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# WE MIGHT BE ON (TO) SOMETHING, BUT WHO KNOWS? A FRESH LOOK AT THE PHARMACIST-PATIENT PRIVILEGE

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*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.*

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## INTRODUCTION

The American justice system is designed to ascertain the truth underlying litigated disputes.[1] To that end, courts have long held that the public,[2] and therefore private litigants,[3] are presumptively entitled to "every person's evidence."[4] When called upon, all potential witnesses possess a corresponding obligation to appear and provide testimony.[5] These corollary principles[6] 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.[7]

Despite the importance of the courts' truth-seeking function,[8] American law recognizes a number of evidentiary "privileges."[9] 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").

2. *See*, *e.g.*, Richards of Rockford, Inc. v. Pac. Gas & Elec. Co., 71 F.R.D. 388, 389 (N.D. Cal. 1976) ("The law begins with the presumption that the public is entitled to every person's evidence.").

3. *See generally* Neary v. Regents of the Univ. of Cal., 834 P.2d 119, 123 (Cal. 1992) ("The courts exist for litigants."); *In re* NHC-Nashville Fire Litig., 293 S.W.3d 547, 574 (Tenn. Ct. App. 2008) ("The primary function of the judicial system is to resolve private disputes, and 'the public shares the parties' interest in a judicial system that can efficiently resolve disputes.'" (quoting The Sedona Conference, *The Sedona Guidelines: Best Practices Addressing Protective Orders, Confidentiality & Public Access in Civil Cases*, 8 SEDONA CONF. J. 141, 147 (2007))).

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 Exam'rs 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").

11. Not all professional relationships are protected by an evidentiary privilege. *See* Steven Lubet, *Expert Witnesses: Ethics and Professionalism*, 12 GEO. J. LEGAL ETHICS 465, 472 (1999) ("[M]any professionals—engineers, architects, economists, chemists, and others—do not ordinarily enjoy a privilege of confidentiality."). Conversely, a few nonprofessional relationships—most notably the one between spouses—enjoy the protection of a privilege. *See, e.g.*, Smith v. B & O R.R. Co., 473 F. Supp. 572, 585 (D. Md. 1979) ("Privileges generally recognized under federal law include those for marital communications [and] those between professional and client . . . ."); *see also* Mikah K. Story, *Twenty-First Century Pillow-Talk: Applicability of the Marital Communications Privilege to Electronic Mail*, 58 S.C. L. REV. 275, 281 (2006) (observing that "unlike the other evidentiary privileges, there is no professional party in the marital relationship").

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. Goodyear 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. Briley, 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,[15] privileges are intended to foster communications deemed essential to the proper functioning of protected relationships.[16] In other words, unlike other evidence rules designed to facilitate the judicial search for truth,[17] privileges "further public policies and protect primary conduct extrinsic to the judicial process."[18]

The physician-patient privilege,[19] recognized in most states (but not under federal law),[20] 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 & COMPAR. 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").

18. Gubiensio-Ortiz v. Kanahele, 857 F.2d 1245, 1253 (9th Cir. 1988), *vacated on other grounds sub nom.* United States v. Chavez-Sanchez, 488 U.S. 1036 (1989); *see also* Springfield Loc. Sch. Dist. Bd. of Educ. v. Ohio Ass'n of Pub. Sch. Emps., Loc. 530, 667 N.E.2d 458, 467 (Ohio Ct. App. 1995) ("Privilege law . . . is anchored in considerations of policy that exist independently of the usual evidentiary concerns with accuracy and reliability of evidence." (quoting 1 GLEN WEISSENBERGER, OHIO EVIDENCE § 501.3 (1995))).

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).

20. *See* Benally v. United States, 216 F.R.D. 478, 479 (D. Ariz. 2003) ("There is no physician-patient privilege under federal statutes, rules or common law."). For a scholarly argument in support of adopting a federal privilege, see generally Ralph Ruebner & Leslie Ann Reis, *Hippocrates to HIPAA: A Foundation for a Federal Physician-Patient Privilege*, 77 TEMP. L. REV. 505 (2004).

health.[21] Like other evidentiary privileges,[22] this physician-patient privilege is not intended to facilitate the judicial search for truth.[23] 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)[24] so physicians can properly diagnose and treat those conditions.[25]

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.[26] 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

21. *See* Weil v. Dillon Cos., 109 P.3d 127, 129 (Colo. 2005) (noting that physician-patient privilege "vests the patient with the power to prevent a treating physician from disclosing information obtained in the course of treatment" (construing COLO. REV. STAT. § 13-90-107)); State v. Jones, 739 N.E.2d 300, 322 (Ohio 2000) (Cook, J., concurring) (emphasis omitted) (stating that "a testimonial privilege . . . allows a patient to prevent his or her doctor from testifying on certain matters arising out of the physician-patient relationship").

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.").

23. *See* Darnell v. State, 674 N.E.2d 19, 21 (Ind. Ct. App. 1996) (observing that "the physician-patient privilege . . . impedes the search for truth"); Stigliano *ex rel.* Stigliano v. Connaught Lab'ys, Inc., 658 A.2d 715, 717 (N.J. 1995) ("The physician-patient privilege, like all privileges, stands as an exception to the general rule that trials are a search for truth.").

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) ("[P]atients 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. Lipham, 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").

29. *See* Cackowski v. Wal-Mart Stores, Inc., 767 So. 2d 319, 325 (Ala. 2000) (stating that "a pharmacist . . . is inextricably linked to a physician's treatment of his patients"); Murphy v. E.R. Squibb & Sons, Inc., 202 Cal. Rptr. 802, 810 (Ct. App. 1984) (stating that "the skill of the pharmacist . . . is perhaps inextricably coupled with the physician's treatment"), *vacated*, 710 P.2d 247 (Cal. 1985); Bordelon v. Lafayette Consol. Gov't, 149 So. 3d 421, 426 (La. Ct. App. 2014) (Saunders, J., dissenting) (stating that a pharmacist's duties "are an important part of a patient's treatment").

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'").

31. *See* United States v. Rattini, 574 F. Supp. 3d 543, 548 (S.D. Ohio 2021) (observing that "the pharmacist is not presented with the patient file—only [a] prescription"). *But see* John Berger, *Patient Confidentiality in a High Tech World*, 5 J. PHARMACY & L. 139, 140 (1996) (asserting that a pharmacist "needs much more information about a patient than that usually contained on a prescription").

32. *See Bordelon*, 149 So. 3d at 426 (Saunders, J., dissenting) ("Often, patients share confidential and personally sensitive information with their pharmacists."); Anonymous v. CVS Corp., 728 N.Y.S.2d 333, 337 (Sup. Ct. 2001) (asserting that "in order for customers to receive reliable advice from their pharmacist, they must disclose the most personal kind of information"); Commonwealth v. Slaton, 556 A.2d 1343, 1356 (Pa. Super. Ct. 1989) (Kelly, J., concurring in part and dissenting in part) (observing that prescriptions "contain extremely private and potentially embarrassing information about the pharmacist's clients"), *aff'd*, 608 A.2d 5 (Pa. 1992).

33. *See* ROBERT A. BUERKI & 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

(citing Act of Mar. 9, 1983, 1983 Miss. Laws ch. 327 (codified at MISS. CODE § 13-1-21(c)))); *see also* Jacob M. Appel, *The Dangers of the Underprivileged Ethicist: Revising the Rules of Evidence After the Bioethics Revolution*, 42 N.M. L. REV. 1, 11 (2012) (stating that "precisely which treating parties are covered by the [physician-patient] privilege varies substantially from state to state, with some states including . . . pharmacists"). For a previous discussion of this possibility, see generally Philip J. Vacco, *The Physician-Patient Privilege: Should the Pharmacist Be Included?*, 2 J. LEGAL MED. 399 (1981).

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.[44] Part VII will consider the importance of existing state physician-patient privilege statutes upon which a pharmacist-patient privilege could be modeled.[45] The Article ultimately will conclude that jurisdictions that lack this protection should adopt a pharmacist-patient privilege as a matter of policy.[46]

## I. THERE IS NO COMMON LAW PHARMACIST-PATIENT PRIVILEGE

Privilege doctrine came to this country as part of the common law,[47] transported here by English colonists[48] and adopted by most American states[49]—Louisiana is the lone exception[50]—when they formed[51] or subsequently joined

44. *See infra* Part VI.

45. *See infra* Part VII.

46. *See infra* Conclusion.

47. *See* Allred v. State, 554 P.2d 411, 413–14 (Alaska 1976) (footnotes omitted) ("Privilege was originally conceived of in England as a judicially recognized point of honor among lawyers and other gentlemen not to reveal confidential communications."); Paul H. Beach, Note, *Viewing Privilege Through a Prism: Attorney-Client Privilege in Light of Bulk Data Collection*, 90 NOTRE DAME L. REV. 1663, 1672 (2015) ("[E]arly American courts generally looked to English law to form their views in most areas of evidentiary privilege."); Philip A. Elmore, Comment, "*That's Just Pillow Talk, Baby": Spousal Privileges and the Right to Privacy in Arkansas*, 67 ARK. L. REV. 961, 964 (2014) ("American courts adopted evidentiary privileges from English common law.").

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. Stoebuck, *Reception of English Common Law in the American Colonies*, 10 WM. & MARY L. REV. 393 (1968).

49. The common law was (and still is) the prevailing legal system in England, and today it is "most recognizable in American and British law." State v. Norton, 117 A.3d 1055, 1059–60 n.10 (Md. 2015). Its defining characteristic is the development of legal principles "through judicial decisions with precedential authority." Parker Waichman LLP v. Salas LC, 320 F. Supp. 3d 327, 334 n.6 (D.P.R. 2018). A contrasting civil law tradition prevails in continental Europe. *See Norton*, 117 A.3d at 1059 n.10. In civil law jurisdictions "laws are overwhelmingly governed by statute rather than by case law." Martinez v. E.I. DuPont de Nemours & Co., 82 A.3d 1, 18 (Del. Super. Ct. 2012), *aff'd*, 86 A.3d 1102 (Del. 2014).

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.[52] The concept of a common law privilege arose in England in response to the courts' authority to compel witnesses to testify.[53] Although this authority did not exist until the sixteenth century,[54] as all witness testimony was voluntary (or effectively prohibited)[55] prior to that time,[56] the authority to compel

v. Price, 672 A.2d 893, 895 (R.I. 1996) (footnote omitted) (stating that "original colonies adhered to English common law after gaining their independence").

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) ("[T]he 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.").

55. *See* United States v. Gecas, 120 F.3d 1419, 1441 (11th Cir. 1997) (observing that "in early-fourteenth-century England, the jury heard no courtroom testimony at all"); Betsy Booth, Comment, *Underprivileged Communications: The Rationale for a Parent-Child Testimonial Privilege*, 36 SW. L.J. 1175, 1176 (1983) ("The modern witness . . . did not appear in England until the fifteenth century."); Charles Donahue, Jr., Comment, *An Historical Argument for the Right to Counsel During Police Interrogation*, 73 YALE L.J. 1000, 1022 (1964) ("[W]itnesses do not appear at civil trials until the mid-fifteenth century, and the date of their appearance in criminal trials is uncertain.").

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[57] and ultimately adopted by the states.[58]

However, apart from an early version of the attorney-client privilege,[59] English common law recognized very few evidentiary privileges.[60] No privilege protecting confidential communications between patients and pharmacists existed under the common law.[61] 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 FLA. 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) ("[U]nlike 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).

60. *See* Terre Haute Reg'l Hosp., Inc. v. Trueblood, 600 N.E.2d 1358, 1360 (Ind. 1992) ("Most privileges were unknown at common law . . . ."); Deirdre M. Smith, *An Uncertain Privilege: Implied Waiver and the Evisceration of the Psychotherapist-Patient Privilege in the Federal Courts*, 58 DEPAUL L. REV. 79, 91 (2008) ("Few evidentiary privileges were recognized at common law . . . ."). *See generally* Senear v. Daily J.-Am., 641 P.2d 1180, 1182 (Wash. 1982) ("Testimonial privilege has not been favored in the common law. Testimonial duty has been the standard.").

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, "[f]ew cases have 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 statute[64]—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 states[66] (but still not recognized in England[67] 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. Kliewer, 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").

66. *See* Camperlengo v. Blum, 436 N.E.2d 1299, 1300 (N.Y. 1982) (citations omitted) ("The physician-patient privilege is . . . in derogation of the common law rule that a physician could be compelled to disclose information acquired in the treatment of a patient."); State Med. Bd. v. Miller, 541 N.E.2d 602, 605 (Ohio 1989) (citations omitted) ("[T]here existed no physician-patient privilege at common law. … Therefore, . . . the privilege is in derogation of the common law . . . .").

67. *See* Kurdeck v. W. Orange Bd. of Educ., 536 A.2d 332, 335 (N.J. Super. Ct. L. Div. 1987) (noting that "the common law rule of no privilege still applies in England"); *Holbrook*, 822 P.2d at 278 (Utter, J., dissenting) ("[E]ven to this day, there is no common law or statutory physician-patient privilege in England.").

68. *See* Geisberger v. Willuhn, 390 N.E.2d 945, 946 (Ill. App. Ct. 1979) ("Unlike the attorney-client relationship, the common law does not recognize a privilege for communication between a doctor and a patient."); Sims v. Charlotte Liberty Mut. Ins. Co., 125 S.E.2d 326, 329 (N.C. 1962) ("At common law communications from patients to physicians are not privileged.").

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

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").

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.").

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.").

72. *See* Carman v. McDonnell Douglas Corp., 114 F.3d 790, 794 (8th Cir. 1997) ("The creation of a wholly new evidentiary privilege is a big step."); Commonwealth v. Chauvin, 316 S.W.3d 279, 297 (Ky. 2010) (Abramson, J., dissenting) ("[C]ourts should be grudgingly slow to read privileges into law."); *cf.* Nat'l Union Fire Ins. Co. v. KPMG Peat Marwick, 742 So. 2d 328, 331 (Fla. Dist. Ct. App. 1999) ("Evidentiary privileges are generally looked on with disfavor, and privileges . . . unknown at common law[] are particularly disfavored . . . ."), *approved*, 765 So. 2d 36 (Fla. 2000).

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, *The Search for the Whole Truth About American and European Criminal Justice*, 3 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.").

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, *The "Privilege" in the Privilege Doctrine: A Feminist Analysis of the Evidentiary Privileges for Confidential Communications*, *in* 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,[75] and arguably, a corresponding contractual obligation,[76] to maintain the confidentiality of information regarding the health of their patients.[77] Although this ethical obligation may serve as an important precursor to the judicial or legislative adoption of a pharmacist-patient privilege,[78] the common law never incorporated this obligation.[79] Even when codified,[80] which is rare,[81] an ethical duty of

75. For a comprehensive discussion of pharmacists' ethical obligations to their patients, see generally BUERKI & VOTTERO, *supra* note 33.

76. *See* Anonymous v. CVS Corp., 728 N.Y.S.2d 333, 340 (Sup. Ct. 2001) ("A pharmacist's professional obligation of nondisclosure may give rise to a contractual duty."); *cf.* Hooks SuperX, Inc. v. McLaughlin, 642 N.E.2d 514, 517 (Ind. 1994) (stating that "relationship between pharmacist and customer is . . . based upon contract"). *But see* Washburn v. Rite Aid Corp., 695 A.2d 495, 501 n.10 (R.I. 1997) ("[T]here is no implied contractual obligation on [a pharmacy's] part to hold . . . prescription-drug information confidential.").

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).

78. *See, e.g.*, Schawbel, *supra* note 35, at 964 ("The Massachusetts [pharmacy] regulations that currently exist are a step in the right direction by the legislature to actually recognize a pharmacist-patient privilege. These rules obligate pharmacists not to disclose confidential patient information . . . ."); *cf. In re* Vioxx Prods. Liab. Litig., 230 F.R.D. 473, 477 (E.D. La. 2005) ("The physician-patient privilege has transfigured from a code of ethics into a matter of law in most states in this Union."). *See generally* Gaumond v. Trinity Repertory Co., 909 A.2d 512, 519 (R.I. 2006) ("Confidentiality of a record or evidence is a mandatory, but not necessarily sufficient, precursor to establishing a privilege.").

79. *See* Weld v. CVS Pharmacy, Inc., 10 Mass. L. Rptr. 217, 219 (Super. Ct. 1999) ("[T]his 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) ("[T]here [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 part 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 ("[A]lthough 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.").

82. Gucci Am., Inc. v. Guess?, Inc., 271 F.R.D. 58, 70 n.5 (S.D.N.Y. 2010); *see, e.g.*, Sorensen v. Barbuto, 177 P.3d 614, 617 (Utah 2008) (noting that "a physician's duty of confidentiality is different and distinct from the physician-patient testimonial privilege"); *see also* People v. Baker, 288 N.W.2d 430, 431 (Mich. Ct. App. 1980) ("The fact that disclosing information concerning a patient is unethical does not mean that such testimony is privileged.").

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.").

84. *See In re* McCann, 422 S.W.3d 701, 713 n.11 (Tex. Crim. App. 2013) (Price, J., dissenting) (emphasis omitted) ("The key difference between confidentiality . . . and privilege is that privilege trumps a court's authority to compel testimony." (quoting Mitchell M. Simon, *Discreet Disclosures: Should Lawyers Who Disclose Confidential Information to Protect Third Parties Be Compelled to Testify Against Their Clients?*, 49 S. TEX. L. REV. 307, 315 (2007))); Emily C. Aldridge, Note, *To Catch a Predator or to Save His Marriage: Advocating for an Expansive Child Abuse Exception to the Marital Privileges in Federal Courts*, 78 FORDHAM L. REV. 1761, 1766 (2010) ("A testimonial privilege bars a court from compelling testimony from a witness in a professional or confidential relationship with a party in a court proceeding.").

85. State v. Mark, 597 P.2d 406, 408 (Wash. Ct. App. 1979); *see also* People v. Monroe, 370 N.Y.S.2d 1007, 1013 (Sup. Ct. 1975) (stating that a "right of confidentiality does not rise to the level of an exemption from testimonial compulsion"); State *ex rel*. Allen v. Bedell, 454 S.E.2d 77, 85 (W. Va. 1994) (Cleckley, J., concurring) ("[T]he adoption of [a] duty of confidentiality does not in any way regulate what may be testified to in judicial proceedings."). *See generally* S.C. State Bd. of Med. Exam'rs v. Hedgepath, 480 S.E.2d 724, 726 (S.C. 1997) (footnote omitted) (stating that "a professional's duty to maintain his client's confidences is independent of the issue whether he can be legally compelled to reveal some or all of those confidences").

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* Rost 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. 153, 165 (2002) ("[J]ust 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]

treatment"); Wheeler v. Comm'r of Soc. Servs., 662 N.Y.S.2d 550, 553 (App. Div. 1993) ("The doctrine of confidentiality is based on a well-accepted premise: The patient whose privacy and sensibilities are safeguarded will be more likely to reveal information that will result in improvement or cure.").

93. *See In re* McCann, 422 S.W.3d 701, 713 n.11 (Tex. Crim. App. 2013) (Price, J., dissenting) ("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) ("[C]ounsel 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,[98] let alone a pharmacist-patient privilege.[99] However, most state legislatures have enacted physician-patient privilege statutes,[100] which could be interpreted expansively to protect confidential communications between patients and their pharmacists.[101] 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."[102]

A few cases consider this possibility.[103] However, courts generally are more concerned with the search for truth than with the interests served by expanding

98. *See* Hermanson v. Multi-Care Health Sys., Inc., 448 P.3d 153, 160 (Wash. Ct. App. 2019) ("Neither federal nor state law has recognized a physician-patient privilege at common law."), *aff'd in part, rev'd in part*, 475 P.3d 484 (Wash. 2020); State v. Anderson, 972 P.2d 86, 88 (Utah Ct. App. 1998) ("The physician patient privilege [has] never existed at common law.").

99. *See* Kohari v. Jessie, No. 2:13-CV-09072, 2014 WL 1338558, at *2 (S.D.W. Va. Apr. 3, 2014) ("[T]here is no federal pharmacist/patient privilege."); Korff v. City of Phoenix, No. CV-13-02317-PHX, 2015 WL 4065070, at *2 (D. Ariz. July 2, 2015) (stating that "no physician-patient privilege exists in federal law between [a patient] and his medical doctors . . . or pharmacists"); Grace-Marie Mowery, Comment, *A Patient's Right of Privacy in Computerized Pharmacy Records*, 66 U. CIN. L. REV. 697, 713 (1998) ("No state expressly provides for a pharmacist-patient privilege . . . at common law . . . .").

100. *See* Filz v. Mayo Found., 136 F.R.D. 165, 168 (D. Minn. 1991) ("Most states have created a physician-patient privilege by statute."). Conversely, "no federal statute creates a physician-patient privilege." *In re* Grand Jury Subpoena John Doe No. A01 209, 197 F. Supp. 2d 512, 514 (E.D. Va. 2002); *see also* Gen. Motors Corp. v. Dir. of Nat'l Inst. for Occupational Safety & Health, 636 F.2d 163, 165 (6th Cir. 1980) (citation omitted) ("The common law did not recognize a physician-patient privilege at all. Neither has Congress codified the concept in a federal statute.").

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) ("[I]t 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) ("[I]t 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).

103. *See, e.g.*, *In re* John Doe, Inc., 466 N.Y.S.2d 202, 203 (Sup. Ct. 1983) (considering contention that "the physician-patient privilege encompasses a pharmacy's transactions with its customers"); *cf.* State v. Mark, 597 P.2d 406, 408 (Wash. Ct. App. 1979) (discussing argument that "a pharmacist, as an agent for the physician, can assert the [physician-patient] privilege"). *See generally* Berger, *supra* note 31, at 143 ("Few cases have addressed whether the pharmacist-patient privilege . . . was included within a statutory physician-patient privilege.").

the scope of an existing privilege,[104] resulting in courts often narrowly construing privilege statutes.[105] Consequently, most courts considering the issue ultimately refused to extend existing statutory protections from compelled testimonial disclosure to pharmacists.[106]

In *Green v. Superior Court*,[107] 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.[108] The pharmacists appeared in response to the subpoenas[109] but refused to answer questions about the wife's prescriptions.[110] Invoking California's statutory physician-patient privilege,[111] 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.").

107. 33 Cal. Rptr. 604 (Dist. Ct. App. 1963).

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. CHI. 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. Stussie, 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."[112]

Although there is little precedential support for this argument,[113] it is a relatively compelling one,[114] and the absence of supporting precedent is not necessarily fatal to a claim of privilege.[115] Indeed, the *Green* court recognized that knowledge of the medications patients are taking, which obviously is reflected in patient prescription records,[116] often reveals the conditions for which they are treated.[117] For example, certain drugs are used exclusively for the treatment of the human immunodeficiency virus ("HIV").[118] A patient who is prescribed one of those drugs is clearly receiving the medication to treat an HIV diagnosis.[119] 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").

115. *See, e.g.*, Fanean v. Rite Aid Corp. of Del., Inc., 984 A.2d 812, 824 (Del. Super. Ct. 2009) (footnote omitted) ("While no Delaware court has decided whether communications between a pharmacist and patient invoke the [physician-patient] evidentiary privilege, that fact is not dispositive."); *see also* Jenkins v. DeKalb Cnty., 242 F.R.D. 652, 655 (N.D. Ga. 2007) ("[T]he absence of controlling precedent is not immediately and necessarily fatal to [an] assertion of privilege.").

116. *See* U.S. Dep't of Just. v. Ricco Jones, 24 F.4th 718, 738 (1st Cir. 2022) (noting that a prescription contains "instructions of what drug, what dosage and frequency, and to whom the controlled substance should be dispensed"); Or. Prescription Drug Monitoring Program v. U.S. DEA, 998 F. Supp 2d 957, 966 (D. Or. 2014) (stating that "prescription information . . . connects a person's identifying information with the prescription drugs they use").

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").

118. *See* Borrome v. Att'y Gen. of the U.S., 687 F.3d 150, 153 n.1 (3d Cir. 2012) (noting that Combivir, Serostim and Zerit "are prescribed for people with the human immunodeficiency virus"); Doe v. Se. Pa. Transp. Auth., 72 F.3d 1133, 1135 (3d Cir. 1995) ("Retrovir is a prescription drug used solely to treat HIV."); State v. Roberts, 805 N.E.2d 594, 595 (Ohio Ct. App. 2004) ("Viracept [is] used for the treatment of HIV.").

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[120]—and that should receive protection from disclosure in judicial proceedings regardless of whether the information is sought from a physician or a pharmacist.[121] 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."[122]

The *Green* court nevertheless rejected the pharmacists' argument.[123] The court recognized that as in many other states,[124] 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."[125] 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) (Nygaard, 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 P.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. . . . [G]enerally 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* Lipsey 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,[134] the court held that a statute embodying the privilege "must be limited to its express language and clear purpose."[135] Much like the California statute at issue in *Green*,[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."[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,"[138] the *Ladner* court held that the privilege did not protect a patient's communications with a health care professional other than a physician or surgeon.[139]

Many other states' physician-patient privilege statutes only protect a patient's communications with a physician or surgeon.[140] As in *Ladner* and

admitted . . . because the physician-patient privilege did not extend protection to pharmacist-patient interactions.").

134. *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"), *suggestion of error overruled*, 158 So. 551 (Miss. 1935).

135. *Ladner*, 436 So. 2d at 1373; *cf.* Cepeda v. 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."). *See generally* 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.").

136. The *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." Green v. Superior Court, 33 Cal. Rptr. 604, 606 (Dist. Ct. App. 1963) (citing CAL. CIV. PROC. CODE § 1881(4) (1965), *superseded by* CAL. EVID. CODE §§ 990-1007); *see also* City of San Francisco v. 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 *prescribe or act* for the patient.'"(quoting CAL. CIV. PROC. CODE § 1881(4))).

137. *Ladner*, 436 So. 2d at 1373 (quoting MISS. CODE ANN. § 13-1-21 (1972)); *see also* Huff v. Polk, 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 MISS. CODE ANN. § 13-1-21 (1972))). The statute at issue in *Ladner* has been amended and now extends to pharmacists and certain other health care professionals who are not physicians or surgeons. *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 . . . .").

138. Powell v. J.J. Newman Lumber Co., 165 So. 299, 302 (Miss. 1936) (discussing *Gulf, Mobile*); *see also, e.g.*, 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 . . . .").

139. *See 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.").

140. *See, e.g.*, 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"); Griggs v. Griggs, 707 S.W.2d 488, 490 (Mo. Ct. App. 1986) ("The physician-patient privilege of § 491.060(5) applies only to a

*Green*, courts in those states typically interpret these statutes narrowly.[141] While pharmacists and other nonphysician health care professionals may have confidentiality obligations comparable to those of physicians and surgeons,[142] "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."[143]

The courts' strict interpretation of these privilege statutes is not simply a mechanical application of literalism.[144] 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 194, 199 (Ariz. Ct. App. 1982) (holding that Arizona's physician-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,[145] and indeed with evidentiary privileges in general.[146] As the court in *Prudential Insurance Co. of America v. Kozlowski*[147] 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."[148] 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."[149] It is primarily for this reason that courts strictly construe privilege statutes,[150] often holding that they only protect those professionals specifically named therein.[151] As the *Prudential Insurance* court explained when interpreting Wisconsin's physician-patient privilege statute,[152]

145. *See* B. Abbott Goldberg, *The Physician-Patient Privilege – An Impediment to Public Health*, 16 PAC. L.J. 787, 791 (1985) ("'[I]n view of the . . . questionable basis of the privilege, any broadening of the present scope of the privilege ought to be opposed.'" (quoting 6 CAL. L. 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) ("[W]hile 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 Court*[156] 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

1961) (emphasis added) (quoting WIS. STAT. § 325.21 (1961)). The Wisconsin legislature subsequently replaced the statute with one that encompasses additional health care professionals, but still affords no protection to communications between patients and their pharmacists. *See* WIS. STAT. § 905.04(2) (2024).

153. *Prudential Ins.*, 276 N.W. at 302.

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) ("Though 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.[158] This holding enabled litigants to obtain confidential information from a patient's pharmacist that they presumably could not obtain from the patient's physician,[159] thereby eviscerating the protection of the privilege.[160] This in turn likely deterred some patients from confiding in or perhaps even consulting pharmacists and physicians,[161] and thus may have diminished the quality of care they received.[162]

Less than two years after the *Green* decision[163] (and partly in response to that decision)[164] 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.L. 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.").

163. *Green* was decided on September 12, 1963. Green v. Superior Ct., 33 Cal. Rptr. 604, 604 (Dist. Ct. App. 1963). The state legislature enacted the California Evidence Code in May 1965, Cross v. Superior Ct., 217 Cal. Rptr. 3d 569, 578 (Ct. App. 2017), but the Code "did not become effective until January 1, 1967." San Joaquin Cnty. v. Galletti, 61 Cal. Rptr. 62, 64 (Ct. App. 1967).

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.[165] The new code, which revised and expanded California's existing evidence laws,[166] included a series of privilege statutes[167] replacing those in effect at the time of its enactment[168]—including the physician-patient privilege statute at issue in *Green.*[169]

In one respect, adoption of the Evidence Code supports the result reached in *Green.*[170] In particular, the code contains a provision, Section 911,[171] which states that "there are no privileges 'except as provided by statute.'"[172] 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."[173] The *Green* court's refusal to judicially "modify" the physician-patient privilege statute to encompass pharmacist-patient communications is

165. *See* Cobey-Song Evidence Act, 1965 Cal. Stat. 1297 (codified at CAL. EVID. CODE § 1 *et seq.*). For a contemporaneous summary of the new code, see generally John R. McDonough, *The California Evidence Code: A Précis*, 18 HASTINGS L.J. 89 (1966).

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.").

167. One commentator stated that the Evidence Code contains "at least six [sic] readily identifiable statutory privileges: lawyer-client, spousal, physician-patient, psychotherapist-patient, clergy-penitent, counselor-victim, and mediator-disputant." Shawn P. Davisson, *Balancing the Scales of "Confidential" Justice: Civil Mediation Privileges in the Criminal Arena — Indispensable, Impracticable, or Merely Unconstitutional?*, 38 MCGEORGE L. REV. 679, 695 n.74 (2007) (citing CAL. EVID. CODE §§ 950-1037, 1115-28 (2005)).

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 (Ct. App. 1982) ("In 1965 the Legislature transferred the privilege sections of the California Code of Civil Procedure to the Evidence Code . . . .").

169. *See* Rudnick v. Superior Ct., 523 P.2d 643, 649 (Cal. 1974) ("Former Code of Civil Procedure section 1881, subdivision (4), was superseded upon enactment of the Evidence Code (in effect Jan. 1, 1967) by sections 990–1007 dealing with the physician-patient privilege."); *In re* Marriage of Meteer, No. B154682, 2003 WL 1084650, at *4 (Cal. Ct. App. Mar. 12, 2003) ("[T]he statute on which the *Green* court relied was superseded by the 1967 [sic] enactment of Evidence Code sections dealing with the physician-patient privilege.").

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.

172. People v. Corona, 259 Cal. Rptr. 524, 532 (Ct. App. 1989) (bracketing omitted) (quoting CAL. EVID. CODE § 911 (1989)); *see also* Roberts v. City of Palmdale, 853 P.2d 496, 501 (Cal. 1993) ("[T]he Legislature has determined that evidentiary privileges shall be available only as defined by statute." (citing CAL. EVID. CODE § 911 (1993))).

173. *Pitchess*, 522 P.2d at 311; *see also* Cal. Pub. Utils. Comm'n v. S. Cal. Edison Co., 892 P.2d 778, 782 (9th Cir. 1989) (citing *Pitchess*, 522 P.2d at 311) ("[U]nder California law, courts are not free to expand the scope of existing privileges.").

consistent with this interpretation of the amendment,[174] which in turn is supported by the legislative history of the Evidence Code[175] and of Section 911 in particular.[176]

However, the California legislature also included another provision in the Evidence Code, Section 912(d),[177] 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.[178] The pertinent legislative history offered an example of such a disclosure: a patient's presentation of a physician's prescription to a pharmacist,[179] which would not constitute a waiver of the physician-patient privilege because such disclosures are reasonably necessary to accomplish a purpose—treatment[180]—for which physicians are consulted.[181]

The California Supreme Court interpreted Section 912(d) in *Rudnick v. Superior Court.*[182] 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)[183] 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. Rels. 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)).

182. 523 P.2d 643 (Cal. 1974).

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.[184] Noting that this reflected a change in California law,[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."[186] Thus, the analysis in *Rudnick* "effectively extended the scope of the physician-patient privilege to incorporate pharmacists."[187]

### *2. The Potential Extension of the Privilege in Other States*

Like California,[188] Ohio lacks a specific pharmacist-patient privilege.[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.[190] Nevertheless, Ohio's physician-patient privilege statute[191] contains a nonwaiver provision similar to the one in the California Evidence Code,[192] albeit one that is

at 316 (applying nonwaiver provision to prevent discovery of medical records a patient's doctor disclosed to "other physicians treating her"). Nor is the nonwaiver provision's application limited to communications protected by the physician-patient privilege; it instead "deals with necessary disclosures for purposes of various privileges." Ceres v. Superior Ct., 159 Cal. Rptr. 3d 789, 806 (Ct. App. 2013); *see also In re Edward D.*, 132 Cal. Rptr. at 107 (Jefferson, J., dissenting) (emphasis omitted) ("Evidence Code section 912 . . . deals with the subject of Waiver of the various confidential-communication privileges.").

184. *See Rudnick*, 523 P.2d at 649 (observing that "a disclosure in confidence by the physician to a third person is not a waiver of the privilege and . . . such third person may now claim the privilege on behalf of the patient"); *see also Blue Cross*, 132 Cal. Rptr. at 636 (citations omitted) ("If the disclosure was reasonably necessary for accomplishment of the medical consultation's purpose, confidentiality is retained, no waiver occurs, and the third person . . . has implied authority to assert the privilege on behalf of the absent patient."). For an extended analysis of the *Rudnick* decision, see generally Ralph W. Tarr, Note, *Protecting the Privacy of the Absent Patient*: Rudnick v. Superior Court, 27 HASTINGS L.J. 99 (1975).

185. *See Rudnick*, 523 P.2d at 648–49 (observing that applicable legislature history indicates that enactment of nonwaiver provision may have changed California law "as embodied in *Green*" (discussing CAL. EVID. CODE § 912(d) comment (1974))); *cf.* Tarr, *supra* note 184, at 122 (referring to California legislature's "decision to reverse the *Green* case and allow a third party to assert the privilege").

186. *Rudnick*, 523 P.2d at 649; *cf.* Tarr, *supra* note 184, at 111 (noting that "the court in *Rudnick* declared *Green v. Superior Court* invalid under the new statutes").

187. Adelman & Zahler, *supra* note 164, at 149; *see also* Vacco, *supra* note 34, at 413 (asserting that *Rudnick* "expands the physician-patient privilege to include pharmacists").

188. *See* Matthews v. Superior Ct., No. B208007, 2008 WL 3892489, at *3 (Cal. Ct. App. Aug. 25, 2008) ("There is no pharmacist-patient privilege in California . . . .").

189. *See* Adelman & Zahler, *supra* note 164, at 127 ("Ohio currently has no law or regulation providing for a pharmacist-patient privilege. Moreover, no Ohio court has held such a privilege to be implied in any existing law."); Canning, *supra* note 19, at 526 ("Ohio does not recognize a privilege for confidential communications with pharmacists or the confidentiality of their prescription records.").

190. *See* Adelman & Zahler, *supra* note 164, at 147 ("Ohio courts have not had the occasion of addressing the issue of whether the privilege against disclosure of confidential information is extended to pharmacists through the physician-patient privilege.").

191. OHIO REV. CODE ANN. § 2317.02(B)(4). For a scholarly examination of Ohio's physician-patient privilege, see generally Robert A. Wade, Note, *The Ohio Physician-Patient Privilege: Modified, Revised, and Defined*, 49 OHIO ST. L.J. 1147 (1989).

192. CAL. EVID. CODE § 912(d). Other states' privilege laws also contain provisions of this nature. Kansas law, for example, "recognizes a physician-patient privilege . . . where the holder of the information

even more specific to pharmacists.[193] Both provisions effectively abrogate the questionable view,[194] represented by *Green v. Superior Court*[195] and other similar cases,[196] 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."[197] Thus, if presented with the issue,[198] 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.[199]

Indeed, some commentators predicted that the *Rudnick* decision would mark the start of a judicial trend in favor of recognizing the pharmacist-patient

is a person to whom disclosure was made because it was reasonably necessary for the accomplishment of the purpose for which the information was transmitted." Phillips v. Medtronic, Inc., 130 F.R.D. 136, 142 (D. Kan. 1990) (citing KAN. STAT. ANN. § 60-427(b) (1990)).

193. *See* OHIO REV. CODE ANN. § 2317.02(B)(4) ("The testimonial privilege . . . is not waived when a communication is made by a physician . . . to a pharmacist or when there is a communication between a patient and a pharmacist in furtherance of the physician-patient . . . relation.").

194. *See* U.S. Dep't of Just. v. Ricco Jonas, 24 F.4th 718, 737–38 (1st Cir. 2022) (observing that "patients do not turn over 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").

195. 33 Cal. Rptr. 604 (Dist. Ct. App. 1963).

196. *See, e.g.*, Deutschmann v. Third Ave. R.R. Co., 84 N.Y.S. 887, 894 (App. Div. 1903) ("Having parted voluntarily with the prescriptions by delivery of them to a [pharmacist], the [patient] could not exclude the testimony offered from such a source."); United States v. Rodriguez, No. 20180138, 2019 WL 4858233, at *4 (Army Crim. App. Oct. 1, 2019) (internal quotation marks omitted) ("A prescription, by its very nature, is intended to be disclosed to a . . . third party—the pharmacist who fills it—which . . . informs our opinion that the medications prescribed to a person are not privileged confidential communications."), *review denied*, 79 M.J. 430 (C.A.A.F. 2020).

197. Adelman & Zahler, *supra* note 164, at 152; *see also* Vacco, *supra* note 34, at 405 ("[W]hen 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."); *cf*. *Wiedeman*, 835 N.W.2d at 712 ("The desire for medical care will not negate the voluntariness of the disclosure to third-party pharmacists.").

198. *See In re* 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.").

199. *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. . . . [L]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.[200] However, those commentators have not proven to be prescient.[201] 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."[202] Nevertheless, the analysis in *Rudnick* suggests that the recognition of a pharmacist-patient privilege is warranted as a matter of public policy[203] and courts in other states may yet recognize the privilege on that basis.[204] 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.[205]

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)).

204. *See* Peterson v. Chesapeake & Ohio Ry. Co., 112 F.R.D. 360, 363 (W.D. Mich. 1986) (asserting that "the common law privileges doctrine is fluid rather that static, and should reflect at least in part . . . evolving considerations of public policy"); Allred v. State, 554 P.2d 411, 416 (Alaska 1976) ("The courts have created privileges in modern times . . . when they have found sufficient policy justification for doing so."). *See generally* Alberts v. Devine, 479 N.E.2d 113, 119 (Mass. 1985) ("[P]ublic policy favors the protection of a patient's right to confidentiality.").

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,"[206] the creation of privileges is also a legislative prerogative[207] and American law now encompasses many statutory privileges.[208] The physician-patient privilege is simply the earliest example.[209] In fact, the era in which courts recognized new common law privileges virtually ended more than a century ago,[210] its demise fueled in part by the otherwise relatively unsuccessful codification movement[211] that captured the interest of many nineteenth century legal scholars.[212] 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 VILL. 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").

209. *See* Hopkins, *supra* note 53, at 176 ("The first legislative privilege appeared as early as 1828, when New York created a statutory physician-patient privilege."); Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit—Is Time for a Change?*, 25 AM J.L. & MED. 7, 50 (1999) (asserting that "the physician-patient privilege . . . was the first noncommon law statutory privilege to be recognized in the United States").

210. *See* Ellison v. State, 500 A.2d 650, 652 (Md. Ct. Spec. App. 1985) ("The development of judge-made privileges halted a century ago." (quoting Charles T. McCormick, *The Scope of Privilege in the Law of Evidence*, 16 TEX. L. REV. 447, 469 (1938))), *aff'd*, 528 A.2d 1271 (Md. 1987); Eli Lilly & Co. v. Marshall, 850 S.W.2d 155, 162 (Tex. 1993) (Doggett, J., dissenting) (describing creation of "an entirely new common law privilege" as "a course long ago abandoned by most courts").

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 22)).

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.[213]

Reflecting this development,[214] some courts held that the question of whether to recognize a pharmacist-patient privilege (or any other new privilege)[215] involves policy issues uniquely suited to legislative resolution.[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.[217] In our representative democracy, this type of policymaking is

[began] to enact privilege statutes to replace the English common law of privileges . . . . By mid-nineteenth century, the common law rules of evidence had begun to dissipate as states conducted statutory revisions of their privilege law."); Wendy Meredith Watts, *The Parent-Child Privileges: Hardly a New or Revolutionary Concept*, 28 WM. & MARY L. REV. 583, 588 (1987) (footnote omitted) ("Faced . . . with the codification movement and enthusiastic scholars forcing it along, state legislatures began to attempt to codify evidence codes. The codification movement prompted state legislatures to adopt privilege statutes to replace the common law privileges.").

213. *See* Babets v. Sec'y of Exec. Off. of Hum. Servs., 526 N.E.2d 1261, 1265 (Mass. 1988) ("Since the early 1800's the vast majority of new privileges created have been of legislative origin." (quoting Robert L. Maxwell, Comment, *The Parent-Child Privilege*, 1984 BYU L. REV. 599, 608–09)); Borngne *ex rel*. Hyter v. Chattanooga-Hamilton Cnty. Hosp. Auth., 671 S.W.3d 476, 501 (Tenn. 2023) (Campbell, J., concurring) ("'[T]he source of newly created privileges shifted decisively from the courts to the legislatures' during the nineteenth century and 'the vast majority of new privileges created since that time have been of legislative origin.'" (quoting 1 KENNETH S. BROUN ET AL., MCCORMICK ON EVIDENCE § 75 (8th ed 2020))).

214. As discussed briefly in *supra* Section III.B.1, courts in California are not authorized "to create new privileges as a matter of judicial policy." Valley Bank of Nev. v. Superior Ct., 542 P.2d 977, 979 (Cal. 1975). The same is true in a few other states. *See, e.g.*, Guerrier v. State, 811 So. 2d 852, 854 (Fla. Dist. Ct. App. 2002) (observing that in Florida "privileges are no longer established by the courts"); State v. Migliorino, 489 N.W.2d 678, 682 (Wis. Ct. App. 1992) (stating that "privileges in Wisconsin may not be created by judicial decision" (citing WIS. STAT. § 905.01)).

215. *See, e.g.*, People *ex rel*. Birkett v. City of Chicago, 686 N.E.2d 66, 70 (Ill. App. Ct. 1997) (noting that courts "have been reluctant to create . . . a [deliberative process] privilege as a matter of common law, stating that the creation of such a privilege is better left to the legislature"), *aff'd*, 705 N.E.2d 48 (Ill. 1998); People v. Dixon, 411 N.W.2d 760, 763 (Mich. Ct. App. 1987) (declining "to adopt a parent-child testimonial privilege" because "recognition of a new privilege is best deferred to the Legislature").

216. *See, e.g.*, Deutschmann v. Third Ave. R.R. Co., 84 N.Y.S. 887, 894 (App. Div. 1903) (emphasis added) ("The necessity of having . . . prescriptions filled by druggists may furnish a reason for the *Legislature* to say that public policy will interpose to prevent them from making disclosures of the information thus obtained, but we are not now dealing with such a question."); *see also* Eureka-Md. Assurance Co. v. Gray, 121 F.2d 104, 107 (D.C. Cir. 1941) ("[I]f public policy demands that the privilege of the physician or surgeon should be extended to . . . other attendants who are neither physicians nor surgeons, the change should be made by the legislature."). *See generally* Senear v. Daily J. Am., 618 P.2d 536, 545 (Wash. Ct. App. 1980) ("[T]he legislature, not the judiciary, is the more appropriate forum to make the public policy determinations underlying the creation of . . . privileges."), *aff'd on other grounds*, 641 P.2d 1180 (Wash. 1982).

217. *See, e.g.*, Petrillo v. Syntex Labs., Inc., 499 N.E.2d 952, 967 (Ill. App. Ct. 1986) ("[I]n creating the physician-patient privilege . . . the legislature was concerned with balancing society's interest in maintaining a confidential relationship between a patient and his physician with society's interest in ascertaining the truth in civil lawsuits"); State v. Almonte, 644 A.2d 295, 304 (R.I. 1994) (Lederberg, J., dissenting) ("The Legislature has . . . by establishing a privilege between a patient and health care provider . . . balanced the need for personal privacy in certain communications with the need for probative evidence at trials."); *see also* Krumme v. W. Point-Pepperell, Inc., 735 F. Supp. 575, 580 (S.D.N.Y 1990) ("[I]n

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.").

219. *See* Babets v. Sec'y of Exec. Off. of Hum. Servs., 526 N.E.2d 1261, 1265 (Mass. 1988) (describing legislatures as "a branch of government not preeminently concerned with the factual results obtained in litigation" (quoting EDWARD W. CLEARY, MCCORMICK ON EVIDENCE § 75, at 180 (3d ed. 1984))); *cf.* Frio v. Superior Ct., 250 Cal. Rptr. 819, 827–28 (Ct. App. 1988) (citing an example of a legislature "favoring the right of privacy at the expense of the truth seeking function at trial").

220. *See* Klaine v. S. Ill. Hosp. Servs., 15 N.E.3d 525, 532 (Ill. App. Ct. 2014) ("[W]hile 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 promote . . . 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").

221. *See, e.g.*, Ladner v. Ladner, 436 So. 2d 1366, 1373 n.3 (Miss. 1983) (noting that a statutory amendment that became effective in 1983 "extend[ed] application of [Mississippi's] privileged communications statute to . . . pharmacists" (citing Act of Mar. 9, 1983, 1983 Miss. Laws ch. 327 (codified at MISS. CODE ANN. § 13-1-21(1)))); Donna M. Lipsmeyer, Survey of Legislation, *Title 16: Practice, Procedure and Courts*, 24 U. ARK. LITTLE ROCK L. REV. 523, 523–24 (2002) (footnote omitted) ("Act 629 of 2001 amends Rule 503 of the Arkansas Uniform Rules of Evidence to extend [the] patient/physician privilege to patients' confidential communications with . . . pharmacists." (discussing Act of Mar. 9, 2001, No. 629, 2001 Ark. Acts 629 (codified at ARK. CODE ANN. § 16-41-101, *repealed by* Act of Apr. 11, 2013, No. 1148, 2013 Ark. Acts 1148))).

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.[224] Many state legislatures seem unaware of the potential benefits of a pharmacist-patient privilege.[225] Others may not be convinced that these potential benefits outweigh the courts' ordinarily predominant interest in the disclosure of evidence.[226] 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.[227]

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."[228] At first blush this statute appears to create a pharmacist-patient privilege,[229] even though the legislature did not use the term "privilege" in the statute.[230] 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.").

226. *See In re* Story, 111 N.E.2d 385, 387–88 (Ohio 1953) (noting existence in Ohio of "a general legislative intention in favor of rather than against requiring testimony and the production of evidence"); *cf.* R.S. v. Thompson, 454 P.3d 1010, 1014 (Ariz. Ct. App. 2019) (identifying other circumstances under which a "legislature determined that society's interests in disclosure outweigh a patient's interest in privacy"), *vacated on other grounds*, 485 P.3d 1068 (Ariz. 2021). *See generally* Meenach v. Gen. Motors Corp., 891 S.W.2d 398, 402 (Ky. 1995) (observing that "claims of 'privilege' are disfavored when balanced against the need for litigants to have access to relevant or material evidence").

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,[231] a pharmacist can—and presumably must[232]—disclose information pertaining to the services provided to a patient in response to a subpoena.[233]

The legislatures of other states enacted similar statutes purporting to make pharmacy records confidential,[234] while nevertheless requiring pharmacists to reveal the information contained in those records in response to subpoenas and court orders.[235] In these states, pharmacists clearly are not protected by an evidentiary privilege,[236] and thus, courts can compel pharmacists to reveal the content of their confidential pharmacist-patient communications in judicial proceedings.[237] For largely unexplained reasons,[238] 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) ("[T]he 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(l) ("[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*.").

236. *See, e.g.*, State v. Mark, 597 P.2d 406, 408 (Wash. Ct. App. 1979) ("[WASH. REV. CODE §] 18.64.245 mandates the production of prescription records when required by court order. . . . The legislature has, therefore, determined that the physician-patient privilege does not apply to prescription records."); *cf.* Van Emrik v. Chemung Cnty. Dep't of Soc. Servs., 121 F.R.D. 22, 25 (W.D.N.Y. 1988) (stating that a "non-disclosure or 'confidentiality' provision in a statute may not always create an evidentiary privilege").

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 (Okla. 2016) ("[T]he 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."[239]

## 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,[240] the court in *Hammonds v. Aetna Casualty & Surety Co.*[241] 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."[242] Accordingly, "he must disclose all information in his consultations with his doctor—even that which is embarrassing, disgraceful or incriminating."[243]

By protecting this information from compelled disclosure in subsequent court proceedings,[244] the physician-patient privilege encourages patients to provide their physicians with their complete medical histories,[245] 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.

240. *See* Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801 (N.D. Ohio 1965) (noting that when "a doctor undertakes the treatment of a patient . . . the consensual relationship of physician and patient is established").

241. 243 F. Supp. 793 (N.D. Ohio 1965).

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))).

245. *See* State *ex rel*. Grimm v. Ashmanskas, 690 P.2d 1063, 1065 (Or. 1984) ("The rationale justifying the suppression in litigation of confidential communications between physician and patient is to encourage patients to disclose freely all matters which may aid in the diagnosis and treatment of disease and injury . . . ."); *cf.* John C. v. Martha A., 592 N.Y.S.2d 229, 233 (Civ. Ct. 1992) (noting that "the

presumably leads to more effective diagnosis and treatment.[246] 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.[247]

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[248] who do not diagnose or treat patients.[249] Under this view of pharmacy practice, pharmacists simply fill prescriptions as written.[250] 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.").

247. Baker v. Indus. Comm'n, 21 N.E.2d 593, 596 (Ohio 1939); *see also* House v. SwedishAmerican Hosp., 564 N.E.2d 922, 927–28 (Ill. App. Ct. 1991) (holding that a litigant "would not be able to discover information concerning [a] patient's medical history and records, unless the patient waived any privileges and consented to releasing this information").

248. *See* Houck v. Iowa Bd. of Pharmacy Exam'rs, 752 N.W.2d 14, 20 (Iowa 2008) (asserting that "the practice of pharmacy primarily consists of preparing and dispensing medications"); Morgan v. Wal-Mart Stores, Inc., 30 S.W.3d 455, 469 (Tex. App. 2000) (referring to pharmacist's traditional role as "a mere dispenser of medication"); Misty Cooper Watt, Comment, *Pharmacist Knows Best? Enacting Legislation in Oklahoma Prohibiting Pharmacists from Refusing to Provide Emergency Contraceptives*, 42 TULSA L. REV. 771, 789 (2007) (footnote omitted) ("The pharmacist . . . is the dispenser. The pharmacist fills the prescription and gives it to the patient with very few exceptions.").

249. *See* Koderick v. Snyder Bros. Drug, Inc., 413 N.W.2d 856, 859 (Minn. Ct. App. 1987) ("Pharmacists do not treat patients, they fill prescriptions for sale to the customer."), *overruled on other grounds by* Kaiser v. Mem'l Blood Ctr. of Minneapolis, Inc., 486 N.W.2d 762 (Minn. 1992); Anonymous v. CVS Corp., 728 N.Y.S.2d 333, 343 (Sup. Ct. 2001) ("[P]harmacists merely administer the receipt of prescription drugs. They do not provide medical 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,[251] pharmacists therefore have no need to obtain, and little familiarity with, their patients' medical histories.[252] Accordingly, there is purportedly no need to protect patients from the compelled disclosure of confidential information their pharmacists are unlikely to possess.[253]

However, even without any other communications between a patient and pharmacist,[254] the mere presentation of a prescription almost invariably conveys confidential information about the patient's medical history to the pharmacist[255] and to anyone else to whom the prescription might be disclosed.[256] In this regard, a prescription is a communication from a physician to a pharmacist,[257] 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").

252. *See* Ingram v. Hook's Drugs, Inc., 476 N.E.2d 881, 887 (Ind. Ct. App. 1985) (stating that "the benefits of [a patient's] medical history" are "not present . . . in the context of a pharmacist filling a prescription"); Makripodis v. Merrell-Dow Pharms., Inc., 523 A.2d 374, 378 (Pa. Super. Ct. 1987) (contending that a "pharmacist is in most instances unfamiliar with the medical history and condition of the patient-consumer"); *cf.* Leesley v. West, 518 N.E.2d 758, 762 (Ill. App. Ct. 1988) (concluding that pharmacists cannot reasonably be expected to know a patient's "medical history and condition").

253. *See generally* U.S. Dep't of Just. v. Ricco 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 & VOTTERO, *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 (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))).

258. *See* Perzik v. Superior Ct., 4 Cal. Rptr. 2d 1, 3 n.6 (Ct. App. 1991) (observing that prescriptions are "written by a physician for a patient"); Sharp v. State, 569 N.E.2d 962, 965 (Ind. Ct. App. 1991) ("Essentially, a prescription is a communication by a doctor to a pharmacist for the benefit of a patient."); Arnold J. Rosoff, *The Changing Face of Pharmacy Benefits Management: Information Technology Pursues a Grand Mission*, 42 ST. LOUIS U. L.J. 1, 34 (1998) ("As the National Community of Pharmacist's Association (NCPA) executive vice president Calvin J. Anthony explained, 'a prescription is a private communication between two health professionals—the physician and the pharmacist—on behalf of the patient.'" (quoting *Retail Pharmacists Ready for Legislative Battles: National Associations Seek to Prevent Gains by Managed Care Plans*, DRUG STORE NEWS, Feb. 17, 1997, at 14)) (bracketing omitted).

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").

261. *See, e.g.*, Ferguson v. Thaemert, 952 N.W.2d 277, 284 (S.D. 2020) ("The physician-patient privilege protects 'confidential communications' between a patient and a doctor 'made for the purpose of diagnosis or treatment.'" (quoting S.D. CODIFIED LAWS § 19-19-503(b))); *see also* State v. Almonte, 644 A.2d 295, 299 (R.I. 1994) ("[O]ver seventy-five percent of the jurisdictions which recognize the physician-patient privilege protect only 'confidential communications' from a patient.").

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").

263. *See* Rite-Aid of N.J., Inc. v. Bd. of Pharmacy, 304 A.2d 754, 757 (N.J. Super. Ct. App. Div. 1973) (stating that "the physician-patient privilege . . . protects the confidentiality of medical prescriptions"); Adelman & Zahler, *supra* note 164, at 152 ("[P]rescriptions are . . . privileged at the moment when the physician writes the prescription order, records it in his files, and hands it to the patient."); *cf.* State v. Pitchford, 697 P.2d 896, 899 (Kan. Ct. App. 1985) (finding that privilege applies to information "helpful in enabling the doctor to prescribe any medication needed").

*Court*,[264] that information should still receive protection if disclosed to a third person when, as is virtually inevitable,[265] the prescription is presented to a pharmacist for filling.[266] 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."[267]

### *B. The Pharmacist's Advisory Role in the Treatment of Patients*

Leaving aside the confidential and arguably privileged nature of prescriptions,[268] the characterization of pharmacists as mere "order fillers"[269] who do not advise and treat patients does not accurately reflect modern pharmacy practice.[270] 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.").

268. *See, e.g.*, Riley v. Walgreen Co., 233 F.R.D. 496, 501 (S.D. Tex. 2005) ("Patient prescription drug orders and medication records contain highly sensitive and personal information, and their privileged status is expressly protected by state law governing the practice of pharmacy in Texas." (citing TEX. OCC. CODE ANN. §§ 551.003(10), 562.052 (2005))); *see also* Sparks v. Donovan, 884 So. 2d 1276, 1280 (La. Ct. App. 2004) (stating that "prescription records are privileged" (citing LA. STAT. ANN. § 13:3734(D) (2004))); Abbott v. Tex. State Bd. of Pharmacy, 391 S.W.3d 253, 257 (Tex. App. 2012) ("There is no dispute that [a] prescription is . . . considered confidential and privileged . . . .").

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.").

270. *See, e.g.*, Kowalski v. Rose Drugs of Dardanelle, Inc., 378 S.W.3d 109, 125 (Ark. 2011) (Brown, J., dissenting) (citing ARK. CODE ANN. § 17-92-101(13) (2011); 070.00.00 ARK. CODE R. § 09-00-0001 (2011)) ("[O]ur own statutes and . . . regulations define the role of pharmacists as more than mere order fillers . . . ."); Suarez v. Pierard, 663 N.E.2d 1039, 1045 (Ill. App. Ct. 1996) (Lytton, J., dissenting) (discussing an Illinois statute that "explicitly extends the role of modern pharmacists beyond the 'mere dispensing' of drugs" (citing 225 ILL. COMP. STAT. 85/3(d) (1996))).

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

271. *See* Horner v. Spalitto, 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.").

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").

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").

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 prescribe . . . 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. § 338.010 (2000))). Some states now provide pharmacists with limited prescriptive authority. *See, e.g.*, CAL. 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).

275. *See In re* Oncology & Hematology Specialists, P.A., No. A-2080-19, 2021 WL 6057217, at *5 (N.J. Super. Ct. App. Div. Dec. 22, 2021) (stating that pharmacists "do not render medical treatment to patients; rather, they are the means by which patients receive access to their treatment needs"); *cf.* Young v. Key Pharms., Inc., 770 P.2d 182, 190 (Wash. 1989) ("With all due respect to the pharmaceutical profession, pharmacists . . . lack the physician's rigorous training in diagnosis and treatment."). *But see* Morgan v. Wal-Mart Stores, Inc., 30 S.W.3d 455, 469 (Tex. App. 2000) (asserting that pharmacists play "a vital role in patient treatment").

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 ("[I]t 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.").

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 physician[279] 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. Spalitto, 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 Pharms., 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.").

284. *See* Pharmcare Okla., Inc. v. State Health Care Auth., 152 P.3d 267, 273 (Okla. Civ. App. 2006) ("A pharmacist may refuse to fill and dispense a prescription . . . which, in his professional judgment, is unsafe as presented." (citing OKLA. ADMIN. CODE § 317:30-5-70.1 (2006))); *cf.* Hooks SuperX, Inc. v. McLaughlin, 642 N.E.2d 514, 518 (Ind. 1994) (noting a pharmacist could "decline to fill a valid prescription" (construing IND. CODE § 25-26-13-16)). Indeed, a pharmacist who harbors such a suspicion might even be prohibited from filling the prescription. *See, e.g.*, Sanchez *ex rel*. Sanchez v. Wal-Mart Stores, Inc., 221 P.3d 1276, 1281 n.3 (Nev. 2009) (citing NEV. ADMIN. CODE § 639.753 (2009) (describing circumstances under which a pharmacist was "mandated *not* to fill" a "potentially harmful" prescription).

before taking medication,[285] the pharmacist at least should warn the patient[286]—and the prescribing physician[287]—of any significant pharmacological risks.[288]

Even when the perceived risk to the patient is negligible,[289] 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."[290] 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. Altilio, *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 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[291] who, in order to promote the health and safety of their patients,[292] are expected to exercise independent judgment when filling prescriptions,[293] and to share their professional expertise with patients and physicians when they deem it appropriate to do so.[294] In this sense, both physicians[295] and pharmacists advise patients about their prescription medications,[296] and therefore, share responsibility for "proper prescribing."[297] In

physician's order to one in which pharmacists recommend drug therapy to prescribers and offer personalized advice to patients on how to maximize the benefits of their medication.").

291. *See* City of San Francisco v. Purdue Pharma, L.P., 620 F. Supp. 3d 936, 959 (N.D. Cal. 2022) ("Pharmacists are highly trained medical professionals . . . ."); Koppers Co. v. Krupp-Koppers GmbH, 517 F. Supp. 836, 845 (W.D. Pa. 1981) (observing that "pharmacists are highly trained and knowledgeable about drugs").

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))), *rev'd and remanded on other grounds*, 586 F.3d 1109 (9th Cir. 2009); Murphy v. E.R. Squibb & Sons, Inc., 202 Cal. Rptr. 802, 810 (Ct. App. 1984) (observing that "the skill of the pharmacist directly safeguards the patient"), *vacated*, 710 P.2d 247 (Cal. 1985); *Horner*, 1 S.W.3d at 522 (discussing "the role a pharmacist must play in making the valuable, but highly dangerous, service of drug therapy as safe and reliable as it can be").

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* 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); *Horner*, 1 S.W.3d at 524 n.5 ("[T]he practice of pharmacy includes consulting with physicians and patients to share with them the pharmacist's expertise in drugs and their interactions. . . . Pharmacists are trained to recognize proper dose and contraindications of prescriptions, and physicians and patients should welcome their insights to help make the dangers of drug therapy safer.").

295. *See* Makripodis v. Merrell-Dow Pharms., 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.").

296. *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))).

297. Smith v. Cal. State Bd. of Pharmacy, 43 Cal. Rptr. 2d 532, 534 (Ct. App. 1995) (summarizing CAL. HEALTH & SAFETY CODE § 11153(a) (1995)); *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

fulfilling this responsibility, these health care professionals provide patients with advice of a similar nature,[298] and their communications with those patients should be considered equally confidential and privileged.[299]

### *C. The Multiple Physician Phenomenon*

In this era of increasing medical specialization,[300] patients often receive treatment from more than one physician simultaneously.[301] In this situation one or more of those physicians might lack familiarity with the medications prescribed by the others,[302] while the pharmacist may possess relatively comprehensive knowledge of the medications the patient is taking,[303] and

upon the prescribing practitioner, but a corresponding responsibility shall rest with the pharmacist who fills the prescription." (quoting MASS. GEN. LAWS ch. 94C, § 19(a) (2018))); *The Challenges of Pharmacogenomics*, *supra* note 285, at 207 ("The complexity of modern pharmaceuticals has led to physician collaboration with pharmacists as trusted colleagues who share with physicians the responsibility for initiation, monitoring, and modification of drug therapy.").

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.").

300. *See* Cline v. Lund, 107 Cal. Rptr. 629, 638 (Ct. App. 1973) ("This is an era of increasingly narrowing areas of medical specialization."); Savasta v. Commonwealth, 403 A.2d 1375, 1377 (Pa. Commw. Ct. 1979) (discussing "the ever-present advances of modern medicine and the increasing specialization in this field"); Broders v. Heise, 924 S.W.2d 148, 152 (Tex. 1996) (referring to "the increasingly specialized and technical nature of medicine"); Thomas v. Raleigh Gen. Hosp., 358 S.E.2d 222, 225 (W. Va. 1987) (discussing "trend toward specialization in medicine").

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.[304] If this is the case, the patient's and the various physicians' need for the pharmacist's expertise and advice will be particularly acute,[305] as the pharmacist is the only health care professional able to identify potentially dangerous, and perhaps even lethal,[306] drug interactions.[307] 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.[308]

### *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

*Capabilities and Legal Responsibilities of Pharmacists: Should "Can" Imply "Ought"?*, 44 DRAKE L. REV. 439, 441–42 (1996) ("[B]ecause patients tend to obtain services from multiple physicians, but only from a single pharmacy, the pharmacy is likely to be the only place where an accurate record exists of all medications a patient has received.").

304. *See* Jennifer D. Oliva, *Prescription-Drug Policing: The Right to Health-Information Privacy Pre- and Post-*Carpenter, 69 DUKE L.J. 775, 784 (2020) ("[I]t 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* Schawbel, *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,[309] pharmacists' familiarity with their patients' medical histories.[310] Whenever a pharmacist is presented with a patient's prescription,[311] information about the patient's health is communicated to the pharmacist.[312] As those prescriptions are refilled and others are issued and presented to the pharmacist,[313] the pharmacist "can literally reconstruct a patient's medical history."[314]

This familiarity with a patient's medical history is critical to the pharmacist's role in the provision of health care.[315] 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."[316] As one commentator explained:

309. *See* Karwaki, *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 pharmac[ist] 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 ("[W]hen a customer's physician writes or telephones a pharmacist about a prescription for medication, medical information is disclosed to a pharmacist.").

313. *See, e.g.*, Robin v. Hebert, 157 So. 3d 63, 65 (La. Ct. App. 2013) (discussing a patient who "routinely filled prescriptions for multiple pain medications, multiple anti-anxiety medications, and an antidepressant"); *see also* United States v. Rattini, 574 F. Supp. 3d 543, 548 (S.D. Ohio 2021) ("[T]he pattern of prescriptions . . . informs a pharmacist's decision whether to fill [a] prescription.").

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."); Vacco, *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.[317]

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

In 1990, Congress passed an Omnibus Budget Reconciliation Act ("OBRA" or "OBRA 90").[318] Insofar as the practice of pharmacy is concerned,[319] 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."[320] 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.")

318. Pub. L. No. 101-508, 104 Stat. 1388 (1990) (codified as amended in relevant part at 42 U.S.C. § 1396r-8(g)). Congress enacted the first omnibus budget reconciliation law in 1981. *See* Edwards v. McMahon, 834 F.2d 796, 798 (9th Cir. 1987) (discussing Pub. L. No. 97-35, 95 Stat. 357 (1981)). That enactment "was the product of a major, highly publicized, and vigorously debated effort by Congress and the President to reverse the growth of federal spending by systematically reducing the level of expenditures in a wide range of federal programs." Phila. Citizens in Action v. Schweiker, 669 F.2d 877, 878 (3rd Cir. 1982). Since that time the budget reconciliation process has become "the tool for consideration of the budget, and every major deficit reduction package since 1981 has had a reconciliation bill as its major component." Donald B. Tobin, *Less is More: A Move Toward Sanity in the Budget Process*, 16 ST. LOUIS U. PUB. L. REV. 115, 120 (1996).

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 Affs., 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,[321] OBRA therefore requires the states to establish drug utilization review ("DUR") programs[322] that, among other things, include provisions for pharmacists to counsel their patients concerning drug interactions.[323]

Not surprisingly,[324] many states reacted to OBRA by enacting laws requiring pharmacists to counsel their patients[325] (or at least offer to counsel them)[326] 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.[327] Reflecting another related aspect of OBRA,[328] these state laws also require pharmacists to attempt to obtain patient medical histories in order to facilitate the counseling they provide.[329] Although pharmacists' efforts to obtain such histories certainly predate these legislative developments,[330] OBRA and the state laws it spawned further undermined the assumption that pharmacists are unfamiliar with their patients' medical histories[331] and therefore are poorly equipped to advise them about their prescription medications.[332] 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." Cacciatori, *supra* note 325, at 110–11.

328. *See* Quick, *supra* note 36, at 145 ("[OBRA] 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 or 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) ("[A]n 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.[338] These authorities seem to conclude that, as in their interactions with physicians,[339] patients are more likely to confide in their pharmacists if the information they provide cannot be disclosed to others without their consent.[340]

On the other hand, "a concern for protecting confidentiality does not equate to privilege,"[341] and some courts and commentators continue to question the need for a pharmacist-patient privilege.[342] In *Reynolds v. State*,[343] for example, the court held that a patient's prescription records were not privileged.[344] The court acknowledged that such records are confidential and that patients have "a right to privacy with respect to them,"[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").

341. Sonnino v. Univ. of Kan. Hosp. Auth., 220 F.R.D. 633, 642, *modified on reconsideration*, 221 F.R.D. 661 (D. Kan. 2004); *see also* State v. Harris, 755 P.2d 825, 829 (Wash. Ct. App. 1988) ("Strong confidentiality requirements do not necessarily create a testimonial privilege.").

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.").

343. 633 A.2d 455 (Md. Ct. Spec. App. 1993).

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."[346]

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 . . . .").

347. 33 Cal. Rptr. 604 (Dist. Ct. App. 1963).

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 WIGMORE: A TREATISE ON EVIDENCE § 5.2.2, at 313–23 (2d ed. 2009))).

349. *See, e.g.*, Lowe's 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."[352]

> 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.[353]

The prevalence of this view may explain, in part,[354] why the courts never recognize a common law physician-patient privilege.[355] Nevertheless, the validity of the underlying assumption is debatable.[356] Many health care professionals are convinced that fear of public disclosure does influence patient behavior.[357] 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 fatal[361]—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 SCIS. 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 Patent*, 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").

361. *See* Jane E. Brody, *The Cost of Not Taking Your Medicine*, N.Y. TIMES (Apr. 17, 2017), https://www.nytimes.com/2017/04/17/well/the-cost-of-not-taking-your-medicine.html (reporting that "lack of adherence . . . is estimated to cause approximately 125,000 deaths . . . a year" (citing Meera Viswanathan et al., *Interventions to Improve Adherence to Self-administered Medications for Chronic Diseases in the United States: A Systematic Review*, 157 ANNALS INTERNAL MED. 785, 785 (2012))).

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 HOUS. 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.[365] This assumption may not have been, and perhaps can never be,[366] empirically validated.[367] However, the resulting uncertainty[368]—which is hardly unique to the physician-patient privilege[369]—has not prompted any state to abandon the privilege,[370] and there is no persuasive reason for refusing to extend the assumption on which it is based to the pharmacist-patient relationship.[371] As one pair of commentators observed:

statute in most states . . . ."); Note, *Medical Jurisprudence – Privileged Communications Between Physician and Patient – State Regulation and Right to Privacy*, 39 TENN L. 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 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 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* Gale v. State, 792 P.2d 570, 624 n.25 (Wyo. 1990) (Urbigkit, 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 *Developments in the Law—Privileged Communications*, *supra* note 140, at 1666)).

367. *See* 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 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 *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, *Giving Codification a Second Chance—Testimonial Privileges and the Federal Rules of Evidence*, 53 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."); *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, e.g.*, State 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."); *see also* Vacco, *supra* note 34, at 403 (footnote omitted) ("[W]hile 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., *Spousal Privilege and the Meanings of Marriage*, 81 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, 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 ("[T]he 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 gradual[375] 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.").

375. *See* State v. Almonte, 644 A.2d 295, 301 (R.I. 1994) (Lederberg, J., dissenting) (asserting that "the number of states recognizing the privilege has gradually grown" (quoting Wade, *supra* note 191, at 1151 n.34)); Earl C. Dudley, Jr., *Federalism and Federal Rule of Evidence 501: Privilege and Vertical Choice of Law*, 82 GEO. L.J. 1781, 1819 (1994) ("The patient-physician privilege has grown largely through legislative action, even in the face of occasionally open judicial hostility.").

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,[377] and some states still do not recognize it.[378] The recognition of a pharmacist-patient privilege seems unlikely in those jurisdictions,[379] in part because there is no existing privilege for a legislature to amend, or for the courts to interpret broadly enough,[380] to protect confidential communications between pharmacists and their patients.[381]

Even in states with a physician-patient privilege statute,[382] the recognition of a corresponding pharmacist-patient privilege seems likely to occur, if at all,[383] only through similar legislative action.[384] This assumption reflects the courts'

*Relationship in West Virginia*, 110 W. VA. L. REV. 1231, 1263 (2008) ("The time is ripe for West Virginia to adopt the physician-patient privilege."); *see also* Tarr, *supra* note 184, at 117 (noting that five states "enacted statutes creating a physician-patient privilege" between 1960 and 1975, reflecting fact that "state legislatures have not heeded the scholarly exhortations to abandon the privilege").

377. *See* Griffin v. Sanders, 914 F. Supp. 2d 864, 869 (E.D. Mich. 2012) ("The physician-patient privilege does not exist under federal common law and Congress has not codified such a privilege.").

378. *See, e.g.*, Veasley v. State, 570 S.E.2d 298, 301 (Ga. 2002) (explaining that "Georgia does not recognize a common-law or statutory physician-patient privilege"); Beck v. Scorsone, 612 S.W.3d 787, 789 (Ky. 2020) (observing that "there is no physician-patient privilege recognized in Kentucky"); *see also* Kurdeck v. W. Orange Bd. of Educ., 536 A.2d 332, 335 (N.J. Super Ct. Law Div. 1987) (stating that "the common law rule of no privilege still applies in . . . several states").

379. *See, e.g.*, Kohari v. Jessie, No. 2:13-CV-09072, 2014 WL 1338558, at *2 (S.D. W. Va. Apr. 3, 2014) ("[T]he only 'health care' privilege recognized in West Virginia is between psychotherapist and patient. That privilege has not been extended to pharmacists and patients."); *see also* Vacco, *supra* note 34, at 413 (footnotes omitted) ("Certainly, before the physician-patient privilege can legitimately be extended to pharmacists, whether by legislative enactment, or through judicial construction, the law must view the physician-patient privilege as a valid legal concept worthy of continued enforcement.").

380. *See* Vacco, *supra* note 34, at 413 (footnote omitted) (asserting that "the physician-patient privilege can legitimately be extended to pharmacists . . . by legislative enactment, or through judicial construction"); *cf*. Diehl v. State, 698 S.W.2d 712, 718 (Tex. App. 1985) (Levy, J., dissenting) ("Creation of . . . a testimonial privilege represents a determination—either judicial or legislative—that fostering certain relationships outweighs the potential benefit to the judicial system of compelled disclosure.").

381. *See, e.g.*, State v. Genna, 112 So. 655, 660 (La. 1927) ("[T]here is no law in this state on [the] subject [of privilege between physician and patient]. . . . It will be time enough to interpret such a statute when one is passed . . . ."); *see also* State v. Quested, 352 P.3d 553, 566 (Kan. 2015) (stating that "statutory construction . . . plays no part" in cases in which there is "no statute to construe").

382. *See generally* United States *ex rel*. Edney v. Smith, 425 F. Supp. 1038, 1041 (E.D.N.Y. 1976) ("Although no state has repealed the privilege once it has been adopted, recognition of its undesirable effects has led to judicial and legislative whittling away so that its scope has been considerably reduced."), *aff'd*, 556 F.2d 556 (2d Cir. 1977); Alexander, *supra* note 353, at 261 ("Even in states which do recognize a physician-patient privilege, debate continues over whether the privilege should be retained . . . .").

383. *See In re* Sealed Case, 676 F.2d 793, 806 (D.C Cir. 1982) ("[N]ot all socially worthy interests or relationships receive the benefits of privilege."); Jennifer Sawyer Klein, Note, *"I'm Your Therapist, You Can Tell Me Anything": The Supreme Court Confirms the Psychotherapist-Patient Privilege in* Jaffee v. Redmond, 47 DEPAUL L. REV. 701, 707 (1998) (observing that "legislatures have refused to acknowledge the existence of a string of purported privileges").

384. *See, e.g.*, Sherman v. Dist. Ct., 637 P.2d 378, 384 (Colo. 1981) ("In view of the . . . general policy of our rules favoring liberal discovery, we conclude that it would not be appropriate to expand the area of privilege absent legislative action."); *see also* Vacco, *supra* note 34, at 414 ("[E]ach state judiciary has followed the guidelines established by its legislature in interpreting the scope of the physician-patient privilege. Accordingly, it seems clear that the logical extension of the physician-patient privilege to pharmacist-customer communications will most appropriately be a product of the state legislatures.").

traditional reluctance to recognize new evidentiary privileges[385] and the occasional efforts of state legislatures to fill the resulting vacuum,[386] such that "in recent times most new privileges have been sought through legislation rather than court action."[387]

## CONCLUSION

Pharmacists and physicians are de facto partners in the provision of modern medical care;[388] both are professionally and ethically obligated to maintain the confidentiality of information about their patients' health.[389] However, pharmacists in many states are not protected by an evidentiary privilege[390] and courts in those states can compel pharmacists to disclose confidential

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 "pharmacists should work with physicians to identify, resolve, and prevent potential and actual drug-related problems"); Karwaki, *supra* note 288, at 544 (footnote omitted) ("[P]hysicians 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 "pharmacists and physicians 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))).

390. *See, e.g.*, Kohari v. Jessie, No. 2:13-CV-09072, 2014 WL 1338558, at *3 (S.D. W. Va. Apr. 3, 2014) (referring to "the absence of a state or federal pharmacist/patient privilege" in West Virginia); Shiffrin v. I.V. Servs. of Am., 729 A.2d 784, 787 (Conn. Ct. App. 1999) ("[T]here is no general pharmacist-customer privilege recognized in Connecticut."); *see also* Holley v. Norwalk Hosp. Ass'n, No. (X10)NNHCV044017092S(CLD), 2006 WL 328818, at *6 (Conn. Super. Ct. Jan 19, 2006) ("Connecticut is not alone in failing to recognize a pharmacist-patient privilege.").

information about their patients' health.[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.[392]

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

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.").

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").

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").

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.").

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.").

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))).

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.[398] Accordingly, the legislatures (or perhaps the courts)[399] in states that are yet to recognize the privilege should act expeditiously to adopt it,[400] just as many states adopted privileges protecting confidential communications between patients and other health care professionals.[401]

*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.* Nilavar 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.").

401. *See, e.g.*, Allred v. State, 554 P.2d 411, 418 (Alaska 1976) ("[W]e recognize a common law privilege, belonging to the patient, which protects communications made to psychotherapists in the course of treatment."); *see also* Arena v. Saphier, 492 A.2d 1020, 1024 (N.J. Super. Ct. App. Div. 1985) (noting that "the psychologist-patient privilege has won legislative recognition in many states"). *See generally* Jackson v. Dendy, 638 So. 2d 1182, 1186 (La. Ct. App. 1994) ("Confidentiality is important in many health care relationships. The existence of so many privilege statutes should make that principle clear." (quoting David V. Snyder, Comment, *Disclosure of Medical Information Under Louisiana and Federal Law*, 65 TUL. L. REV. 169, 201 (1990))).