Statement of Facts

The allegations of Sorensen's Complaint, and reasonable inferences therefrom, can be summarized thus: Barbuto voluntarily disclosed false medical information about his former patient, Nick Sorensen, to a third party, *i.e.*, an attorney representing the defendant in a lawsuit filed by Sorensen. Additionally, in furtherance of his own financial and philosophical agendas, Barbuto secretly agreed to change his own prior diagnosis and to act as a retained expert against his former patient.[2]

Specific allegations include: On July 24, 1999, Nicholas Sorensen was a passenger in a single-vehicle rollover accident on I-15. Another passenger in the vehicle was killed, and both Sorensen and the driver were seriously injured. Sorensen was treated by Barbuto for head injuries and seizures for nearly a year and a half before Barbuto was removed by Sorensen's medical insurer from its list of approved providers, at which time Sorensen began treating with other doctors. Barbuto's treatment of Sorensen included diagnostic tests and examinations, prescriptions for medicine, overseeing cognitive therapy, and other treatment for seizures and brain injury. (R. 2, ¶¶ 5, 6; Op., ¶ 2.)

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[2] Barbuto argues repeatedly that he did nothing more than review records that had already been produced. (*See, e.g.,* Appellants' Brief on Writ of Certiorari at 5, 7, 18-19.) That ignores the allegations of Sorensen's Complaint, one of which is that Barbuto disclosed opinions, observations, and other information that were not in the records, for example, changing his diagnosis to something far different from that stated in the records. A new spin on a physician's own diagnosis is, by definition, previously undisclosed information. Moreover, if Barbuto did nothing more than disclose information that was already contained in the medical records, why an hours-long meeting with defense counsel? Why did Barbuto refuse to provide a copy of his newly changed report to his own patient's attorney? (See p. 7, *infra*.) A reasonable inference could be drawn by a factfinder that Barbuto discussed information beyond the bare content of the medical records themselves.

Association Principles of Medical Ethics, Principle IV (adopted by the Utah Medical Association, R. 83-85) ("The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. . . . The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law"), and the widely publicized privacy protections of the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 201, *et seq*., discussed further in the brief of amicus Utah Trial Lawyers Association.

The same cannot be said regarding the testimonial privilege. Because there was no physician-patient evidentiary privilege at common law, patients had no reasonable expectation that doctors could be prevented from testifying in court proceedings.

6. Other courts recognize that the fiduciary duty of confidentiality and the physician-patient privilege are not coextensive.

In *McCormick v. England*, 328 S.C. 627, 494 S.E.2d 431 (1994), the South Carolina Court of Appeals addressed the issue of whether a tort claim could be maintained for breach of confidentiality by a physician when that state has not adopted a physician-patient privilege. The answer was yes, the court held, "because this evidentiary privilege is distinguishable from a duty of confidentiality. . . . The terms 'privilege' and 'confidences' are not synonymous, and 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, that is, whether those communications are

privileged." 480 S.E.2d at 434, quoting *South Carolina State Board of Medical Examiners v. Hedgepath*, 325 S.C. 166, 480 S.E.2d 724 (1997).

The court noted that disclosures made by a patient are not wholly voluntary, because the patient's lack of training requires him to rely solely on the physician in medical matters. "Being a fiduciary relationship, mutual trust and confidence are essential," the court observed; the belief that physicians should respect patients' confidences dates back to the ancient Hippocratic Oath. *Id.* at 435 (citation omitted). The court summarized the state of the law:

> The modern trend recognizes that the confidentiality of the physician-patient relationship is an interest worth protecting. A majority of the jurisdictions faced with the issue have recognized a cause of action against a physician for the unauthorized disclosure of confidential information unless the disclosure is compelled by law or is in the patient's interest or the public interest. . . . The jurisdictions that recognize the duty of confidentiality have relied on various theories for the cause of action, including invasion of privacy, breach of implied contract, medical malpractice, and breach of a fiduciary duty or a duty of confidentiality.

Id. at 435-36.

"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," the court recognized. "However, that principle has no application to disclosures made out of court. Hence, it does not preclude a cause of action based on such disclosures." *Id.* at 436, *quoting Alberts v. Devine*, 395 Mass. 59, 479 N.E.2d 113, 119 (1985).

Other courts have recognized a distinction between the duty of confidentiality and the testimonial privilege. *See, e.g., Horne v. Patton*, 291 Ala. 701, 287 So.2d 824 (1973)