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Jacob M. Appel

THE DANGERS OF THE UNDERPRIVILEGED ETHICIST: REVISING THE RULES OF EVIDENCE AFTER THE BIOETHICS REVOLUTION

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I. INTRODUCTION

If courts are to serve as effective agents of justice, judges and juries must have meaningful access to relevant evidence. In his seminal treatise on the laws of evidence, John Henry Wigmore condensed this principle into his second axiom: "All facts having rational probative value are admissible, unless some specific rule forbids."[1] Yet Professor Wigmore emphasized that public policy often justifies exceptions to this rule that are "extensive in scope."[2] Some of these exceptions, such as the rules governing hearsay, are designed to ensure a fair trial.[3] Other exclusionary rules, however, actually restrict the availability of relevant evidence—and reduce the likelihood of a just verdict—in order to protect extrajudicial interests or serve broader social goals.[4] In the memorable language of James Bradley Thayer, some evidence is "unsafe on public grounds."[5] Among these policy-based exclusions are the testimonial privileges that protect criminal defendants and civil litigants from the personal evidence of witnesses with whom they have certain familial or professional relationships.

This article advocates for the creation of a new testimonial privilege to govern communications between clinical ethicists and the patients and family members who rely upon them in healthcare institutions. Part II of

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1. 1 JOHN HENRY WIGMORE, A TREATISE ON THE ANGLO-AMERICAN SYSTEM OF EVIDENCE IN TRIALS AT COMMON LAW, §10 at 152 (2d ed. 1923).

2. *Id.*

3. *See* Myrna S. Raeder, *The Uniform Rules of Evidence: Finding the Proper Balance in Hearsay Policy*, 54 OKLA. L. REV. 631, 631–46 (2001) (discussing the purposes of the hearsay rule).

4. Wendy Meredith Watts, *The Parent-Child Privileges: Hardly a New or Revolutionary Concept*, 28 WM. & MARY L. REV. 583, 587 (1987).

5. JAMES B. THAYER, *A PRELIMINARY TREATISE ON EVIDENCE AT THE COMMON LAW* 266 (1898).

this article briefly traces the history of testimonial privileges and situates the patient-ethicist relationship within the debate over the merits of creating additional privileges. Part III examines existing state and federal rules regarding patient-provider privilege. Part IV explores the policy implications of carving out a new privilege for ethicists. Part V attempts to explain the parameters under which a limited privilege might operate. The goal of this article is to place the creation of this privilege on the political agenda in the hope that doing so will protect the confidentiality of the ethics consultation process and ultimately protect the long term integrity of that process.

II. BACKGROUND ON TESTIMONIAL PRIVILEGES AND ETHICS CONSULTATION

The origins of testimonial privileges at common law are directly connected to the creation of rules that compelled the appearance of witnesses at trials.[6] Prior to the passage of the Perjury Act of 1562, privileges were superfluous, as unwilling witnesses could simply refuse to appear in court. Only after the general principle of compulsory testimony was established did such privileges become necessary.[7] In 1577, *Berd v. Lovelace* established the first of these privileges, which protected confidential communications between litigators and clients.[8] As the English litigator Richard Pike noted, "a privilege preventing lawyers from being compelled to give evidence arose almost as soon as it could provide any benefit."[9] Shortly afterwards, English courts recognized "a second broad privilege" that protected "communications between spouses."[10] These privileges were subsequently recognized by nearly all American jurisdictions.[11]

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6. Richard S. Pike, *The English Law of Legal Professional Privilege: A Guide for American Attorneys*, 4 LOY. U. CHI. INT'L L. REV. 51, 52 (2006).

7. *See* Perjury Act, 1562, 5 Eliz. 9 §§ 1–6 (Eng.). *See also* The Law Reform Commission of Western Australia, Project No. 28, *Official Attestation of Forms and Documents* (1978) (discussing the origins of compulsory process).

8. Berd v. Lovelace, Cary 62, 21 Eng. Rep. 33 (Ch. 1577).

9. PIKE, *supra* note 6, at 52.

10. Harv. L. Rev. Ass'n, *Development in the Law: Privileged Communications*, 98 HARV. L. REV. 1450, 1456 (1985). Spousal privilege today often consists of two distinct but related privileges: "The confidential communications privilege, which protects private marital communication, and the adverse testimony privilege, which insulates spouses from being compelled to incriminate one another."; Amanda H. Frost, *Updating the Marital Privileges: A Witness-Centered Rationale*, 14 WIS. WOMEN'S L.J. 1 (1999) (discussing the distinct origins of and rationales for each of these separate exclusionary principles).

11. *See* Blau v. United States, 340 U.S. 332, 333–34 (1951) ("Petitioner's refusal to betray his wife's trust therefore was both understandable and lawful. We have no

Since the 1820s, American state legislatures and courts have at various times recognized a series of additional privileges including those protecting communications between physicians and patients,[12] nurses and patients,[13] clergymen and penitents,[14] psychotherapists (including social workers) and clients,[15] parents and children,[16] journalists and sources,[17] accountants and taxpayers,[18] sign-language interpreters and deaf people,[19] mediators and participants in mediation,[20] and sexual assault and domes-

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doubt that he was entitled to claim his privilege."); Wolfe v. United States, 291 U.S. 7, 14 (1934) ("The basis of the immunity given to communications between husband and wife is the protection of marital confidences . . . ."); Stein v. Bowman, 38 U.S. (13 Pet.) 209 (1839) (accepting spousal privilege); *see also* James A. Gardner, *A Re-Evaluation of the Attorney-Client Privilege*, 8 VILL. L. REV. 279 (1963) (explaining the acceptance of attorney client privilege).

12. *See* Note, *Legal Protection of the Confidential Nature of the Physician-Patient Relationship*, 52 COLUM. L. REV. 383, 385–88 (1952) (discussing early history of statutes); *but see* B. Abbott Goldberg, *The Physician-Patient Privilege—An Impediment to Public Health*, 16 PAC. L.J. 787 (1985) (critiquing the physician-patient privilege).

13. *See, e.g.*, N.Y. C.P.L.R. 4504 (MCKINNEY 2011), *limited by* Keshecki v. St. Vincent's Medical Center, 785 N.Y.S.2d 300 (N.Y. Sup. Ct. 2004).

14. *See* Rena Durrant, Comment, *Where There's Smoke, There's Fire (And Brimstone): Is It Time to Abandon the Clergy-Penitent Privilege?*," 39 LOY. L.A. L. REV. 1339, 1342 (2006) (noting that all fifty American states have adopted some version of clergyman-penitent privilege).

15. *See* Jaffee v. Redmond, 518 U.S. 1, 18 (1996); *see also* Christopher D. Jones, Recent Development, Jaffee v. Redmond: *The Supreme Court Adopts a Testimonial Privilege for Psychotherapists and Extends the Privilege to Licensed Social Workers*, 23 J. CONTEMP. L. 252 (1997) (explaining the social worker privilege).

16. *See* Gregory W. Franklin, Note, *The Judicial Development of the Parent-Child Testimonial Privilege: Too Big for Its Britches?*, 26 WM. & MARY L. REV. 145, 155–68 (1984); *see also* Jaynie Randall, Case Comment, *Freeing Newsgathering from the Reporter's Privilege:* McKevitt v. Pallasch, 114 YALE L.J. 1827 (2005).

17. *See* Anne M. Macrander, *Bloggers as Newsmen: Expanding the Testimonial Privilege*, 88 B.U.L. REV. 1075, 1086–88 (2008); *see also* Jeffrey S. Nestler, Comment, *The Underprivileged Profession: The Case for Supreme Court Recognition of the Journalist's Privilege*, 154 U. PA. L. REV. 201 (2005); Kristina Spinneweber, Note, Branzburg, *Who? The Existence of a Reporter's Privilege in Federal Courts*, 44 DUQ. L. REV. 317 (2006).

18. *See* Thomas J. Molony, Note, *Is the Supreme Court Ready to Recognize Another Privilege? An Examination of the Accountant-Client Privilege in the Aftermath of* Jaffee v. Redmond, 55 WASH. & LEE L. REV. 247, 270 (1998).

19. *See* Alice J. Baker, *Sign Language Interpreters and Testimonial Privileges*, 2 VA. J. SOC. POL'Y & L. 165, 191–96 (1994).

20. *See* Folb v. Motion Picture Indus. Pension & Health Plans, 16 F. Supp. 2d 1164, 1181 (C.D. Cal. 1998), *aff'd,* 216 F.3d 1082 (9th Cir. 2000); *see also* Ryan D. O'Dell, *Federal Court Positively Adopts a Federal Common Law Testimonial Privilege*

tic violence counselors and victims.[21] All fifty states have also enacted some form of privilege that protects in-house medical peer review.[22] Many other privileges have been proposed, including those governing relationships between cohabiting couples,[23] Alcoholics Anonymous members,[24] alternative health practitioners and patients,[25] "jailhouse lawyers" and fellow inmates,[26] union representatives and employees,[27] and Secret Service officers and the President.[28] While the federal courts have generally proven reluctant to recognize new privileges,[29] states have catered to a wide variety of interest groups and policy considerations, such as New York's specific protection for podiatrist-patient privilege[30] and Alaska's

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for Mediation: Is It Justified? Folb v. Motion Picture Indus. Pension & Health Plans, 1999 J. DISP. RESOL. 203.

21. Leslie A. Hagen & Kim Morden Rattet, *Communications and Violence Against Women: Michigan Law on Privileges, Confidentiality, and Mandatory Reporting*, 17 T.M. COOLEY L. REV. 183, 200–201 (2000); *see also* Patricia A. Furci, *The Sexual Assault Nurse Examiner: Should the Scope of the Physician-Patient Privilege Extend That Far?*, 5 QUINNIPIAC HEALTH L.J. 229, 243 (2002); Anne W. Robinson, *Evidentiary Privileges and the Exclusionary Rule: Dual Justifications for an Absolute Rape Victim Counselor Privilege*, 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 331, 331–32 (2005).

22. Teresa L. Salamon, *When Revoking Privilege Leads to Invoking Privilege: Whether There Is a Need to Recognize a Clearly Defined Medical Peer Review Privilege in* Virmani v. Novant Health Inc., 47 VILL. L. REV. 643, 652 (2002).

23. Katherine M. Forbes, *Time for a New Privilege: Allowing Unmarried Cohabitating Couples to Claim the Spousal Testimony Privilege*, 40 SUFFOLK U. L. REV. 887 (2007).

24. Jessica G. Weiner, *And the Wisdom to Know the Difference: Confidentiality vs. Privilege in the Self-Help Setting*, 144 U. PA. L. REV. 243 (1995).

25. Betty Lay, *Healer-Patient Privilege: Extending the Physician-Patient Privilege to Alternative Health Practitioners in California*, 48 HASTINGS L.J. 633 (1997).

26. Julie B. Nobel, *Ensuring Meaningful Jailhouse Legal Assistance: The Need for a Jailhouse Lawyer-Inmate Privilege*, 18 CARDOZO L. REV. 1569 (1997).

27. Michael Moberly, *Extending a Qualified Evidentiary Privilege to Confidential Communications Between Employees and Their Union Representatives*, 5 NEV. L.J. 508 (2004).

28. Julie Prouty, *How Secret Is the Service?: Exploring the Validity and Legality of a Secret Service Testimonial Privilege*, 104 DICK. L. REV. 227 (1999).

29. *See* United States v. Bryan, 339 U.S. 323 (1950); *see also* Paul W. Mosher, *Psychotherapist-Patient Privilege: The History and Significance of the U.S. Supreme Court's Decision in the case of* Jaffee v. Redmond, *in* CONFIDENTIAL RELATIONSHIPS: PSYCHOANALYTIC, ETHICAL, AND LEGAL CONTEXTS 177, 193 (Christine M. Koggel et al. eds., 2003) ("[T]he creation of a new privilege is not only unusual; it signifies a very notable recognition by the Supreme Court of a most important societal need.").

30. N.Y. C.P.L.R. 4504 (MCKINNEY 2011), *limited by* Keshecki v. St. Vincent's Medical Center, 785 N.Y.S.2d 300 (N.Y. Sup. Ct. 2004). *Accord* WASH. REV. CODE ANN. § 5.60.060(4) (2011) (covering podiatrists as well).

de facto recognition of a privilege shielding pet adoption agencies from revealing the identities of individuals who adopt rescue pets.[31] Some of these new and proposed privileges, like those that apply to the press, cover expansive areas of human interaction that were not previously protected at all.[32] Others seek to fill in gaps in the existing framework of protections.[33]

Social change, particularly with regard to which profession delivers a particular set of services, often renders the expansion of such privileges consistent with existing policy goals.[34] For example, the State of Washington created a statutory privilege in 1983 to protect communications between counselors at community mental health clinics and agencies and their patients.[35] The legislature recognized that employees of these clinics had largely replaced psychiatrists and psychologists in providing mental health services to the indigent.[36] Although the clinics cared for patients with "many of the same mental and social disorders as [did] psychiatrists and licensed psychologists . . . very few of the employees in the clinics [were] members of either profession."[37] As a result, by the early 1980s, fewer than 7 percent of the counselors in these clinics could "guarantee confidentiality under the physician-patient or psychologist-client privileges," creating a need to broaden existing privilege protections if the policy goals of those original protections were to be met.[38] Justice John Paul Stevens acknowledged a related phenomenon when including "licensed social workers" among those protected by federal psychotherapist-patient privilege in *Jaffee v. Redmond*.[39] Similarly, the origins of

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31. John J. Tiemessen & Jason A. Weiner *The Golden Retriever Rule: Alaska's Identity Privilege for Animal Adoption Agencies and for Adoptive Animal Owners*, 21 ALASKA L. REV. 77 (2004). The authors discuss the Alaska Superior Court's ruling in *Wall v. Gyuricsko*, which does not call itself a privilege, but adopts one in all but name. Similar protections exist in Georgia and Vermont. *See* Lamare v. North Country Animal League Vermont, 743 A.2d 598, 604 (Vt. 1999); Johnston v. Atlanta Humane Society, 326 S.E.2d 585, 588 (Ga. Ct. App. 1985).

32. See CHARLES TILFORD MCCORMICK, EVIDENCE 165 (1954) (discussing the reasons why new privileges, such as those protecting the press, are adopted).

33. In this regard, these new privileges created by the judiciary display the gap-filling role of the judiciary as envisioned by future Supreme Court Justice Benjamin N. Cardozo in *The Nature of the Judicial Process*, originally published in 1921.

34. *See* MCCORMICK, *supra* note 32.

35. William Whitmore Hague, *The Psychotherapist-Patient Privilege in Washington: Extending the Privilege to Community Health Clinics*, 58 WASH. L. REV. 565 (1983).

36. *Id.* at 579.

37. *Id.* at 580.

38. *Id.*

39. 518 U.S. 1 (1996).

accountant-client privilege lay in the recognition that lawyers may be ill-equipped to understand intricate tax matters and will often need specialists who can serve as "interpreters" of tax-related transactions.[40] In adopting the Federal Rules of Evidence (FRE), Congress rejected a static list of testimonial privileges in favor of a dynamic approach that allows the judiciary to expand such protections to new classes of relationships based on "reason and experience."[41] In short, legislatures and courts have recognized that the law of privileges must adapt to significant changes in society.

The revolution in clinical ethics qualifies as one of these societal transformations. Although ethical considerations have governed the practice of medicine since the days of Hippocrates, the past forty years have witnessed radical changes in the ways in which ethical matters are addressed in medical practice.[42] One of the pioneers of modern bioethics, John C. Fletcher, described the field as "a child of the 1960s" and a product of "revolutionary zeal."[43] Prior to the 1960s, the governing value in clinical ethics was beneficence; medical providers strove to serve their perceived notion of the patient's best interests, often without reference to his or her wishes.[44] By the 1980s, a focus upon patient autonomy and informed consent had supplanted this paternalistic model.[45] Before making significant medical decisions, providers were now expected to investigate the specific health goals of the individuals receiving care.[46] Moreover, a mechanism was needed to negotiate conflicts between idiosyncratic pa-

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40. Kim J. Gruetzmacher, Comment, *Privileged Communications with Accountants: The Demise of* United States v. Kovel, 86 MARQ. L. REV. 977 (2003); *see* United States v. Kovel, 296 F.2d 918 (2nd Cir. 1961).

41. FED. R. EVID. 501. The Federal Rules of Evidence became law on Jan. 2, 1975, with the enactment of An Act to Establish Rules of Evidence for Certain Courts and Proceedings, Pub. L. No. 93-595, 88 Stat. 1926 (1974).

42. A complete history of the modern clinical ethics movement is beyond the scope of this article. There are several articles that offer a detailed discussion of the rise of clinical ethics consultation and its impact. *See* Albert R. Jonsen, *Can an Ethicist Be a Consultant?*, *in* FRONTIERS IN MEDICAL ETHICS: APPLICATIONS IN A MEDICAL SETTING 151 (Virginia Abernethy ed., 1980); Edmund Pellegrino, *Ethics and the Moment of Clinical Truth*, 239 J. AM. MED. ASS'N 960 (1978); Mark Siegler, Edmund D. Pellegrino & Peter A. Singer, *Clinical Medical Ethics*, 1 J. CLINICAL ETHICS 5 (1990).

43. John C. Fletcher, *The Bioethics Movement and Hospital Ethics Committees*, 50 MD. L. REV. 859, 861 (1991).

44. Timothy E. Quill & Howard Brody, *Physician Recommendations and Patient Autonomy: Finding a Balance between Physician Power and Patient Choice*, 124 ANNALS INTERNAL MED. 763, 763–64 (1996).

45. *Id.* at 764–65.

46. *See* H. Tristram Engelhardt, Jr., *Healthcare Ethics Committees: Re-examining their Social and Moral Functions*, 11 HEC FORUM 87, 87–92 (1999).

tient wishes and established medical norms.[47] Interdisciplinary committees of ethically minded clinicians were established to fill this role.[48]

Ethics committees burgeoned in response to several high-profile legal controversies, particularly the New Jersey Supreme Court's 1976 ruling in the Karen Ann Quinlan case and the enactment of the federal "Baby Doe" Law in 1984.[49] Ethics consultation services arose soon afterwards.[50] While these consultation services provide information and counseling that enables patients and families to make high-stakes medical decisions, frequently the consultants are not physicians;[51] even when the consultants are physicians, it is not clear that they are engaging in medical care that would qualify for a testimonial privilege.[52] Yet the confidentiality of such consultations is essential for their effective functioning.[53] Otherwise, patients and relatives may be reluctant to speak openly with consultants out of fear that their communications might then be used to their detriment in any future legal proceedings relating to the ethical dilemma under consideration.[54]

Although the process of ethics consultation varies significantly from institution to institution, certain fundamental aspects of the process are largely uniform.[55] Nancy Dubler, one of the nation's foremost authorities

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47. Fred Rosner, *Hospital Ethics Committees: A Review of their Development*, 253 J. AM. MED. ASS'N 2693, 2693–97 (1985).

48. *See* Ronald E. Cranford & A. Edward Doudera, *The Emergence of Institutional Ethics Committees*, 12 J.L. MED. & ETHICS 13, 13 (1984).

49. Fred Rosner, *Hospital Ethics Committees: A Review of their Development*, 253 J. AM. MED. ASS'N 2693, 2694 (1985).

50. Pat Milmoe McCarrick, *Bioethics Consultation*, 3 KENNEDY INST. OF ETHICS J. 433 (1993).

51. *See* George A. Kanoti, *Professional Identities of the Bioethics Consultant*, TRENDS IN HEALTH CARE, L. & ETHICS, Fall 1993, at 17, 22; Patricia A. Murphy, *A Nurse-Ethicist Model of Ethics Consultation*, TRENDS IN HEALTH CARE, L. & ETHICS, Fall 1993, at 23; *see also* Frank H. Marsh, *Why Physicians Should Not Do Ethics Consults*, 13 THEORETICAL MED. & BIOETHICS 285 (1992).

52. For an intriguing comparison with peer-to-peer professional ethics consultation, see Michael C. Gottlieb, *A Template for Peer Ethics Consultation*, 16 ETHICS & BEHAVIOR 151, 155 (2006).

53. *See* Uwe Fahr & Andreas Frewer, *Clinical Ethics and Confidentiality: Opinions of Experts and Ethics Committees*, 19 HEC FORUM 277, 281–82 (2007); Gerald Neitzke, *Confidentiality, Secrecy and Privacy in Ethics Consultation*, 19 HEC FORUM 293 (2007); Robert Baker, *Confidentiality in Professional Medical Ethics*, 6 AM. J. BIOETHICS 39, 40 (2006); H. Draper & W.A. Rogers, *Confidentiality and the Ethics of Medical Ethics*, J. MED. ETHICS 220 (2003).

54. *See* Eric M. Meslin et al., *Hospital Ethics Committees in the United Kingdom*, 8 HEC FORUM, 301 (1996).

55. Robert D. Orr & Wayne Shelton, *A Process and Format for Clinical Ethics Consultation*, 20 J. CLINICAL ETHICS 79, 80–83 (2009).

on clinical ethics consultation services, describes the purpose of such services as "to improve the process and outcomes of patient care by helping to identify, analyze and resolve ethical problems."[56] At most hospitals, either patients or members of the clinical team may request an ethics consultation by contacting the ethics service directly.[57] If the patient lacks capacity, a proxy or surrogate (usually a family member) may act on the patient's behalf.[58] The ethics consultant then meets, if possible, with both the patient or surrogate and the providers, almost always in private, to discuss their ethical concerns. During these consultations, patients may share motives, fears, and even ulterior motives that they would not want revealed in court.[59] For example, a patient's relative might inform the ethicist that the reason he wants the patient's life support removed is that the patient wanted her resources to go to her church, not to futile medical care—arguably a reasonable motive, but not necessarily one that the family member might want to share with either the patient's physicians or in a courtroom.

III. EXISTING RULES GOVERNING PROVIDER-PATIENT PRIVILEGE

The creation of a new privilege is necessary only if the communications that society wishes to protect are not already shielded by existing privileges. No American jurisdiction has explicitly embraced a privilege for clinical ethics consultations either through legislation or court ruling. That does not necessarily indicate that such communications are not already protected under other existing privileges. In hospitals where members of the clergy conduct ethics consultations, it is plausible (but by no means assured) that matters shared with these clergy in confidence are protected under the clergyman-penitent privilege of certain jurisdictions.[60] In the vast majority of cases, however, any protections afforded to

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56. Nancy Neveloff Dubler et al., *Charting the Future: Credentialing, Privileging, Quality and Evaluation in Clinical Ethics Consultation*, 2009 HASTINGS CTR. REP. 23, 25.

57. George J. Agich & Stuart J. Youngner, *For Experts Only? Access to Hospital Ethics Committees*, HASTINGS CTR. REP., Sept.–Oct. 1991, at 17.

58. *See* H.A. Llewellyn-Thomas, E.C. Thiel & R.M. Clark, *Patients Versus Surrogates: Whose Opinion Counts on Ethics Review Panels?*, 37 CLINICAL RES. 501, 501–505 (1989).

59. John La Puma & Stephen E. Toulmin, *Ethics Consultants and Ethics Committees*, 149 ARCHIVES OF INTERNAL MEDICINE, May 1989, No. 5, 1109–12.

60. The frequency with which members of the clergy wear a second hat and conduct clinical ethics consultations does not appear to have been formally studied. However, Glenn McGee and others report a significant presence of clergy on hospital

participants in ethics consultation would theoretically stem from physician-patient privilege (or associated provider privileges, such as nurse-patient privilege, in hospitals where nurses conduct clinical ethics consultations within jurisdictions that apply testimonial privilege to non-physician healthcare workers).[61] A brief survey of both state and federal protections reveals that existing law generally does not apply to ethics consultations by non-physicians. Furthermore, in cases where licensed physicians themselves do serve as consultants, the nature of ethics consultation may well place these sessions beyond the scope of the activities covered by doctor-patient privilege.

A. Current State Rules Present Barriers to Creation of an Ethicist Privilege

No physician-patient privilege existed at common law.[62] In fact, none of the leading early commentators on evidence accepted such a testimonial exemption.[63] However, American physicians themselves sought the privilege and pressed for legislative intervention.[64] New York introduced a testimonial privilege for physicians by statute in 1828.[65] Missouri followed in 1834.[66] At present, forty-two states and the District of Colum-

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ethics committees. Glenn McGee et al., *A National Study of Ethics Committees*, AM. JUR. OF BIOETHICS, Fall 2001, at 60, 63.

61. It appears highly unlikely that attorney-client privilege or psychotherapist-patient privilege will protect communications during ethics consultations, even in situations where the consultant happens to be an attorney or a licensed psychotherapist.

62. Daniel W. Shuman, *Origins of the Physician-Patient Privilege and Professional Secret*, 39 SW. L.J. 661, 669–678 (1985). Many physicians testified during the era between 1562 and 1776. The physician-patient privilege was first formally rejected by the British courts in the Duchess of Kingston's Case, a celebrated bigamy trial in the House of Peers. The Trial of Elizabeth Duchess Dowager of Kingston for Bigamy, 52 (1776), *reprinted in* 20 State Trials No. 551, at 355–652 (T.B. Howell ed., 1814).

63. Most notably, Blackstone makes no mention of the privilege at all. 1–4 WILLIAM BLACKSTONE, COMMENTARIES.

64. Joseph Augustus Santry, *The Patient's Privilege*, 10 ALB. L. REV. 60, 60 (1940–1941).

65. 2 N.Y. REV. STAT. pt. 3, ch. 7, § 73, at 406 (1828):

> No person duly authorised to practice physic or surgery, shall be allowed to disclose any information which he may have acquired in attending any patient, in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him, as a surgeon.

Shuman reports that an earlier, unreported divorce case from Pennsylvania may have adopted the privilege in 1800, but the only evidence is an 1823 draft of *A System of Medical Ethics* by the New York State Medical Society. Shuman, *supra* note 62.

66. MO. REV. STAT. §17 (1835):

> No person authorized to practice physic or surgery, shall be required or allowed to disclose any information which he have acquired from any patient,

bia have adopted a physician-patient privilege by statute, although many confine its use to civil matters.[67] Eight states have not done so.[68] While

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> while attending him in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician or do any act for him as a surgeon.

Note the similarity with the New York statute, except that New York's statute leaves discretion with the physician, while Missouri's statute prohibits all disclosure.

67. *See* ALASKA R. EVID. 504(b) (Lexis 2011); ARIZ. REV. STAT. ANN. § 12-2235 (1974); ARK. CODE ANN. § 16-41-101, R. 503(b) (2001); CAL. EVID. CODE § 994 (West 1994); COLO. REV. STAT. § 13-90-107(d) (2011); CONN. GEN. STAT. § 52-1460 (West 1996); DEL. R. EVID. 503(b); D.C. CODE § 14-307(a) (2010); GA. CODE ANN. § 24-9-40 (2011); HAW. REV. STAT. § 626-1(b) (West 2002); IDAHO CODE ANN. § 9-203(4) (1996); 735 ILL. COMP. STAT. ANN. 5/8-802 (West 2011); IND. CODE ANN. § 34-46-3-1 (West 1998); IOWA CODE § 622.10 (West 2011); KAN. STAT. ANN. § 60-427(b) (West 2009); LA. CODE EVID. ANN. art. 510(B) (2001); ME. R. EVID. 503(b); MICH. COMP. LAWS § 600.2157 (West 1995); MINN. STAT. ANN. § 595.02(d) (West 2008); MISS. CODE ANN. § 13-1-21 (1988); MO. REV. STAT. § 491.060 (West 1999); MONT. CODE ANN. § 26-1-805 (2009); NEB. REV. STAT. ANN. § 27-504 (LexisNexis 2007); NEV. REV. STAT. ANN. §§ 49.215–.245 (West 2002); N.H. REV. STAT. ANN. § 329:26 (2011); N.J. REV. STAT. § 2A:84A-22.2(B) (1968); N.M. R. EVID. 11-504(B); N.Y. C.P.L.R. 4504(a) (McKinney 1993), *limited by* Keshecki v. St. Vincent's Medical Center, 785 N.Y.S.2d 300 (N.Y. Sup. Ct. 2004); N.C. GEN. STAT. § 8-53 (1983); N.D. R. EVID. 503(b); OHIO REV. CODE ANN. § 2317.02(B)(1) (West 2010); OKLA. STAT. ANN. tit. 12, § 2503(B) (West 2009); OR. REV. STAT. ANN. § 40.235(2) (West 2005); 42 PA. CONS. STAT. ANN. § 5929 (West 1976); R.I. GEN. LAWS § 5-37.3-4(a)(1) (2010); S.D. CODIFIED LAWS § 19-13-7 (1976); TEX. R. ANN. 509(c)(1); UTAH CODE ANN. § 78B-1-137(4) (West 2008); VT. STAT. ANN. tit. 12, § 1612(a) (2009); VA. CODE ANN.§ 8.01-399 (2009); WASH. REV. CODE ANN. § 5.60.060(4) (West 2009); WIS. STAT. ANN. § 905.04 (West 2009); WYO. STAT. ANN. § 1-12-101(a)(i) (1991).

68. The eight states are Alabama, Florida, Kentucky, Maryland, Massachusetts, South Carolina, Tennessee, and West Virginia. Regarding Alabama, see Laural C. Alexander, *Should Alabama Adopt a Physician-Patient Evidence Privilege?*, 45 ALA. L. REV. 261, 261 (1993). The Alabama Supreme Court explicitly rejected the privilege in *Dyer v. State*, 4 So.2d, 311, 313 (Ala. 1941) and reaffirmed this approach in *Beecher v. State*, 256 So.2d 154, 164 (Ala. 1971), *rev'd on other grounds*, 408 U.S. 234 (1972). Florida's Supreme Court appears to have created a privilege subject to limitations through statutory interpretation in *Acosta v. Richter*, 671 So.2d 149 (Fla. 1996). *See* J.B. Harris, *The Limits of Ex Parte Communications with a Plaintiff's Treating Physicians Under Florida Law*, 70 FLA. BAR J., Nov. 1996, at 57. For Kentucky law, see Steven R. Smith, *Medical and Psychotherapy Privileges and Confidentiality: On Giving With One Hand and Removing with the Other*, 75 KY. L.J. 473. 503 (1986) (stating that Kentucky once had such a statute, but in 1941 the Kentucky Court of Appeals "essentially gutted the physician-patient privilege by ruling that [the statute] applied only to the accumulation of vital statistics and did not provide for a general physician-patient privilege"). For Maryland law, see *Butler-Tulio v. Scroggins*, 774 A.2d 1209, 1216 (Md. Ct. Spec. App. 2001). For Massachusetts law, see *Commonwealth v. Senior*, 744 N.E.2d 614, 617 (Mass. 2001); *Tower v. Hirshhorn*, 492 N.E.2d 728, 733 (Mass. 1986); *Bratt v. Int'l Bus. Machs. Corp.*, 467 N.E.2d 126, 136 n. 22 (Mass. 1984) (citing

precisely which treating parties are covered by the privilege varies substantially from state to state, with some states including chiropractors,[69] pharmacists[70] and dentists,[71] the scope of the medical activities covered and the nature of the communications protected is strikingly uniform across jurisdictions.

Four general provisions must be met for a communication to qualify under the provider-patient privilege rules of most states: (1) the provider whose disclosure the privilege-holder wishes to prevent must be a qualified provider under the statute;[72] (2) the knowledge must have been acquired by the provider during the course of the provider-patient relationship;[73] (3) the material that the privilege-holder wishes to exclude must qualify as "communication" or "information";[74] and (4) the communication must have been "necessary" for the diagnosis or treatment of the patient.[75] Rarely, if ever, will a clinical ethics consultation meet all four of these requirements. Data on the professional backgrounds of ethics consultants remains highly limited, but many hospitals use non-physicians for such consultations.[76] Senior nurses are among those non-physicians who

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P.J. LIACOS, MASSACHUSETTS EVIDENCE 186–88 (5th ed. 1981)). For South Carolina law, see *Snavely v. AMISUB of S. Carolina, Inc.*, 665 S.E.2d 222, 225 (S.C. 2008), *Peagler v. Atl. Coast Line R.R. Co.*, 101 S.E.2d 821, 825 (S.C. 1958). For Tennessee law, see *Overstreet v. TRW Commercial Steering Div.*, 256 S.W.3d 626, 631 (Tenn. 2008). Regarding West Virginia law, see Franklin D. Cleckley, *A Modest Proposal: A Psychotherapist-Patient Privilege for West Virginia*, 93 W. VA. L. REV. 1, 36 (1990).

69. *See, e.g.*, N.Y. C.P.L.R. 4504-a (MCKINNEY 2011), *limited by* Keshecki v. St. Vincent's Medical Center, 785 N.Y.S.2d 300 (N.Y. Sup. Ct. 2004).

70. *See, e.g.*, GA. CODE ANN. § 24-9-40 (West 2011); MISS. CODE ANN. § 13-1-21 (1988).

71. Dentists are explicitly included in the privilege rules in Mississippi, Missouri, Montana, Oregon, New York, and Vermont. *See* MISS. CODE ANN. § 13-1-21(1) (1988); MO. REV. STAT. § 491.060(5) (West 2010); MONT. CODE ANN. § 26-1-805 (2009); OR. REV. STAT. § 40.235(c)(2009); N.Y. C.P.L.R. 4504-a (MCKINNEY 2011), *limited by* Keshecki v. St. Vincent's Medical Center, 785 N.Y.S.2d 300 (N.Y. Sup. Ct. 2004); VT. STAT. ANN. tit. 12, § 1612(a) (2011). Dentists have been included by court rulings in Illinois and New Jersey. People v. Manos, 761 N.E.2d 208, 210 (Ill. App. Ct. 2001); Kessler v. Troum, 392 A.2d 662, 665 (N.J. Super. Ct. Law Div. 1978). However, dentists have been overtly excluded in Michigan and Texas. People v. De France, 62 N.W. 709, 712 (Mich. 1895); Buchanan v. Mayfield, 925 S.W.2d 135, 138 (Tex. App. 1996).

72. Note, *supra* note 12, at 390–91.

73. *Id.*

74. *Id.* at 390–91.

75. *Id.* at 391.

76. One comprehensive study of the background of ethics consultations in the United States has been conducted to date. *See* Ellen Fox, Sarah Myers & Robert A. Pearlman, *Ethics Consultation in United States Hospitals: A National Survey*, 7 AM. J.

most often provide such services, yet they are qualified providers for the purposes of privilege in only a minority of states.[77] Other hospitals use lay people, such as bioethicists with graduate degrees in philosophy, who are certainly not providers under any state laws.[78]

The most significant obstacle to claiming protections under the existing privilege rules is that ethics consultations are rarely—if ever—necessary, in the strictest sense, for either diagnosis or treatment of a patient. Courts have generally construed what constitutes diagnosis and treatment narrowly.[79] A few states, such as New York, have statutes that could conceivably cover the sort of services provided during ethics consultation. The protection in New York applies to "any information which [was] acquired in attending a patient in a professional capacity, and which enabled him to act in that capacity."[80] Iowa also has a broadly-phrased privilege.[81] The majority of jurisdictions, in contrast, do not. In Kansas, for example, the privilege is restricted to information "the patient or the physician reasonably believed. . .necessary or helpful to enable the physician to make a diagnosis of the condition of the patient or to prescribe or render treatment therefor."[82] North Carolina's statute covers an even narrower realm of activity, protecting only "information . . . necessary to en-

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BIOETHICS 13, 17 (2007). According to their survey, hospitals use the following individuals at these rates: 94% physicians, 91% nurses, 71% social workers, 70% chaplains, 61% administrators, 32% lawyers, other 25% healthcare providers, and 23% lay people. *Id.* This use of non-physicians to address aspects of care related to professional duty is not without its critics. *See* Frederick Adolf Paola & Robert Walker, *Ethicians, Ethicists and the Goals of Clinical Ethics Consultation*, 1 INTERNAL AND EMERGENCY MED. 5, 5 (2006).

77. *See* Murphy, *supra* note 51; See also Fox, Myers & Pearlman, *supra* note 76, at 17.

78. Fox, Myers & Pearlman, *supra* note 76.

79. *See, e.g.*, *In re* Kathleen M., 493 A.2d 472, 477 (N.H. 1985) (noting that a psychiatrists observations of a patient "when not made for the purpose of diagnosis and treatment, are not privileged").

80. N.Y. C.P.L.R. 4504-a (MCKINNEY 2011), *limited by* Keshecki v. St. Vincent's Medical Center, 785 N.Y.S.2d 300 (N.Y. Sup. Ct. 2004).

81. Iowa's statute reads:

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

IOWA CODE ANN. § 622.10(1) (West 2011).

82. KAN. STAT. ANN. § 60-427(b) (West 2010). The Kansas statute is representative of those in the majority of states.

able [a provider] to prescribe for such patient as a physician, or to do any act for him as a surgeon."[83] Since many clinical ethics services allow individuals not legally permitted to diagnose and treat patients to perform ethics consultations, one can reasonably conclude that these individuals are not engaged in such practices.[84] If licensed providers engage in identical conduct, common sense strongly suggests that these individuals are also not engaged in diagnosis or treatment. That is not to say that ethics consultations do not facilitate the healthcare choices of patients and providers. However, facilitating choices cannot reasonably be the standard under which communications are protected under current law, otherwise *any* advice solicited from a third party that leads to a change in a healthcare decision would logically be protected under physician-patient privilege. For the acutely ill patient in an intensive care unit, such a standard might encompass *most or all* communications—a dramatic and highly problematic extension of the rules that surely would not pass judicial muster.

Two additional challenges prevent participants in ethics consultations from claiming protection under existing physician-patient privilege statutes. The first of these obstacles is that many of the participants in these sessions are not patients. Often the need for an ethics consultation will arrive when a patient is critically ill or non-communicative; ethicists will work with the patient's surrogates or family members to determine the appropriate course of care.[85] State statutes, designed to protect direct communications between patients and providers, largely fail to account for such complex dynamics.[86] While a number of states extend the privilege to guardians, only a few—notably Louisiana and Wisconsin—offer a broad protection of confidentiality that might apply to the sorts of interested parties who participate in family meetings and other forms of collective decision-making.[87] Moreover, the definition of patients eligible for

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83. N.C. GEN. STAT. ANN. § 8-53 (West 2011).

84. Fox, Myers & Pearlman, *supra* note 76.

85. *See* Mary Ellen Wojtasiewicz, *Damage Compounded: Disparities, Distrust and Disparate Impact in End-of-Life Conflict Resolution Policies*, 6 AM. J. BIOETHICS 8, 8–12 (2006).

86. *See* Christina L. Lewis, *The Exploitation of Truest: The Psychotherapist-Patient Privilege in Alaska as Applied to Prison Group Therapy*, 18 ALASKA L. REV. 295 (2001) (discussing similar challenges in group therapy).

87. *See* LA. CODE EVID. ANN. art. 510 (2001). Louisiana's statute specifically applies not only to the patient but to any "representative of a patient" defined as "any person who makes or receives a confidential communication for the purpose of effectuating diagnosis or treatment of a patient. *Id. See also* WIS. STAT. ANN. 905.04 (West 2011) (defining "patient" broadly as "an individual, couple, family or group of individuals who consults with or is examined or interviewed by a physician, podiatrist,

physician-patient privilege has often been construed narrowly. In Texas, for example, even blood donors are not considered patients of the providers who draw their blood.[88] Absent legislative intervention, the likelihood that state courts will reinterpret the definition of patient to include all participants in that patient's care is extremely low.

A second barrier to the inclusion of ethics consultations under existing physician-patient privilege protections is that many statutes and court rulings require the protected communications to have been confidential. The nature of ethics consultation, however, does not lend itself to the variety of strict confidentiality that is appropriate for a privilege to vest in other medical settings. For instance, effective ethics consultations frequently require family meetings in which various parties with a vested interest in the patient's welfare participate.[89] Often these parties have adversarial relationships. Information shared at such meetings may prove essential for determining the best interests of a non-responsive patient—and it might be necessary, for clarity, that the adversarial parties hear these communications. Interactions of this nature are simply not provided for in most of the state statutes governing physician-patient privilege.[90]

A small percentage of ethics consultations may already meet many of the requirements of physician-patient privilege, especially in Wisconsin, which has adopted expansive definitions of the terms provider, pa-

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registered nurse, chiropractor, psychologist, social worker, marriage and family therapist or professional counselor").

88. Thomas C. Riney & Christopher D. Wolek, *Hippocrates Enters the New Millennium—Texas Medical Privileges in the Year 2000*, 41 S. TEX. L. REV. 315, 318 (2000).

89. An excellent discussion of how ethics consultations are—and ought to be—conducted can be found in Robert D. Orr & Wayne Shelton, *A Process and Format for Clinical Ethics Consultation*, 20 J. CLINICAL ETHICS 79 (2009).

90. *Cf.* WIS. STAT. ANN. 905.04 (West 2011). Wisconsin's statute is a noteworthy exception because it defines confidentiality in a way that would include the sorts of family meetings and collective decision-making that are part of the ethics consultation process:

> A communication or information is "confidential" if not intended to be disclosed to 3rd persons other than those present to further the interest of the patient in the consultation, examination, or interview, to persons reasonably necessary for the transmission of the communication or information, or to persons who are participating in the diagnosis and treatment under the direction of the physician, podiatrist, registered nurse, chiropractor, psychologist, social worker, marriage and family therapist or professional counselor, including the members of the patient's family.

Id.

tient, and confidentiality.[91] However, virtually no ethics consultations will meet *all* of the requirements of existing state physician-patient privilege statutes, particularly the requirements that the disclosure occur during diagnosis, treatment, or the direct provision of medical care.

B. Federal Rules of Evidence Afford a Framework for Adopting New Privileges

The federal courts do not recognize an ethicist-patient privilege, a physician-patient privilege, or any other exclusionary rule that shields clinical ethics consultants from providing testimonial evidence.[92] Nonetheless, the federal courts—to a much greater degree than the states—do have clear guidelines for the circumstances under which new privileges may be created.[93] As early as 1933, Justice George Sutherland observed in *Funk v. United States* that "in the taking of testimony in criminal cases, the federal courts are bound by the rules of the common law as they existed at a definitely specified time in the respective states, unless Congress has otherwise provided."[94] Chief Justice Harlan Stone elaborated on this principle in *Wolfle v. United States*, noting that the rules of privileges were to be "governed by common law principles as interpreted and applied by the federal courts in the light of reason and experience."[95] When Congress adopted the Federal Rules of Evidence (FRE) in 1975, these rules explicitly embraced this discretionary approach.[96] Although the Advisory Committee for the FRE recommended nine "specific non-constitu-

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91. *Id.* It is worth nothing that even Wisconsin prevents family members from asserting the privilege on behalf of patients, although it does allow providers to do so. *Id.*

92. *See generally* Erie R. Co. v. Tompkins, 304 U.S. 64 (1938). This case discusses one exception to this rule, which are claims filed in federal court under diversity jurisdiction which remain governed by the individual state laws of privilege. It is also worth noting that the vast majority of cases stemming from controversies at stake in ethics consultations will either take place in state courts or involve claims governed by *Erie*, reducing the opportunities for the federal courts to recognize an ethicist-patient privilege. The matter does not yet appear to have arisen before the federal courts. However, with increased federal involvement in high-stakes ethics cases, such as the matter of Terri Schiavo, it is likely only a matter of time before such a case appears on a federal docket.

93. *See* Edward J. Imwinkelried, *An Hegelian Approach to Privileges Under Federal Rule of Evidence 501: The Restrictive Thesis, the Expansive Antithesis, and the Contextual Synthesis*, 73 NEB. L. REV. 511 (1994) (discussing a different approach that the Supreme Court could have taken to privileges in response to the FRE).

94. Funk v. United States, 290 U.S. 371, 379 (1933).

95. Wolfle v. United States, 291 U.S. 7, 12 (1933).

96. FED. R. EVID. 501.

tional privileges,"[97] federal legislators—presumably seeking to avoid a thorny political debate—gladly shifted the matter entirely to the courts.[98] Rule 501 of the FRE, which governs privileges, adopted the nearly identical wording of Justice Stone in *Wolfle*: "[T]he privilege of a witness . . . shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience."[99]

In one of the Supreme Court's first major decisions regarding the meaning of "reason and experience" in the FRE era, *Jaffee v. Redmond*, Justice John Paul Stevens laid out a framework for the adoption of new privileges by the federal courts.[100] According to Stevens, the FRE "did not freeze the law governing the privileges of witnesses in federal trials at a particular point in our history."[101] Rather, as Chief Justice Warren E. Burger had noted earlier in *Trammel v. United States*, the rules "acknowledge the authority of the federal courts to continue the evolutionary development of testimonial privileges."[102] Justice Stevens advanced two fundamental principles that should govern any assessment as to whether a new privilege is required. First, he argued that the courts should accept the "general rule disfavoring testimonial privileges."[103] Second, he stated that exceptions should be established if there exists "a public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth."[104] The standard Stevens used in determin-

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97. H.R. REP. No. 93-650, at 7 (1974), reprinted in 1974 U.S.C.C.A.N. 7075, 7082. The nine privileges to be applied in federal courts were those that applied to relationships between lawyer and client, psychotherapist and patient, husband and wife, and penitent and clergyman, as well as those covering required reports, political vote, trade secrets, secrets of state, and the identity of an informer. Physician-patient privilege was notably absent from the list.

98. *See* Raymond F. Miller, *Creating Evidentiary Privileges: An Argument for the Judicial Approach*, 31 CONN. L. REV. 771, 772–75 (1999) (detailing the controversy surrounding the committee's proposal).

99. FED. R. EVID. 501.

100. Jaffee v. Redmond, 518 U.S. 1 (1996). The first such significant case after the adoption of the FRE was *Trammel v. United States*, 445 U.S. 40 (1980), but that case dealt with the extent of an existing spousal privilege and did not elaborate on a broader mechanism or rubric for adopting new privileges. *See* Nissa Ricafort, Jaffee v. Redmond*: The Supreme Court's Dramatic Shift Supports the Recognition of a Federal Parent-Child Privilege*, 32 IND. L. REV. 259, 259 (1988) (arguing that *Jaffee* represents a "major shift in the Supreme Court's approach to the creation of new privileges").

101. *Jaffee*, 518 U.S. at 9 (quoting *Trammel*, 445 U.S. at 47).

102. *Trammel*, 445 U.S. at 47.

103. *See Jaffee*, 518 U.S. at 9.

104. *Id.* (quoting Elkins v. United States, 364 U.S. 206, 234 (1960) (Frankfurter, J. dissenting)).

ing whether an exception is justified is whether the exception "promotes sufficiently important interests."[105] In *Jaffee*, Stevens found that a privilege between patients and psychotherapists met this standard.[106] However, he did not conceptualize the privilege as a subset of physician-patient or healthcare provider-patient privilege, such testimonial exclusions that had long been rejected at common law.[107] Instead, he noted the ways in which psychotherapist-patient relationships differed from those between physicians and patients and used this distinction, in part, to justify the creation of a new privilege.[108] A strong case can be made that clinical ethicists similarly require a higher standard of protection in order to perform their duties effectively.

Stevens offered three additional guideposts for adopting future privileges. First, he argued that the relationship between the professional and the privilege-holder should be "rooted in the imperative need for confidence and trust."[109] Second, he argued that the privilege must serve "public ends," as opposed to meeting a worthwhile but principally private need.[110] Third, he contended that the degree to which a new privilege impedes truth-seeking should be assessed; if little evidence of probative value would actually be lost as a result of the testimony and "the likely evidentiary benefit that would result from the denial of the privilege is modest," these factors favors the recognition of a new privilege.[111] A testimonial privilege between clinical ethicists and patients meets all of these requirements.

C. An Ethicist Privilege Is a Natural and Needed Outgrowth of Existing Privileges

A strong case can be made that clinical ethicists similarly require a higher standard of protection in order to perform their duties effectively.

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105. *Jaffee*, 518 U.S. at 9 (quoting *Trammel*, 445 U.S. at 51).
106. *Jaffee*, 518 U.S. at 10.
107. *Id.*
108. *Id.* For example, Stevens noted:

> Treatment by a physician for physical ailments can often proceed successfully on the basis of a physical examination, objective information supplied by the patient, and the results of diagnostic tests. Effective psychotherapy, by contrast, depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears.

Id.
109. *Id.* at 10 (quoting Trammel v. United States, 445 U.S. at 51).
110. *Jaffee*, 518 U.S. at 11 (quoting Upjohn Co. v. United States, 449 U.S. 383 (1981)).
111. *Jaffee*, 518 U.S. at 11.

Confidence and trust are imperative to the ethics consultation process.[112] Clinical ethics consultants address matters of personal and often intimate concerns at moments when patients are often most vulnerable such as during periods of critical illness and even impending death.[113] The reality of ethics consultation is that ethicists are frequently called upon during situations of high tension—often during disputes between family members or between patients and medical professionals.[114] It is not uncommon for patients and relatives to have lost confidence in their medical providers prior to the involvement of the ethicist.[115] Under these circumstances, it is crucial that ethicists offer confidentiality to all parties in the consultation process and assure them that the ethics process itself will not be used against their interests in future litigation. Moreover, unlike physicians—but similar to psychotherapists—ethicists cannot rely on physical examination or laboratory tests to provide their services. They need the cooperation of patients and family members if their efforts are to be effective. In short, if patients feared that their discussions with ethicists could be used against them in legal proceedings, many would be reluctant to avail themselves of these services. The reason that such a chill has not already deterred open communication between patients and ethicists is that most patients are unaware that their communications are not already privileged. One high-profile case could rapidly and decisively change the situation to the severe detriment of those involved in the clinical ethics process.

Clinical ethics consultations clearly serve public ends. That is not to say that private interests are not furthered by ethics consultation as well. Certainly, most parties to ethics consultations are primarily interested in the resolution of their own medical or familial dilemma. However, ad-

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112. This approach rests to some degree on the notion that ethics consultation must be consensual. For a discussion of this question beyond the scope of this article, see Stuart G. Finder, *Is Consent Necessary for Ethics Consultation?*, 18 CAMBRIDGE Q. HEALTHCARE ETHICS 384 (2009); Robert M. Veatch, *Ethics Consultation: Permission from Patients and Other Problems of Method*, 1 AM. J. BIOETHICS 43, 43–45 (2001).

113. *See, e.g.*, Lisa Anderson-Shaw, William Ahrens & Marny Fetzer, *Ethics Consultation in the Emergency Department*, 9 JONA's HEALTHCARE LAW, ETHICS & REGULATION 32 (2007) ("The most common scenarios prompting an ethics consultation identified by our clinical ethics consult service involve issues of decisional capacity and surrogate decision making, advance healthcare directives, decisions related to withholding or withdrawing life-sustaining treatments (including do-not-resuscitate orders), and conflict resolution/communication problems between caregivers and patient/family.").

114. Neil Wenger, *Waiting for Conflict Before Requesting an Ethics Consultation*, 175 W. J. MED. 31 (2001).

115. *See id.*

dressing these challenging cases furthers numerous policy objectives. At the most basic level, ethics consultations that result in satisfactory resolutions may reduce litigation over these matters, saving hospitals resources and sparing courts the burden of adjudicating these disputes. Patients and families, already suffering with illness, also avoid the emotional and financial consequences of having their medical difficulties resolved by the judiciary. Ethics consultation has also been shown, in some studies, to prevent unnecessary healthcare expenditures.[116] Yet the benefits of ethics consultation transcend purely material gains. A consistent and effective method for addressing ethical challenges in hospitals fosters the welfare of patients collectively, ensuring that providers reflect on the ethical implications of their practice.[117] Such services, when they operate effectively, generate public confidence in the overall healthcare system. In rare cases where providers choose to operate at the edges of acceptable ethical practice, or beyond, an ethics consultation service offers patients and staff a means for questioning their care—a safety mechanism by which egregious ethical choices can be prevented.[118]

As with the psychotherapist-patient privilege, an ethicist-patient privilege is likely to result in minimal loss of evidence. The use of information garnered in ethics consultations in court testimony against the participants in these consultations would have a chilling effect on future participants. Patients may be willing to share information with doctors, even knowing that it can be used against them in court, under the emergent demands of pain or physical suffering. Even in the absence of psychotherapist-patient privilege, some patients will divulge personal secrets to mental health providers under the strain of emotional distress—although not as frequently as in interactions with internists. In contrast, participants in ethics consultation have no incentive to speak openly with consultants if they fear their words may be used against them in court, particularly because the consultations and the court hearings are designed to address precisely the same concerns. A patient who wants his broken leg fixed or his anxiety assuaged is not going to ask a court to fix his broken leg or assuage his anxiety; however, a patient who asks an ethicist to resolve an end-of-life dispute may later ask a court to resolve that same dispute. This overlap in the roles of ethics consultants and courts,

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116. *See* Todd Gilmer et al., *The Costs of Non-beneficial Treatment in the Intensive Care Setting*, 24 HEALTH AFFAIRS 961 (2005).

117. Marion Danis et al., *Does Fear of Retaliation Deter Requests for Ethics Consultation?*, 11 MED., HEALTH CARE & PHIL. 27, 33 (2008) ("One possible interpretation of the findings here is that ethics consultation offers a sanctioned and safe venue in the healthcare workplace for raising ethical questions.").

118. *See id.*

unique among the services offered by healthcare providers, further justifies a special rule to govern confidences shared during consultations.

One guideline that Justice Stevens did not propose in *Jaffee* is strict reliance on existing state statutes or common law regarding the existence of a particular privilege. Instead, he notes that the existence of such privilege in all fifty states confirms the Supreme Court in its approach.[119] This distinction is important. The Court has historically used state law as a guidepost for determining the extent of numerous federal legal principles from the nature of cruel and unusual punishment[120] to the scope of the applicability of the Fourteenth Amendment's protections to the states.[121] Strikingly, Stevens does not embrace a standard akin to "the evolving standards of decency that mark the progress of a maturing society" so frequently invoked by the Supreme Court in Eighth Amendment cases.[122] Instead, Stevens suggests that, even in the absence of state legislative or judicial action, a federal privilege can be recognized if the other criteria outlined above are met. In short, widespread state recognition of a privilege may be sufficient to justify a new federal privilege, but it is not necessary. In the case of an ethicist-patient privilege, the federal government could set an example for the states. The discretion that Congress granted the judiciary with regard to testimonial privileges affords the courts the authority to create precisely this sort of rule.

D. HIPPA Creates a Pathway for the Federal Courts to Adopt an Ethicist-Patient Privilege

The passage of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) may provide an avenue for adoption of an ethicist-patient privilege in federal courts. HIPPA significantly complicated the issue of federal privilege as it relates to healthcare.[123] As a general rule,

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119. *See* Jaffee v. Redmond, 518 U.S. 1, 12 (1996).

120. *See* Roper v. Simmons, 543 U.S. 551 (2005); Atkins v. Virginia, 536 U.S. 304 (2002); *see also* Joanna H. D'Avella, *Death Row for Child Rape-Cruel and Unusual Punishment under the Roper-Atkins Evolving Standards of Decency Framework*, 92 CORNELL L. REV. 129 (2006).

121. *See, e.g.*, Palko v. Connecticut, 302 U.S. 319 (1937); Adamson v. California, 332 U.S. 46 (1947); Rochin v. California, 342 U.S. 165 (1952). *See also* William J. Brennan, Jr., *Bill of Rights and the States: The Revival of State Constitutions as Guardians of Individual Rights*, 61 N.Y.U. L. REV. 535 (1986).

122. Trop v. Dulles, 356 U.S. 86, 101 (1958).

123. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936. *See* Ralph Ruebner & Leslie Ann Reis, *Hippocrates to HIPAA: A Foundation for a Federal Physician-Patient Privilege*, 77 TEMP. L. REV. 505 (2004) (analyzing in greater depth the relationship between HIPAA and state physician-patient privilege law than the scope of this article permits).

when acts of Congress conflict with state law, the language of the federal statute predominates.[124] HIPPA contains a provision that mandates precisely the opposite. According to Section 264(c)(e) of the statute, any regulations designed to effectuate HIPPA "shall not supersede a contrary provision of State law, if the provision of State law imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications imposed under the regulation."[125] In other words, it is clear that no provision in HIPPA is designed to undercut previously existing privacy protections, such as state rules governing physician-patient privilege. What remains less clear is whether Section 264(c)(e) of HIPPA requires federal courts addressing federal questions to adopt the more stringent state standards, including local rules governing physician-patient privilege. Ralph Ruebner and Leslie Ann Reis have argued persuasively that it does.[126] Ruebner and Reis note that FRE 501 allows for new federal privileges to be adopted by act of Congress.[127] They argue that in adopting HIPPA's provision that federal standards must yield to more stringent state standards, Congress effectively incorporated a physician-patient privilege in jurisdictions where it exists at the state level.[128] The Department of Health and Human Services (HHS), tacitly agreed with this approach. The HHS explained:

> Under the applicable preemption provisions of HIPPA, state laws relating to the privacy of medical information that are more stringent than the federal rule are not preempted. To the extent that an applicable state law precludes disclosure of protected health information that would otherwise be permitted under the rule, state law governs.[129]

At least one federal district court has agreed with this interpretation. In *National Abortion Federation v. Ashcroft*, Chief Judge Charles Kocoras of the Northern District of Illinois found that HIPPA applied Illinois' physician-patient privilege statute to a federal question before his court.[130] "If

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124. Maryland v. Louisiana, 451 U. S. 725, 746 (1981).

125. 42 U.S.C. § 1320(d)(2) (2006).

126. Ruebner & Reis, *supra* note 123, at, 532–38.

127. *Id.* at 532 (quoting FED. R. EVID. 501).

128. *Id.* at 533–34.

129. *Id.* An alternative interpretation of this statement is that HHS did not intend to apply stricter state law to all federal questions, but only in diversity cases governed by *Erie*. Here, Ruebner and Reis argue that had the agency's scope been so limited, it would have specified so.

130. Nat'l Abortion Fed'n v. Ashcroft, 2004 U.S. Dist. LEXIS 1701, at *15–17 (7th Cir. Feb. 6, 2004).

the case were otherwise," wrote Kocoras, "Congress' directive to the Secretary of Health and Human Services to set standards and regulations with respect to the privacy of individually identifiable health information, would be rendered meaningless . . . ."[131] Although this aspect of Judge Korcoras's ruling was rejected by Judge Richard Posner of the Seventh Circuit on appeal, Posner conceded that the question is not one "free from doubt."[132]

The relationship between HIPPA and state physician-patient privilege statutes remains uncertain and is likely to be the subject of additional litigation.[133] If the approach advanced by Ruebner and Reis does prevail, however, it will create a pathway for the adoption of ethicist-physician privilege in federal courts without any additional action by Congress or the federal courts. All that would be required for the federal recognition of such a privilege would be the passage of a state statute covering ethicists, which HIPPA would automatically incorporate into federal procedure in that jurisdiction.

IV. POLICY CONSIDERATIONS OF ADOPTING AN ETHICIST-PATIENT PRIVILEGE

While a solid legal foundation exists for establishing or recognizing an ethicist-patient privilege, it does not follow automatically that doing so represents a wise approach to public policy. On the contrary, any effort to create such a new privilege should face rigorous examination on policy grounds. It is plausible that all of the legal criteria for recognizing a new privilege may be met, yet some overriding policy concern might still justify *not* recognizing such a privilege in order to preserve probative evidence.[134] Another policy consideration is the scope of the privilege to be recognized. In this regard, the decision to adopt a privilege is not the end of a policy discussion, but rather the beginning of a debate regarding precisely which relationships shall be covered by the privilege and under which circumstances. Finally, whether the new privilege is to be enacted

131. *Id.* at *15–19 (internal quotation marks omitted). Although Judge Korcoras stated that HIPPA applied Illinois law to the federal question, he then added dicta that seemingly applied a balancing test to the question of whether the material is covered by privilege, and finds that it does in abortion cases, so it is not certain that his ruling applies to all medical matters. *See id.*

132. Northwestern Mem'l Hosp. v. Ashcroft, 362 F.3d 923, 925 (7th Cir. 2004).

133. *See* Jenna Phipps, *State of Confusion: The HIPPA Privacy Rule and State Physician-Patient Privilege Laws in Federal Question Cases*, 12 SUFFOLK J. TRIAL & APP. ADVOC. 159 (2007).

134. *See, e.g.*, United States v. Nixon, 418 U.S. 683 (1974) (representing such a case with regard to executive privilege).

by the legislature or adopted by the judiciary is a policy matter for serious consideration. While the privilege will likely have the same effect on litigants inside the courtroom no matter what its origin, privileges—unlike other rules of evidence and procedure—serve social purposes outside the courtroom,[135] and whether a privilege is the creature of elected representatives or of the courts may prove consequential for its societal impact.[136] Policy considerations weigh both for and against adoption of an ethicist-patient privilege. On balance, however, sound policy favors the creation of a new privilege covering this relationship.

A. Policy Arguments Favoring an Ethicist Privilege

While considerable controversy exists regarding the policy justifications for testimonial privileges, Wigmore outlined four standards required to meet the "preponderance of extrinsic policy which alone can justify the recognition of any such exception" to the general principle that probative evidence should be admitted.[137] These principles serve as a strong starting point for analyzing the policy benefits of adopting an ethicist-patient privilege.

First, Wigmore notes that "the communications must originate in a *confidence* that they will not be disclosed."[138] Physician-patient confidentiality is a well-recognized cultural trope, featured in literature and on televisions.[139] As a result, many patients and their relatives assume that

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135. Mosher, *supra* note 29, at 180 ("Unlike other rules of evidence, privilege rules extend their effect to the behavior of citizens, and to the arrangements that citizens make, outside the courtroom, in a variety of settings.").

136. A discussion of the differences between legislatively enacted and judicially recognized privileges is largely beyond the scope of this article. In short, legislative privileges may convey the imprimatur of "the people" on particular social arrangements, but are also subject to suspicions that they reflect the undue influence of particular professions; in contrast, judicially created privileges may not place the same public stamp of approval or sanctity on certain relationships, but the motives for their creation (and thus their legitimacy) is less likely to be questioned. *See, e.g.*, Sanford Levinson, *Testimonial Privileges and the Preferences of Friendship*, 1984 DUKE L.J. 631 (discussing the social meaning of privileges).

137. 8 JOHN HENRY WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2285, at 527 (John T. McNaughton ed., 1961).

138. *Id.*

139. Susan B. Apel, *Privacy in Genetic Testing: Why Women Are Different*, 11 S. CAL. INTERDISC. L.J. 1, 2 (2001). There have been several movies and television shows with themes centered around physician-patient privilege. *See A Family Thing* (MGM 1996); *Law & Order: Criminal Intent: Scared Crazy* (NBC television broadcast Dec. 4, 2005); *Law & Order: LA: East Pasadena* (NBC television broadcast Apr. 18, 2011); *Moloney* (multiple episodes, CBS television broadcast Sept. 1996–May 1997); *Murder One* (series, ABC television broadcast 1995–1997).

their communications with their providers are confidential and shielded from disclosure in court. The passage of HIPPA certainly enforced this widespread perception—even if the perception is often inaccurate with regard to the admissibility of testimony. When an ethicist in a white coat or a clerical collar enters a hospital room to conduct a consultation, the odds are overwhelming that the participants assume that the information that they share is to be held in confidence. The possibility that high-stakes medical matters discussed with a professional staff member in a hospital are not accorded the same level of protection afforded to communications with physicians is counterintuitive and would probably surprise most participants.[140]

Second, Wigmore demands that "[t]his element of confidentiality must be essential to the full and satisfactory maintenance of the relationship between the parties."[141] As noted above, patients and family members will limit participation in ethics consultations if they fear that their communications can be used against them in court. It is worth emphasizing that, for the most part, participation in the clinical ethics process is entirely voluntary.[142] In this sense, it is essentially a form of medical mediation designed to prevent the parties from availing themselves of the legal process. Failure to recognize a privilege raises two dangers in this regard. On the one hand, some parties may forgo the ethics process entirely and take their claims directly to court if they fear that the consultation process can be used to their detriment. On the other hand, other parties may try to use the ethics process as a back-door discovery mechanism to gather information or lay the groundwork for future legal arguments. The absence of ethicist-patient privilege raises the risk of ethics consultation degenerating into an extralegal pretrial hearing. Such use of the ethics consultation process would inevitably prove detrimental to the wellbeing of patients.

Wigmore's third principle requires that "[t]he *relation* must be one in which the opinion of the community ought to be sedulously *fos-*

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140. Of course, the ethicist might warn the participants that their communications could be used against them in a future court hearing—delivering some sort of ethical *Miranda* warning. However, such a disclaimer risks undermining the participants' confidence in the consultation process and may limit the nature and quantity of information provided.

141. 8 WIGMORE, *supra* note 137 (emphasis omitted).

142. Some hospitals do require mandatory ethics consultation, such as New York's Columbia-Presbyterian Hospital, which requires such consultations to withdraw life support. *See* Megan E. Romano et al., *Mandatory Ethics Consultation Policy*, 84 MAYO CLINIC PROC. 581, 581–85 (2009), *available at* http://www.mayoclinicproceedings.com/content/84/7/581.full.

tered."[143] The value of ethics consultation as an enterprise, of course, is a subjective matter.[144] However, it is an enterprise that has grown increasingly widespread over the past two decades and an ethics service is now an integral part of medical care at most major hospitals.[145] Moreover, issues of ethics in healthcare have drawn considerable media and political attention over the past few years, suggesting that matters such as end-of-life care and resource expenditure are matters of considerable public concern. Translating such public attention to healthcare policy into evidence of a preference for hands-on assistance may prove a stretch, but it does demonstrate a widespread awareness of the sorts of issues addressed by ethics consultants. The very frequency with which ethics services are called upon by both patients and providers strongly suggests the sort of public demand that justifies community support for the process.

Finally, Wigmore's approach demands that "the *injury* that would inure to the relation by the disclosure of the relations must be *greater than the benefit* thereby gained for the correct disposal of litigation."[146] In other words, the privilege can only be justified if it would not result in the loss of more probative evidence than it is worth. In the case of ethics consultations, the amount of evidence that would be lost because of the privilege in the long run is likely to be insubstantial. If participants recognized in advance that their communications might be used against them in court, few, if any, participants would disclose damaging information during ethics consultation. Thus, the sorts of communications that might prove most valuable in court would never be shared in the first place. While it might take some time for this chilling effect to curtail the flow of information—leading to a short-term loss of valuable testimony—the effect over time of an absence of privilege would be increasingly less additional evidence. Demanding testimony of ethicists would ultimately damage the ethics process to the point that ethicists will no longer have any probative testimony to offer. In short, information needed to conduct meaningful ethics consultations would no longer be available, while the courts would not actually garner any additional information upon which to base decisions.

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143. 8 WIGMORE, *supra* note 137 (emphasis added).

144. *See* Giles R. Scofield, *What Is Medical Ethics Consultation?*, 36 J.L. MED. & ETHICS 95 (2008) (critiquing the value of ethics consultation).

145. Nancy Neveloff Dubler et al., *Charting the Future: Credentialing, Privileging, Quality, and Evaluation in Clinical Ethics Consultation*, 2009 HASTINGS CTR. REP. 23, 23–33.

146. WIGMORE, *supra* note 1, at 2.

B. Policy Arguments Against an Ethicist Privilege

Two distinct sets of reasons argue against the creation of a clinical ethicist-patient testimonial privilege. The first of these are concerns regarding the creation of new privileges generally. The second apply specifically to a proposed ethicist-patient exclusionary rule.

New privileges often come with a hefty evidentiary price tag. Dissenting in *Jaffee v. Redmond* from the Supreme Court's decision to recognize a psychotherapist-patient privilege, Justice Antonin Scalia wrote:

> The Court has discussed at some length the bene?t that will be purchased by creation of the evidentiary privilege in this case: the encouragement of psychoanalytic counseling. It has not mentioned the purchase price: occasional injustice. That is the cost of every rule which excludes reliable and probative evidence—or at least every one categorical enough to achieve its announced policy objective.[147]

As with any other new privilege, an ethicist-patient privilege may serve worthwhile policy goals outside the courthouse, but it will also reduce—at least at the margins—the likelihood that justice will be served in particular cases. However, the impact here may be lesser than with other privileges, such as the psychotherapist-patient privilege, because one of the purposes of the ethics consultation itself is to achieve just outcomes. Justice "gained" in cases that do not go to court, as a result of open dialogue made possible by the privilege, may exceed justice "lost" as a result of the privilege. In this sense, an ethicist-patient privilege is more like the privilege enjoyed by mediators than that enjoyed by psychotherapists or physicians. Moreover, as with the psychotherapist-patient privilege, the weight of injustice from excluding such testimony is likely to fall upon innocent parties. Scalia made this point with regard to psychotherapist-patient privilege in *Jaffee*:

> For the rule proposed here, the victim is . . . likely to be some individual who is prevented from proving a valid claim . . . . The latter is particularly unpalatable for those who love justice, because it causes the courts of law not merely to let stand a wrong, but to become themselves the instruments of wrong.[148]

Excluding such evidence from trial might lead to a patient receiving unwanted medical care or result in a failure to adhere to someone's end-of-life wishes. In cases where family members have conflicting goals, the

147. Jaffee v. Redmond, 518 U.S. 1, 18–19 (1996) (Scalia, J., dissenting).
148. *Id.* at 19.

result of such evidentiary exclusion may be the emotional suffering of the relatives whose efforts to effectuate the wishes of the patient have been stymied.

Another objection to creating new privileges, particularly privileges that will be invoked rarely, is that doing so waters down the social power of the testimonial privileges. Privileges, after all, do not merely reflect the importance of certain social and professional relationships; they perpetuate and reinforce the unique and hallowed nature of those relationships.[149] Extending this recognition to additional occupations inevitably renders the professions that are already protected a little bit less exalted with each act of expansion. The invocation of an ethicist privilege may prove an uncommon occurrence; although clinical ethics consultations have been occurring for over three decades, and with increasing frequency, no federal or state case has yet turned on the question of an ethicist's testimony regarding private communications obtained during a consultation. Needless to say, some critics will object to diluting the general power of privileges for such a rare contingency.[150]

A final group of policy objections to the ethicist-patient privilege are specific to that relationship. Foremost among these is the possibility that such a privilege, created in the absence of physician-patient privilege, may have the unintended consequence of driving a wedge between ethicists and medical providers. Tensions already exist between medical providers and ethics consultants at many institutions.[151] Carving out a rule of exclusion that applies to ethicist consultants, but not to medical practitioners, may have the unintended consequence of defining ethics consultation as extra-medical and outside the normal functioning of hospital practice.[152] In addition, treating physicians and ethicists differently may lead to legal ambiguities. Sometimes, whether a physician is serving as a provider or providing ethical consultation will be unclear to the patient. Hospitalized patients and their relatives, already visited by many specialists, may have difficulty discerning that a distinguished caller in a white coat is not acting as a physician. If such an ethicist promises confidentiality, including with regard to potential testimony, many patients may gen-

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149. *See* Levinson, *supra* note 136.

150. *See* Comment, *Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine*, 71 YALE L.J. 1226, 1258 (1962).

151. *See* J.P. Orlowski, et al., *Why Doctors Use or Do Not Use Ethics Consultation*, 32 J. MED. ETHICS 499 (2006).

152. *See* Joel E. Frader, *Political and Interpersonal Aspects of Ethics Consultation*, 13 THEORETICAL MED. AND BIOETHICS 31 (1992) (noting existing perceptions of ethical consultants as extra-medical in their function).

eralize their reliance upon such confidentiality to all providers—even in jurisdictions where no such protection actually exists. However, this objection might be said to favor the creation of a broader physician-patient privilege, rather that to oppose the establishment of a more limited ethicist-patient privilege.

V. A BLUEPRINT FOR ETHICIST PRIVILEGE: SCOPE AND LIMITATIONS

In adopting a testimonial privilege between clinical ethicists and patients, policymakers will be forced to delineate the scope of that privilege. Will communications between patients and ethicists be excluded only from civil trials or from criminal prosecutions as well? Will the privilege be a blanket protection that covers all confidential communications, such as those that generally govern relationships between clergymen and penitents and between psychotherapists and patients? Or will the privilege be confined to confidences specifically related to the ethical controversy for which they have been consulted, similar to physician-patient privilege statutes that only cover disclosures related to diagnosis and treatment? And will the privilege be held solely by the patient or by both the patient and the ethicist? Will the patient's surrogates and family members be permitted to exercise the privilege on his behalf? While the details of these matters will likely be worked out on a case-by-case basis, as particular controversies arise, several general observations regarding a potential ethicist-patient privilege can be offered that may serve as a blueprint for future decision-makers.

The policy arguments outlined above strongly favor the recognition of a narrow clinician-ethicist testimonial privilege that would exclude only communications directly related to the matter of ethical controversy for which the ethicist has been consulted. No significant societal benefit arises from extending the privilege to criminal matters or ancillary civil matters. Participants are less likely to assume the confidentiality of their disclosures relating to matters extraneous to the consultation and nothing is to be gained by fostering such disclosures. The patient who offers a murder confession during an ethics consultation should do so at his own peril. Some disclosures that prove relevant for conducting an ethics consultation may also have probative value in outside matters—such as divorce, child custody, or testamentary litigation in which the patient or his relatives are involved. Although the fate of this evidence is a closer call, the policy justifications for a privilege do not appear compelling in such ancillary matters. The primary purpose of an ethicist-patient privilege should be to keep the ethicist from testifying in legal cases and controver-

sies directly related to the consultation itself. Expanding the privilege beyond this narrow scope should be done with considerable caution.

Answering the question of who should hold the privilege presents a far more difficult challenge. The patient himself must certainly be a holder of the privilege if it is to serve the policy goals outlined above; surrogates and family members must also be able to assert the privilege on behalf of the non-communicative or impaired patient. A corollary to this principle is that family members should not be permitted to assert such a privilege on their own behalf when it runs contrary to the interests or wishes of the patient. The unique privacy required for ethics consultation may justify vesting the privilege in the ethicist himself as well.[153] Rare circumstances may arise where an ethicist feels his testimony will undermine patient welfare or the cause of justice; granting an ethicist the power to withhold evidence in such cases recognizes the complex role that ethicists play. While these circumstances are likely to prove highly unusual, it would be an error to preemptively deny the ethicist the right to decide these matters.

One final question that must be addressed if an ethicist-patient privilege is to be recognized is whether that privilege will extend beyond the testimony of the individual ethicist. Many of the most difficult ethics cases are ultimately presented to hospital ethics committees for further assessment. Will the deliberations of the hospital ethics committee also be protected by such a privilege? Although this question is largely beyond the scope of this article, it is worth emphasizing that any protection afforded individual ethicists must cast a wide enough net that it cannot be circumvented by subpoenaing the records of the hospital ethics committee. A reasonable argument can be advanced that ethics committees should benefit from a privilege of their own, akin to the medical peer review privilege, as the significant social purposes these committees serve outweigh any minimal probative evidence lost by excluding their records from evidence. In this regard, an effective ethicist-patient privilege might ultimately lead to a need for an ethics committee-patient privilege.

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153. Several states have already recognized a similar joint possession of privilege for clergy and penitents. *See* John J. Montone, III, *In Search of Forgiveness:* State v. Szemple *and the Priest-Penitent Privilege in New Jersey*, 48 RUTGERS L. REV. 263, 310–11 (1995). *See also* Chad Horner, *Beyond the Confines of the Confessional: The Priest-Penitent Privilege in a Diverse Society*, 45 DRAKE L. REV. 697 (1997).

VI. CONCLUSION

The laws of testimonial privilege appear to be in a stage of rapid evolution.[154] After many years of reluctance to tamper with existing privilege rules, the Supreme Court has broadened protections to include psychotherapist-patient relationships, and has hinted at the possibility of further expansion.[155] Congress, which was all too willing to skirt the subject of new privileges at the time the Federal Rules of Evidence were adopted, has also recently hinted that it is open to expanding testimonial exclusions by statute.[156] In light of the crucial role that ethics consultation has come to play in hospital-based medical practice, it is imperative that the federal government and each state adopt a narrow ethicist-patient privilege before an episode of compulsory testimony in a high profile case undermines public confidence in the ethics consultation process.

The role of clinical ethics consultation is limited and carefully circumscribed, but it has become increasingly vital for patient well-being. Leading bioethicists Peter A. Singer, Edmund D. Pellegrino, and Mark Siegler predicted two decades ago that "physician-ethicists and professional ethicists will continue to work side by side in the future. One is not likely to replace the other, nor is this desirable, because each brings a different perspective and different capabilities to the situation."[157] Twenty years of experience have confirmed these predictions. As clinical ethics matures as a field in its own right, its practitioners must be permitted to acquire the procedural tools and prerogatives that will enable them to

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154. Jeffrey J. Lauderdale, *A New Trend in the Law of Privilege: The Federal Settlement Privilege and the Proper Use of Federal Rule of Evidence 501 for the Recognition of New Privileges*, 35 U. MEM. L. REV. 255, 289 (2005) (noting that we may be entering "a new era of privilege law, wherein federal courts will be more inclined to interpret Rule 501 broadly and accept 'new' privileges"); *See, eg.*, Oleszko v. State Compensation Insurance Fund, 243 F.3d 1154 (9th Cir. 2001) (giving an example of an extraordinarily broad application of *Jaffee*); Goodyear Tire & Rubber Co. v. Chiles Power Supply, Inc., 332 F.3d 976, 979–80 (6th Cir. 2003) (using an expansive approach to FRE 501 to adopt settlement privilege).

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

156. The most notable example is the ongoing consideration of a law to shield communications between reporters and sources. *See Compromise Reached on Media Shield Law*, WASH. TIMES, Oct. 31, 2009, *available at* http://www.washingtontimes.com/news/2009/oct/31/compromise-reached-on-media-shield-law. Such legislation appears closer to passage now that at any time since Senator Allan Cranston pushed such a bill in the early 1970s. *See Cranston Pushes Shield Bill*, MIAMI NEWS, Feb. 20, 1973.

157. Peter A. Singer, Edmund D. Pellegrino & Mark Siegler, *Ethics Committees and Consultants*, 1 J. CLINICAL ETHICS 263 (1990).

serve critically ill patients and their loved ones. A testimonial privilege that will allow consultants to promise meaningful confidentiality is an essential step in the development of this noble enterprise.