when the Wisconsin Supreme Court decided *Prudential Insurance*, the Wisconsin physician-patient privilege statute provided that “no physician or surgeon shall be permitted to disclose ‘any information he may have acquired in attending any patient in a professional character, necessary to enable him professionally to serve such patient,’ with certain exceptions . . . .” *In re Ganchoff’s Will*, 107 N.W.2d 474, 480 (Wis.
“there is no call to extend the exemption of the statute beyond its letter, and every reason why it should not be so extended. Chiropractors, orthopedists, Christian science practitioners, dentists, druggists, and public health nurses have been held not within the statute.” 153

B. Authority Supporting Extension of the Physician-Patient Privilege to Pharmacists

1. The Adoption of the California Evidence Code

To fill a prescription, patients in California (and other states)154 ordinarily must submit their prescriptions to a pharmacist.155 The court in Green v. Superior Court156 nevertheless essentially held that in doing so, those patients are voluntarily disclosing the information that may pass from those prescriptions to a third person,157 consequently waiving the protection of the physician-patient privilege with respect to any information contained or gleaned from the

154. See, e.g., Cackowski v. Wal-Mart Stores, Inc., 767 So. 2d 319, 325 (Ala. 2000) (citing ALA. CODE § 34-23-1(17)-(18) (2000)) (“Although it is the physician who prescribes the medication, it is only a pharmacist/pharmacy that can fill the prescription, by supplying the patient with the called-for medication.”); Hosto v. Brickell, 577 S.W.2d 401, 406 (Ark. 1979) (citing ARK. STAT. ANN. §§ 82-1001 82-1002, 82-1006 (1979)) (“Only a licensed pharmacist is authorized to sell and dispense narcotic drugs upon a written prescription.”); see also Walmart, Inc. v. U.S. Dep’t of Just., 21 F.4th 300, 305 (5th Cir. 2021) (“Although opioids are prescribed by doctors, those prescriptions must be filled by pharmacists...”).
155. See Murphy v. E.R. Squibb & Sons, Inc., 710 P.2d 247, 251 (Cal. 1985) (observing that “[w]ith a few exceptions, only a licensed pharmacist may dispense prescription drugs”); Magan Med. Clinic v. Cal. State Bd. of Med. Exam’rs, 57 Cal. Rptr. 256, 262 (Ct. App. 1967) (“Ethical drugs may be purchased only with a doctor’s prescription and only a registered pharmacist may fill that prescription.”). Under certain circumstances physicians in California can dispense drugs “to their own patients for the condition for which the patient was seeking treatment,” although they are prohibited from “dispensing drugs to the general public.” Park Med. Pharmacy v. San Diego Orthopedic Assocs. Med. Grp., Inc., 120 Cal. Rptr. 2d 858, 863 (Ct. App. 2002) (construing CAL. BUS. & PROF. CODE § 4170(a) (2002)). The same is true in other states. See, e.g., Ye Olde Apothecary v. McClellan, 253 S.E.2d 545, 547 (W. Va. 1979) (holding that in West Virginia “physicians may supply drugs to their own patients but not fill prescriptions written by other physicians” (interpreting W. VA. CODE § 30-5-21 (1979))). However, “physicians do not usually dispense their own prescribed drugs but [instead] must rely on pharmacists.” Green v. Superior Ct., 33 Cal. Rptr. 604, 605 (Dist. Ct. App. 1963).
156. Green, 33 Cal. Rptr.
157. The court asserted that the wife’s disclosure of information concerning her health to a “number[ ] of both doctors and drugstores,” and perhaps to “a miscellany of drug clerks,” made it doubtful that she “ever contemplated that her disclosures were in confidence.” Id. at 607; cf. Anonymous v. CVS Corp., 728 N.Y.S.2d 333, 341 (Sup. Ct. 2001) (asserting that “prescription information is typically freely and voluntarily disclosed”).
prescription. This holding enabled litigants to obtain confidential information from a patient’s pharmacist that they presumably could not obtain from the patient’s physician, thereby eviscerating the protection of the privilege. This in turn likely deterred some patients from confiding in or perhaps even consulting pharmacists and physicians, and thus may have diminished the quality of care they received.

Less than two years after the Green decision (and partly in response to that decision) the California legislature enacted a comprehensive Evidence

---

158. As a general rule, the “[d]isclosure of otherwise confidential information to third persons with the acquiescence of the patient destroys the confidentiality of a communication and constitutes a waiver of the physician-patient privilege.” Muller ex rel. Muller v. Rogers, 534 N.W.2d 724, 727 (Minn. Ct. App. 1995); see also Berger, supra note 31, at 143 (asserting that some courts, who refused to extend physician-patient privilege to pharmacists, concluded that patient “waived any such privilege . . . by the very furnishing of the prescription to the pharmacist”).

159. See Brant, supra note 89, at 26 (“Frequently, attorneys will seek to obtain medical records from [a] . . . pharmacist, who usually cannot claim the protection of the physician-patient privilege.”); cf. Schawbel, supra note 35, at 958 (“[M]edical information that is protected when included in a physician’s record may not enjoy the same protection when it is part of a pharmacist’s record.”).

160. See Vacco, supra note 34, at 399 (asserting that ability of litigants to obtain information from a patient’s pharmacist that they are prohibited from obtaining from patient’s physician would result in “an erosion of the physician-patient privilege”); cf. Quick, supra note 36, at 157 (“[B]y providing . . . information to the pharmacist, the patient may be jeopardizing his right to privacy with regard to the nature of his illness.”).

161. See Bennett ex rel. Bennett v. Fieser, 152 F.R.D. 641, 642 (D. Kan. 1994) (“Denial of the privilege would possibly cause one suffering from a particular ailment to withhold pertinent information of an embarrassing or otherwise confidential nature for fear of being publicly disclosed.”); Schawbel, supra note 35, at 961 (asserting that without protection of a privilege “patients may be reluctant to reveal private information to their pharmacists”).

162. See In re Marriage of Peters-Farrell, 802 N.E.2d 1250, 1254 (Ill. App. Ct. 2003) (“If [a litigant] were able to obtain [a patient’s prescription] records from the pharmacy where [the patient] filled a prescription for medication . . . [the patient] might be reluctant to fill such a prescription and might not receive necessary treatment.”), vacating as moot and appeal dismissed, 835 N.E.2d 797 (Ill. 2005); David B. Brushwood, Maximizing the Value of Electronic Prescription Monitoring Programs, 31 J. Med. & ETHICS 41, 43 (2003) (footnote omitted) (“Information that would be impossible to obtain from a patient’s physician may be readily available from the patient’s pharmacist. Sharing [such] private information . . . threatens the quality of care by deterring patient disclosure to physicians of information that physicians need to know but patients prefer to keep private.”).


164. One commentator asserted that a provision in the California Evidence Code that “broadened the scope of the physician-patient privilege” was “enacted in response to the . . . decision in Green v. Superior Court and was intended to ensure that the . . . privilege would not evolve into a meaningless piece of legislation, presumably by including the pharmacist within its protection.” Vacco, supra note 34, at 412 (footnote omitted) (discussing CAL. EVID. CODE § 992 (1979)); see also Harlin G. Adelman & Wendy L. Zahler, Pharmacist-Patient Privilege and the Disclosure of Prescription Records, 1 J. PHARMACY & L. 127, 149 (1992) (asserting that “legislative amendment to the California Evidence Code [that] broadened the scope of the physician-patient privilege” was “enacted in response to the Green decision”).
Code. The new code, which revised and expanded California’s existing evidence laws, included a series of privilege statutes replacing those in effect at the time of its enactment—including the physician-patient privilege statute at issue in Green.

In one respect, adoption of the Evidence Code supports the result reached in Green. In particular, the code contains a provision, Section 911, which states that “there are no privileges ‘except as provided by statute.’” The California Supreme Court subsequently held that this amendment deprived the California courts of any authority “to modify existing privileges or to create new privileges.” The Green court’s refusal to judicially “modify” the physician-patient privilege statute to encompass pharmacist-patient communications is


166. See In re Cindy L., 947 P.2d 1340, 1347 (Cal. 1997) (“In 1965, the statutory law of evidence was revised and expanded, and transferred from the Code of Civil Procedure into the newly created Evidence Code.”).


168. See Pitchess v. Superior Ct., 532 P.2d 305, 311 (Cal. 1974) (“With respect to the subject of privileges, the code states specifically that ‘[t]he provisions . . . relating to privileges shall govern any claim of privilege made after December 31, 1966.’ Thus, the Legislature has codified, revised, or supplanted any privileges previously available . . . .” (quoting CAL. EVID. CODE § 12(c) (1974))); KSDO v. Superior Ct., 186 Cal. Rptr. 211, 213 (Cal. App. 1982) (“In 1965 the Legislature transferred the privilege sections of the California Code of Civil Procedure to the Evidence Code . . . .”).


170. See generally In re Cindy L., 947 P.2d at 1347 (“As a general rule, the Code permits the courts to work toward greater admissibility of evidence but does not permit the courts to develop additional exclusionary rules.” (quoting 7 CAL. L. REVISION COMM’N REP. 34 (1965))).

171. CAL. EVID. CODE § 911.


consistent with this interpretation of the amendment, which in turn is supported by the legislative history of the Evidence Code and of Section 911 in particular.

However, the California legislature also included another provision in the Evidence Code, Section 912(d), which states that a privilege is not waived by the disclosure of a confidential communication to a third person if the disclosure is reasonably necessary to accomplish the purpose for which the communication was made. The pertinent legislative history offered an example of such a disclosure: a patient’s presentation of a physician’s prescription to a pharmacist, which would not constitute a waiver of the physician-patient privilege because such disclosures are reasonably necessary to accomplish a purpose—treatment—for which physicians are consulted.

The California Supreme Court interpreted Section 912(d) in Rudnick v. Superior Court. In Rudnick, the court held that a third person to whom a disclosure protected by this nonwaiver provision is made (e.g., a pharmacist who is presented with a patient’s prescription) can now claim the privilege on the

174. See Green v. Superior Ct., 33 Cal. Rptr. 604, 607 (Dist. Ct. App. 1963) (indicating that unlike state’s courts, California legislature could enact a statute that “included pharmacists within the cloak of the protective privilege”).

175. See In re Cindy L., 947 P.2d at 1347 (“In some instances—the Privileges division, for example—the code to a considerable extent precludes further development of the law except by legislation.” (quoting 7 CAL. L. REVISION COMM’N REP. 34 (1965))).

176. See Montebello Rose Co. v. Agric. Lab. Rel. Bd., 173 Cal. Rptr. 856, 876 (Ct. App. 1981) (“The Law Revision Commission’s comment to section 911 emphasizes the absolute policy of confining privileges to those created by statute: ‘This section codifies the existing law that privileges are not recognized in the absence of statute . . . .’” (quoting 7 CAL. L. REVISION COMM’N REP. 1153 (1965))). The California Supreme Court indicated that the official comments are an “integral aspect” of the Evidence Code due to the “special attention given them by the legislative committees that considered the code.” Berroteran v. Superior Ct., 505 P.3d 601, 611, 611 n.12 (Cal. 2022) (quoting McDonough, supra note 165, at 89–90 n.4).

177. CAL. EVID. CODE § 912(d).

178. See Roberts v. Superior Ct., 508 P.2d 309, 316 (Cal. 1973) (“Evidence Code Section 912, subdivision (d), provides: ‘A disclosure in confidence of a communication that is protected by a privilege provided by Section . . . 994 (physician-patient privilege), or 1014 (psychotherapist-patient privilege), when such disclosure is reasonably necessary for the accomplishment of the purpose for which the . . . physician, or psychotherapist was consulted, is not a waiver of the privilege.’”).

179. See In re Edward D., 132 Cal. Rptr. 100, 108 (Ct. App. 1976) (Jefferson, J., dissenting) (stating that “the patient’s presentation of a physician’s prescription to a registered pharmacist would not constitute a waiver of the physician-patient privilege” (quoting CAL. EVID. CODE § 912(d) comment)).

180. See Blue Cross of N. Cal. v. Superior Ct., 132 Cal. Rptr. 635, 636 (Ct. App. 1976) (“[D]iagnosis or treatment or both form the objective of most medical consultations. Thus . . . disclosure to third persons falls within the rule of reasonably necessary purpose when it aims to promote the patient’s treatment.”).

181. See In re Edward D., 132 Cal. Rptr. at 108 (Jefferson, J., dissenting) (stating that “presentation of a physician’s prescription to a registered pharmacist . . . is reasonably necessary for the accomplishment of the purpose for which the physician is consulted” (quoting CAL. EVID. CODE 912(d) comment)).


183. See id. at 649, 649 n.9. A pharmacist is not the only person to whom information protected by the physician-patient privilege can be disclosed without waiving the privilege. See, e.g., Roberts, 508 P.2d
patient’s behalf.\textsuperscript{184} Noting that this reflected a change in California law,\textsuperscript{185} the Rudnick court concluded that the holding in Green that pharmacists cannot claim the protection of the physician-patient privilege “no longer has vitality.”\textsuperscript{186} Thus, the analysis in Rudnick “effectively extended the scope of the physician-patient privilege to incorporate pharmacists,”\textsuperscript{187}

2. \textit{The Potential Extension of the Privilege in Other States}

Like California,\textsuperscript{188} Ohio lacks a specific pharmacist-patient privilege.\textsuperscript{189} But unlike their California counterparts, the Ohio courts have not had occasion to address whether the physician-patient privilege might encompass confidential communications between a patient or physician and a pharmacist.\textsuperscript{190} Nevertheless, Ohio’s physician-patient privilege statute\textsuperscript{191} contains a nonwaiver provision similar to the one in the California Evidence Code,\textsuperscript{192} albeit one that is
even more specific to pharmacists. Both provisions effectively abrogate the questionable view, represented by *Green v. Superior Court* and other similar cases, that once a patient gives a prescription to a pharmacist “it loses its status as privileged since the patient has voluntarily divulged the contents of the prescription to the pharmacist.” Thus, if presented with the issue, the Ohio courts seem likely to follow the *Rudnick* court’s lead and hold that the physician-patient privilege protects a patient’s prescription information and other treatment related communications between a patient or physician and a pharmacist.

Indeed, some commentators predicted that the *Rudnick* decision would mark the start of a judicial trend in favor of recognizing the pharmacist-patient relationship of any semblance of confidentiality. Both provisions effectively abrogate the testimonial privilege, whereas the patient privilege protects a patient's prescription records voluntarily inasmuch as the only way to avoid such sharing is by forgoing medical treatment; State v. Wiedeman, 835 N.W.2d 698, 715 (Neb. 2013) (Connolly, J., dissenting) (criticizing viewpoint that “if a citizen presents a prescription to a pharmacist, he or she has voluntarily disclosed medical information disclosed by the prescription”).

See *Vacco*, supra note 34, at 405 (“When the patient takes the prescription to the pharmacist to be filled, the voluntary act of divulging the contents of the prescription to the pharmacist has been interpreted to be a public disclosure, rendering the information contained within it no longer confidential within the meaning of the privilege.”); *Hearst Corp. v. Clyne*, 409 N.E.2d 876, 877 (N.Y. 1980) (citations omitted) (“It is a fundamental principle of our jurisprudence that the power of a court to declare the law only arises out of, and is limited to, determining the rights of persons which are actually controverted in a particular case pending before the tribunal.”); *Hodge v. Craig*, 382 S.W.3d 325, 338 (Tenn. 2012) (“The courts develop common-law principles on a case-by-case basis over time by deciding specific cases or controversies brought to them by particular parties.”).

See *Vacco*, supra note 34, at 414 (“California courts have concluded that [patient-pharmacist] communications legitimately fall within the purview of the [physician-patient] privilege, whereas . . . New York courts have stripped the pharmacist-customer relationship of any semblance of confidentiality . . . [I]awmakers would be well served to follow the California example of statutory construction.”); cf. *State v. Penn*, 576 N.E.2d 790, 796 (Ohio 1991) (Resnick, J., concurring) (discussing an Ohio statute “aimed at protecting the confidentiality of persons who are taking prescription drugs” (citing OHIO REV. CODE ANN. § 3719.13)).
privilege. However, those commentators have not proven to be prescient. Nearly a quarter of a century after the Rudnick decision, a pair of commentators, who favor recognition of the privilege, found “shockingly few specific laws, regulations and court cases concerning the confidentiality of pharmacist-patient communications and the extension of privilege to such relationships.” Nevertheless, the analysis in Rudnick suggests that the recognition of a pharmacist-patient privilege is warranted as a matter of public policy and courts in other states may yet recognize the privilege on that basis. As one commentator explained:

In this era, when . . . the specialized state of the medical art make[s] the participation of numerous third parties more than reasonably necessary to accomplish the purpose for which the physician was consulted, the patient’s privacy may be properly protected only by empowering such third parties to assert the privilege to protect the patient in his absence.

200. See Adelman & Zahler, supra note 164, at 149 (asserting that Rudnick “may be construed to indicate a trend towards recognizing the existence of a pharmacist-patient privilege”); Vacco, supra note 34, at 413 (“At a time when the physician-patient privilege has been the subject of lengthy attacks, [the Rudnick decision] may indeed represent the appearance of a trend toward revival and broader application of the privilege.”).

201. See Adelman & Zahler, supra note 164, at 127 (finding “very little authority” addressing “the viability of a pharmacist-patient privilege”); Vacco, supra note 34, at 413–14 (“Today, the pharmacy profession . . . [is] faced with an inadequately developed body of law regarding the confidentiality of pharmacist-customer communications . . . .”).

202. Craft & McBride, supra note 38, at 377; see also Berger, supra note 31, at 144 (“Except for a few states, there is little case law or statutory law to guarantee the protection of communications between pharmacists and patients.”).

203. See Tarr, supra note 184, at 119 (“[T]he policy base upon which Rudnick rests is quite sound.”); cf. La. State Bd. of Med. Exam’rs v. Booth, 76 So. 2d 15, 18 (La. Ct. App. 1954) (“[T]he Constitution of 1921 declares the public policy of the State concerning medicines and medical professionals as follows: ‘The Legislature shall provide . . . for protecting confidential communications made to . . . druggists by their patients and clients while under professional treatment and for the purpose of such treatment . . . .’” (quoting La. CONST. of 1921, art. 6, § 12)).


205. Tarr, supra note 184, at 119; cf. State v. Acquino-Cervantes, 945 P.2d 767, 772 (Wash. Ct. App. 1997) (noting that if physician-patient privilege did not protect disclosures to third parties that are reasonably necessary to treat patient “the free flow of information between physician and patient . . . would be chilled by the potential for such third parties to be called as witnesses against the patient . . . in future legal actions”).
IV. POTENTIAL PHARMACIST-PATIENT PRIVILEGE LEGISLATION

Although privilege doctrine originated as a “common law concept,” the creation of privileges is also a legislative prerogative and American law now encompasses many statutory privileges. The physician-patient privilege is simply the earliest example. In fact, the era in which courts recognized new common law privileges virtually ended more than a century ago, its demise fueled in part by the otherwise relatively unsuccessful codification movement that captured the interest of many nineteenth century legal scholars. As a

206. Cook v. King Cnty., 510 P.2d 659, 661 (Wash. Ct. App. 1973); see also Peterson, 112 F.R.D. at 363 (noting that “much of the law of privileges is uniquely judge-made”). The concept of an evidentiary privilege actually may have originated in ancient Roman law, which recognized a “general moral duty not to violate the underlying fidelity upon which the protected relation was built.” State ex rel. State Highway Dep’t v. 62.96247 Acres of Land in New Castle Cnty., 193 A.2d 799, 806, 806 n.7 (Del. Super. Ct. 1963) (citing Max Radin, The Privilege of Confidential Communication Between Lawyer and Client, 16 CAL. L. REV. 487 (1928)). Indeed, “[t]he word ‘privilege’ is a corruption of the Latin phrase ‘privata lex,’ [sic] meaning a private law applicable to a small group of persons as their special prerogative.” Allred, 554 P.2d at 413 (citing Ralph Slovenko, Psychiatry and a Second Look at the Medical Privilege, 6 WAYNE L. REV. 175, 181 (1960)). However, no definitive connection between Roman law and the English common law precedents from which American privilege law evolved is established. See James A. Gardner, A Re-Evaluation of the Attorney-Client Privilege, 8 VIT. L. REV. 279, 288–90 (1963).

207. See, e.g., D.C. v. SA., 670 N.E.2d 1136, 1141 (Ill. App. Ct. 1996) (“[N]o one can dispute that the legislature has the power, through the enactment of evidentiary privileges, to inhibit the truth seeking process to protect certain relationships.”), rev’d on other grounds, 687 N.E.2d 1032 (Ill. 1997); see also State v. Harris, 755 P.2d 825, 828 (Wash. Ct. App. 1988) (“The creation of a testimonial privilege is a recognized function of legislative power.”).

208. See, e.g., Commonwealth v. Chauvin, 316 S.W.3d 279, 286 (Ky. 2010) (“When Kentucky reformed its evidence law, various privileges—including the spousal privilege, the religious privilege, and the psychiatrist-patient privilege—were creatures of statute, and their validity is not in doubt.”); Diaz v. Eighth Jud. Dist. Ct., 993 P.2d 50, 57 (Nev. 2000) (“[C]onfidential communications made between persons in certain special relationships are privileged from compelled disclosure. Nevada’s legislature has expressly recognized such privileges.”); see also Schachar v. Am. Acad. of Ophthalmology, Inc., 106 F.R.D. 187, 189 (N.D. Ill. 1985) (referring to “statutory privileges recognized by the various states”).


211. See Developments in the Law—Privileged Communications, supra note 140, at 1460 (“Although the efforts at general codification of evidence law proved largely unsuccessful, the codification movement’s advocacy of statutory law did result in a ‘wave of statutory alterations of the common law rules’ of evidence during the mid-nineteenth century.”) (quoting 21 WRIGHT & GRAHAM, supra note 13, § 5001, at 222).

212. See Morrison v. State, 845 S.W.2d 882, 905 n.13 (Tex. Crim. App. 1992) (Benavides, J., dissenting) (observing that “the law of evidence, developed first by decisions of the courts and later by formal codification, is replete with rules of privilege”); Hopkins, supra note 53, at 176 (“[M]any states
result, most modern evidentiary privileges have been created through legislative action rather than by judicial decision.\textsuperscript{213}

Reflecting this development,\textsuperscript{214} some courts held that the question of whether to recognize a pharmacist-patient privilege (or any other new privilege)\textsuperscript{215} involves policy issues uniquely suited to legislative resolution.\textsuperscript{216} Specifically, the process involves weighing society’s interest in fostering the relationship at issue against the courts’ interest in the disclosure of relevant evidence.\textsuperscript{217} In our representative democracy, this type of policymaking is
ordinarily left to the branch of government comprised of duly elected representatives of the people. 218

A legislature balancing the competing interests involved in the potential recognition of a privilege might be relatively unconcerned with the judicial interest in the production of evidence, 219 yet attach considerable weight to the countervailing interests served by the privilege. 220 In this vein, some state legislatures amended their physician-patient privilege statutes to encompass confidential communications between patients and pharmacists, 221 as the California legislature effectively did when it revised the state’s evidence laws. 222 Other legislatures achieved the same result by enacting independent pharmacist-patient privilege statutes. 223

allowing certain privileges, the courts and legislators have weighed the policy concerns of the privilege against the value of having evidence before the court.”).

218. See Commonwealth v. Chauvin, 316 S.W.3d 279, 302 n.6 (Ky. 2010) (Abramson, J., dissenting) (stating that “privileges [are] primarily substantive, reflecting policy which ‘should be left to forums that are closer to the public than the courts’” (quoting Robert G. Lawson, Modifying the Kentucky Rules of Evidence – A Separation of Powers Issue, 88 Ky. L.J. 525, 579 (2000)); In re Grand Jury Subpoena, 722 N.E.2d 450, 456 (Mass. 2000) (“[T]he decision whether to create [a] privilege necessarily depends on balancing vital, yet competing, social policies . . . . In most instances, the balancing of such important and competing social interests is better left to elected representatives.”).


220. See Klaine v. S. Ill. Hosp. Servs., 15 N.E.3d 525, 532 (Ill. App. Ct. 2014) (“While the courts value policies that favor the admission of all relevant and reliable evidence which directly assists the judicial function of ascertaining the truth, it is the responsibility of the legislature to . . . . broader social goals that may conflict in some way with the judicial function.”), aff’d, 47 N.E.2d 966 (Ill. 2016); cf. Timothy P. Glynn, Federalizing Privilege, 52 AM. U. L. REV. 59, 140–41 (2002) (asserting that courts facing “the stark costs of [a] privilege in the case before them . . . may discount or ignore the extrinsic values that the privilege is supposed to serve”).


222. See supra Section III.B.1.

223. See, e.g., ARK. CODE ANN. § 16-41-101 (2013) (“A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made to a pharmacist or persons under the direction of a pharmacist.”), repealed by Act of Apr. 11, 2013, No. 1148, 2013 Ark. Acts 1148; NEB. REV. STAT. § 38-2868(1) (“Information with regard to a patient maintained by a pharmacist . . . shall be privileged and confidential . . . .”).
Nevertheless, these enactments are rare. Many state legislatures seem unaware of the potential benefits of a pharmacist-patient privilege. Others may not be convinced that these potential benefits outweigh the courts’ ordinarily predominant interest in the disclosure of evidence. Indeed, some state legislatures seem to have weighed the competing interests and affirmatively concluded that the relationship between patients and pharmacists does not merit the protection of an evidentiary privilege.

For example, the Connecticut legislature enacted a statute in 1995 that purports to prohibit pharmacists from revealing “any records or information concerning the nature of pharmaceutical services rendered to a patient without the oral or written consent of the patient or the patient’s agent.” At first blush this statute appears to create a pharmacist-patient privilege, even though the legislature did not use the term “privilege” in the statute. However, the statute

224. See, e.g., State v. Welch, 624 A.2d 1105, 1109 (Vt. 1992) (“Neither the statute, 12 [VT. STAT. ANN.] § 1612(a), nor the evidentiary rule, V.R.E. 503, includes pharmacists among the professionals covered by the patient’s privilege.”); see also Booth, supra note 55, at 1195 (“[L]egislatures are usually reluctant to create new privileges, because such privileges impede the judicial process by preventing disclosure of relevant information.”).

225. See Craft & McBride, supra note 38, at 377 (concluding that most states seem to be “terribly unaware” of need for a pharmacist-patient privilege). The pharmacy profession may bear some responsibility for this situation, as the legislative recognition of a number of privileges has resulted from “intensive lobbying efforts by professionals seeking special status for their communications.” Smith, supra note 60, at 91. Taking their cue from these efforts, pharmacists who “do not have privileged status . . . should demand to have their individual state legislation amended as appropriate.” Craft & McBride, supra note 38, at 377; see also Berger, supra note 31, at 144–45 (“[P]harmacists should support legislation enhancing protection of patients’ records.”).


227. See, e.g., Shiffrin v. I.V. Servs. of Am., Inc., 729 A.2d 784, 788 (Conn. App. Ct. 1999) (discussing a Connecticut statute that “permits a pharmacy to disclose [patient] information when such information is sought pursuant to a subpoena” (citing CONN. GEN. STAT. ANN. § 20-626(b)(6))); cf. Holmes v. Holmes, 96 N.W.2d 547, 553–54 n.2 (Minn. 1959) (“W]here the legislature has specifically enumerated instances where testimony shall be privileged it has by inference expressed an intention to exclude any other privilege as to testimony or production of evidence.”).

228. 1995 Conn. Acts 95-85 (Reg. Sess.) (codified at CONN. GEN. STAT. § 20-626(a)).

229. See generally Commonwealth v. Chauvin, 316 S.W.3d 279, 287 (Ky. 2010) (“The essence of a privilege is to prohibit disclosure, and thus also discovery.”); Baker v. Indus. Comm’n, 21 N.E.2d 593, 596 (Ohio 1939) (explaining that a privilege “protects and seals . . . confidential and intimate communications of the patient against intrusion by the outside world, unless the patient gives his express consent to their revealment”).

230. Cf. Chauvin, 316 S.W.3d at 287 (“Although the intent of the legislature certainly would have been more perfectly expressed if the statute specifically discussed the prohibition on disclosure as a ‘privilege,’ this Court does not generally require statutes to use magic words.”); Hartsock v. Goodyear Dunlop Tires N. Am. Ltd., 813 S.E.2d 696, 699–700 (S.C. 2018) (“When construing a purported statutory
goes on to state that even without a patient’s consent, a pharmacist can—and presumably must—disclose information pertaining to the services provided to a patient in response to a subpoena.

The legislatures of other states enacted similar statutes purporting to make pharmacy records confidential, while nevertheless requiring pharmacists to reveal the information contained in those records in response to subpoenas and court orders. In these states, pharmacists clearly are not protected by an evidentiary privilege, and thus, courts can compel pharmacists to reveal the content of their confidential pharmacist-patient communications in judicial proceedings. For largely unexplained reasons, the legislatures of these states

privilege, there is no requirement that the word ‘privilege’ be used by the [legislature] in order to evidence an intent to create one.

231. The holder of an evidentiary privilege can waive its protection by consenting to the disclosure of the privileged information. See Stetson v. Silverman, 770 N.W.2d 632, 641 (Neb. 2009) (“Generally, an evidentiary privilege is waived when the holder of the privilege voluntarily discloses or consents to disclosure of any significant part of the matter or communication.”).

232. See Craft & McBride, supra note 38, at 375 (“Even where a state legislature has deemed material ‘confidential,’ . . . the confidential material still must be produced under subpoena power or court order.”).

233. See CONN. GEN. STAT. § 20-626(b) (stating that notwithstanding confidentiality of information pertaining to a pharmacist’s treatment of a patient, pharmacists “may provide pharmacy records or information . . . pursuant to a subpoena”); cf. Shiffrin v. I.V. Servs. of Am., Inc., 729 A.2d 784, 788 (Conn. App. Ct. 1999) (“The legislature envisioned situations where the disclosure of pharmaceutical information would be permitted.” (discussing CONN. GEN. STAT. § 20-626(b))).

234. See, e.g., GA. CODE ANN. § 26-4-80(c) (“Any pharmacist who transmits, receives, or maintains any prescription or prescription refill either orally, in writing, or electronically shall ensure the security, integrity, and confidentiality of the prescription and any information contained therein . . . .”); IDAHO CODE § 54-1727(b) (“[A]ll prescriptions, drug orders, records or any other prescription information that specifically identifies an individual patient shall be held in the strictest confidence.”); see also supra note 80 and accompanying text.

235. See, e.g., GA. CODE ANN. § 24-12-1(b) (emphasis added) (“No pharmacist . . . shall be required to release any medical information concerning a patient except . . . upon appropriate court order or subpoena . . . .”); WASH. REV. CODE § 18.64.245(1) (stating that although prescription records are confidential, they must be produced “in court or before any grand jury whenever lawfully required”); see also David Woodward, Recent Multistate Enforcement Initiative: Prescription Drug Promotional Practices, 50 FOOD & DRUG L.J. 295, 297 (1995) (emphasis added) (“Certain state laws . . . prohibit pharmacists from releasing confidential information about consumers to third parties without the consumers’ consent or an authorizing court order.”).


237. See In re Patel, 218 S.W.3d 911, 920 n.6 (Tex. App. 2007) (“Material that is required to be kept ‘confidential’ may not be protected from disclosure in judicial proceedings.”); Craft & McBride, supra note 38, at 375–76 (“Should sensitive oral communications occur in a state where they are not protected, the pharmacist will not be able to legally preserve their content or sanctity.”).

238. See generally Wheelabrator Balt., L.P. v. Mayor of Baltimore, 449 F. Supp. 3d 549, 565 (D. Md. 2020) (“Legislatures are not required to identify or explain the rationale underlying their statutory decisions.”); Torres v. Seaboard Foods, LLC, 373 P.3d 1057, 1068 (Okl. 2016) (“The legislature is not
at least implicitly rejected the view that a “public interest in fostering open communication between patients and health care professionals warrants the creation of a statutory pharmacist-patient privilege.”

V. THE PHARMACIST-PATIENT PRIVILEGE’S POTENTIAL VALUE IN THE PROVISION OF HEALTH CARE

A. The Privileged Nature of Prescriptions

Analyzing the relationship between patients and their physicians, the court in *Hammonds v. Aetna Casualty & Surety Co.*, observed that because the typical patient “is unfamiliar with the road to recovery, he cannot sift the circumstances of his life and habits to determine what is information pertinent to his health.” Accordingly, “he must disclose all information in his consultations with his doctor—even that which is embarrassing, disgraceful or incriminating.”

By protecting this information from compelled disclosure in subsequent court proceedings, the physician-patient privilege encourages patients to provide their physicians with their complete medical histories, which required to explain its reasons for creating a statute or expressly state that it has a particular intent when crafting legislation.

239. Adelman & Zahler, supra note 164, at 152. Although unstated, legislative indifference to the concept of a pharmacist-patient privilege may reflect an assumption that pharmacists can “defend the confidentiality of patient records by resorting to . . . the Code of Ethics for Pharmacists.” BUERKI & VOTTERO, supra note 33, at 95. However, as discussed in more depth in Part II, supra, an “ethical standard of confidentiality . . . does not offer the pharmacist any legal ground to refuse a requested disclosure of records by a court of law.” Vacco, supra note 34, at 406–07.


242. Id. at 801; see also Fall v. White, 449 N.E.2d 628, 633 (Ind. Ct. App. 1983) (“Frequently, if not usually, patients are not learned enough to know what facts are of critical importance and which are not.” (quoting Brief of Appellant at 71, Fall, 449 N.E.2d 628 (No. 4–1181A182))).

243. *Hammonds*, 243 F. Supp. at 801; see also McCormick v. England, 494 S.E.2d 431, 435 (S.C. Ct. App. 1997) (“A person who lacks medical training usually must disclose much information to his or her physician which may have a bearing upon diagnosis and treatment.”).

244. See Landelius v. Sackellares, 556 N.W.2d 472, 475 (Mich. 1996) (observing that “rationale for the physician-patient privilege . . . [is] to encourage patients to freely divulge symptoms and conditions without fear that the information will be disclosed in court and embarrass them”); Cline v. William H. Friedman & Assocs., Inc., 882 S.W.2d 754, 761 (Mo. Ct. App. 1994) (noting that privilege “prevents a physician from disclosing by testimony in court or formal discovery confidential medical information acquired while attending a patient in a professional manner” (construing MO. REV. STAT. § 491.060(5) (1994))).

presumably leads to more effective diagnosis and treatment. One court described the intended effect of the privilege in the following terms:

It is well known that the modern physician, when undertaking to diagnose a difficult case, requires and usually receives a complete medical history of the patient, including any and all diseases which the patient may have had. The [privilege] protects and seals such confidential and intimate communications of the patient against intrusion by the outside world, unless the patient gives his express consent to their revealment or testifies in respect thereto.

The failure to extend similar protection to a patient’s communications with a pharmacist reflects a persistent, but outdated, perception of pharmacists as mere dispensers of medication who do not diagnose or treat patients. Under this view of pharmacy practice, pharmacists simply fill prescriptions as written. In

physician-patient privilege . . . assumes that proper medical care is dependent on complete and accurate medical history”). See generally Dorris v. Detroit Osteopathic Hosp. Corp., 594 N.W.2d 455, 461–62 (Mich. 1999) (“Historically, confidentiality has been understood to be necessary to promote full disclosure of a patient’s medical history and present medical conditions.”).

246. See Lewin v. Jackson, 492 P.2d 406, 410 (Ariz. 1972) (“It is well settled that the purpose of the physician-patient privilege is to insure that the patient will receive the best medical treatment by encouraging full and frank disclosure of medical history and symptoms by a patient to his doctor.”); State v. Gillespie, 710 N.W.2d 289, 297 (Minn. Ct. App. 2006) (“The purpose of the privilege is to encourage patients’ full disclosure of information, which will enable medical providers to extend the best medical care possible.”); cf. Collins v. Bair, 268 N.E.2d 95, 98 (Ind. 1971) (“[F]ree communications and frank disclosure between patient and physician . . . provide assistance in proper diagnosis and appropriate treatment.”).


250. See Suarez v. Pierard, 663 N.E.2d 1039, 1042 (Ill. App. Ct. 1996) (“The pharmacist . . . is largely limited to filling the prescription as ordered by the physician.”); Rite Aid Corp. v. Levy-Gray, 894 A.2d 563, 579 (Md. 2006) (asserting that in “the ordinary pharmacist-patient relationship . . . the pharmacist merely fills the prescription as ordered by the physician”); Abrams v. Bute, 27 N.Y.S.3d 58, 65 (App. Div. 2016) (citations omitted) (“The pharmacist’s traditional role in [the] system of distribution is to accurately fill the prescription in accordance with the instructions provided by the prescribing physician.”).
contrast to prescribing physicians, pharmacists therefore have no need to obtain, and little familiarity with, their patients’ medical histories. Accordingly, there is purportedly no need to protect patients from the compelled disclosure of confidential information their pharmacists are unlikely to possess.

However, even without any other communications between a patient and pharmacist, the mere presentation of a prescription almost invariably conveys confidential information about the patient’s medical history to the pharmacist and to anyone else to whom the prescription might be disclosed. In this regard, a prescription is a communication from a physician to a pharmacist made on

251. See Ramirez v. Richardson-Merrell, Inc., 628 F. Supp. 85, 88 (E.D. Pa. 1986) (asserting that a prescribing physician “presumably knows the patient’s present condition as well as his or her complete medical history”); Parr v. Rosenthal, 57 N.E.3d 947, 962, n.17 (Mass. 2016) (arguing that, in some circumstances, “the physician’s unique familiarity with the patient’s medical history enables the physician to treat the patient’s condition most effectively”).


253. See generally U.S. Dep’t of Just. v. Rico Jonas, 24 F.4th 718, 736 (1st Cir. 2022) (“[P]rescription drug records do not generally or necessarily contain the more personal and intimate information that other medical records do.”); Jennifer L. Smith, Comment, Between a Rock and a Hard Place: The Propriety and Consequence of Pharmacists’ Expanding Liability and Duty to Warn, 2 HOUS. J. HEALTH L. & POL’Y 187, 213 (2002) (observing that a pharmacist’s records are “unlikely to be as detailed or as thorough as the information a physician has”).

254. See, e.g., Kasin v. Osco Drug, Inc., 728 N.E.2d 77, 78 (Ill. App. Ct. 2000) (“No discussion occurred between [the patient] and the pharmacist regarding the side effects or risks associated with [the prescribed medication].”); see also BUERKI & VOTERO, supra note 33, at 83 (“In terms of patient consultation, . . . pharmacists operating under the older, passive paradigm discussed nothing substantive with their patients, and often circumvented such discussions by referring all but the most trivial patient questions to the physician.”).

255. See Lewis v. Superior Ct., 172 Cal. Rptr. 3d 491, 502 (3d Ct. App. 2014) (observing that “prescription records contain . . . sensitive information related to drugs used to treat a person’s medical condition”), opinion superseded, 334 P.3d 684 (Cal. 2014), and aff’d, 397 P.3d 1011 (Cal. 2017); State v. Russo, 790 A.2d 1132, 1148 (Conn. 2002) (recognizing that “prescription records may contain information of a private nature regarding a person’s physical or mental health”).

256. See, e.g., Walgreen Co. v. Hinchy, 21 N.E.3d 99, 103 (Ind. Ct. App. 2014) (“In this case, a pharmacist breached one of her most sacred duties by viewing the prescription records of a customer and divulging the information she learned from those records to the client’s ex-boyfriend.”), aff’d on reh’g, 25 N.E.3d 748 (Ind. Ct. App. 2015); Washburn v. Rite Aid Corp., 695 A.2d 495, 496 (R.I. 1997) (discussing “a pharmacy’s disclosure of a woman’s prescription-drug records to her estranged husband’s attorney without first notifying her or obtaining her consent”); see also State v. Skinner, 10 So. 3d 1212, 1216 (La. 2009) (noting that a pharmacist “could voluntarily reveal information on a prescription form”).

257. See Ingram v. Adena Health Sys., 777 N.E.2d 901, 905 (Ohio Ct. App. 2002) (“Prescriptions involve medical records that are created by a physician, which are communications.”); State v. Welch, 624 A.2d 1105, 1109 (Vt. 1992) (stating that “communications involved in pharmacy records are between a prescriber and a pharmacist”); cf. De Freese v. United States, 270 F.2d 730, 733 n.5 (5th Cir. 1959) (“A prescription, by strict definition, is a physician’s written order to a pharmacist for medicinal substances
a patient’s behalf,258 relaying confidential information the patient provided to the physician,259 and at least inferentially summarizing “the physician’s diagnosis, prognosis, and treatment of the patient’s illness.”260 This might not qualify as precisely the type of “confidential communication”261 between a patient and physician that is ordinarily protected by the physician-patient privilege.262 Nevertheless, the information a patient provides to a physician is protected by the privilege when the physician issues a prescription reflecting that information.263 As the California Supreme Court held in Rudnick v. Superior

for a patient. It includes directions to the pharmacist regarding the preparation and to the patient regarding the use of the medicine.” (quoting Louis S. Goodman & Alfred Gilman, The Pharmacological Basis of Therapeutics 1759 (2d ed. 1955)).


259. See Rudnick v. Superior Ct., 523 P.2d 643, 649 (Cal. 1974) (noting that medication prescribed for a patient reflects “information which had been confidentially communicated by the patient to the doctor”); Advantage Behav. Health Sys. v. Cleveland, 829 S.E.2d 763, 772 (Ga. Ct. App. 2019) (stating that prescriptions “necessarily originate from communications, as the only way . . . health professionals can diagnose patients, [or] determine what medications to prescribe, . . . is by communicating with them”). See generally State v. Moses, 80 P.3d 1, 13 (Haw. Ct. App. 2002) (“The invitation to the physician to prescribe . . . is an implied communication of all the data which the physician may by any method seek to obtain as necessary for the prescription.” (quoting 8 Wigmore, supra note 6, § 2384, at 844–45)), aff’d in part and vacated and remanded in part, 77 P.3d 940 (Haw. 2003).

260. De Freese, 270 F.2d at 733 n.5 (quoting Goodman & Gilman, supra note 257, at 1759); see also Lewis, 172 Cal. Rptr. 3d at 502 (observing that prescriptions “reveal medical decisions concerning the course of [a patient’s] treatment”); State v. Wiedeman, 835 N.W.2d 698, 716 (Neb. 2013) (Connolly, J., dissenting) (discussing “the private medical information that our prescription records reveal about our physical ailments and medical decisions”).


262. See, e.g., In re Miner’s Will, 133 N.Y.S.2d 27, 28 (Sur. Ct. 1954) (concluding that “prescriptions . . . are not confidential communications”); State v. Treadway, 328 N.E.2d 825, 826 (Ohio Ct. App. 1974) (holding that a prescription was “not privileged by the physician-patient relationship” because it was not a “communication . . . between a patient and his physician”).

that information should still receive protection if disclosed to a third person when, as is virtually inevitable, the prescription is presented to a pharmacist for filling. As one court concluded: “Regarding [the] argument that only confidential communications, and not . . . prescription records, . . . are subject to the privilege, the Court finds that the privilege is not so limited. . . . [D]rawing [such] a distinction . . . would undermine the point of the privilege in the first place.”

B. The Pharmacist’s Advisory Role in the Treatment of Patients

Leaving aside the confidential and arguably privileged nature of prescriptions, who do not advise and treat patients does not accurately reflect modern pharmacy practice. The physician is admittedly the health care professional primarily

264. See supra notes 182–87 and accompanying text.

265. See U.S. Dep’t of Just. v. Ricco Jonas, 24 F.4th 718, 738 (1st Cir. 2022) (“A physician does not write a prescription for the patient to keep to himself. Instead, the prescription is meant to be turned over to a drug dispenser . . . .”); Griffin v. Phar-Mor, Inc., 790 F. Supp. 1115, 1118 (S.D. Ala. 1992) (noting that “a patient wishing to fill a prescription . . . cannot legally have the prescription filled by a non-pharmacist”); Wiedeman, 835 N.W.2d at 716 (Connolly, J., dissenting) (“Obviously, a prescription must be revealed to a pharmacist.”).

266. See Rudnick v. Superior Ct., 523 P.2d 643, 648 (Cal. 1974); see also Phillips v. Medtronic, Inc., 130 F.R.D. 136, 142 (D. Kan. 1990) (“[T]hird parties . . . have asserted, and courts have applied, the physician-patient privilege when the third parties are necessary recipients of the communication.”); Meier v. Awaad, 832 N.W.2d 251, 261 (Mich. Ct. App. 2013) (“[T]he privilege continues to protect against disclosure by parties other than a physician after the physician conveys privileged communications obtained in the physician-patient relationship to those third parties.”).

267. United States v. Sheppard, 541 F. Supp. 3d 793, 801 (W.D. Ky. 2021); cf. State v. Albritton, 58 So. 3d 894, 899 (Fla. Dist. Ct. App. 2011) (Altenbernd, J., concurring in part and dissenting in part) (“[P]rescriptions are currently obtained within a patient-physician relationship that creates an expectation of at least some level of privacy. Given that a prescription can only be filled when it is on file with a licensed pharmacy, the prescription on file with the pharmacy should retain a significant degree of privacy.”).


269. See Michele L. Hornish, Note, Just What the Doctor Ordered—Or Was It?: Missouri Pharmacists’ Duty of Care in the 21st Century, 65 Mo. L. Rev. 1075, 1076 (2000) (“Courts have not always treated pharmacists as professionals. Instead, pharmacists have traditionally been viewed as ‘order fillers’ for the true professionals: the prescribing physicians.”).

responsible for determining what medication to prescribe for a patient\textsuperscript{271} (and thus for “treating” the patient)\textsuperscript{272} in the first instance.\textsuperscript{273} Pharmacists, on the other hand, ordinarily do not prescribe medication,\textsuperscript{274} nor do they necessarily treat patients in the traditional sense.\textsuperscript{275} As a result, pharmacists may not always be (or at least arguably may not need to be)\textsuperscript{276} as familiar with a patient’s medical history as the prescribing physician.\textsuperscript{277}

\textsuperscript{271} See Horner v. Spalito, 1 S.W.3d 519, 524 (Mo. Ct. App. 1999) (stating that physician “is responsible for assessing what medication is appropriate for a patient’s condition”); Leibowitz v. Ortho Pharm. Corp., 307 A.2d 449, 457 (Pa. Super. Ct. 1973) ("It is for the prescribing physician to use his own independent medical judgment, taking into account the data supplied to him... and weighing that knowledge against the personal medical history of his patient, whether to prescribe a given drug.").

\textsuperscript{272} See Cackowski v. Wal-Mart Stores, Inc., 767 So. 2d 319, 325 (Ala. 2000) (“Upon examining the patient, the physician may determine that a course of medication is necessary to treat the patient’s condition.”); State v. Collier, 581 N.E.2d 552, 555 (Ohio 1991) (noting that prescriptions “are issued by practitioners with the notion that the drugs are required as part of medical treatment”); Providence Health Ctr. v. Dowell, 262 S.W.3d 324, 332 n.1 (Tex. 2008) (Wainwright, J., concurring in part and dissenting in part) (describing a situation in which “prescribing medication was part of the physician’s treatment”).

\textsuperscript{273} See Blackburn v. Shire U.S., Inc., 380 So. 3d 354, 369 (Ala. 2022) (Sellers, J., dissenting) (“Physicians... are in the best position to evaluate patients to determine, based on a particular patient’s unique medical history, personal features, and individual characteristics, whether to prescribe medication in the first place and how each patient should be monitored thereafter.”); Supermarkets Gen. Corp. v. Sills, 225 A.2d 728, 736 (N.J. Super. Ct. Ch. Div. 1966) (noting that “the primary responsibility for drug prescription rests with the physician”).

\textsuperscript{274} See Siddiqui v. Ill. Dep’t of Pro. Regul., 718 N.E.2d 217, 227 (Ill. App. Ct. 1999) (“[T]he pharmacist’s role does not extend to deciding whether to prescribe drugs.” (construing 225 ILL. COMP. STAT. 85/3(d) (1999))); Chiney v. Am. Drug Stores, Inc., 21 S.W.3d 14, 17 (Mo. Ct. App. 2000) (“The pharmacist does not possess... but rather he or she fills and dispenses prescriptions according to the directions of other health care providers authorized to prescribe medication.” (citing MO. REV. STAT. § 354.050; “Allowing pharmacists with limited prescriptive authority to fill prescriptions at chain pharmacies... is... inconsistent with the pharmacist’s role.”); BUS. & PROF. CODE § 4052.6; OR. REV. STAT § 689.689. For a discussion of this development, see generally Olivia Plinio, Comment, Your Pharmacist Will See You Now: The Expansion of Prescribing Rights Reaches the Pharmacist, 44 SETON HALL LEGIS. J. 399 (2020).


\textsuperscript{276} See Jill Casson Owen, Note, The Pharmacist’s Duty to Warn: Lasley v. Shrake’s Country Club Pharmacy, 37 ARIZ. L. REV. 677, 699 (1995) (footnote omitted) (“The doctor, who has the complete medical history and condition of the patient makes the decision on which drug to use. The pharmacist does not need this history and condition to provide information as to side effects on drugs.”). But cf. Vacco, supra note 34, at 413 (“It is necessary that the pharmacist be familiar with each customer’s personal health profile. This includes, inter alia, knowledge of patient allergies, physical ailments, and medication history. All of these factors play a vital role in arriving at the proper drug therapy.”).

\textsuperscript{277} See Springhill Hosps., Inc. v. Larrimore, 5 So. 3d 513, 519 (Ala. 2008) (asserting that “the physician, not the pharmacist, has... the knowledge of a patient’s individual medical history necessary for properly prescribing medication”); Morgan, 30 S.W.3d at 467 (stating that pharmacists “do not possess the extensive knowledge of a physician with respect to a patient’s complete medical history”).
Nevertheless, today’s pharmacists do not invariably dispense medication precisely as directed by a physician.278 For one thing, pharmacists typically possess greater knowledge of the potential risks and benefits of prescription medication than a prescribing physician279 and certainly than a typical patient.280 Employing this superior knowledge,281 a pharmacist who concludes that the ingestion of a particular medication could be harmful to the patient,282 either taken alone or in conjunction with other medication,283 might refuse to fill the prescription.284 As the last health care professional the patient is likely to see

278. See Kohl v. Am. Home Prods. Corp., 78 F. Supp. 2d 885, 891 (W.D. Ark. 1999) (“[T]he courts have concluded that, in some cases, the pharmacist’s duty will extend beyond merely accurately filling a prescription.”); Horner v. Spaulito, 1 S.W.3d 519, 524 (Mo. Ct. App. 1999) (“We reject the suggestion . . . that the only function[] which a pharmacist must perform to fulfill his duty is to dispense drugs according to a physician’s prescription.”).

279. See Pysz v. Henry’s Drug Store, 457 So. 2d 561, 562 (Fla. Dist. Ct. App. 1984) (noting that a pharmacist may have “greater knowledge of the propensity of drugs than that of the physician”); Morgan, 30 S.W.3d at 463 (observing that “a pharmacist might in some instances possess greater knowledge than a physician of the adverse effects of drugs”). See generally Moore v. Mem’l Hosp., 825 So. 2d 658, 668 (Miss. 2002) (McRae, P.J., concurring) (“Pharmacists go to school for many years to learn about drugs and their reactions to other drugs; doctors’ exposure is not nearly as in depth or intense as they take only one or two courses.”).

280. See, e.g., Walker v. Jack Eckard Corp., 434 S.E.2d 63, 70 (Ga. Ct. App. 1993) (Pope, C.J., dissenting) (discussing errors in a prescription written by a physician that “the patient could not detect but which would be readily apparent to a properly trained pharmacist”); see also Burke v. Bean, 363 S.W.2d 366, 368 (Tex. Civ. App. 1962) (“The general customer ordinarily has no definite knowledge concerning many medicines, and must rely implicitly on the druggist, who holds himself out as one having the peculiar learning and skill, and license from the state, to fill prescriptions.”).

281. See Moore, 825 So. 2d at 668 (McRae, P.J., concurring) (stating that pharmacists “are experts in pharmacology, unlike doctors”); Anonymous v. CVS Corp., 728 N.Y.S.2d 333, 338 (Sup. Ct. 2001) (“The pharmacist has vastly superior knowledge of pharmaceuticals, a highly specialized type of goods with the potential to cause great harm to customers.”).

282. See generally Murphy v. E.R. Squibb & Sons, Inc., 202 Cal. Rptr. 802, 810 (Ct. App. 1984) ("[I]t is the pharmacist’s obligation to have specialized knowledge in the area of toxicology, being able to recognize various contraindications for drugs prescribed, inclusive of numerous potentially dangerous drug interactions."). vacated, 710 P.2d 247 (Cal. 1985).

283. See, e.g., People v. Medina, 705 P.2d 961, 968 (Colo. 1985) (“Antipsychotic medications, either alone or in combination, can cause numerous and varied side effects, and carry with them the risk of serious and possibility permanent disabilities in the patient.”); see also Makripodis v. Merrell-Dow Pharm., Inc., 523 A.2d 374, 376–77 (Pa. Super. Ct. 1987) (“Prescription drugs . . . may be dangerous when used in conjunction with other drugs or substances, or may be harmful if taken by persons suffering from certain diseases or conclusions.”).

before taking medication, the pharmacist at least should warn the patient and the prescribing physician—of any significant pharmacological risks.

Even when the perceived risk to the patient is negligible, pharmacists “may be in the best position to determine how . . . medication should be taken to maximize the therapeutic benefit to [the] patient, [and] to communicate that information to the [patient] or his physician.” In short, pharmacists are highly

285. See Anonymous, 728 N.Y.S.2d at 337 (stating that pharmacists “are often the last health care professional a patient may have contact with before treatment, i.e., pharmaceutical drugs are administered”); David B. Brushwood, The Challenges of Pharmacogenomics for Pharmacy Education, Practice, and Regulation, in PHARMACOGENOMICS: SOCIAL, ETHICAL, AND CLINICAL DIMENSIONS 207, 212 (Mark A. Rothstein ed., 2003) (“[P]harmacists are the final professional risk evaluators in a long chain of careful decisions about risk that precede the dispensing of medication to a patient.”) [hereinafter The Challenges of Pharmacogenomics].

286. See Kowalski v. Rose Drugs of Dardanelle, Inc., 378 S.W.3d 109, 125 (Ark. 2011) (Brown, J., dissenting) (stating that “pharmacists should . . . counsel with their customers about the dosages and side effects” of prescription medication (discussing 070.00.00 Ark. Code R. § 09-00-0001(a)-(d) (2011))); Huggins v. Long Drug Stores Cal., Inc., 862 P.2d 148, 153 (Cal. 1993) (“Pharmacists . . . spend substantial amounts of time advising patients about the proper use of a prescribed drug and its possible side effects or interaction with other medications.”); Smith, supra note 253, at 213 (“The pharmacist [has] the ability to alert patients to possible drug interactions, allergies, addictiveness, and side effects.”).

287. See, e.g., Sanchez, 221 P.3d at 1281 n.3 (noting that in Nevada a pharmacist who “declines to fill a prescription, because in his professional judgment the prescription is . . . potentially harmful to the customer’s health” must confer with the prescribing physician “to resolve the pharmacist’s concerns” (citing NEV. ADMIN. CODE § 639.753)); see also Bordelon v. Lafayette Consol. Gov’t, 149 So. 3d 421, 426 (La. Ct. App. 2014) (Saunders, J., dissenting) (“Pharmacists are responsible for . . . communicating with prescribers when a prescription order is unclear or potentially harmful for the patient . . . .”); Horner v. Spalitto, 1 S.W.3d 519, 523 (Mo. Ct. App. 1999) (asserting that pharmacists “are in the best position to contact the prescribing physician, to alert the physician about . . . any contraindications relating to other prescriptions the [patient] may be taking as identified by the pharmacy records”).

288. See, e.g., Stock v. Gray, 663 F. Supp. 3d 1044, 1054 (W.D. Mo. 2023) (“[A] pharmacist may call the prescribing doctor to alert him that a widely used drug is no longer recommended because of new information about side effects, or he may call a patient to warn about a potential drug interaction.”); see also Tanya E. Karwaki, Establishing a Patient-Pharmacist Relationship: Clarifying Duties and Improving Patient Care, 72 BAYLOR L. REV. 507, 511 (2020) (noting that as “the last health care professional a patient sees before taking a medication” the pharmacist “is well positioned to provide warnings about potential adverse events or dangers associated with the drug”).

289. A pharmacist could conclude that the ingestion of virtually any prescription medication would potentially harm the patient. See Brown v. Superior Ct., 751 P.2d 470, 477 (Cal. 1988) (observing that “all prescription drugs involve inherent risks”). However, in many cases the risk will be “so trifling in comparison to the advantage to be gained as to be de minimis.” Davis v. Wyeth Labs., Inc., 399 F.2d 121, 129 (9th Cir. 1968). Thus, neither physicians, nor pharmacists, should be expected to inform patients “of every possible risk, no matter how remote or bizarre.” Wolfe v. United States, 604 F. Supp. 726, 729 (S.D. Cal. 1985); see also Mason v. Smithkline Beecham Corp., 596 F.3d 387, 392 (7th Cir. 2010) (stating that “overwarning can deter potentially beneficial uses of [a] drug by making it seem riskier than warranted”).

290. Horner, 1 S.W.3d at 524; see also Jason V. Allilio, The Pharmacist’s Obligations to Patients: Dependent or Independent of the Physician’s Obligations?, 37 J.L. MED. & ETHICS 358, 364 (2009) (“Pharmacists are uniquely situated to give competent professional advice and thereby aid the patient in making a decision that will . . . benefit his or her health.”); Amy M. Haddad, Reflections on the Pharmacist-Patient Covenant, AM. J. PHARM. Educ., Sept. 2018, at 732 (“The pharmacist-patient relationship has changed . . . from one in which pharmacists focused solely on filling prescriptions without questioning a
trained professionals who, in order to promote the health and safety of their patients, are expected to exercise independent judgment when filling prescriptions and to share their professional expertise with patients and physicians when they deem it appropriate to do so. In this sense, both physicians and pharmacists advise patients about their prescription medications and therefore, share responsibility for “proper prescribing.”


292. See generally Stormans, Inc. v. Selecky, 524 F. Supp. 2d 1245, 1251 (W.D. Wash. 2007) (“A pharmacist’s primary responsibility is to ensure patients receive safe and appropriate medication therapy.” (quoting WASH. ADMIN. CODE § 246-863-095(1) (2007), repealed by 21-05 WASH. REG. 054 (Mar. 18, 2021))). The view that a pharmacist does not exercise any professional judgment has been criticized by courts and commentators alike. See Smith v. Cal. State Bd. of Pharmacy, 43 Cal. Rptr. 2d 532, 534 (Ct. App. 1995) (summarizing Kowalski v. Rose Drugs of Dardanelle, Inc., 378 S.W.3d 109, 125 (Ark. 2011) (Brown, J., dissenting) (asserting that “pharmacists should work with physicians to . . . counsel with their customers about the dosages and side effects” of prescribed medication); Vacco, supra note 34, at 406 (“[T]he pharmacist retains professional independence in instructing the patient as to how to take . . . medication, informing the patient of what side effects to be aware of and ultimately, in questioning the physician as to the particular medication prescribed for the patient.”)).

293. See Kohl v. Am. Home Prods. Corp., 78 F. Supp. 2d 885, 890 (W.D. Ark. 1991) (describing modern pharmacist “exercising professional judgment independent of the prescribing physician in screening prescriptions”); Abrams v. Bute, 27 N.Y.S.3d 58, 67 (App. Div. 2016) (“The view that a pharmacist does not exercise any professional judgment has been criticized by courts and commentators alike . . . .”); Vacco, supra note 34, at 406 (“[T]he pharmacist retains professional independence in instructing the patient as to how to take . . . medication, informing the patient of what side effects to be aware of and ultimately, in questioning the physician as to the particular medication prescribed for the patient.”).

294. See Makripodis v. Merrell-Dow Pharmas., Inc., 523 A.2d 374, 378 (Pa. Super. Ct. 1987) (“It is . . . the duty of the prescribing physician to advise the patient of any dangers or side effects associated with the use of [a] drug as well as how and when to take the drug.”); cf. West v. Searle & Co., 806 S.W.2d 608, 613 (Ark. 1991) (“[T]he patient relies upon the physician’s judgment in selecting [a] drug, and the patient relies upon the physician’s advice in using the drug.”).

295. See Bordelon v. Lafayette Consol. Gov’t, 149 So. 3d 421, 426 (La. Ct. App. 2014) (Saunders, J., dissenting) (observing that pharmacists are responsible for “advising the patient of any potential drug interactions, of any potential side effects, and of any recommendations concerning how and when to take medication”); cf. Pittman v. Upjohn Co., 890 S.W.2d 425, 434 (Tenn. 1994) (“The increased complexity of pharmacotherapeutics and the accompanying adverse reactions to drugs and interactions between drugs have resulted in an expanded role for pharmacists as drug therapy counselors.” (quoting David B. Brushwood, The Informed Intermediary Doctrine and the Pharmacist’s Duty to Warn, 4 J. LEGAL MED. 349, 351 (1983))).

296. See also Correa v. Schoeck, 98 N.E.3d 191, 199 (Mass. 2018) (“The responsibility for the proper prescribing and dispensing of controlled substances shall be
C. The Multiple Physician Phenomenon

In this era of increasing medical specialization, patients often receive treatment from more than one physician simultaneously. In this situation one or more of those physicians might lack familiarity with the medications prescribed by the others, while the pharmacist may possess relatively comprehensive knowledge of the medications the patient is taking, and fulfilling this responsibility, these health care professionals provide patients with advice of a similar nature, and their communications with those patients should be considered equally confidential and privileged.

298. See Murphy v. E.R. Squibb & Sons, Inc., 710 P.2d 247, 251 (Cal. 1985) (“In counseling patients, [a pharmacist] imparts the same kind of information as would a medical doctor about the effects of the drugs prescribed.”).

299. See, e.g., KAN. STAT. ANN. § 65-1654(a) (“The confidential communications between a licensed pharmacist and the pharmacist’s patient and records of prescription orders filled by the pharmacist are placed on the same basis of confidentiality as provided by law for communications between a physician and the physician’s patient and records of prescriptions dispensed by a physician.”); see also Vacco, supra note 34, at 413 (“[T]he pharmacist legitimately and of necessity acquires much of the same information about the patient’s medical background as does the patient’s physician. To say that the pharmacist acquires this information in a less confidential manner than the physician seems unreasonable from a public policy standpoint.”).


301. See, e.g., Johnson v. Walgreen Co., 675 So. 2d 1036, 1037 (Fla. Dist. Ct. App. 1996) (describing a patient who “was seeing a number of doctors for treatment, each of whom prescribed different medications”); Robin v. Hebert, 157 So. 3d 63, 65 (La. Ct. App. 2013) (identifying a patient who was taking multiple medications “prescribed to her by several different physicians”); State v. Wiedeman, 835 N.W.2d 698, 706 (Neb. 2013) (providing example of a patient who “was filling narcotic prescriptions from multiple doctors”).

302. See Lawson v. Lawson, 821 So. 2d 142, 145 (Miss. Ct. App. 2002) (discussing a patient who was “simultaneously seeking treatment from multiple physicians, without sharing the fact that she was seeing and obtaining prescriptions from all of them”); Wiedeman, 835 N.W.2d at 700 (describing a patient taking prescription medication who “did not inform her medical providers that she was being prescribed similar medications elsewhere”).

303. See Hernandez v. Walgreen Co., 49 N.E.3d 453, 462 (Ill. App. Ct. 2015) (internal punctuation omitted) (explaining that when a patient “has seen numerous doctors . . . each doctor would know only what prescription she herself has written for the patient” and thus, the pharmacist “may have more information than the doctor”); Supermarkets Gen. Corp. v. Sills, 225 A.2d 728, 736 (N.J. Super. Ct. Ch. Div. 1966) (“[I]f the customer frequents one pharmacy for all of his prescription needs, that pharmacist is in a position to check his records and thereby determine if a prescription is in any way antagonistic or contra-indicated by his previous prescription record.”); David B. Brushwood, The Professional
accordingly, of the patient’s overall medical condition. If this is the case, the patient’s and the various physicians’ need for the pharmacist’s expertise and advice will be particularly acute, as the pharmacist is the only health care professional able to identify potentially dangerous, and perhaps even lethal, drug interactions. As one commentator explained:

Many patients see several different doctors for their different needs . . . and, of course, pharmacists may also be involved. The different providers may not be aware of concurrent therapies, making the . . . pharmacist the one professional most likely to be able to know about and assess the drug interactions and contraindications.

D. The Pharmacist’s Familiarity with Patient Medical Histories

The now largely discredited view that pharmacists merely dispense medication to patients who are diagnosed and treated by other health care professionals and the various physicians a person may be ingesting on the prescription of more than one physician. At other times, however, the pharmacist may have more information about the patient than the physician.

See Jennifer D. Oliva, Prescription-Drug Policing: The Right to Health-Information Privacy Pre-and Post-Carpenter, 69 DUKE L.J. 775, 784 (2020) (“It is often possible to divine a patient’s medical condition, diagnosis, or disease—and even the stage and severity of that condition, diagnosis, or disease—simply by reference to the patient’s prescribing history.”); cf. Quick, supra note 36, at 155 (“It may be fair to assume that more often than not a treating physician knows more about a patient’s condition than the patient’s dispensing pharmacist. At other times, however, the pharmacist may have more information about the patient than the physician.”).

305. See, e.g., Terry v. Cal. State Bd. of Pharmacy, 395 F. Supp. 94, 106 (N.D. Cal. 1975) (“[P]harmacists . . . advise purchasers on the proper use of drugs which doctors prescribe and . . . monitor the interactions of the various drugs a person may be ingesting on the prescription of more than one physician.”), aff’d, 426 U.S. 913 (1976); Michael D. Roth & Leonard M. Fromer, Identifying and Resolving Disputes in New Accountable Care Settings, 69 DISP. RESOL. J. 1, 10 (2014) (“[A] pharmacist who sees a contraindication for prescriptions ordered by different physicians will need to communicate with the physicians; in turn, the physicians will need to communicate with each other and with the pharmacist.”).

306. See, e.g., Horner v. Spalitto, 1 S.W.3d 519, 521 (Mo. Ct. App. 1999) (discussing a patient whose “death resulted from adverse effects of multiple medications”); see also Johnson, 675 So. 2d at 1037 (describing prescription medications that “in combination . . . had potentially lethal effects”); Disciplinary Couns. v. Owen, 30 N.E.3d 910, 913 (Ohio 2014) (referring to a prescription medication “found to be lethal to some patients”).

307. See Patterson Drug Co. v. Kingery, 305 F. Supp. 821, 824 (W.D. Va. 1969) (observing that familiarity with a patient’s prescription history enables pharmacist to counsel patient concerning “the simultaneous use of antagonistic drugs, of which the patient’s doctor may not be aware”); Supermarkets Gen. Corp., 225 A.2d at 735 (noting that a pharmacist “may ‘monitor’ each prescription as to dosage, and possibly determines whether the prescribed drug may be antagonistic to another previously prescribed for the patient by another physician”).

308. Owen, supra note 276, at 697 (footnote omitted); see also Schowbel, supra note 35, at 920 (footnote omitted) (“If a patient is being treated by several doctors at one time, each doctor may be unaware of which medication the other is prescribing. The pharmacist, however . . . , is able to view all of the medications currently being used by a patient and can notify the patient’s primary care physician about potentially harmful interactions.”).
professionals causes courts to overlook, or at least to discount, pharmacists’ familiarity with their patients’ medical histories. Whenever a pharmacist is presented with a patient’s prescription, information about the patient’s health is communicated to the pharmacist. As those prescriptions are refilled and others are issued and presented to the pharmacist, the pharmacist “can literally reconstruct a patient’s medical history.”

This familiarity with a patient’s medical history is critical to the pharmacist’s role in the provision of health care. Among other things, pharmacists review their patients’ medical histories to identify “any potential allergic reactions, harmful interactions with other medications, or adverse side effects that a [patient] may have to a particular medication.” As one commentator explained:

309. See Karwak, supra note 288, at 532 (“[T]he law . . . fails to sufficiently acknowledge the importance of a pharmacist’s professional judgment and patient specific knowledge in promoting patient care.”).

310. See Anonymous v. CVS Corp., 728 N.Y.S.2d 333, 341 (Sup. Ct. 2001) (noting that “typically pharmacists possess highly sensitive information related to the medical condition and treatment of their customers”); Adelman & Zahler, supra note 164, at 152 (observing that modern pharmacists “maintain extensive patient medication records”); Smith, supra note 253, at 214 (discussing “pharmacists’ increased . . . access to patients’ medical history”).

311. See Griffin v. Phar-Mor, Inc., 790 F. Supp. 1115, 1118 (S.D. Ala. 1992) (“In the usual scenario . . . a doctor prescribes medicine for a patient, and the patient takes the prescription to a pharmacist to fill.”); Perzik v. Superior Ct., 4 Cal. Rptr. 2d 1, 3 n.6 (Ct. App. 1991) (stating that in “the normal situation . . . a prescription is written by a physician for a patient who has the prescription filled by a pharmacist”).

312. See IMS Health Corp. v. Rowe, 532 F. Supp. 2d 153, 158 (D. Me. 2007) (“As a patient fills a prescription, the pharmacist gains a wealth of information about the transaction, the prescriber, and the patient.”), rev’d on other grounds sub nom. IMS Health Inc. v Mills, 616 F.3d 7 (1st Cir. 2010), vacated sub nom. IMS Health, Inc. v. Schneider, 564 U.S. 1051 (2011); CVS Corp., 728 N.Y.S.2d at 341 (“When a customer’s physician writes or telephones a pharmacist about a prescription for medication, medical information is disclosed to a pharmacist.”).


314. Suarez v. Pierard, 663 N.E.2d 1039, 1044 (Ill. App. Ct. 1996) (Breslin, P.J., concurring); see also Smith, supra note 253, at 213 (“Each time a prescription is filled, the pharmacist can review and build upon a patient’s medical history.”); Vaccio, supra note 34, at 399 (“[T]he pharmacist is constantly acquiring a more comprehensive record of each patient’s medical history.”).

315. See, e.g., Doe v. CVS Pharmacy, Inc. 982 F.3d 1204, 1207 (9th Cir. 2020) (noting that ability “to consult knowledgeable pharmacists who [are] familiar with their personal medical histories” is “critical to HIV/AIDS patients, who must maintain a consistent medication regimen to manage their chronic disease”; see also McKee v. Am. Home Prods. Corp., 782 P.2d 1045, 1053 (Wash. 1989) (asserting that “without benefit of a patient’s medical history” a pharmacist cannot “determine the propriety of a particular drug regimen”); Berger, supra note 31, at 145 (“There is a need for pharmacists to have access to available patient information. It is the only way to ensure that an individual is getting the best possible care, not only from the physician, but also from the pharmacist.”).

316. Klasch v. Walgreen Co., 264 P.3d 1155, 1157 (Nev. 2011); see also United States v. Ilayayev, 800 F. Supp. 2d 417, 445 (E.D.N.Y. 2011) (“Problems that a pharmacist may be required to identify include ‘therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect dosage
[O]ne “must understand the patient’s personal condition to effectively treat a wide range of diseases in which factors relating to the patient’s family and/or social condition or personal psychological factors may play a role.” Without understanding the patient in such a way, it would be difficult for a pharmacist to decide what a patient truly needs.

E. The Impact of the Omnibus Budget Reconciliation Act of 1990

In 1990, Congress passed an Omnibus Budget Reconciliation Act ("OBRA" or "OBRA 90"). Insofar as the practice of pharmacy is concerned, Congress intended OBRA “to improve patient drug therapy by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical effects.” As a condition to receiving federal Medicaid

or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.” (quoting David B. Brushwood, From Confrontation to Collaboration: Collegial Accountability and the Expanding Role of Pharmacists in the Management of Chronic Pain, 29 J.L. MED. & ETHICS 69, 74 (2001)).

317. Watt, supra note 248, at 791 (footnote omitted) (quoting David Meltzer, Hospitalists and the Doctor-Patient Relationship, J. LEGAL STUD., June 2001, at 589, 595); see also Schawbel, supra note 35, at 919 (footnote omitted) (“In order to perform their job effectively, pharmacists must have access to all of a patient’s relevant medical information. This access allows pharmacists to provide better treatment to each individual because they are better informed about an individual’s medical background and the circumstances which have led to the need for a particular type of medication.”)


319. As in the case of other budget reconciliation acts, Congress’s ultimate objective in enacting OBRA 90 “was reduction of the federal budget deficit.” Disabled Am. Veterans v. U.S. Dep’t of Veterans Affairs, 962 F.2d 136, 139 (2d Cir. 1992); cf. Karpa v. Comm’r, 909 F.2d 784, 786 (4th Cir. 1990) (“The Senate Report accompanying OBRA 1986 indicates that a primary purpose of the act was to reduce the budget deficit.” (citing S. REP. No. 348 (1986), as reprinted in 1986 U.S.C.C.A.N. 3607)). However, because these acts are “often adopted under tremendous time pressure” and “without extensive public scrutiny or debate,” they are also “attractive vehicles for [substantive] program changes or even expansions.” Timothy Stoltzfus Jost, Governing Medicare, 51 ADMIN. L. REV. 39, 68–69 (1999); see also Tobin, supra note 318, at 120 n.31 (indicating that Congress uses budget reconciliation process “as a method for enactment of major substantive pieces of legislation”).

320. R. Paul Asbury, Comment, Pharmacist Liability: The Doors of Litigation Are Opening, 40 SANTA CLARA L. REV. 907, 924, 924 n.165 (2000) (citing 42 U.S.C. § 1396r-8(g)(1)(A)); see also Tara L. Furnish, Departing from the Traditional No Duty to Warn: A New Trend in Pharmacy Malpractice?, 21 AM. J. TRIAL ADVOC. 199, 199 (1997) (“In an effort to increase overall patient medical care, Congress enacted the Omnibus Budget Reconciliation Act of 1990 (OBRA). . . . Specifically, the statute requires states to implement drug review programs . . . to assure that prescriptions are appropriate, medically necessary and not likely to cause adverse medical results.”); Smith, supra note 253, at 209 (“The stated goals of OBRA 90 focus on the appropriateness of prescriptions and drug therapy and the reduction of error, fraud, overuse, abuse, drug interactions, and medically unnecessary care.”).
funds, OBRA therefore requires the states to establish drug utilization review ("DUR") programs that, among other things, include provisions for pharmacists to counsel their patients concerning drug interactions. Not surprisingly, many states reacted to OBRA by enacting laws requiring pharmacists to counsel their patients (or at least offer to counsel them) concerning the characteristics and potential interactions of prescription

321 See Estate of Johnson ex rel. Johnson v. Badger Acquisition of Tampa LLC, 983 So. 2d 1175, 1182 (Fla. Dist. Ct. App. 2008) ("OBRA primarily regulates how states receive federal funding for . . . Medicaid patient benefits."). Medicaid is "a program that pays the costs of medical services for indigent persons who cannot afford such care and that is jointly funded by the federal and State governments.") Concourse Rehab. & Nursing Ctr. Inc. v. DeBuono, 179 F.3d 38, 40–41 (2d Cir. 1999). If a state elects to participate (which is not mandatory), it is required to establish and operate a Medicaid program that complies with federal standards, and the federal government shares with the state "the cost of reimbursing participating agencies, physicians, and pharmacists for services rendered to eligible recipients." Pharmcare Okla., Inc. v. State Health Care Auth., 152 P.3d 267, 269–70 (Okla. Civ. App. 2006) (citing 42 U.S.C. §§ 1396a, 1396d).

322 See Estate of Johnson, 983 So. 2d at 1182 ("OBRA was designed to 'enhance the role of the pharmacists in providing quality medical care through a comprehensive drug utilization review program."") (quoting 42 U.S.C. § 1396r-8(g)). Drug utilization review "is the process of checking to make sure that prescriptions are appropriate for the condition of the patient and that the drugs are being taken as called for in the treatment regimen." Rosoff, supra note 258, at 14. The concept is "far from revolutionary." Richard D. Baylis, Drug Utilization Review: A Description of Use for a Medicaid Population (Maryland) 1986–1994, 22 J. L. MED. & ETHICS 247, 247 (1994). A number of states implemented DUR programs on their own initiative "long before Congress’s mandate" in OBRA 90. Id. at 248.

323 See Kowalski v. Rose Drugs of Dardanelle, Inc., 378 S.W.3d 109, 116 (Ark. 2011) (observing that OBRA "requires states to establish programs, including counseling customers concerning drug interactions"); Horner v. Spalitto, 1 S.W.3d 519, 523 (Mo. Ct. App. 1999) ("In 1990, the federal government enacted the Omnibus Budget Reconciliation Act which required states to establish standards for pharmacist counseling of pharmacy customers or their caregivers."); Kenneth R. Baker, The OBRA 90 Mandate and Its Developing Impact on the Pharmacist's Standard of Care, 44 Drake L. Rev. 503, 510 (1996) ("OBRA 90 requires states to enact legislation or regulations requiring pharmacists to provide counseling . . . in order to be eligible for federal Medicaid matching funds.") (citing 42 U.S.C. § 1396r-8(g)(2)(A)).

324 See Ill. Health Care Ass’n v. Bradley, 776 F. Supp. 411, 424 n.26 (N.D. Ill. 1991) (referring to “the incentives for states to participate in the voluntary Medicaid program”), aff’d, 983 F.2d 1460 (7th Cir. 1993); Kenneth R. Wiggins, Note, Medicaid and the Enforceable Right to Receive Medical Assistance: The Need for a Definition of “Medical Assistance,” 47 WM. & MARY L. REV. 1487, 1506 (2006) ("It is apparent that a state, especially a poor one, may have a large incentive to adopt a Medicaid program. In fact, most states depend on Medicaid funding to meet their overall cost of medical care.").

325 Although OBRA’s counseling provisions apply only to Medicaid patients, “most states have made them applicable to all patients receiving prescription drugs.” Gary G. Cacciatori, Computers, OBRA 90 and the Pharmacist’s Duty to Warn, 5 J. PHARMACY & L. 103, 111 (1996); see also Smith, supra note 253, at 209 (footnote omitted) ("Although the requirements of OBRA 90 apply only to those pharmacy services provided to Medicaid beneficiaries, most states have passed legislation extending the requirements to all patients.").

326 See, e.g., GA, CODE ANN. § 26-4-85(b) ("Upon receipt of a prescription drug order and following a review of the patient’s record, the pharmacist . . . shall personally offer to discuss matters which will enhance or optimize drug therapy with each patient or caregiver of such a patient."); Correa v. Schoeck, 98 N.E.3d 191, 199 (Mass. 2018) (discussing a state statute that “requires pharmacists to ‘offer to counsel’ any patient when the pharmacist fills a new prescription” (quoting MASS. GEN. LAWS ch. 94C, § 21A (2018))); Horner, 1 S.W.3d at 523 (noting that Missouri Board of Pharmacy promulgated a regulation in
medications. Reflecting another related aspect of OBRA, these state laws also require pharmacists to attempt to obtain patient medical histories in order to facilitate the counseling they provide. Although pharmacists’ efforts to obtain such histories certainly predate these legislative developments, OBRA and the state laws it spawned further undermined the assumption that pharmacists are unfamiliar with their patients’ medical histories and therefore are poorly equipped to advise them about their prescription medications. As one pair of commentators explained:

response to OBRA that requires pharmacists “to offer to discuss with each customer or their caregiver information about the safe and appropriate use of [prescribed] medication” (citing Mo. Code Regs. Ann. tit. 4, § 220-2.190 (1999)).

327. See Kowalski, 378 S.W.3d at 117 (noting that “state regulations establishing standards for the pharmacist’s counseling of pharmacy customers or their caregivers . . . were enacted as a result of the passage of OBRA”). Although OBRA only mandates the enactment of state laws requiring that pharmacists “offer to discuss” significant matters with their patients, “some states have disposed [sic] with the ‘offer’ to counsel altogether and have imposed mandatory patient counseling requirements,” Cacciatore, supra note 325, at 110–11.

328. See Quick, supra note 36, at 145 (”[O]BRA] places upon the several states a duty to pass laws which require pharmacists to assume certain legal responsibilities. These responsibilities include . . . a requirement that . . . pharmacists attempt to obtain personal data on each patient, including the patient’s medical history.” (citing 42 U.S.C. §§ 1396r-8(g)(2)(A)(ii)(I) & (II)); Asbury, supra note 320, at 924 (stating that under OBRA states must “require pharmacists to obtain medical histories on each patient” (citing 42 U.S.C. § 1396r-8(g)(2)(A)(ii)(II))); Mowery, supra note 99, at 721 (asserting that OBRA “requires pharmacists to . . . attempt to obtain personal data on each patient, including the medical history of the patient”).

329. See, e.g., Horner, 1 S.W.3d at 523 (noting that a Missouri regulation enacted in response to OBRA requires a pharmacist’s counseling to be “based on the pharmacist’s review of available patient information” (citing Mo. Code Regs. Ann. tit. 4, § 220-2.190 (1999)); Anonymous v. CVS Corp., 728 N.Y.S.2d 333, 337 (Sup. Ct. 2001) (observing that pharmacists in New York “are required to collect otherwise confidential medical information, and are obligated to review that information before each prescription is dispensed” (citing N.Y. Comp. Codes R. & Regs. tit. 8, § 63.6(b)(7) (2001))).

330. See, e.g., Rite Aid of N.J., Inc. v. Bd. of Pharmacy, 304 A.2d 754, 755, 757 (N.J. Super. Ct. App. Div. 1973) (upholding a pre-OBRA 90 state pharmacy regulation requiring pharmacists to attempt to ascertain “any allergies or idiosyncrasies of the patient and any chronic conditions which may relate to drug utilization, as communicated to the pharmacist by the patient”); see also Lynnette S. Pisone, Comment, The Political Debate Concerning Discriminating Pricing Practices Within Health Care Reform, 4 J. PHARMACY & L. 63, 84 (1995) (“The common practice has always operated on the premise that the patient was responsible to inform the pharmacist of the present medications being used and for what purpose the pharmacist would solicit such information when not initially provided.”).

331. See Richard Hight Gastineau, Comment, Drug Therapy Counseling: Whose Duty to Warn?, 2 J. PHARMACY & L. 293, 308 (1993) (indicating that OBRA 90 has cast doubt on the assumption that the physician “is more knowledgeable of the patient’s medical history” than the pharmacist); Smith, supra note 253, at 213–14 (observing that in wake of OBRA “pharmacists have . . . become increasingly knowledgeable about patients’ medical histories,” and describing argument that they lack knowledge of those histories as “unpersuasive when applied to the contemporary pharmacist”).

332. See Gastineau, supra note 331, at 308 (asserting that OBRA 90 undermined premise that “the physician . . . is in a better position to advise a patient with respect to the best medication available to fit the patient’s specific needs”); cf. Steven W. Huang, The Omnibus Budget Reconciliation Act of 1990: Redefining Pharmacists’ Legal Responsibilities, 24 AM. J.L. & MED. 417, 442 (1998) (“In the past pharmacists only filled prescriptions according to physicians’ specifications; OBRA 90 now calls for greater duties for pharmacists.”); Asbury, supra note 320, at 924 (“OBRA mandates that pharmacists take
Prior to OBRA, the courts noted that pharmacists had no access to a patient’s medical history, and therefore could not make completely knowledgeable judgments on what . . . would be proper under the circumstances. . . . The mandates of the OBRA statutes may completely change the outcome of such cases. Because OBRA requires pharmacists to maintain records of an individual’s medical history, pharmacists may be considered knowledgeable enough to make judgments with respect to what medications are proper for a certain patient.333

VI. THE DEBATE OVER THE PRIVILEGE’S EFFECTIVENESS

Not surprisingly,334 privilege doctrine fails to keep pace with the rapid evolution of the pharmacy profession;335 as a result, no pharmacist-patient privilege currently exists in most states.336 The recognition of such a privilege is nevertheless warranted if the relationship interests the privilege would serve outweigh the courts’ interest in the production of evidence.337 In weighing these

a more active role in drug therapy by inquiring into patients’ conditions, reviewing their relevant drug history, and performing drug counseling.’

333. John C. West & David E. Smith, A Prescription for Liability: The Pharmacy Mandate of the Omnibus Budget Reconciliation Act of 1990 and Its Impact Upon Pharmacists’ Common Law Duties, 2 J. PHARMACY & L. 127, 138–39 (1994); see also Robert A. Gallagher, Comment, Pennsylvania Pharmacists Should No Longer Assume That They Have No Duty to Warn, 45 DUQ. L. REV. 59, 75 (2006) (footnote omitted) (“Under OBRA-90, the pharmacist is required to discuss with each person who presents a prescription matters that are significant in the pharmacist’s professional judgment, such as special directions and precautions for preparing, administering and using the drug, common severe or adverse effects or interactions, and contraindications. The pharmacist must also make a reasonable effort to obtain a record [of] and maintain the patient’s history, including known allergies, drug reactions and the medications taken.” (citing 42 U.S.C. § 1396r-8(g)(2)(a)(ii))).

334. See Timken Roller Bearing Co. v. United States, 38 F.R.D. 57, 64 (N.D. Ohio 1964) (“The traditional privileges have been established only after generations of jurists and/or legislators have recognized a social interest greater than a fully informed search for truth.”); In re Alt v. Cline, 589 N.W.2d 21, 33 (Wis. 1999) (Bradley, J., dissenting) (“Privileges are glaciers moving— inching, bit by bit—along the surface of the Anglo-American legal tradition.”).

335. See, e.g., Schawbel, supra note 35, at 946 (noting that OBRA “fails to give patients any legal guarantees that their pharmacy records will remain confidential and will not be disclosed without their consent sometime in the future”); see also Adelman & Zahler, supra note 164, at 139 (“[T]he legal status of the pharmacist-patient relationship has not been modified to reflect the changing nature of the relationship.”).

336. See Vacco, supra note 34, at 404–05 (“[T]he legal status of the pharmacist-customer relationship has remained relatively unchanged offering the patient little protection from potential compulsory disclosure by the pharmacist of confidential patient information.”); Jeffrey Begens, Comment, Parent-Child Testimonial Privilege: An Absolute Right or an Absolute Privilege?, 11 U. DAYTON L. REV. 709, 712 n.35 (1986) (“No privilege exists . . . between patients and their pharmacist regarding the disclosure of prescription records.”)

337. See In re Sealed Case, 676 F.2d 793, 806 (D.C. Cir. 1982) (“Competent authority must determine that a privilege is necessary in a particular context to protect that which society seeks to protect, and that the benefits of protecting the privileged interest outweigh the benefits of getting at the truth.”); Jackson v. Harvard Univ., 721 F. Supp. 1397, 1408 n.5 (D. Mass. 1989) (“An evidentiary privilege . . . is—or should be—a highly functional and strictly limited device for advancing some particular professional role
conflicting interests, several courts and commentators acknowledged the importance of confidentiality in the pharmacist-patient relationship.\textsuperscript{338} These authorities seem to conclude that, as in their interactions with physicians,\textsuperscript{339} patients are more likely to confide in their pharmacists if the information they provide cannot be disclosed to others without their consent.\textsuperscript{340}

On the other hand, “a concern for protecting confidentiality does not equate to privilege,”\textsuperscript{341} and some courts and commentators continue to question the need for a pharmacist-patient privilege.\textsuperscript{342} In Reynolds v. State,\textsuperscript{343} for example, the court held that a patient’s prescription records were not privileged.\textsuperscript{344} The court acknowledged that such records are confidential and that patients have “a right to privacy with respect to them,”\textsuperscript{345} but nevertheless concluded that they were as to which society is willing to pay the severe cost of being deprived of relevant evidence when communications and documents concerning that role are put in issue.”), aff’d, 900 F.2d 464 (1st Cir. 1990).

338. See, e.g., United States v. Gayden, 977 F.3d 1146, 1152 (11th Cir. 2020) (acknowledging patients’ interests “in the confidential nature of . . . medical information which they choose to disclose to a pharmacist to get [a prescription] filled”); see also Scott v. Flynt, 704 So. 2d 998, 1004 (Miss. 1996) (“[T]he need for patient confidentiality outweighs that of judicial expeditiousness. A patient’s privilege of medical confidentiality is of paramount importance and must be afforded protection.”).

339. See Dorris v. Detroit Osteopathic Hosp. Corp., 594 N.W.2d 455, 462 (Mich. 1999) (“[P]atients . . . may not be as willing to reveal their full medical history for fear that, ultimately, that information . . . may lose its confidential status. This chilling of the patient’s desire to disclose would have a detrimental effect on the physician’s ability to provide effective and complete medical treatment . . . .”).

340. See Cohan v. Ayabe, 322 P.3d 948, 958 (Haw. 2014) (“If citizens feel that their privacy rights in health care information are not adequately protected, this may lead to various negative outcomes for patients, including ‘. . . patient reluctance to share sensitive information with their doctors or pharmacists.’” (quoting Christopher R. Smith, Somebody’s Watching Me: Protecting Patient Privacy in Prescription Health Information, 36 Vt. L. Rev. 931, 943 (2012))); Quick, supra note 36, at 161, 165 (asserting that pharmacy patients “might be much more willing to share personal information if they are assured that the information could not be used against them or cause them embarrassment at some time in the future” which in turn “would allow the pharmacist to provide the patient with better services”).


342. See, e.g., Ladner v. Ladner, 436 So. 2d 1366, 1373 (Miss. 1983) (“We fail to see any substantial reason for requiring nondisclosure of communications between a pharmacist and his client where such communications contain material and relevant evidence.”).


344. See id. at 464. Reynolds arose in Maryland, which is among the states that do not recognize a physician-patient privilege, let alone a pharmacist-patient privilege. See Att’y Grievance Comm’n v. Sloane, 290 A.3d 1026, 1033 (Md. 2023) (noting that “a ‘physician/patient’ privilege . . . does not exist under Maryland law”). For a discussion of the impact the existence (or nonexistence) of a physician-patient privilege may have on the recognition of a pharmacist-patient privilege, see infra Part VII.

345. Reynolds, 633 A.2d at 464; see also Suarez v. Pierard, 663 N.E.2d 1039, 1044 (Ill. App. Ct. 1996) (Breslin, J., concurring) (“Surely the public has a right to expect that pharmacists will keep the health conditions and treatments of their patients in confidence.”); Murphy v. State, 62 P.3d 533, 541 (Wash. Ct. App. 2003) (“We recognize, as have other courts, that patients have a limited expectation of privacy in prescription records.”).
not protected from disclosure in court proceedings “under the theory that they are privileged.”  

Perhaps most notably, the court in *Green v. Superior Court*347 based its now discredited refusal to recognize the privilege in part on Dean John Henry Wigmore’s assertion that the absence of an evidentiary privilege would not deter people from seeking medical treatment.348 Other courts also followed Wigmore’s view,349 concluding, in effect, that “[o]nly a foolish patient would withhold relevant information . . . and jeopardize his or her health on the supposition that the information might be relevant in a subsequent lawsuit.”350 Discussing the physician-patient privilege at which this criticism is typically directed,351 one court insisted that there is “little merit, factually speaking,” in the view that

---

346. *Reynolds*, 633 A.2d at 464; cf. *State v. Welch*, 624 A.2d 1105, 1109 (Vt. 1993) (“[T]here is no patient’s privilege . . . with respect to . . . pharmaceutical records . . . [The patient] does have a privacy interest that derives from her expectation that these records cannot be arbitrarily disclosed . . . .”).


348. See id. at 606 (“Dean Wigmore opines that few communications by a patient . . . are intended to be confidential and that even where they are the patient is not deterred from making them by the possibility of their disclosure.” (citing 8 *Wigmore*, supra note 6, § 2380a, at 829)); cf. *State v. Thompson*, 836 N.W.2d 470, 494 n.7 (Iowa 2013) (Appel, J., concurring) (asserting that author of “at least one leading treatise” concluded that empirical studies “do not bear out the assumption that in the mind of the typical patient, the existence of an evidentiary privilege has a major influence either on the decision to consult a professional or on the decision to make revelations to a consulted professional” (quoting EDWARD J. IMWINKELRIED, THE NEW WIGMOORE: A TREATISE ON EVIDENCE § 5.2.2, at 313–23 (2d ed. 2009))).

349. See, e.g., *Lowes’ of Roanoke, Inc. v. Jefferson Standard Life Ins. Co*, 219 F. Supp. 181, 187 (S.D.N.Y. 1963) (“[A]s Wigmore points out ‘ . . . [e]ven where the disclosure . . . is actually confidential, it would nonetheless be made though no privilege existed. People would not be deterred from seeking medical help because of the possibility of disclosure in court.’” (quoting 8 *Wigmore*, supra note 6, § 2380a, at 829)); *State v. Aucoin*, 362 So. 2d 503, 505 (La. 1978) (“It is doubtful whether most physician-patient communications are truly intended to be kept in confidence, or whether people would stop going to doctors if they feared disclosure.” (citing 8 *Wigmore*, supra note 6, § 2380a)).

350. Felder v. Wyman, 139 F.R.D. 85, 89 (D.S.C. 1991); see also *United States v. Newman*, 965 F.2d 206, 210 (7th Cir. 1992) (asserting that “a person who believes that he or she may be ill or injured has a strong incentive to tell the professional from whom he seeks diagnosis or treatment the truth about his medical history, symptoms, etc. because if he doesn’t it will be harder for the professional to diagnose his problem and treat it effectively”); *State ex rel. Allen v. Bedell*, 454 S.E.2d 77, 86 (W. Va. 1994) (Cleckley, J., concurring) (“I have serious reservations whether an evidentiary privilege is necessary to facilitate proper medical treatment. Indeed, a wise patient who wants to survive his or her current medical problems would have a natural incentive to disclose all relevant information when seeking medical treatment.”).

351. See *Stempler v. Speidell*, 495 A.2d 857, 860 (N.J. 1985) (“Critics of the privilege maintain that . . . the absence of privilege would not deter patients from frank communications with their physicians because their primary concern is to secure proper medical attention.” (citing 8 *Wigmore*, supra note 6, § 2380a, at 829–30)). In refusing to extend the physician-patient privilege to encompass pharmacists, the court in *Green* noted that the privilege “has been roundly criticized by common-law scholars.” *Green*, 33 Cal. Rptr. at 606; see also *State ex rel. Grimm v. Ashmanskas*, 690 P.2d 1063, 1065 (Or. 1984) (“The validity of the [physician-patient] privilege has been questioned by most of the leading evidence authorities in the country.” (citing, inter alia, 8 *Wigmore*, supra note 6, §§ 2380-91)).
“people will be deterred from engaging medical help because of the possibility of subsequent disclosure in court.”

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

The prevalence of this view may explain, in part, why the courts never recognize a common law physician-patient privilege. Nevertheless, the validity of the underlying assumption is debatable. Many health care professionals are convinced that fear of public disclosure does influence patient behavior. In the opinion of these interested and presumably well-informed

352. State v. Tu, 478 N.E.2d 830, 833–34 (Ohio Ct. App. 1984), abrogated on other grounds by State v. Smorgala, 553 N.E.2d 672 (Ohio 1990); see also United States ex rel. Edney v. Smith, 425 F. Supp. 1038, 1040–41 (E.D.N.Y. 1976) (“This whole argument that the privilege is necessary to induce persons to see a doctor sounds like a philosopher’s speculation on how men may logically be expected to behave rather than the result of observation of the way men actually behave.”) (quoting Chafee, supra note 143, at 609), aff d, 556 F.2d 556 (2d Cir. 1977).

353. Tu, 478 N.E.2d at 834 (citing 8 WIGMORE supra note 6, § 2380a); see also Goldberg, supra note 145, at 789 (“[N]o one has ever been able to demonstrate that public health or recourse to medical aid has been impeded in the handful of states that have not adopted the privilege.”); Laural C. Alexander, Comment, Should Alabama Adopt a Physician-Patient Evidence Privilege?, 45 ALA. L. REV. 261, 263 (1993) (“[T]here is no evidence that public health or the availability or quality of health care has suffered in states which do not recognize the privilege.”).

354. Cf. Tarr, supra note 184, at 112 (“[T]he common law rule rejecting any . . . privilege for communications between a physician and his patient was grounded on the theory that ‘disclosure of the whole truth was essential to the proper administration of justice and that the need for it far outweighed any considerations of professional confidence.’” (quoting DeWITT, supra note 140, at 10)).

355. See Guerrier v. State, 811 So. 2d 852, 855 (Fla. Dist. Ct. App. 2002) (“The fact that the common law [does] not recognize a physician-patient privilege can best be explained by reference to the generally accepted notion, evidently premised on the natural inclination toward self preservation, that potential disclosure of a patient’s confidences to the physician in court proceedings would not be a deterrent to submission by the patient of information necessary to obtain proper medical treatment for their physical ailments.”).

356. See, e.g., Anker v. Brodnitz, 413 N.Y.S.2d 582, 584 (Sup. Ct. 1979) (citation omitted) (“While the courts of other states have severely questioned the value of the physician-patient privilege, . . . the New York Court of Appeals has not repudiated the rationale underlying the privilege.”), aff’d, 422 N.Y.S.2d 887 (App. Div. 1979); see also Ruebner & Reis, supra note 20, at 574 (“Obviously, much has changed in the last half century. Wigmore’s arguments no longer hold true.”).

357. See Peter A. Winn, Confidentiality in Cyberspace: The HIPAA Privacy Rules and the Common Law, 33 Rutgers L.J. 617, 622 (2002) (“[H]ealthcare providers have long known that fear of disclosure of health information may cause people to withhold information, to lie, or to avoid treatment altogether. Accordingly . . . healthcare providers have maintained a strong presumption against disclosure of their patients’ health information.”).
observers,358 the failure to recognize a pharmacist-patient privilege is likely to cause some patients to withhold important information about their health from their physicians or pharmacists,359 and occasionally even to forego medical treatment altogether.360 Such a decision ultimately could prove harmful—and perhaps even fatal361—to the reticent patient.362

In any event, judicial and scholarly criticism of the physician-patient privilege has created no appreciable impact on its statutory recognition among the states.363 In all of the states that recognize the privilege,364 its existence is

---

358. See Julie Bruce, Bioterrorism Meets Privacy: An Analysis of the Model State Emergency Health Powers Act and the HIPAA Privacy Rule, 12 ANNALS HEALTH L. & LIFE SCI. 75, 94 (2003) (“Health care providers handle sensitive information on a daily basis and, therefore, are aware of the importance of confidentiality.”).

359. See Laburre v. E. Jefferson Gen. Hosp., 555 So. 2d 1381, 1383 (La. 1990) (“The threat of disclosure of patient confidences may deter patients from revealing information that could result in humiliation, embarrassment, or disgrace to the patient or that could be the basis for the patient’s legal liability.”); Scott D. Anderson, Comment, A Right Without a Remedy: The Unenforceable Medical Procedure Patient, 3 MARQ. INTELL. PROP. L. REV. 117, 133–34 (1999) (“Patients may be less likely to fully disclose medical conditions if they know that their treatment is not absolutely confidential.”).

360. See United States v. Sheppard, 541 F. Supp. 3d 793, 801 (W.D. Ky. 2021) (“Whether the treatment-related information sought is the content of conversations between provider and patient or . . . prescription records, the possibility of disclosure may chill an individual’s choice to seek treatment . . . .”); Commonwealth v. Kyle, 533 A.2d 120, 126 (Pa. Super. Ct. 1987) (observing that where “information revealed by the patient is extremely personal, the threat of disclosure to outsiders may cause the patient to hesitate or even to refrain from seeking treatment”).


362. See In re Marriage of Peters-Farrell, 802 N.E.2d 1250, 1254 (Ill. App. Ct. 2003) (“If [a litigant] were able to obtain . . . records from the pharmacy where [a patient] filled a prescription . . . [the patient] might be reluctant to fill such a prescription and might not receive necessary treatment.”), vacated on other grounds and appeal dismissed as moot, 835 N.E.2d 797 (Ill. 2005); The Challenges of Pharmacogenomics, supra note 285, at 213 (“Adverse patient outcomes can . . . result from the failure to use a drug that should have been prescribed for a patient.”); Schawbel, supra note 35, at 964 (“[Patients] will hesitate to reveal vital medical information to their pharmacists in an effort to avoid unwanted disclosure, and the price they will pay for privacy is the possibility of inadequate treatment.”).

363. See, e.g., Leritz v. Koehr, 844 S.W.2d 583, 585 (Mo. Ct. App. 1993) (citation omitted) (“[T]he physician-patient privilege has been the subject of severe criticism. Nevertheless, it has been a matter of public policy in Missouri since first enacted by the General Assembly in 1835.”); Dillenbeck v. Hess, 536 N.E.2d 1126, 1131 (N.Y. 1989) (“Although the physician-patient privilege has been criticized by commentators . . . the privilege remains rooted in both the statutory law and public policy of New York State.”); State v. Betts, 384 P.2d 198, 204–05 (Or. 1963) (“Wigmore . . . attacks the privilege in either civil or criminal proceedings. Because of the Oregon statute there is no question, however, that in this jurisdiction the privilege exists in civil proceedings.”) (discussing OR. REV. STAT. § 44.040(1)(d) (1963))); Steven Goode & M. Michael Sharlot, Texas Rules of Evidence Handbook: Part I, Article V: Privileges, 30 HOUST. L. REV. 489, 606 (1993) (“Texas adopted the privilege after it had been subject to decades of withering criticism and ridicule from the pens of the most prominent evidence scholars of this century.”).

364. See Alvin O. Boucher, Implied Waiver of Physician and Psychotherapist-Patient Privilege in North Dakota Medical Malpractice and Personal Injury Litigation, 83 N.D. L. REV. 855, 861 (2007) (“Despite the arguments advanced by Wigmore against the privilege, its existence was established by
premised on the assumption that patients are more likely to confide in medical professionals if the information they disclose is shielded from future disclosure to third parties.\textsuperscript{365} This assumption may not have been, and perhaps can never be,\textsuperscript{366} empirically validated.\textsuperscript{367} However, the resulting uncertainty—\textsuperscript{368}which is hardly unique to the physician-patient privilege—\textsuperscript{369}has not prompted any state to abandon the privilege,\textsuperscript{370} and there is no persuasive reason for refusing to extend the assumption on which it is based to the pharmacist-patient relationship.\textsuperscript{371} As one pair of commentators observed:

\begin{quote}
statute in most states … .\textsuperscript{377})]; Note, Medical Jurisprudence – Privileged Communications Between Physician and Patient – State Regulation and Right to Privacy, 39 TENN. \textsc{Rev.} 515, 521 (1972) (footnote omitted) (“The physician-patient privilege has won at least limited recognition in a majority of states, despite disparaging treatment by Dean Wigmore and others.”).

365. See Snyker \textit{v. Snyker}, 72 N.W.2d 357, 359 (Minn. 1955) (“The theory of all physician-patient privilege statutes is that [a] patient’s fear of revelation in court of information given to his doctor [would] deter and discourage him from freely disclosing his symptoms to the detriment of his health.”); Randa \textit{v. Bear}, 312 P.2d 640, 644 (Wash. 1957) (“The purpose of the various state legislatures in creating the privilege was to foster the physician-patient relationship by inspiring confidence in the patient and encouraging him to make a full disclosure to the physician of his symptoms and condition, free of the worry that an embarrassing condition might become public knowledge.”).

366. See \textit{Gale v. State}, 792 P.2d 570, 624 n.25 (Wyo. 1990) (Urbitigt, J., dissenting) (“Both camps in the privilege debate are hampered by empirical uncertainty. One can never prove that costs outweigh benefits or vice-versa with regard to a particular privilege: such arguments inevitably degenerate into simple unsupported assertions.” (quoting \textit{Developments in the Law—Privileged Communications, supra note 140, at 1666})).

367. See \textit{Long v. Am. Red Cross}, 145 F.R.D. 658, 668 (S.D. Ohio 1993) (finding it likely that physician-patient privilege was “created without a significant amount of empirical proof that this assumption is accurate”).

368. See \textit{In re Grand Jury Subpoena (Psychological Treatment Records)}, 710 F. Supp. 999, 1007 (D.N.J.) (emphasizing “[a]n extremely thorough review of the law of privileges concluded that there is no authoritative empirical evidence which proves or disproves the proposition that the existence of a … physician-patient privilege encourages persons to seek treatment and to freely communicate [with their physicians]”) (citing \textit{Developments in the Law—Privileged Communications, supra note 140, at 1474–77, 1542–44}), aff’d, 879 F.2d 861 (3d Cir. 1989).

369. See Kenneth S. Broun, \textit{Giving Codification a Second Chance—Testimonial Privileges and the Federal Rules of Evidence}, 53 \textsc{Hastings L.J.} 769, 793 (2002) (“There is little empirical evidence on the value of evidentiary privileges in promoting the free flow of information in the case of protected relationships.”); \textit{Developments in the Law—Privileged Communications, supra note 140, at 1543 n.92 (emphasis added)” (“There is, in fact, no authoritative empirical evidence to prove or disprove the proposition that the physician-patient privilege, or any other privilege, actually encourages communication.”).

370. See, \textit{e.g.}, State \textit{v. Broussard}, 529 P.2d 1128, 1130, (Wash. Ct. App. 1974) (“The physician-patient privilege has been in effect in this state for so many years that we should not change the rule without grave necessity.”); \textit{also see Vacco, supra note 34, at 403 (footnote omitted) (“While legal commentators have vigorously attacked the physician-patient privilege, not one state that has adopted the privilege has seen fit to repeal it.”). See generally Milton C. Regan, Jr., \textit{Spousal Privilege and the Meanings of Marriage}, 81 \textsc{Va. L. Rev.} 2045, 2132 (1995) (“Skepticism about the direct effect of [a] privilege on behavior . . . hardly distinguishes this body of law from many legal rules.”).

371. See, \textit{e.g.}, Adelman \& Zahler, supra note 164, at 152 (asserting that “absence of an express pharmacy-patient privilege” is “likely to hamper the patient’s willingness to freely disclose pertinent medical information to medical and health care professionals”); Quick, supra note 36, at 161 (“The law [should] . . . guarantee a pharmacist’s patients some degree of confidentiality. Certainly, patients might
In order to ensure proper and effective drug therapy, it is essential that the pharmacist develop a medical history on the patient which would include, among other things, information about the patient’s allergies, physical ailments, and medication history. In ascertaining this information, the pharmacist acquires much of the same information about the patient’s medical background as the patient’s physician. Consequently, it seems unreasonable to assume that the pharmacist acquired this information in a less confidential manner than the physician.372

VII. THE SIGNIFICANCE OF EXISTING PHYSICIAN-PATIENT PRIVILEGE STATUTES

In the nearly two centuries since its initial adoption by the New York legislature,373 most other states have recognized the physician-patient privilege, as well.374 The expansion of this privilege has been gradual375 and may not have fully run its course.376 Nevertheless, neither Congress, nor the federal courts, be much more willing to share personal information if they are assured that the information could not be used against them or cause them embarrassment at some time in the future.”); see also State v. Gutierrez, 482 P.3d 700, 708 (N.M. 2019) (“In a relationship involving a layperson and a professional, the absence of a privilege protecting confidentiality could chill beneficial communication because the layperson might refuse to communicate with the professional.”).

372. Adelman & Zahler, supra note 164, at 152; see also Schawbel, supra note 35, at 962 (“Many in the professions of law and pharmacy have indicated that communications between pharmacists and patients should be treated similarly to those between doctors and patients.”).

373. See In re Grand Jury v. Kuriansky, 505 N.E.2d 925, 927 (N.Y.1987) (“The physician-patient privilege originated in this State. It did not exist at common law and the first statute to recognize the privilege was adopted by the New York Legislature in 1828.”). Adoption of the privilege appears to have been prompted in part by “the lament of Mr. Justice Buller in Wilson v. Rastall, 100 Eng. Rep. 1283, 1287 (1792), that the law of privilege was not extended to ‘medical persons’ as to ‘the information which they acquire by attending in their professional characters.’” Phipps v. Sasser, 445 P.2d 624, 627–28 (Wash. 1968); see also Shuman, supra note 62, at 676–77 (stating that “Justice Buller’s lamentation” was “noted and agreed with by the New York Legislature” when it enacted nation’s first physician-patient privilege statute (discussing Extracts from the Original Reports of the Revisers, REVISED STATUTES OF THE STATE OF NEW YORK 737 (Benjamin F. Butler & John C. Spencer eds., 1836))).

374. See Laburre v. E. Jefferson Gen. Hosp., 555 So. 2d 1381, 1383 (La. 1990) (“The physician-patient privilege, which did not exist at common law, was first enacted in the United States in New York in 1828 and has since been adopted in one form or another by almost all of the states.”); Culver v. Union Pac. R.R. Co., 199 N.W. 794, 796 (Neb. 1924) (“The statutory privilege originated in a statute of New York passed in 1828. Its terms have been adopted in substance in many of the other states of the Union.”).


376. See, e.g., Caldwell v. Chauvin, 464 S.W.3d 139, 160 (Ky. 2015) (Keller, J., concurring) (“I believe that it is time for Kentucky to adopt a general physician-patient privilege.”); Alexander, supra note 353, at 273 (“Alabama should recognize the importance of protecting the confidentiality of physician-patient communications by enacting a physician-patient privilege statute.”); Mary Claire Johnson, Note, “I Will Not Divulge”: How to Resolve the “Mass of Legal Confusion” Surrounding the Physician-Patient
adopted the privilege, and some states still do not recognize it. The recognition of a pharmacist-patient privilege seems unlikely in those jurisdictions, in part because there is no existing privilege for a legislature to amend, or for the courts to interpret broadly enough to protect confidential communications between pharmacists and their patients.

Even in states with a physician-patient privilege statute, the recognition of a corresponding pharmacist-patient privilege seems likely to occur, if at all, only through similar legislative action. This assumption reflects the courts’
Pharmacists and physicians are de facto partners in the provision of modern medical care; they both are professionally and ethically obligated to maintain the confidentiality of information about their patients’ health. However, pharmacists in many states are not protected by an evidentiary privilege and courts in those states can compel pharmacists to disclose confidential information about their patients.

Conclusion

Pharmacists and physicians can work collaboratively to better patient care and the two professions have experience working together under collaborative practice agreements.

385. See United States ex rel. Riley v. Franzen, 653 F.2d 1153, 1160 (7th Cir. 1981) (“[C]ourts have been reluctant to create new privileges . . . despite any policy reasons supporting recognition of a particular privilege.”).

386. See, e.g., Yolanda L. Ayala & Thomas C. Martin, Note, To Tell or Not to Tell? An Analysis of Testimonial Privileges: The Parent-Child and Reporter’s Privileges, 9 ST. JOHN’S J. LEGAL COMMENT. 163, 185 (1993) (“Where state judiciaries have failed to act, twenty-six state legislatures have enacted statutes granting newsgatherers a privilege of nondisclosure.”); Molly Silfen, Note, I Want My Information Back: Evidentiary Privilege Following the Partial Birth Abortion Cases, 38 J. HEALTH L. 121, 125–26 (2005) (footnote omitted) (“Because courts refuse to recognize a physician-patient privilege under common law, many state legislatures have tried to fill the void through statutory privileges.”).

387. Davison v. St. Paul Fire & Marine Ins. Co., 248 N.W.2d 433, 441 (Wis. 1977); cf. Three Juveniles v. Commonwealth, 455 N.E.2d 1203, 1205–06 (Mass. 1983) (“In recent years . . . courts have tended to leave the creation of evidentiary privileges to legislative determination.”); In re Alt v. Cline, 589 N.W.2d 21, 33 (Wis. 1999) (Bradley, J., dissenting) (“Where the common law was silent, legislatures acted to create the privileges we commonly recognize today.”).

388. See Kowalski v. Rose Drugs of Dardanelle, Inc., 376 S.W.3d 109, 125 (Ark. 2011) (Brown, J., dissenting) (asserting that “physicians should work with physicians to identify, resolve, and prevent potential and actual drug-related problems”); Karwaki, supra note 288, at 544 (footnote omitted) (“Physicians and pharmacists can work collaboratively to better patient care and the two professions have experience working together under collaborative practice agreements.”); Schawbel, supra note 35, at 959 (observing that “physicians and pharmacists frequently work together for the patient’s benefit.”).

389. See Sparks v. Donovan, 884 So. 2d 1276, 1280 (La. Ct. App. 2004) (discussing “duty of confidentiality . . . owed by health care providers, including pharmacists, to their patients”); Stempler v. Speidel, 495 A.2d 857, 860 (N.J. 1985) (“[I]n general, a physician does have a professional obligation to maintain the confidentiality of his patient’s confidences.”); Steinberg v. Jensen, 534 N.W.2d 361, 370 (Wis. 1995) (“Physicians owe an ethical duty of confidentiality to their patients . . . .”); Buerki & Vottero, supra note 33, at 93 (“The keeping of confidences is . . . one of the classical ethical requirements of professional health-care ethics. The 1994 Code of Ethics for Pharmacists pledges ‘serving the patient in a private and confidential manner’ . . . .”) (quoting AM. PHARM. ASS’N, CODE OF ETHICS FOR PHARMACISTS § II (1994)).

information about their patients’ health.\textsuperscript{391} As a result, patients may feel reluctant to provide the type of sensitive personal health information necessary to enable pharmacists to fulfill their proper role in the provision of health care.\textsuperscript{392}

By adding much needed force to the patient’s (and derivatively, the pharmacist’s)\textsuperscript{393} right to confidentiality,\textsuperscript{394} the recognition of a pharmacist-patient privilege would eliminate the ethical dilemma inherent in this situation,\textsuperscript{395} as well as the pharmacist’s potential temptation to testify untruthfully.\textsuperscript{396} More importantly, recognition of the privilege would encourage patients to confide in their pharmacists,\textsuperscript{397} thereby facilitating treatment and quite possibly enhancing

\textsuperscript{391} See Adelman & Zahler, supra note 164, at 139 (“[P]harmacists have little means of protecting themselves against compelled disclosure of confidential information contained in prescription records, pharmacy patient profiles, or other records maintained by pharmacists.”); Craft & McBride, supra note 38, at 377 (“[W]ithout the protection of [a] privilege, pharmacists risk being compelled by law to testify against their own patients.”); Watt, supra note 248, at 792 (footnote omitted) (“Even when pharmacists have the desire to keep patients’ prescription information confidential, pharmacists may be compelled to release it. They are not given the same statutory protection to keep things confidential . . . as physicians.”).

\textsuperscript{392} See Berger, supra note 31, at 144 (“In the absence of the knowledge that the pharmacist will respect the confidential nature of the communication, the information may not be given and the pharmacist may not be able to effectively provide the appropriate needed services.”); Craft & McBride, supra note 38, at 377 (asserting that in absence of a privilege, “pharmacists will never be able to expect patients to freely disclose information necessary to evaluate treatment”).

\textsuperscript{393} Any pharmacist-patient privilege undoubtedly would inure to the benefit of the patient. See Williams v. State, 959 N.E.2d 360, 367 (Ind. Ct. App. 2012). However, patients “share with their pharmacists an expectation that [prescription] information . . . will not be disclosed.” State v. Welch, 624 A.2d 1105, 1109 (Vt. 1992); see also People v. Privitera, 128 Cal. Rptr. 151, 158 (App. Dep’t Super. Ct. 1976) (acknowledging contention that “the expanding concept of the ‘right to privacy’ includes the right of the physician to prescribe, the right of the pharmacist to dispense, and the right of the patient to take any drug or medicine on the market”). But cf. Pharm. Mfrs. Ass’n v. Whalen, 430 N.E.2d 1270, 1274 (N.Y. 1981) (questioning existence of a “right to privacy between pharmacist and patient”).

\textsuperscript{394} See Vacco, supra note 34, at 399 (advocating for recognition of a privilege “protecting the patient and, at the same time, the professional duty of confidentiality arising from the pharmacist’s increased access to personal information”); cf. Rost v. State Bd. of Psych., 659 A.2d 626, 630 (Pa. Commw. Ct. 1995) (stating that a “duty of confidentiality would be illusory if it could be overridden anytime a conflicting duty to testify arose”). See generally Berger, supra note 31, at 145 (“If a privilege were put in place, all those concerned would benefit. Pharmacists would have access to all patient information and patients would have the security that their records are being kept strictly confidential.”).

\textsuperscript{395} See Canning, supra note 19, at 549 (“Other professional relationships, such as the attorney-client, physician-patient, and priest-penitent, are all bound by professional ethics of some sort, yet these relationships are afforded a testimonial privilege which assists in eliminating any ethical dilemma that forced disclosure would cause.”); cf. Brushwood, supra note 162, at 43 n.23 (“The ethical principle of confidentiality in pharmacy does not have the same level of legal authority as does the same principle for physicians.”).

\textsuperscript{396} See Rancho Publ’ns v. Superior Ct., 81 Cal. Rptr. 2d 274, 280 n.6 (Ct. App. 1990) (“[P]rivileges may promote truth-seeking by avoiding conflicts of interest that could lead to perjury.”) (citing David W. Louisell, Confidentiality, Conformity and Confusion: Privileges in Federal Court Today, 31 Tul. L. Rev. 101, 114–15 (1956)).

\textsuperscript{397} See Adelman & Zahler, supra note 164, at 151–52 (“The overriding public policy consideration for extending the physician-patient privilege to include pharmacists is the nurturing and maintenance of free and open communication between pharmacists and patients.”); cf. Robert Weisberg, Note, Defendant v. Witness: Measuring Confrontation and Compulsory Process Rights Against Statutory Communications
public health in general. Accordingly, the legislatures (or perhaps the courts) in states that are yet to recognize the privilege should act expeditiously to adopt it, just as many states adopted privileges protecting confidential communications between patients and other health care professionals.

Privileges, 30 STAN. L. REV. 935, 947 (1978) ("Although privileges also may prevent the concern of perjured testimony, their main goal is not promoting the search for the truth, but rather promoting privacy and confidentiality in favored social relationships.").

398. See In re Grattan v. People, 480 N.E.2d 714, 716 (N.Y. 1985) (observing that confidentiality is "designed to encourage afflicted persons to seek and secure treatment, which in the case of communicable disease serves individual interests as well as those of society"); Commonwealth v. Moore, 548 A.2d 1250, 1254 (Pa. Super. Ct. 1988) (ellipses omitted) ("Clearly, the purpose of confidentiality is two-fold: first, the purpose of the privilege is to protect the individual from disease . . . and second, the purpose is to protect society from disease by encouraging ‘those who are ill, diseased and plagued with any of the multitude of organisms which can inflict themselves upon humans to seek out treatment’ confident that disclosure of the sensitive and private matters necessary for proper medical treatment will not be revealed to the public." (quoting In re Allegheny Cnty. Grand Jury, 415 A.2d 73, 79 (Pa. 1980) (Larsen, J., dissenting)), rev’d on other grounds, 584 A.2d 936 (Pa. 1991).

399. See Adelman & Zahler, supra note 164, at 139–40 (asserting that “pharmacy records and documents should be accorded common-law . . . protection”); cf. Nilvar v. Mercy Health Sys.—W. Ohio, 210 F.R.D. 597, 606 (S.D. Ohio 2002) (asserting that “there must always be, in the absence of legislation, that court which takes the first step into an area left to common law development”).

400. See Quick, supra note 36, at 164 ("[A] serious effort should be made to enact laws that guarantee some patient confidentiality with regard to pharmaceutical records, if not in the . . . patient’s prescription record, at least in . . . the patient’s personal medical history."); Schawbel, supra note 35, at 964 ("In light of the changing role of pharmacists today, . . . legislation is needed to protect the information revealed by individuals to their pharmacists in a similar fashion to that disclosed to physicians.").