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ALABAMA MEDICAL RECORDS

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INTRODUCTION

This article addresses five topics: (1) sources of duties to create and maintain accurate medical records; (2) accessibility to such records; (3) discoverability of such records; (4) admissibility into evidence of such records; and (5) exceptions to discoverability and admissibility. Section I outlines the state, federal, and voluntary bases of duties to create and maintain accurate medical records. Section II discusses accessibility to medical records. Section III discusses their discoverability. Section IV discusses admissibility of the records. Finally, Section V surveys the exceptions to discoverability and admissibility—such as when records contain quality assurance or peer review matters—and catalogues many of the controlling state and federal reported decisions.

Why be concerned with these varying requirements? Because we presently are in the midst of great changes in the way judges, lawyers, and litigants must understand and use medical records in litigation. Changes from traditional paper medical records to electronic medical records systems are occurring across the spectrum of healthcare providers, as intended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), which was enacted as part of the American Recovery and Reinvestment Act of 2009, (commonly known as "The Stimulus" or "The Recovery Act"). HITECH provided substantial monetary incentives[1] (Congress appropriated in excess of $50 billion) for eligible healthcare providers to transition from paper to electronic medical records systems. As these changes unfold, problems concerning obtaining *complete* and *accurate* patient records for use in litigation have become commonplace.[2]

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[1] OFFICE OF THE NAT'L COORDINATOR FOR HEALTH INFO. TECH., U.S. DEP'T OF HEALTH AND HUMAN SERVS., ENCOURAGE HEALTH INFORMATION TECHNOLOGY FACTSHEET, https://www.healthit.gov/achieving-MU/ONC_Encourage_HealthIT_FS.PDF.

[2] See, *e.g.*, Chad P. Brouillard, *The First Wave: Emerging Trends in Electronic Health Record Liability*, 52 NO. 7 DRI FOR DEFENSE 39 (July 2010), https://www.ndha.org/im-

Our goal is to marshal the hodgepodge of state and federal statutes, regulations, Joint Commission standards, and common law decisions into one relatively comprehensive guide. We scrupulously avoid editorializing with the express hope our article becomes a useful tool for all judges and lawyers in this State

I. DUTY TO CREATE AND MAINTAIN ACCURATE MEDICAL RECORDS

There are three fundamental sources of duty for creation, maintenance, and access to accurate medical records. They are found in: (A) Alabama's statutes and administrative regulations governing: physicians, nurses, hospitals, nursing facilities, and assisted living facilities; (B) federal Medicare and Medicaid regulations applying to: participating hospitals, nursing facilities, assisted living facilities, and other specialties; and (C) accreditation guidelines issued by The Joint Commission ("JC").[3]

A. Alabama Statutes and Administrative Regulations

1. Physicians

Pursuant to the regulatory authority granted in Section 34-24-311 of the Alabama Code, the Alabama Medical Licensure Commission and the Alabama Board of Medical Examiners jointly promulgate regulations concerning physicians' duties to create, maintain, and provide access to medical records. The duties are mandatory, as shown by Section 34-24-360(22), which gives the Alabama Medical Licensure Com-

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age/cache/ehr_liability_issues.pdf (surveying areas of medical liability involving electronic health records and catalogs new risks impacting medical providers' practices and standard of care issues); Jeffrey L. Masor, Note, *Electronic Medical Records and E-Discovery: With New Technology Come New Challenges*, 5 HASTINGS SCI. & TECH. L.J. 245, 248 (Summer 2013)("[N]ew and different challenges have arisen during the transition from paper medical records to electronic medical records. A major question that medical care providers face is how to produce a single patient's electronic medical record to the lawyer.").

[3] The American Hospital Association, the American College of Physicians, the American College of Surgeons, the Canadian Medical Association, and the American Medical Association formed the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") in 1951 as a not-for-profit corporation. THE JOINT COMMISSION, https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx (last visited Feb. 10, 2017). In 2007, the JCAHO shortened its name to The Joint Commission. THE JOINT COMMMISSION, THE JOINT COMMISSION: OVER A CENTURY OF QUALITY AND SAFETY, https://www.jointcommission.org/assets/1/6/TJC-history-timeline_through_20161.PDF. *See also* THE JOINT COMMMISSION, FACTS ABOUT THE JOINT COMMISSION, https://www.jointcommission.org/about_us/fact_sheets.aspx (last visited Feb. 10, 2017).

mission "the power and duty to suspend, revoke, or restrict" a physician's license to practice for failing to maintain a patient's medical record to the "minimum standards" set by the Commission.[4] Specifically relying upon the "minimum standard" provision of Section 34-24-360(22), the Medical Licensure Commission promulgated minimum standards concerning creation, maintenance, and accessibility of medical records that "every physician licensed to practice medicine in Alabama shall maintain for each of his or her patients."[5] Among other requirements, Alabama Administrative Code rule 545-X-4-.08(1) requires physicians to "maintain legible well documented records reflecting the history, findings, diagnosis and course of treatment in the care

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[4] The statute provides:

> The Medical Licensure Commission shall have the power and duty to suspend, revoke, or restrict any license to practice medicine or osteopathy in the State of Alabama or place on probation or fine any licensee whenever the licensee shall be found guilty on the basis of substantial evidence of any of the following acts or offenses:
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> . . . .
>
> (22). Failure to maintain for a patient a medical record which meets the minimum standards stated in the rules and regulations promulgated by the commission.

ALA. CODE § 34-24-360(22) (2016).

[5] The Alabama Administrative Code provides:

> The maintenance of adequate medical records is an integral part of good medical care. Adequate records are necessary to ensure continuity of care, not only by the physician who maintains a particular record, but by other medical professionals. Therefore, every physician licensed to practice medicine in Alabama shall maintain for each of his or her patients, a record which, in order to meet the minimum standard for medical records, shall:
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> (1) be legible, and written in the English language;
>
> (2) contain only those terms and abbreviations that are or should be comprehensive [sic] to other medical professionals;
>
> (3) contain adequate identification of the patient;
>
> (4) indicate the date any professional service was provided;
>
> (5) contain pertinent information concerning the patient's condition;
>
> (6) reflect examinations, vital signs, and tests obtained, performed, or ordered and the findings or results of each;
>
> (7) indicate the initial diagnosis and the patient's initial reason for seeking the physician's services;
>
> (8) indicate the medications prescribed, dispensed, or administered and the quantity and strength of each;
>
> (9) reflect the treatment performed or recommended;
>
> (10) document the patient's progress during the course of treatment; and
>
> (11) include all patient records received from other health care providers, if those records formed the basis for a treatment decision by the physician.

ALA. ADMIN. CODE r. 545-X-4-.09 (2017).

of a patient . . . for such period as may be necessary to treat the patient and for such additional time as may be required for medical legal purposes."[6] Further, records must: (a) "reflect examinations, vital signs, and tests obtained, performed, or ordered and the findings or results of each";[7] (b) "indicate the medications prescribed, dispensed, or administered and the quantity and strength of each";[8] (c) "reflect the treatment performed or recommended";[9] and (d) "document the patient's progress during the course of treatment."[10]

The Medical Licensure Commission has "the power and duty to suspend, revoke, or restrict" a physician's license for "[u]nprofessional conduct as defined herein or in the rules and regulations promulgated by the commission."[11] The Commission has defined, without limitation, "unprofessional conduct" to include "[i]ntentionally, knowingly or willfully causing or permitting a false or misleading representation of a material fact to be entered on any medical record of a patient,"[12] and "[f]ailing or refusing to maintain adequate records on a patient or patients."[13]

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[6] ALA. ADMIN. CODE r. 545-x-4-.08(1) (2017).

[7] ALA. ADMIN. CODE r. 545-X-4-.09(6) (2017).

[8] ALA. ADMIN. CODE r. 545-X-4-.09(8) (2017).

[9] ALA. ADMIN. CODE r. 545-X-4.09(9) (2017).

[10] ALA. ADMIN. CODE r. 545-X-4-.09(10) (2017).

[11] ALA. CODE § 34-24-360(2) (2016).

[12] ALA. ADMIN. CODE r. 545-X-4-.06(2) (2017).

[13] ALA. ADMIN. CODE r. 545-X-4-.06(11) (2017). This regulation additionally provides:

> Unprofessional conduct shall mean the commission or omission of any act that is detrimental or harmful to the patient of the physician or detrimental or harmful to the health, safety, and welfare of the public, and which violates the high standards of honesty, diligence, prudence and ethical integrity demanded from physicians and osteopaths licensed to practice in the State of Alabama. Furthermore, without limiting the definition of unprofessional conduct in any manner, the Commission sets out the below as examples of unprofessional conduct:
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> (1) The refusal by a physician to comply, within a reasonable time, they request from another physician for medical records or medical information when such request is accompanied by a properly executed authorization of the patient.
>
> (2) Intentionally, knowingly or willfully causing or permitting a false or misleading representation of a material fact to be entered on any medical record of a patient.
>
> (3) Intentionally, knowingly or willfully preparing, executing or permitting the preparation by another of a false or misleading report or statement concerning the medical condition or extent of disability of a patient. . .
>
> (11) Failing or refusing to maintain adequate records on a patient or patients. . .
>
> (13) Signing a blank, undated or predated prescription form. . .
>
> (16) Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or osteopathy or in applying for privileges

Section 34-24-504 of the Alabama Code expresses the State's public policy requiring physicians to protect patients' medical information:

> Any licensee licensed under the provision of this article shall comply with all laws, rules, and regulations governing the maintenance of patient medical records, including patient confidentiality requirements, regardless of the state where the medical records of any patient within this state are maintained.[14]

2. Nurses

The state legislature has given the Board of Nursing statutory authority to adopt regulations and standards governing the licensure and conduct of nurses.[15] The Board of Nursing also has statutory authority to "deny, revoke, or suspend any license" for various infractions, including if a nurse is found "guilty of unprofessional conduct of a character likely to deceive, defraud, or injure the public in matters pertaining to health."[16]

The governing regulations concerning duties owed by registered and licensed professional nurses relative to medical records are found in Chapter 610-X-6 of the Alabama Administrative Code. The regulations define both "comprehensive assessments"[17] (performed by RNs) and "focused assessments"[18] (performed by RNs and LPNs).

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or renewing an application for privileges at a health care institution. . .

(21) Giving false testimony in any judicial or administrative proceeding.

ALA. ADMIN. CODE r. 545-X-4-.06 (2017).

[14] ALA. CODE § 34-24-504 (2016).

[15] ALA. CODE § 34-21-2(1), (21) (2016). (providing "The board may: (1) Adopt and, from time to time, revise such rules and regulations, not inconsistent with law, as may be necessary to carry out this chapter . . . (21) Adopt standards for registered and practical nursing practice . . . .").

[16] ALA. CODE § 34-21-25(b)(1)(g) (2016).

[17] The regulation states:

> (2) Assessment, Comprehensive: the systematic collection and analysis of data including the physical, psychological, social, cultural and spiritual aspects of the patient by the registered nurse for the purpose of judging a patient's health and illness status and actual or potential health needs. Comprehensive assessment includes patient history, physical examination, analysis of the data collected, development of the patient plan of care, implementation and evaluation of the plan of care.

ALA. ADMIN. CODE r. 610-X-6-.01 (2017).

[18] The regulation provides in pertinent part:

> (3) Assessment, Focused: An appraisal of a patient's status and specific complaint through observation and collection of objective and subjective data by the registered nurse or licensed practical nurse. Focused assessment involves identification of normal and abnormal findings, anticipation and recognition of changes or potential changes in patient's health status, and may contribute to a comprehensive assessment performed by the registered nurse.

The standards adopted by the Board of Nursing require nurses to "[r]espect the dignity and rights of patients . . . including, but not limited to" the patients' rights to privacy, safety, and "[p]rotection of confidential information, unless disclosure is required by law."[19] Especially pertinent here, the Board requires nurses to "[a]ccept individual responsibility and accountability for accurate, complete, and legible documentation related to . . . [p]atient care records."[20] The Board defines "responsibility" as "[t]he charge to do something that is expected performance."[21] "Accountability" is being held "[a]nswerable or responsible for action."[22]

As with physicians, RNs and LPNs risk severe sanctions should they fail to comply with the regulatory requirements. Chapter 8 of the Board of Nursing's regulations provides for disciplinary action.[23] "The Board may reprimand, fine, probate, suspend, revoke and/or otherwise discipline any registered nurse or licensed practical nurse upon proof that the person" has committed any of a number of offenses, including if the nurse:

> Is guilty of unprofessional conduct of a character likely to deceive, defraud, or injure the public in matters pertaining to health, as demonstrated by one or more of the following: . . .
>
> (a) Failure to practice nursing in accordance with the standards adopted by the Board . . . .
>
> . . . .
>
> (f) Falsifying, altering, destroying, or attempting to destroy patient, employer, or employee records.
>
> . . . .
>
> [or] (h) Failure to respect or safeguard the patient's dignity, right to privacy, and confidential health information unless disclosure is required by law.[24]

3. Hospitals

Article 2 of Chapter 21 of Title 22 of the Alabama Code governs "Licensing of hospitals, nursing homes, and other health care institutions." The purpose of the article is:

> to promote the public health, safety, and welfare by providing for the

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Id.

[19] *Id.* at r. 610-X-6-.03(11).

[20] *Id.* at r. 610-X-6-.03(15).

[21] *Id.* at r. 610-X-6-.01(16).

[22] *Id.* at r. 610-X-6-.01(1).

[23] ALA. ADMIN. CODE r. 610-X-8 (2016).

[24] *Id.* at r. 610-X-8-.03(7).

> development, establishment, and enforcement of standards for the treatment and care of individuals in institutions within the purview of this article and the establishment, construction, maintenance, and operation of such institutions which will promote safe and adequate treatment and care of individuals in such institutions.[25]

A license is required to "establish, conduct or maintain any hospital as defined in Section 22-21-20."[26] A person must apply to the State Board of Health for such a license.[27] "The State Board of Health may grant licenses for the operation of hospitals which are found to comply with the provisions of this article and any regulations lawfully promulgated by the State Board of Health."[28] The Board may suspend or revoke a license on grounds including "[v]iolation of any of the provisions of this article or the rules and regulations issued pursuant thereto."[29] Section 22-21-28 gives the Board "the power to make and enforce, and . . . modify, amend, and rescind, reasonable rules and regulations governing the operation and conduct of hospitals as defined in Section 22-21-20. All such regulations shall set uniform minimum standards applicable alike to all hospitals of like kind and purpose."[30]

The pertinent Alabama State Board of Health regulations concerning hospitals' duties to create and maintain medical records are found at Alabama Administrative Code rules 420-5-7-.13(1) to (5).[31] For example, "The hospital shall use a system of author identification and

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[25] ALA. CODE § 22-21-21 (2016).

[26] § 22-21-22.

[27] § 22-21-23.

[28] § 22-21-25(a).

[29] § 22-21-25(b)(1).

[30] § 22-21-28(a).

[31] ALA. ADMIN. CODE r. 420-5-7-.13. The rule states:

> (1) The hospital shall have a medical record service that has administrative responsibility for medical records. A medical record shall be maintained for every individual evaluated or treated in the hospital.
>
> (2)) Organization and staffing. The organization of the medical record service shall be appropriate to the scope and complexity of the services performed. The hospital shall employ adequate personnel to ensure prompt completion, filing, and retrieval of records.
>
> (3) Form and retention of record. The hospital shall maintain a medical record for each inpatient and outpatient. Medical records shall be accurately written, promptly completed, properly filed and retained, and accessible. The hospital shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

(a) Medical records shall be retained in their original or legally reproduced form for a period of at least five years. In the case of minor patients, records shall be retained for at least five years after the patient has reached the age of majority.

(b) The hospital shall have a system of coding and indexing medical records. The system shall allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.

(c) The hospital shall have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital shall ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records shall be released by the hospital only in accordance with federal or state laws, court orders, or subpoenas.

(4) Content of record. The medical record shall contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

(a) All patient medical record entries shall be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

1. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, except as noted below.

2. All orders, including verbal orders, shall be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient and authorized to write orders by hospital policy.

3. All verbal orders must be authenticated within such time period as provided by hospital policy, but no more than 30 days following entry of the order.

(b) All records shall document the following, as appropriate:

1. Evidence of: (i) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination shall be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

(ii) An updated examination of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration.

record maintenance that ensures the integrity of the authentication and protects the security of all record entries."[32] "Medical records shall be accurately written, promptly completed, properly filed and retained, and accessible."[33] Additionally, "All patient medical record entries shall be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures."[34]

4. Nursing Facilities

The definition of "hospitals" in Section 22-21-20 of the Alabama Code includes "skilled nursing facilities, intermediate care facilities, assisted living facilities, and specialty care assisted living facilities rising to the level of intermediate care." The Alabama Supreme Court has also held that a nursing home is a "hospital" for purposes of the Alabama Medical Liability Act.[35] Thus, the statutes quoted above regarding licensure and governance of hospitals by the State Board of

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> Documentation of the updated examination shall be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
>
> 2. Admitting diagnosis.
>
> 3. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.
>
> 4. Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.
>
> 5. Properly executed informed consent forms for procedures and treatments specified by the medical staff.
>
> 6. All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.
>
> 7. Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.
>
> 8. Final diagnosis with completion of medical records within 30 days following discharge.
>
> (5) The hospital shall maintain a plan to transfer all records to another facility in the event the hospital ceases operation.

Id.

[32] *Id.* at r. 420-5-7-.13(3).

[33] *Id.*

[34] *Id.* at r. 420-5-7-.13(4)(a).

[35] Husby v. South Alabama Nursing Home, Inc., 712 So. 2d 750, 753 (Ala. 1998); *Ex parte* Northport Health Service, Inc., 682 So. 2d 52, 55 (Ala. 1996).

Health also authorize regulations to govern nursing facilities.

The duties imposed upon nursing facilities by the Alabama State Board of Health for creation and maintenance of medical records are found at Alabama Administrative Code rules 420-5-10-.03(32) to (36).[36] Among other requirements, the records must be "in accordance with accepted professional standards and practices" and must be complete, accurately documented, readily accessible, and systematically organized.[37] The clinical record must be retained for five years, and the "facility must safeguard clinical record information against loss, destruction, or unauthorized use."[38]

5. Assisted Living Facilities

Assisted living facilities are also within the statutory definition of

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[36] ALA. ADMIN. CODE r. 420-5-10-.03(32)–(36). These subsections state:

(32) Clinical records. The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

(a) Complete;

(b) Accurately documented;

(c) Readily accessible; and

(d) Systematically organized.

(33) Clinical records must be retained for:

(a) Five years from the date of discharge when there is no requirement in State law; or

(b) For a minor, three years after a resident reaches legal age under State law.

(34) The facility must safeguard clinical record information against loss, destruction, or unauthorized use.

(35) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

(a) Transfer to another health care institution;

(b) Law;

(c) Third party payment contract; or

(d) The resident.

(36) The clinical record must contain:

(a) Sufficient information to identify the resident;

(b) A record of the resident's assessments;

(c) The Plan of Care and services provided;

(d) The results of any pre-admission screening conducted by the State; and

(e) Progress notes.

Id.

[37] *Id.* at r. 420-5-10-.03(32).

[38] *Id.* at r. 420-5-10-.03(33)–(34).

hospitals[39] and thus subject to the licensing and other provisions of Article 2 of the "Hospitals and Other Health Care Facilities" chapter of the Alabama Code. The duties imposed upon assisted living facilities to create and maintain medical records are found in Alabama Administrative Code rules 420-5-4-.05(1) to (3).[40] Records necessary for care,

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[39] ALA. CODE § 22-21-20 (2016).

[40] ALA. ADMIN. CODE r. 420-5-4-.05. The rule provides:

(1) General.

(a) Responsibility for Records. The administrator shall prepare and file all records, or shall oversee the preparation and filing of records. This duty shall be assigned to other employees in the administrator's absence.

(b) Storage and Safety. Provision shall be made for the safe storage of records within the facility. Records shall be stored in a manner to reasonably protect them from water or fire damage. Records shall be safeguarded from unauthorized access.

(c) Preservation of Records. Those portions of residents' records necessary for staff to provide care, including the care plans and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. Records shall be current from the time of admission to the time of discharge or death and shall be retained in the facility for at least three years after a resident's death or discharge.

(d) Maintenance and Filing of Records and Reports.

1. All records and reports required by these Rules shall be completed in a timely manner, and shall be maintained, and filed in an orderly manner within the assisted living facility premises.

2. All entries on all records and reports shall be made by typewriter or printer or shall otherwise be written legibly using ink. Documents printed on a plain paper electronic facsimile machine shall be deemed to meet this requirement.

3. Adult Protective Services Reports. Incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law, and shall also be reported to the Department within 24 hours. Such incidents shall be immediately investigated by the facility, and the results of the investigation shall be promptly reported to the Department.

(e) Records Shall be Confidential. When an individual is admitted to an assisted living facility, records and information regarding the resident shall be protected from unauthorized disclosure. Employees and authorized agents of the Department shall be permitted to review all medical records and all other records to determine compliance with these rules. With the written consent of the resident, or with the written consent of the legal guardian of an incompetent resident, the local ombudsman shall be permitted access to all records regarding the resident. Records necessary to assess a resident's medical condition or to otherwise render good medical care shall be provided to the resident's treating physician or physicians. A resident or his or her legal guardian may grant permission to any other individual to review the resident's confidential records by signing a standard release.

. . . .

(3) Resident Records. For each resident an assisted living facility shall maintain

including care plans and admissions and examination records "shall be accessible to the direct care staff at all times . . . . [They] shall be current . . . and shall be retained in the facility for at least three years after a resident's death or discharge."[41] Such facilities are required to create and maintain incident reports for specified incidents with specified contents.[42] The records shall be confidential, but "[a] resident or his or her legal guardian may grant permission to any other individual to re-

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on its premises the seven required documents listed below and any other documents required by the facility's policies and procedures. The seven required documents are the resident's Financial Agreement, the resident's Admission Record, the resident's Medical Examination Record, the resident's Plan of Care, any Incident Report involving the resident, a Statement of Resident Rights signed by the resident, and the resident's Inventory of Personal Effects. In addition to the above seven documents, the facility shall also maintain on its premises any Advance Directive that has been executed by the resident. NOTE: under no circumstances shall the facility require a resident to execute an advance directive, nor may a facility require a resident to refrain from executing an advance directive. No staff member of the facility may encourage or discourage any resident with respect to the execution of an advance directive or contemplated execution of an advance directive. These records, either typewritten or legibly written ink, shall be protected from unauthorized disclosure. The resident records shall be retained for a period of not less than three years after the resident is discharged or dies.

. . . .

(f) Incident Report.

1. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct an investigation, and appropriate interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 24 hours of the incident. The report shall be given immediately upon completion to the administrator for review. The entire investigative file shall be made available for inspection and copying by representatives of the Alabama Department of Public Health. The entire investigative file means the incident report itself and all records and documents created or reviewed in connection with the investigation. Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff.

. . . .

2. Incidents which require investigations are:

(i) An accident or injury of known or unknown origin that was unusual or suspicious in nature or for which medical treatment was sought.

(ii) A fracture or an injury resulting in hospitalization.

(iii) The onset of wandering behavior by any resident who is not fully cognitively intact;

[and fourteen others].

41 ALA. ADMIN. CODE r. 420-5-4-.05(1)(c).

42 *Id.* at r. 420-5-4-.05(3)(f).

view the resident's confidential records by signing a standard release."[43]

B. Alabama Common Law

The duties owed by healthcare providers to create, maintain, and provide accurate medical records also spring from Alabama common law. When a healthcare provider destroys, hides, conceals, alters, or tampers with medical records, they risk suffering adverse evidentiary inferences at trial, and they may be liable in tort for spoliation.

An overview of the common law of spoliation of evidence appears in the Alabama Pattern Jury Charge on Spoliation of Evidence by a Defendant.[44] This instruction allows a jury to consider whether a defendant intentionally destroyed, hid, concealed, altered, or tampered with evidence and, if the jury so finds, to "draw such inferences that you believe are reasonable from the wrongful conduct."[45]

Alabama Pattern Jury Instruction 15.13[46] outlines the common law

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[43] *Id.* at r. 420-5-4-.05(e).

[44] 1 ALA. PATTERN JURY INSTR. CIV. 15.12 (3d ed.). The instruction states:

> The doctrine of spoliation of evidence applies when one party attempts to, or does (destroy/conceal/hide/alter/tamper with) evidence that is favorable to the other party. (It applies to an attempt to influence a witness's testimony).
>
> (Name of plaintiff) says (name of defendant) intentionally (destroyed/hid/concealed/altered/tampered with) (describe the evidence) (attempted to influence (name of witness)'s testimony). If you find (name of defendant) did this, you may draw such inferences that you believe are reasonable from the wrongful conduct.
>
> Before you make this inference, you must be reasonably satisfied from the evidence that:
>
> 1. (Name of defendant) knew that the evidence was important to (name of plaintiff)'s case; and,
>
> 2. (Name of defendant) intentionally (destroyed/hid/concealed/altered/tampered with) (describe the evidence).

Id.

[45] *Id.*

[46] 1 ALA. PATTERN JURY INSTR. CIV. 15.13 (3d ed.). The instruction provides:

> (Name of plaintiff) says (he/she/it) was harmed when (describe the event), and (he/she/it) (intended to sue) (did sue) (name of potential defendant) for the harm.
>
> (Name of plaintiff) further says (name of defendant) (negligently/wantonly/willfully) (destroyed/lost) vital evidence (describe the evidence). Because of this, (name of plaintiff) says (he/she/it) had no chance to win (the/a) lawsuit against (name of third party).
>
> (Name of defendant) denies what (name of plaintiff) says, and (he/she/it) says (state the defendant's position).
>
> To recover damages on this claim, (name of plaintiff) must reasonably satisfy you from the evidence that:

tort claim of spoliation recognized in *Smith v. Atkinson*.[47] These principles have been applied to the alteration, attempted alteration, or destruction of medical records in other cases. For example, in *May v. Moore*,[48] the hospital administrator made a copy of the original hospital treatment chart of a child-patient of the defendant, Dr. May, after which the original chart inexplicably disappeared.[49] The trial court allowed the hospital administrator to testify she had made a practice of copying the original charts of Dr. May because, on several occasions prior to the treatment of the infant in the instant case, hospital charts of a number of Dr. May's patients had inexplicably and permanently disappeared.[50] Only the charts of Dr. May's patients went missing—not those of other doctors.[51] The Alabama Supreme Court sustained the admission into evidence of this testimony and other evidence regarding alterations by Dr. May of the copies that he produced, which differed

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1. (Name of defendant) knew that (name of plaintiff) had sued (name of third party), or (name of defendant) knew (name of plaintiff) might file a lawsuit,

2. (Name of defendant) volunteered to preserve the evidence, or (he/she/it) agreed to preserve the evidence, or (name of person or company) asked (name of defendant) to preserve the evidence and offered to pay (him/her/it) the cost to preserve it,

3. (Name of defendant) (negligently/wantonly/willfully) (destroyed/lost) the evidence; and

4. The evidence was vital to (name of plaintiff)'s lawsuit. Vital evidence is evidence which, if (destroyed/lost), defeated any chance that (name of plaintiff) could have recovered in a lawsuit against (name of third party).

If (name of plaintiff) does not prove these things, you must find for (name of defendant). If (name of plaintiff) does prove these things you will presume (he/she/it) would have won (his/her/its) lawsuit against (name of third party) if (name of defendant) had not (destroyed/lost) the evidence.

(Name of defendant) must then prove to your reasonable satisfaction that (name of plaintiff) would not have won the lawsuit even if (he/she/it) had the evidence. If (name of defendant) does not prove (name of plaintiff) would not have won the lawsuit, you must find for (name of plaintiff) and you will award the amount of compensatory damages that (name of plaintiff) would have recovered in (the/a) lawsuit against (name of third party).

If you determine that (name of defendant)'s conduct was (wanton/willful), you may award punitive damages against (name of defendant).

[47] 771 So. 2d 429 (Ala. 2000) (recognizing a cause of action against a third-party that spoliates evidence vital to a plaintiff's claim against another).

[48] 424 So. 2d 596 (Ala. 1982).

[49] *Id.* at 603.

[50] *Id.*

[51] *Id.*

from the charts that the hospital administrator had copied and retained.[52] "The trial court found the testimony of [the hospital administrator] relevant to the issue of whether Dr. May might have tampered with the original medical chart of the infant Moore in attempting to conceal his guilt or negligence and we see no error in its decision."[53]

In *Campbell v. Williams*,[54] the Alabama Supreme Court affirmed the giving of a spoliation instruction to the effect that an attempt to suppress material evidence favorable to one's adversary is sufficient foundation for inferences of the spoliator's guilt or negligence.[55] In that case, the defendant, Dr. Campbell, was found to have asked another doctor to change that doctor's notes to have them reflect more favorably on Dr. Campbell's treatment because Dr. Campbell's own notes gave a version of the patient's signs and symptoms that was contradicted by the testimony of the treating nurse.[56] The trial court allowed the jury to "consider that concealment existed and [punish] accordingly."[57]

C. Federal Medicare and Medicaid Regulations

The United States imposes conditions on payments of Medicare and Medicaid funds.[58] The regulations setting forth these conditions are in the "Public Health" regulations, Title 42 of the Code of Federal Regulations. Chapter IV (Parts 400-699) of Title 42 gives the regulations pertinent to the Centers for Medicare and Medicaid Services within the Department of Health and Human Services. Subchapter G gives Standards and Certification provisions, including the pertinent Conditions of Participation in Medicare or Medicaid. These conditions of participation impose additional duties upon federally-funded healthcare providers to create and maintain accurate medical records.

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[52] *Id.*

[53] *Id.*

[54] 638 So. 2d 804 (Ala. 1994).

[55] *See id.* at 817, n.9.

[56] *Id.* at 817.

[57] *Id.* (quoting the trial court's post-judgment order).

[58] *See* 42 U.S.C. § 1302(a) (2012). Congress directed: "The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which each is charged under this chapter." *Id.* Pursuant to 42 U.S.C. § 1395hh, "The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter." 42 U.S.C. § 1395hh (2012).

1. Hospitals

Section 482.24 Condition of Participation: Medical Records Services

Part 482 of Subchapter G gives Conditions of Participation for Hospitals. Section 482.24 is the main provision for medical record services in a hospital. It requires a hospital to "have a medical record service that has administrative responsibility for medical records" and maintain a medical record "for every individual evaluated or treated in the hospital."[59] Among the pertinent requirements are "Medical records must be accurately written, promptly completed, properly filed,

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[59] 42 C.F.R. § 482.24 (2017). Other pertinent provisions include:

(a) Standard: Organization and Staffing. The organization of the medical records service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records.

(b) Standard: Form and Retention of Record. The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed, and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

(1) Medical records must be retained in their original or legally reproduced form for a period of at least 5 years.

. . . .

(c) Standard: Content of Record. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

(1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided consistent with hospital policies and procedures.

(2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with state law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

. . . .

(4) All records must document the following, as appropriate:

(i) Evidence of —

(A) A medical history and physical examination completed and documented no more than 30 days before or 24 after admission or registration . . . .

(B) An updated examination of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration.

. . . .

and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries."[60]

2. Ambulatory Care Centers ("ASCs")

Section 416.47 Condition for Coverage: Medical Records

Part 416 governs "ambulatory surgical services" provided by ambulatory surgical centers, or ASCs.[61] An ASC "must maintain complete, comprehensive, and accurate medical records to ensure adequate patient care."[62] The ASC must "develop and maintain a system for the proper collection, storage, and use of patient records"[63] and "maintain a medical record for each patient."[64] Additionally, "[e]very record must be accurate, legible, and promptly completed."[65] The regulation specifies the minimum contents of medical records.[66]

(ii) Admitting diagnosis.

(iii) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.

(iv) Documentation of complications, hospital acquired infections and unfavorable reactions to drugs and anesthesia.

(v) Properly executed informed consent forms . . . .

(vi) All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.

(vii) Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.

(viii) Final diagnosis with completion of medical records within 30 days following discharge.

Id.

60 42 C.F.R. § 482.24(b).

61 42 C.F.R. § 416.2.

62 § 416.47.

63 § 416.47(a).

64 § 416.47(b).

65 *Id.*

66 *Id.* 42 C.F.R. § 416.47(b) provides:

Medical records must include at least the following:

(1) Patient identification.

(2) Significant medical history and results of physical examination.

(3) Pre-operative diagnostic studies (entered before surgery), if performed.

(4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body.

(5) Any allergies and abnormal drug reactions.

(6) Entries related to anesthesia administration.

3. Hospices

Section 418.104 Condition of Participation: Clinical Records

Part 418 governs hospice care.[67] Within subpart D—which provides conditions of participation regarding the organizational environment—section 418.104 begins: "A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically."[68] Patient records are to contain the initial plan of care, update of plans of care, assessments and clinical notes, among other things.[69] Records "must be retained for 6 years after the death or discharge of the patient, unless State law stipulates a longer period of time."[70]

4. Elder Care Facilities

Section 460.210 Medical Records

Part 460 governs "Programs of All-Inclusive Care for the Elderly (PACE)." Section 460.2 defines the basis of these PACE regulations for Medicare and Medicaid payments.[71] As to the scope and purpose

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(7) Documentation of properly executed informed patient consent.

(8) Discharge diagnosis.

Id.

[67] 42 C.F.R. § 418.2 (2017).

[68] § 418.104 (2017).

[69] *Id.* 42 C.F.R. § 418.104(a) requires the record to contain the following seven items:

(1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.

(2) Signed copies of the notice of patient rights in accordance with § 418.52 and election statement in accordance with § 418.24.

(3) Responses to medications, symptom management, treatments, and services.

(4) Outcome measure data elements, as described in § 418.54(e) of this subpart.

(5) Physician certification and recertification of terminal illness as required. . . .

(6) Any advance directives as described in § 418.52(a)(2).

(7) Physician orders.

Id.

[70] § 418.104(d).

[71] 42 C.F.R. § 460.2 (2017). The section provides:

This part [of 42 C.F.R. § 460.2] implements sections 1894, 1905(a), and 1934 of the Act, which authorized the following:

(a) Medicare payments to, and coverage of benefits under, PACE.

(b) The establishment of PACE as a State option under Medicaid to provide for Medicaid payments to, and coverage of benefits under, PACE.

of the PACE regulations, "PACE provides pre-paid, capitated, comprehensive health care services . . . for frail, older adults."[72]

Subpart L governs data collection, record maintenance, and reporting. "A PACE organization must maintain a single, comprehensive medical record for each participant, in accordance with accepted professional standards."[73] The regulation specifies the requirements and content of the records.[74]

Two other sections are generally relevant: Section 460.200, which covers maintenance of records and reporting of data, and Section 460.202, which covers participant health outcomes data.

Id.

[72] § 460.4(b).

[73] § 460.210(a)(1).

[74] *Id.* 42 C.F.R. § 460.210(a)(2) and (b) provide:

The medical record for each participant must meet the following requirements:

Be complete.

(ii) Accurately documented.

(iii) Readily accessible.

(iv) Systematically organized.

(v) Available to all staff.

(vi) Maintained and housed at the PACE center where the participant receives services.

(b) *Content of medical records.* At a minimum, the medical record must contain the following:

(1) Appropriate identifying information.

(2) Documentation of all services furnished, including the following:

(i) A summary of emergency care and other inpatient or long-term care services.

(ii) Services furnished by employees of the PACE center.

(iii) Services furnished by contractors and their reports.

(3) Interdisciplinary assessments, reassessments, plans of care, treatment, and progress notes that include the participant's response to treatment.

(4) Laboratory, radiological and other test reports.

(5) Medication records.

(6) Hospital discharge summaries, if applicable.

(7) Reports of contact with informal support (for example, caregiver, legal guardian, or next of kin).

(8) Enrollment Agreement.

(9) Physician orders.

(10) Discharge summary and disenrollment justification, if applicable.

(11) Advance directives, if applicable.

(12) A signed release permitting disclosure of personal information.

Id.

5. Home Health Services

Section 484.48 Condition of Participation: Clinical Records

Part 484 governs home health services. The "Clinical Records" section begins: "A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services."[75] The introductory paragraph specifies required contents and other provisions. Paragraph (a) provides standards for retention of records, and paragraph (b) provides standards for protection of records.[76]

6. Other Specialized Providers

Part 485 governs conditions of participation for specialized providers. Specialized providers include comprehensive outpatient rehabilitation facilities (subpart B),[77] critical access hospitals (subpart F),[78] "Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services" (subpart H),[79] community mental health centers (subpart J),[80] and psychiatric hospitals.[81] Subparts A, C–E, G, and I are reserved.

a. Comprehensive Outpatient Rehabilitation Facilities ("CORFs")

Section 485.60 Condition of Participation: Clinical Records

The "Clinical Records" section for CORFs begins:

> The facility must maintain clinical records on all patients in accordance with accepted professional standards and practice. The clinical records must be completely, promptly, and accurately documented, readily accessible, and systematically organized to facilitate retrieval and compilation of information.[82]

Paragraph (a) provides a standard requiring the content, paragraph (b) provides a standard for protection of clinical record information, and paragraph (c) provides a standard for retention and preservation.[83]

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75 42 C.F.R. § 484.48 (2017).

76 *Id.*

77 §§ 485.50–485.74.

78 §§ 485.601–485.647.

79 §§ 485.701–485.729.

80 §§ 485.900–485.918 (2017).

81 §§ 482.1–482.23, 482.25–482.57, 482.60–482.61.

82 § 485.60.

83 *Id.*

b. Critical Access Hospitals

Section 485.638 Conditions of Participation: Clinical Records

Section 485, subpart F, at paragraph (a) provides standards for a records system which begins: "The [critical access hospital] maintains a clinical records system in accordance with written policies and procedures."[84] Paragraph (a)(2) requires the records to be "legible, complete, accurately documented, readily accessible, and systematically organized."[85] Paragraph (a)(4) provides what must be included in the record.[86] Paragraph (b) provides for protection of medical records, and paragraph (c) provides a standard for retention of records.[87]

c. Clinics, Rehabilitation Agencies, and Other Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services

Section 485.721 Condition of Participation: Clinical Records

Paragraph (a) requires "Protection of clinical record information." Paragraph (b) lists the general categories of data the records must contain.[88] The regulations require the records to be completed promptly, centralized in the patient's clinical record, and signed by the physician who makes the record.[89] The records must be preserved at least five years or three years after a minor becomes of age, whichever is longer.[90] The regulations provide standards for indexing records and providing for their prompt retrieval.[91]

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[84] § 485.638.

[85] § 485.638(a)(2).

[86] § 485.638(a)(4).

[87] § 485.638.

[88] 42 C.F.R. § 485.721 (2017):

(1)Documented evidence of the assessment of the needs of the patient, of an appropriate plan of care, and of the care and services furnished.

(2)Identification data and consent forms.

(3)Medical history.

(4)Report of physical examinations, if any.

(5)Observations and progress notes.

(6)Reports of treatment and clinical findings.

(7)Discharge summary including final diagnosis(es) and prognosis.

[89] § 485.721(c).

[90] § 485.721(d).

[91] § 485.721(e)–(f).

d. Community Mental Health Centers ("CMHCs")

Section 485.914 Condition of Participation: Admission, Initial Evaluation, Comprehensive Assessment, and Discharge or Transfer of the Client

The regulations in section 485.914 specify "requirements that are considered necessary to ensure the health and safety of clients,"[92] including: detailed provisions for documenting treatment plans,[93] data,[94] training of staff personnel,[95] and other matters.

"The CMHC must ensure that all clients admitted into its program are appropriate for the services the CMHC furnishes in its facility."[96] In subsection (b), the statute provides: "A licensed mental health professional employed by the CMHC and acting within his or her state scope of practice requirements must complete [an] initial evaluation within 24 hours of the client's admission to the CMHC."[97] At minimum, this initial evaluation must include: (1) "[t]he admitting diagnosis";[98] (2) "[t]he source of referral";[99] (3) "[t]he reason for admission";[100] (4) "[i]dentification of the client's immediate clinical care needs related to the psychiatric diagnosis";[101] (5) "[a] list of current prescriptions and over-the-counter medications";[102] and (6) "[f]or partial hospitalization services only . . . an explanation as to why the client would be at risk for hospitalization if the partial hospitalization services were not provided." Moreover, section 485.914 further requires that a comprehensive assessment containing specific details "be completed in a timely manner . . . , but no later than 4 working days after admission to the CMHC."[103]

e. Psychiatric Hospitals

Section 482.61 Condition of Participation: Special Medical

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92 § 485.900.
93 § 485.916.
94 § 485.917.
95 § 485.910(f)(4).
96 § 485.914.
97 § 485.914(b)(1).
98 § 485.914(b)(2)(i)–(vi).
99 42 C.F.R. § 485.914(b)(2)(ii).
100 42 C.F.R. § 485.914(b)(2)(iii).
101 42 C.F.R. § 485.914(b)(2)(iv).
102 42 C.F.R. § 485.914(b)(2)(v).
103 § 485.914(c).

Record Requirements for Psychiatric Hospitals

"The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution."[104] "Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized."[105] The record must include "identification data" such as the "patient's legal status"; "provisional or admitting diagnosis . . . at the time of admission . . ."; "reasons for admission . . ."; and further, "[e]ach patient must receive a psychiatric evaluation that must . . . [b]e completed within 60 hours of admission," including medical history and other specific criteria.[106] Each psychiatric patient "must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities," which "must include—[a] substantiated diagnosis; [s]hort-term and long-range goals; [t]he specific treatment modalities utilized; [t]he responsibilities of each member of the treatment team; and [a]dequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out."[107]

7. Rural Health Clinics

Section 491.10 Patient health records

Part 491 governs certification of certain health facilities, such as rural health clinics. Its only subpart is subpart A, entitled "Rural Health Clinics: Conditions for Certification; and [FQHCs] Conditions for Coverage."[108] These records must include, as applicable:

> (i)Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;
>
> (ii)Reports of physical examinations, diagnostic and laboratory test results, and consultative findings;
>
> (iii)All physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the patient's progress;

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104 § 482.61.

105 § 482.61(a).

106 42 C.F.R. §§ 482.61(a)–(b).

107 §§ 482.61(c)(1)(i)–(v).

108 § 491.1.

(iv)Signatures of the physician or other health care professional.[109]

8. Laboratories

Section 493.1105 Standard: Retention Requirements

Part 493 governs laboratory requirements. The cited section is in subpart J—"Facility Administration for Nonwaived Testing."[110] Subsection (a) begins, "The laboratory must retain its records and, as applicable, slides, blocks, and tissues as follows: . . . ."[111] The remainder of subsection (a) has detailed retention provisions for the specified items; the shortest retention provision is "at least 2 years."[112] Subsection (b) requires the laboratory to make provisions to ensure that the records and other items are retained and available for the time frame specified if the laboratory ceases operation.[113]

9. End-Stage Renal Disease Facilities

Section 494.170 Condition: Medical Records

Part 494 governs end-stage renal disease facilities. Section 494.170 states:

> The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility.[114]

Subsection (a) provides the standard for protection of the patient's record; subsection (b) provides the standard for the completion of patient records and centralization of clinical information; subsection (c) provides a standard for record retention and preservation; and subsection (d) provides a standard for transfer of patient record information.[115]

D. Joint Commission Standards

1. Medical Records Standards, Generally

The Joint Commission accredits more than 21,000 healthcare or-

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[109] §§ 491.10(a)(3)(i)–(iv).
[110] § 493.1100.
[111] § 493.1105(a).
[112] §§ 493.1105(a)(1)–(7).
[113] § 493.1105(b).
[114] § 494.170.
[115] *Id.*

ganizations and programs including general, psychiatric, children's, rehabilitation, and critical care hospitals; home healthcare organizations, nursing homes, and other long-term care facilities; and ambulatory care providers, clinical laboratories, and other specialty healthcare providers.[116] For each category of accredited organizations, The Joint Commission has developed standards provided in organization-specific accreditation manuals.[117] The Joint Commission performs periodic accreditation reviews of healthcare providers' compliance with its standards.[118] Medical records services are among criteria surveyed for accreditation.[119]

The Comprehensive Accreditation Manual for Hospitals, which became effective in January 2016, is "a one-stop resource to help your hospital achieve or maintain continuous compliance with The Joint Commission's standards."[120] Pertinent here are the chapters on Information Management ("IM") and Record of Care, Treatment, and Services ("RC").

Standard IM.01.01.01 provides: "The hospital plans for managing information." The Elements of Performance for that standard are:

> 1. The hospital identifies the internal and external information needed to provide safe, quality care.
>
> 2. The hospital identifies how data and information enter, flow within, and leave the organization.
>
> 3. The hospital uses the identified information to guide development of processes to manage information.
>
> 4. Staff and licensed independent practitioners, selected by the hospital, participate in the assessment, selection, integration, and use of information management systems for the delivery of care, treatment, and services.[121]

Standard IM.02.01.03 provides: "The hospital maintains the security and integrity of health information."[122] The introduction to this standard provides:

> Even simple mistakes, such as writing the incorrect date of service or

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[116] THE JOINT COMMMISSION, FACTS ABOUT THE JOINT COMMISSION, https://www.jointcommission.org/about_us/fact_sheets.aspx (last visited Feb. 10, 2017).

[117] *Id.*

[118] THE JOINT COMMISSION, JOINT COMMISSION FAQ PAGE, https://www.jointcommission.org/about/jointcommissionfaqs.aspx#298.

[119] *Id.*

[120] THE JOINT COMMISSION, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSTPITALS § HM-1 (2016) [hereinafter CAMH].

[121] CAMH, at § IM 3–4.

[122] CAMH at § IM-6.

> diagnosis, can undermine data integrity just as easily as intentional breaches. For these reasons, an examination of the use of paper and electronic information systems is considered in the hospital's approach to maintaining the security and integrity of health information.[123]

Under the Elements of Performance for this standard, elements six and seven are especially pertinent to the integrity of health care records:

> 6. The hospital protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.
>
> 7. The hospital controls the intentional destruction of health information.[124]

Standard IM.02.02.01 provides: "The hospital effectively manages the collection of health information."[125] Element of Performance 1 requires "uniform data sets to standardize data collection throughout the hospital."[126] Element of Performance 2 requires "standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations."[127]

Standard IM.02.02.03 provides: "The hospital retrieves, disseminates, and transmits health information in useful formats."[128]

Standard IM.03.01.01 provides: "Knowledge-based information resources are available, current, and authoritative."[129]

Standard CAMH, p. IM - 9 provides: "The hospital maintains accurate health information."[130] This requires both that the hospital's health information be accurate and that the hospital maintain it.

2. *Record of Care, Treatment, and Services*

The overview of this chapter describes how important it is to maintain complete and accurate medical records:

> The "Record of Care, Treatment, and Services" (RC) chapter contains a wealth of information about the components of a complete medical record. A highly-detailed document when seen in its entirety, the record of care comprises all data and information gathered about a patient from the moment he or she enters the hospital to the moment of discharge or transfer. As such, the record of care functions not only as a historical record of a patient's episode(s) of care, but also as a method of communication between practitioners and staff that can facilitate the

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[123] *Id.*

[124] *Id.* at § IM-7.

[125] *Id.*

[126] *Id.*

[127] *Id.*

[128] CAMH, at § IM-8.

[129] *Id.*

[130] I*d.* at § IM-9.

continuity of care and aid in clinical decision making.[131]

Required standards include:

- Standard RC.01.01.01 provides: "The hospital maintains complete and accurate medical records for each individual patient."
- Standard RC.01.02.01 provides: "Entries in the medical record are authenticated."
- Standard RC.01.03.01 provides: "Documentation in the medical record is entered in a timely manner."
- Standard RC.01.04.01 provides: "The hospital audits its medical records."
- Standard RC.01.05.01 provides: "The hospital retains its medical records."
- Standard RC.02.01.01 provides: "The medical record contains information that reflects the patient's care, treatment, and services." Element of Performance 2 for RC.02.01.01 is critical:

> 2.The medical record contains the following clinical information:
>
> The reason(s) for admission for care, treatment, and services;
>
> The patient's initial diagnosis, diagnostic impression(s), or condition(s);
>
> Any findings of assessments and reassessments (*See also* PC.01.02.01, EPs 1 and 4; PC.03.01.03, EPs 1 and 8 ["PC" is Provision of Care, Treatment and Services, a chapter of its own]);
>
> Any allergies to food;
>
> Any allergies to medication;
>
> Any conclusions or impressions drawn from the patient's medical history and physical examination;
>
> Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnoses includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses;
>
> Any consultation reports;
>
> Any observations relevant to care, treatment, and services;

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[131] CAMH, at § RC-1.

> The patient's response to care, treatment, and services;
>
> Any emergency care, treatment, and services provided to the patient before his or her arrival;
>
> Any progress notes;
>
> All orders;
>
> Any medications ordered or prescribed;
>
> Any medications administered, including the strength, dose, and route;
>
> Any access site for medication, administration devices used, and rate of administration;
>
> Any adverse drug reactions;
>
> Treatment goals, plan of care, and revisions to the plan of care (*See also* PC.01.03.01, EPs 1 and 23);
>
> Results of diagnostic and therapeutic tests and procedures;
>
> Any medications dispensed or prescribed on discharge;
>
> Discharge diagnosis;
>
> Discharge plan and discharge planning evaluation.[132]

- Standard RC.02.01.03 provides: "The patient's medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia."
- Standard RC.02.01.07 provides: "The medical record contains a summary list for each patient who receives continuing ambulatory care services."
- Standard RC.02.03.07 provides: "Qualified staff receive and record verbal orders." The Elements of Performance for this standard are also important:
    - The hospital identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation.
    - Only authorized staff receive and record verbal orders.
    - Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders.
    - Verbal orders are authenticated within the time frame specified by law and regulation.
- Standard RC.02.04.01 provides: "The hospital documents the patient's discharge information."

3. Sentinel Events Records

As part of the accreditation process, The Joint Commission also

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[132] CAMH, at § RC 6–7. *See also* PC.01.02.03, EPs 6-8.

reviews responses to sentinel events that signal the need for immediate investigation and response. The Commission defines a sentinel event as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof . . . [including] any process variation for which a recurrence would carry a significant chance of a serious adverse outcome."[133] The purpose of its sentinel event policy is explained in the Manual:

> The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help hospitals that experience serious adverse events, improve safety, and learn from those sentinel events. Careful investigation and analysis of patient safety events, as well as strong corrective actions that provide effective and sustained system improvement, is essential to reduce risk and prevent patient harm. The Sentinel Event Policy explains how The Joint Commission partners with hospitals that have experienced a serious patient safety event to protect the patient, improve systems, and prevent further harm.[134]

The chapter defines "sentinel event" as follows:

> A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:
>
> Death;
>
> Permanent harm;
>
> Severe temporary harm, which is defined as "critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires a transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.[135]

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[133] CAMH at SE-1.

[134] CAMH, at § SE-1.

[135] An event is also considered sentinel if it is one of the following:

> Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED);
>
> Unanticipated death of a full-term infant;
>
> Discharge of an infant to the wrong family;
>
> Abduction of any patient receiving care, treatment, and services;
>
> Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient;
>
> Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups);
>
> Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at

The Joint Commission prescribes the following responses to sentinel events:

> Such events are considered "sentinel" because they signal a need for immediate investigation and response. All sentinel events must be reviewed by the hospital and are subject to review by The Joint Commission. Accredited hospitals are expected to identify and respond appropriately to all sentinel events (as defined by The Joint Commission) occurring in the hospital or associated with services that the hospital provides. An appropriate response includes all of the following:
>
> A formalized team response that stabilizes the patient, discloses the event to the patient and family, and provides support for the family as well as staff involved in the event;
>
> Notification of hospital leadership;
>
> Immediate investigation;
>
> Completion of a comprehensive systematic analysis for identifying the causal and contributory factors;
>
> Identification of corrective actions to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors;
>
> Time line for implementation of corrective actions;
>
> Systemic improvement.
>
> This chapter has further sections on the Goals of the Sentinel Event Policy, Responding to Sentinel Events, The Sentinel Event Database, Determination That a Sentinel Event is Subject to Review, Optional On-Site Review of a Sentinel Event, Disclosable Information, The

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> the hospital;
>
> Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital;
>
> Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure;
>
> Unintended retention of a foreign object in a patient after an invasive procedure, including surgery;
>
> Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter);
>
> Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose;
>
> Fire, flame, or unanticipated smoke, or flashes occurring during an episode of patient care;
>
> Any intrapartum (related to the birth process) maternal death;
>
> Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in any of the following: Permanent harm or severe temporary harm.

CAMH, at § SE 1–3 (footnotes omitted).

Joint Commission's Response, Sentinel Event Measure of Success, Handling Sentinel Event-Related Documents, Oversight of the Sentinel Event Policy, Survey Process, and an Appendix on Accreditation Requirements Related to Sentinel Events.[136]

E. ASTM Standards

"[E]vidence of a defendant's compliance with applicable industry standards may be relevant and admissible for purposes of determining whether a defendant breached a duty of care it owed an injured plaintiff."[137]

The American Society for Testing and Materials ("ASTM") is a globally-recognized leader in the development and delivery of voluntary consensus standards.[138] ASTM employs more than 140 Technical Standards writing committees, which have promulgated more than 12,000 ASTM standards used around the world to enhance health and safety.[139] Pertinent here, ASTM has several standards concerning electronic medical records:

- Standard Practice for Content and Structure of the Electronic Health Record[140]
- Standard Specification for Audit and Disclosure Logs for Use in Health Information Systems[141]
- Standard Guide for Confidentiality, Privacy, Access, and Data Security Principles for Health Information Including Electronic Health Records[142]
- Standard Specification for Coded Values Used in the Electronic Health Record[143]
- Standard Practice for View of Emergency Medical Care in the Electronic Health Record[144]
- Standard Practice for Defining and Implementing Pharmacotherapy Information Services within the Electronic Health Record (EHR) Environment and Networked Architectures[145]

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[136] *See* CAMH at § SE 4–17.

[137] Galaxy Cable, Inc. v. Davis, 58 So. 3d 93, 99 (Ala. 2010) (citing Standard Plan, Inc. v. Tucker, 582 So. 2d 1024 (Ala. 1991)).

[138] *Detailed Overview*, ASTM INTERNATIONAL, https://www.astm.org/ABOUT/full_overview.html (last visited October 15, 2017).

[139] *Id.*

[140] ASTM-E1384-07 (2013).

[141] ASTM-E2147-01 (2013).

[142] ASTM-E1869-04 (2014).

[143] ASTM-E1633-08A (2013).

[144] ASTM-E1744-04 (2010).

[145] ASTM-E2538-06 (2011).

II. ACCESS TO MEDICAL RECORDS

Patient access to medical records was traditionally governed by state law; however, federal law now plays an increasingly important role, especially with the advent of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), now codified at 42 U.S.C. §§ 1320d-1, *et seq.* HIPAA's implementing regulations are found at 45 C.F.R. Part 160 and 164, as augmented by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), now codified at 42 U.S.C., §§ 17935, *et seq.*, with implementing regulations at 45 C.F.R. 164.524, *et seq.*

A. The Alabama Code

In Alabama, access to medical records is governed in the first instance by state statutes and state regulations. Section 12-21-6.1 of the Alabama Code, which covers reproduction and delivery of medical records, states:

> (a) The following words and phrases used in this section shall have the following meanings:
>
> (1) ACTUAL COSTS. The cost of material and supplies used to duplicate the medical record, the labor costs, and other costs associated with duplication of the medical records.
>
> (2) PERSON. Any medical provider or company or other legal entity that maintains medical records.
>
> (b)(1) Notwithstanding any other provision of law, any person required to release copies of medical records may condition the release upon payment by the requesting party of the reasonable costs of reproducing the medical records.
>
> (2) The reasonable costs of reproducing copies of written or typed documents, or reports shall not be more than one dollar ($1) for each page of the first 25 pages, not more than 50 cents ($.50) for each page in excess of 25 pages, and a search fee of five dollars ($5). If the medical records are mailed to the person making the request, reasonable costs shall include the actual costs of mailing the medical records.
>
> (3) A person may charge in addition to the fees allowed in subdivision (2) of this subsection the actual cost of reproducing X-rays and other special medical records.
>
> (4) Unless other arrangements for payments are made between the requesting party and the person supplying the medical records, the requesting party shall pay the fees charged for reproduction and delivery of the medical records prior to delivery of the medical records.
>
> (c) The provisions of this section shall not apply to records subpoenaed by the State Board of Medical Examiners.
>
> (d) This section shall not affect any fees or costs currently paid by state

agencies.[146]

Note that Section 12-21-6.1(a)(2) defines "person" as "[a]ny medical provider or company or other legal entity that maintains medical records."[147] This definition presumably includes physicians. Section 22-11A-22 of the Alabama Code cloaks medical records of persons with sexually transmitted diseases with special protection from public disclosure and admission into evidence.[148] Section 22-50-62 of the Alabama Code cloaks mental health records compiled by Alabama Department of Mental Health and Mental Retardation with special protections.[149] Section 34-26-2 of the Alabama Code and Rule 503 of the Alabama Rules of Evidence protect from disclosure and admission into evidence records of confidential relations and communications between patients and psychologists, psychiatrists, and other psychotherapists.[150]

B. Alabama Administrative Regulations

Regulations promulgated by the State Board of Medical Examiners and the Medical Licensure Commission also specify the duties of Alabama's physicians to make medical records accessible to their patients. For example, rule 545-X-4-.08(2) states:

1. Alabama Administrative Code § 545-X-4-.08

Joint Guidelines of the State Board of Medical Examiners and Medical Licensure Commission for Medical Records Management.

On the request of a patient, and with the authorization of the patient, a physician should provide a copy or a summary of the medical record to the patient or to another physician, attorney or other person designated by the patient. By state law, a physician is allowed to condition the release of copies of medical records on the payment by the requesting party of the reasonable costs of reproducing the record. Reasonable cost as defined by law may not exceed one dollar ($1.00) per page for the first twenty-five (25) pages, fifty cents ($.50) per page for each page in excess of twenty-five (25) pages, a search fee of five dollars ($5.00) plus the actual cost of mailing the record. In addition,

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146 ALA. CODE § 12-21-6.1 (2016).

147 *Id.*

148 ALA. CODE § 22-11A-22 (2015).

149 ALA. CODE § 22-50-62 (2015) (prohibiting state employees from disclosing mental health records or other patient information).

150 ALA. CODE § 34-26-2 (2014); ALA. R. EVID. 503.

the actual costs of reproducing x-rays or other special records may be included. For medical records provided in an electronic file, a flat fee that would not exceed the cost of providing the records in paper form may be charged. Records subpoenaed by the State Board of Medical Examiners are exempt from this law. Physicians charging for the cost of reproduction of medical records should give primary consideration to the ethical and professional duties owed to other physicians and to their patients, and waive copying charges when appropriate.

C. Alabama Common Law

In *Horne v. Patton*,[151] the Alabama Supreme Court held a complaint alleging that a doctor improperly disclosed the plaintiff's medical information to the plaintiff's employer, resulting in his being fired, stated causes of action for breach of fiduciary duty, invasion of privacy, and breach of implied contract. The Court wrote, "It must be concluded that a medical doctor is under a general duty not to make extra-judicial disclosures of information acquired in the course of the doctor-patient relationship and that a breach of that duty will give rise to a cause of action."[152] *Horne* was subsequently followed by the supreme court in *Mull v. String*[153] and *Crippen v. Charter Southland Hospital, Inc.*[154]

D. HIPAA

In 1996, Congress enacted, and President Clinton signed into law, the Health Insurance Portability and Accountability Act ("HIPAA"). Section 244 of HIPAA added a section to the United States Code on "False Statements Relating to Health Care Matters."[155] This section

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[151] 287 So. 2d 824 (1974).

[152] *Id.*

[153] 448 So. 2d 952 (Ala. 1984) (holding that "when a patient sues a defendant other than his or her physician, and the information acquired by the physician as a result of the physician-patient relationship would be legally discoverable . . . then the patient will be deemed to have waived any right to proceed against the physician for the physician's disclosure" and reversing the dismissal of the complaint).

[154] 534 So. 2d 286 (Ala. 1988) (holding that plaintiff's employer requiring as a condition of employment possible production of medical records does not grant consent to defendant, and reversing summary judgment for defendant, since there was evidence that the release of medical records proximately caused plaintiff's injury). *See also*, Lonette, E. Lamb, *To Tell or Not To Tell: Physicians Liability for Disclosure of Confidential Information About a Patient*, 13 CUMB. L. Rev. 617 (1983); Judy E. Zelin, *Annotation, Tort Liability for Unauthorized Disclosure of Confidential Information About Patient*, 48 ALR 4th 668 (1986 & Supp.) (collecting state and federal cases in which courts have considered whether tort liability exists when a physician or other medical practitioner makes an unauthorized disclosure of health information).

[155] Pub. L 104-191, § 244, adopting 18 U.S.C. § 1035.

makes it a federal crime to, "in any matter involving a health care benefit program, knowingly and willfully . . . [make] any materially false, fictitious or fraudulent statements or representations . . . in connection with the delivery of" health care services.[156] The Department of Health and Human Services ("HHS") adopted regulations regarding the privacy of individually identifiable health information.[157]

Individually identifiable health information is information that . . . [i]s created or received by a health care provider . . . and [r]elates to the past, present, or future physical or mental health or condition of an individual; [or] the provision of health care to an individual; . . . and [t]hat identifies the individual.[158] Further, "protected health information" is defined as "individually identifiable health information" that is transmitted or maintained in electronic media or in any other form or medium.[159]

HIPAA mandates that a health care provider "may not use or disclose protected health information" except as allowed by other provisions such as disclosing the information to the individual patient or for further treatment of the individual or for payment for the health care provider's services.[160] The regulations allow a health care provider to "obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations."[161]

Pursuant to these regulations, every health care provider now provides patients with a HIPAA Privacy Notice to sign; most readers probably have encountered these when visiting a doctor's office or other treatment facility. These notices derive from the regulation giving "an individual . . . a right to adequate notice of the uses and disclosures of protected health information that may be made by the covered entity, and of the individual's rights and the covered entity's legal duties with respect to protected health information."[162] The notice must have a header or other prominent display of the following: "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET

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156 18 U.S.C. § 1035(a)(2).

157 The privacy rule is found in parts 160 and 164 of 45 C.F.R.

158 45 C.F.R § 160.103.

159 *Id.*

160 § 164.502.

161 § 153.506(b)(1). 42 C.F.R § 164.501 defines "Health care operations" to include matters such as "[c]onducting quality assessment and improvement activities," and "[r]eviewing the competence or qualifications of health care professionals," and other similar activities.

162 45 C.F.R. § 164.520(a)(1).

ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."[163]

"[A]n individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set."[164] There are exceptions for psychotherapy notes and information for use in a civil, criminal, or administrative action or proceeding.[165] The HIPAA regulations also include security standards for the protection of electronic protected health information.[166]

In short, HIPAA provides a *federal* baseline of health information privacy protections, which states are free to rise above in order to best protect their citizens. HIPAA and the standards promulgated by the Secretary of HHS expressly supersede any contrary provision of state law except as provided in 42 U.S.C. § 1320(d) to (7)(a)(2). Under that exception, HIPAA and its standards expressly do not preempt contrary state law if the state law "relates to the privacy of individually identifiable health information," and is "more stringent" than HIPAA's requirements.[167] Many reported decisions address the scope and effect of HIPAA's preemption provision.[168]

HIPAA's implementing regulations, located at 42 C.F.R. § 482.13, give patients a right of access to their medical records. This section begins: "A hospital must protect and promote each patient's rights." Paragraph (a) gives a standard for giving patients notice of their rights. Paragraph (b) gives a standard for exercise of rights. Par-

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163 § 164.520(b)(1)(i).

164 § 164.524(a)(1).

165 § 164.524(a)(1)(i), (ii) (2014).

166 § 164.306 (2013).

167 45 C.F.R. § 160.202.

168 *See* Moreland v. Austin, 670 S.E.2d 68, 71–72 (Ga. 2008) ("[W]e find that HIPAA preempts Georgia law with regard to ex parte communications between defense counsel and plaintiff's prior treating physicians because HIPAA affords patients more control over their medical records when it comes to informal contacts between litigants and physicians. HIPAA . . . prevents a medical provider from disseminating a patient's medical information in litigation, whether orally or in writing, without obtaining a court order or the patient's express consent, or fulfilling certain other procedural requirements designed to safeguard against improper use of the information."). *See also* David G. Wirtes, Jr. and R. Edwin Lamberth, Revisiting "An Important Consequence of HIPAA: No More Ex Parte Communications Between Defense Attorneys and Plaintiffs' Treating Physicians"—An examination of Alabama's Experience with HIPAA's Privacy Regulations, 40 Am. J. Trial Adv. 323 (2016); David G. Wirtes, Jr., R. Edwin Lamberth, Joanna Gomez, *An Important Consequence of HIPAA: No More Ex Parte Communications Between Defense Attorneys And Plaintiffs' Treating Physicians*, 27 AM. J. TRIAL ADVOC. 1 (2003).

agraph (c) gives a standard for privacy safety. Paragraph (d), the standard for confidentiality of patient records, grants a patient "the right to access information contained in his or her clinical records within a reasonable time frame."[169] Most importantly, "[t]he hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits."[170]

The HIPAA regulation applicable to judicial proceedings is 45 C.F.R. § 164.512(e)(1), which defines the circumstances when a covered healthcare provider may reveal protected health information in the course of judicial proceedings.[171] Specifically, disclosure of protected health information is permissible only under the following conditions:

> (i) In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order; or
>
> (ii) In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if:
>
> (A) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iii) of this section, from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or
>
> (B) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iv) of this section, from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements of paragraph (e)(1)(v) of this section.[172]

When producing such information, healthcare providers must produce only the minimum information necessary.[173]

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[169] 42 C.F.R. § 482.13(d). The provision provides:

> (1) The patient has the right to the confidentiality of his or her clinical records.
>
> (2) The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requirements as quickly as its record keeping system permits.

Id.

[170] § 482.13(d)(2).

[171] § 164.512(e).

[172] §§ 164.512(e)(I), (II).

[173] *See* § 164.512(b)(1).

E. HITECH

Congress promulgated HITECH with the intention that new electronic medical records be afforded the same protections provided by HIPAA.[174]

Under HITECH, a patient has the right to obtain a copy of their medical records in an electronic format, and the healthcare provider is permitted to bill only the cost of copying, including the cost of supplies for and labor of copying.[175] This is all part of the comprehensive push by Congress to move our country's healthcare providers to easily accessible electronic health records under HITECH.

Lawyers representing patients are equally entitled to obtain clients' electronic health information. "The final rule adopts the proposed amendment Section 164.524(c)(3) to expressly provide that, if requested by an individual, a covered entity must transmit the copy of protected health information directly to another person designated by the individual."[176]

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[174] *See* HITECH Act, Subtitle D, Part 2, 42 U.S.C. § 13421. This section states in pertinent part:

> (a) Application of HIPAA State Preemption.—Section 1178 of the Social Security Act (42 U.S.C. 1320d–7) shall apply to a provision or requirement under this subtitle in the same manner that such section applies to a provision or requirement under part C of title XI of such Act or a standard or implementation specification adopted or established under sections 1172 through 1174 of such Act.
>
> (b) Health Insurance Portability and Accountability Act.—The standards governing the privacy and security of individually identifiable health information promulgated by the Secretary under sections 262(a) and 264 of the Health Insurance Portability and Accountability Act of 1996 shall remain in effect to the extent that they are consistent with this subtitle. The Secretary shall by rule amend such Federal regulations as required to make such regulations consistent with this subtitle.
>
> (c) Construction.—Nothing in this subtitle shall constitute a waiver of any privilege otherwise applicable to an individual with respect to the protected health information of such individual.

[175] 42 U.S.C. § 17935(e)(1) (2010); 45 C.F.R. 164.524(c)(4)(i) (2014).

[176] 78 Fed. Reg. 5634 (Jan. 25, 2013). Note that "fees charged to incur a profit from the disclosure of protected health information are not allowed. We [HHS] believe allowing a profit margin would not be consistent with the language contained in Section 13405 of the HITECH Act." Rules and Regulations: Department of Health and Human Services, 78 Fed. Reg. 5566, 5607 (Jan. 25, 2013).

III. DISCOVERY

A. *Discovery of Medical Records*

1. State Law

Section 10 of the Alabama Constitution of 1901 guarantees the "Right to Prosecute Civil Cause":

> That the great, general, and essential principles of liberty and free government may be recognized and established, we declare:
>
> . . . .
>
> That no person shall be barred from prosecuting or defending before any tribunal in this state, by himself or counsel, any civil cause to which he is a party.[177]

This section "elucidates this state's commitment to protect an individual's right to attain an adjudication on the merits."[178] Section 13 of the Alabama Constitution of 1901 guarantees a right to a remedy, stating: "[E]very person, for any injury done him, in his lands, goods, person, or reputation, shall have a remedy by due process of law."[179]

Alabama Rule of Civil Procedure 26(b)(1) states the scope of discovery in Alabama as follows:

> Parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action, whether it relates to the claim or defense of the party seeking discovery or to the claim or defense of any other party, including the existence, description, nature, custody, condition and location of any books, documents, or other tangible things and the identity and location of persons having knowledge of any discoverable matter. It is not ground for objection that the information sought will be inadmissible at the trial if the information sought appears reasonably calculated to lead to the discovery of admissible evidence.[180]

According to the Committee Comments on the 1973 adoption of subdivision (b), "The purpose of discovery is to allow a broad search for facts, the names of witnesses, or any other matters which may aid a

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[177] ALA. CONST. ART. I, § 10 (1901).

[178] Kirtland v. Fort Morgan Authority Sewer Service, Inc., 524 So. 2d 600, 606 (Ala.1988).

[179] ALA. CONST. ART I, § 13 (1901).

[180] ALA. R. CIV. P. 26(b)(1); *see* ALA. R. EVID. 401 (providing the definition of "relevant evidence" as "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence.").

party in the presentation of his case."[181] Rule 26 should thus be followed liberally. As the Committee Comments observes, "In simplest parlance, it was, at an early date, held that discovery cannot be defeated by a cry of 'fishing expedition.'"[182]

The 2010 amendment to Rule 26(b)(2), modeled after amendments to the corresponding federal rule, speaks to discovery of electronically stored information including electronic medical records:

> A party need not provide discovery of electronically stored information from sources that the party identifies to the requesting party as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the party from whom discovery is sought must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the court may nonetheless order discovery from such sources if the requesting party shows good cause for compelling the discovery, considering the limitations of subdivision (b)(2)(B) of this rule. The court may specify conditions for such discovery.[183]

The Committee Comments concerning this new language are instructive.

2. Federal Law

In the federal context, discovery of medical records, including new electronic records, is governed largely by Federal Rules of Civil Procedure 26 and 34. The 2006 amendment to Rule 26(b) substantially rewrote the rule. The 2015 amendment, with its emphasis upon restricting discovery to what is "proportionate" to claims and defenses, will be definitively construed in forthcoming opinions. The new Rule 26(b)(1)–(2) states:

> (b) Discovery Scope and Limits.
>
> (1) *Scope in General.* Unless otherwise limited by court order, the scope of discovery is as follows: Parties may obtain discovery regarding any nonprivileged matter that is relevant to any party's claim or defense and proportional to the needs of the case, considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. Information within this scope of discovery need not be admissible in evidence to be discoverable.

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[181] ALA. R. CIV. P. 26 advisory committee's note.

[182] *Id.*(quoting Laverett v. Continental Briar Pipe Co., 25 F. Supp. 80, 82 (D.C. N.Y. 1938)).

[183] ALA. R. CIV. P. 26(b)(2).

> (2) *Limitations on Frequency and Extent.*
>
> (A) *When Permitted.* By order, the court may alter the limits in these rules on the number of depositions and interrogatories or on the length of depositions under Rule 30. By order or local rule, the court may also limit the number of requests under Rule 36.
>
> (B) *Specific Limitations on Electronically Stored Information.* A party need not provide discovery of electronically stored information from sources that the party identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the party from whom discovery is sought must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the court may nonetheless order discovery from such sources if the requesting party shows good cause, considering the limitations of Rule 26(b)(2)(C). The court may specify conditions for the discovery.
>
> (C) *When Required.* On motion or on its own, the court must limit the frequency or extent of discovery otherwise allowed by these rules or by local rule if it determines that:
>
> (i) the discovery sought is unreasonably cumulative or duplicative, or can be obtained from some other source that is more convenient, less burdensome, or less expensive;
>
> (ii) the party seeking discovery has had ample opportunity to obtain the information by discovery in the action; or
>
> (iii) the proposed discovery is outside the scope permitted by Rule 26(b)(1).[184]

The Advisory Committee's Notes provide insight about the promulgation of the 2006 and 2015 amendments. The official notes concerning the 2006 amendment ensure medical records are discoverable even when objections based upon claims of privilege are asserted.[185] The Advisory Committee's Notes to the 2015 amendments ensure continuing discoverability of electronic records, so long as it is "proportionate" to claims or defenses.[186]

Presently, Rule 34 of the Federal Rules of Civil Procedure states:

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[184] FED. R. CIV. P. 26(b)(1).

[185] *See* FED. R. CIV. P. 26(b)(1) advisory committee's note to 2006 amendment.-*See also* Damian Vargas, *Electronic Discovery: 2006 Amendments to the Federal Rules of Civil Procedure*, 34 RUTGERS COMPUTER & TECH. L.J. 396 (2008).

[186] FED. R. CIV. P. 26(b)(1) advisory committee's note to 2015 amendment.

Rule 34. Producing Documents, Electronically Stored Information, and Tangible Things, or Entering Onto Land, for Inspection and Other Purposes

(a) In General. A party may serve on any other party a request within the scope of Rule 26(b):

(1) to produce and permit the requesting party or its representative to inspect, copy, test, or sample the following items in the responding party's possession, custody, or control:

(A) any designated documents or electronically stored information – including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations – stored in any medium from which information can be obtained either directly or, if necessary, after translation by the responding party into a reasonably usable form; or

(B) any designated tangible things; or

(2) to permit entry onto designated land or other property possessed or controlled by the responding party, so that the requesting party may inspect, measure, survey, photograph, test, or sample the property or any designated object or operation on it.

(b) Procedure.

(1) *Contents of the Request.* The request:

(A) must describe with reasonable particularity each item or category of items to be inspected;

(B) must specify a reasonable time, place, and manner for the inspection and for performing the related acts; and

(C) may specify the form or forms in which electronically stored information is to be produced.

(2) *Responses and Objections.*

(A) *Time to Respond.* The party to whom the request is directed must respond in writing within 30 days after being served or—if the request was delivered under Rule 26(d)(2)—within 30 days after the parties' first Rule 26(f) conference. A shorter or longer time may be stipulated to under Rule 29 or be ordered by the court.

(B) *Responding to Each Item.* For each item or category, the response must either state that inspection and related activities will be permitted as requested or state with specificity the grounds for objecting to the request, including the reasons. The responding party may state that it will produce copies of documents or of electronically stored information instead of permitting inspection. The production must then be completed no later than the time for inspection specified in the request or another reasonable time specified in the response.

(C) *Objections.* An objection must state whether any responsive materials are being withheld on the basis of that objection. An objection to

part of a request must specify the part and permit inspection of the rest.

(D) *Responding to a Request for Production of Electronically Stored Information.* The response may state an objection to a requested form for producing electronically stored information. If the responding party objects to a requested form—or if no form was specified in the request—the party must state the form or forms it intends to use.

(E) *Producing the Documents or Electronically Stored Information.* Unless otherwise stipulated or ordered by the court, these procedures apply to producing documents or electronically stored information:

(i) A party must produce documents as they are kept in the usual course of business or must organize and label them to correspond to the categories in the request;

(ii) If a request does not specify a form for producing electronically stored information, a party must produce it in a form or forms in which it is ordinarily maintained or in a reasonably usable form or forms; and

(iii) A party need not produce the same electronically stored information in more than one form.

(c) Nonparties. As provided in Rule 45, a nonparty may be compelled to produce documents and tangible things or to permit an inspection.

The Advisory Committee's Notes explain the intentions behind the 2006 and 2015 amendments to Rule 34.[187]

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[187] *See* FED. R. CIV. P. 34. advisory committee's note to 2006 amendment:

The addition of testing and sampling to Rule 34(a) with regard to documents and electronically stored information is not meant to create a routine right of direct access to a party's lectronic information system, although such access might be justified in some circumstances. Courts should guard against undue intrusiveness resulting from inspecting or testing such systems.

Rule 34(a)(1) is further amended to make clear that tangible things must – like documents and land sought to be examined – be designated in the request.

Subdivision (b). Rule 34(b) provides that a party must produce documents as they are kept in the usual course of business or must organize and label them to correspond with the categories in the discovery request. The production of electronically stored information should be subject to comparable requirements to protect against deliberate or inadvertent production in ways that raise unnecessary obstacles for the requesting party. Rule 34(b) is amended to ensure similar protection for electronically stored information.

The amendment to Rule 34(b) permits the requesting party to designate the form or forms in which it wants electronically stored information produced. The form of production is more important to the exchange of electronically stored information than of hard-copy materials, although a party might specify hard copy as the requested form. Specification of the desired form or forms may facilitate the orderly, efficient, and cost-effective discovery of electronically stored information. The rule recognizes that different forms of production may be appropriate for different types of electronically stored information. Using current technology, for example, a party might be called upon to produce word processing documents, e-mail messages, electronic spreadsheets, different image or sound

files, and material from databases. Requiring that such diverse types of electronically stored information all be produced in the same form could prove impossible, and even if possible could increase the cost and burdens of producing and using the information. The rule therefore provides that the requesting party may ask for different forms of production for different types of electronically stored information.

The rule does not require that the requesting party choose a form or forms of production. The requesting party may not have a preference. In some cases, the requesting party may not know what form the producing party uses to maintain its electronically stored information, although Rule 26(f)(3) is amended to call for discussion of the form of production in the parties' prediscovery conference.

The responding party also is involved in determining the form of production. In the written response to the production request that Rule 34 requires, the responding party must state the form it intends to use for producing electronically stored information if the requesting party does not specify a form or if the responding party objects to a form that the requesting party specifies. Stating the intended form before the production occurs may permit the parties to identify and seek to resolve disputes before the expense and work of the production occurs. A party that responds to a discovery request by simply producing electronically stored information in a form of its choice, without identifying that form in advance of the production in the response required by Rule 34(b), runs a risk that the requesting party can show that the produced form is not reasonably usable and that it is entitled to production of some or all of the information in an additional form. Additional time might be required to permit a responding party to assess the appropriate form or forms of production.

If the requesting party is not satisfied with the form stated by the responding party, or if the responding party has objected to the form specified by the requesting party, the parties must meet and confer under Rule 37(a)(2)(B) in an effort to resolve the matter before the requesting party can file a motion to compel. If they cannot agree and the court resolves the dispute, the court is not limited to the forms initially chosen by the requesting party, stated by the responding party, or specified in this rule for situations in which there is no court order or party agreement.

If the form of production is not specified by party agreement or court order, the responding party must produce electronically stored information either in a form or forms in which it is ordinarily maintained or in a form or forms that are reasonably usable. Rule 34(a) requires that, if necessary, a responding party "translate" information it produces into a "reasonably usable" form. Under some circumstances, the responding party may need to provide some reasonable amount of technical support, information on application software, or other reasonable assistance to enable the requesting party to use the information. The rule does not require a party to produce electronically stored information in the form it which it is ordinarily maintained, as long as it is produced in a reasonably usable form. But the option to produce in a reasonably usable form does not mean that a responding party is free to convert electronically stored information from the form in which it is ordinarily maintained to a different form that makes it more difficult or burdensome for the requesting party to use the information efficiently in the litigation. If the responding party ordinarily maintains the information it is producing in a way that makes it searchable by electronic means, the information should not be produced in a form that removes or significantly degrades this feature.

Some electronically stored information may be ordinarily maintained in a form that is not reasonably usable by any party. One example is "legacy" data that can be used only by superseded systems. The questions whether a producing party should be required to convert such information to a more usable form, or should be required to produce it at all, should be addressed under Rule 26(b)(2)(B).

Whether or not the requesting party specified the form of production, Rule 34(b) provides that the same electronically stored information ordinarily need be produced in only one form.

2015 Amendment

Several amendments are made in Rule 34, aimed at reducing the potential to impose unreasonable burdens by objections to requests to produce.

Rule 34(b)(2)(A) is amended to fit with new Rule 26(d)(2). The time to respond to a Rule 34 request delivered before the parties' Rule 26(f) conference is 30 days after the first Rule 26(f) conference.

Rule 34(b)(2)(B) is amended to require that objections to Rule 34 requests be stated with specificity. This provision adopts the language of Rule 33(b)(4), eliminating any doubt that less specific objections might be suitable under Rule 34. The specificity of the objection ties to the new provision in Rule 34(b)(2)(C) directing that an objection must state whether any responsive materials are being withheld on the basis of that objection. An objection may state that a request is overbroad, but if the objection recognizes that some part of the request is appropriate the objection should state the scope that is not overbroad. Examples would be a statement that the responding party will limit the search to documents or electronically stored information created within a given period of time prior to the events in suit, or to specified sources. When there is such an objection, the statement of what has been withheld can properly identify as matters "withheld" anything beyond the scope of the search specified in the objection.

Rule 34(b)(2)(B) is further amended to reflect the common practice of producing copies of documents or electronically stored information rather than simply permitting inspection. The response to the request must state that copies will be produced. The production must be completed either by the time for inspection specified in the request or by another reasonable time specifically identified in the response. When it is necessary to make the production in stages the response should specify the beginning and end dates of the production.

Rule 34(b)(2)(C) is amended to provide that an objection to a Rule 34 request must state whether anything is being withheld on the basis of the objection. This amendment should end the confusion that frequently arises when a producing party states several objections and still produces information, leaving the requesting party uncertain whether any relevant and responsive information has been withheld on the basis of the objections. The producing party does not need to provide a detailed description or log of all documents withheld, but does need to alert other parties to the fact that documents have been withheld and thereby facilitate an informed discussion of the objection. An objection that states the limits that have controlled the search for responsive and relevant materials qualifies as a statement that the materials have been "withheld."

IV. ADMISSIBILITY

A. State Law

The State of Alabama appears to consider hospital records presumptively trustworthy. This is shown by the legislature's codification of a statutory procedure allowing the introduction of certified copies of original hospital records without requiring attorneys to call to trial or depose the records' custodian or physician to authenticate and/or establish a foundation for their introduction. Alabama Code Sections 12-21-5 through 12-21-7 provide a practical procedure whereby copies of a patient's medical records may be admitted in court proceedings without the unnecessary expense and delay in calling the custodian to lay a foundation or predicate for admissibility:

> **§ 12-21-5. Copy of hospital records—Admissibility.**
>
> When the original would be admissible in any case or proceeding in a court in the state, a certified copy of the hospital records of any hospital organized or operated under or pursuant to the laws of Alabama, including records of admission, medical, hospital, occupational, disease, injury and disability histories, temperature and other charts, X rays and written interpretations thereof, pictures, photographs, files, written orders, directions, findings and reports and interpretations of physicians, doctors, surgeons, pathologists, radiologists, specialists, dentists, technicians and nurses, as well as of all employees of such hospital, forming a part of such hospital records as to the health, condition, state, injuries, sickness, disease, mental, physical and nervous disorders, duration and character of disabilities, diagnosis, prognosis, progress, wounds, cuts, contusions, lacerations, breaks, loss of blood, incisions, operations, injuries, examinations, tests, transfusions, hospitalization and duration thereof, medication, medicines, supplies, treatment and care and the cost, expenses, fees and charges therefor and thereof, a part of, or shown on or in, said hospital records of any patient in said hospital, when certified and affirmed by the custodian of said hospital records as provided in Section 12-21-7, shall be admissible in evidence, without further proof in any court in the state where admissible, if and when said hospital records were made and kept in the usual and regular course of business of said hospital and it was in the regular course of business of said hospital to make and keep said records and that said records were made at the time of such acts, transactions, occurrences or events therein referred to occurred or arose or were made, or within a reasonable time thereafter.
>
> **§ 12-21-6. Copy of hospital records—Subpoena duces tecum; inspection form; weight.**
>
> (a) A certified copy of said hospital records may be procured by any litigant in any court of competent jurisdiction in the state by subpoena duces tecum, and when any such subpoena duces tecum is issued for

said hospital records, the custodian of said hospital records shall prepare a copy of said hospital records as provided in this subsection and securely seal the same in an envelope or other container and date and fill out and sign a certificate in substantially the form provided in Section 12-21-7 and place on, or securely fasten said certificate to the outside of, said envelope or container in which said copy of said hospital records are placed and deliver the same to the clerk or register of the court hearing, or to hear or to try, the case or proceeding in which the records are sought, and he shall not otherwise be required to appear in court unless thereafter ordered to do so by the court. The copy of the hospital records shall not be open to inspection or copy by other persons than the parties to the case or proceeding and their attorneys until ordered published by the court trying the case at the time of the trial. When so prepared and certified, the copy of said hospital records shall be admissible in evidence in any court in the state, if and when admissible, in prima facie proof of the facts therein shown just as if otherwise verified and just as if the copy were the original. The copy of the hospital records may be photostated, photographed or made by microphotographic plate or film, or otherwise made, so long as clear and easily legible. All the circumstances of the making of such hospital records, including lack of personal knowledge of the entrant or maker of such hospital records, may otherwise be shown to affect the weight of such hospital records, but this shall not affect their admissibility.

§ 12-21-7. Copy of hospital records—Certificate of custodian.

The certificate of the custodian of the hospital records provided for in Sections 12-21-5 and 12-21-6 shall show the name of the parties to the case or proceeding and the name of the court to which made, by appropriate caption, and said certificate shall be in form in substance as follows, to-wit:

> I, _, hereby certify and affirm in writing that I am _____of the_____Hospital, a hospital organized or operated pursuant to or under the laws of Alabama, located at_____, Alabama, that I am custodian of the hospital records of said hospital and that the within copy of said hospital records are an exact, full, true and correct copy of said hospital records pertaining to _____.
>
> I further certify that I am familiar with and know, and knew when made and charged, the reasonable value and price for the various charges made and shown in said hospital records pertaining to _____and that said charges are in my judgment just, reasonable and proper and in keeping with those generally charged in the county and community where said hospital is located.
>
> All of which I hereby certify and affirm on this day of _____, 20 _.

In practical terms, once the hospital custodian receives a subpoena

duces tecum, the custodian must copy the patient's medical records as provided in sections 12-21-6 and 12-21-7 and must forward the certified medical records to the court's clerk for admission at trial. Once submitted to the court under this statutory procedure, the records are considered self-authenticating business records. Specifically, medical records come within an exception to the hearsay rule as business records under Alabama Rule of Evidence 803(6). Additionally, they often contain statements for purposes of medical diagnosis and treatment, which allows their admission under Rule 803(4). Such records also come within the omnibus provision of Rule 901(b)(10), which allows for authentication by any means provided by statute or other rules prescribed by the Alabama Supreme Court; this could include Rule 902(11), under which such records are self-authenticating as certified domestic records of a regularly conducted activity.

In *Jackson v. Brown*, the Alabama Court of Civil Appeals held that the custodian's certificate, including the language quoted from section 12-21-7, "was evidence of the reasonableness of the hospital charges, which charges thus were properly before the jury for their consideration as elements of damages."[188]

B. Federal Law

The Federal Rules of Evidence allow electronic medical records to be admitted over a hearsay objection if two conditions are satisfied: (1) the record is made "in the course of a regularly conducted activity of a business" and (2) it is "regular practice" to create such a record.[189] Additionally, such records must be authenticated before they may properly be admitted.[190]

V. EXCEPTIONS TO DISCOVERABILITY AND ADMISSIBILITY

A. Quality Assurance, Peer Review, and Utilization Review Committee Statutes

Healthcare providers often object to the discoverability and admissibility of medical records and assert claims of privileges premised upon Alabama's so-called quality assurance, peer review, and utilization review committee statutes. Close evaluation of the plain language of the governing statutes provides clear insight into how the statutes

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[188] 268 So.2d 837, 841 (Ala. Civ. App. 1972).

[189] FED. R. EVID. 803(6); *see also* FED. R. CIV. P. 34(b)(2)(E)(i) ("A party must produce documents as they are kept in the usual course of business or must organize and label them to correspond to the categories in the request.").

[190] FED. R. EVID. 901(a).

should be construed. Further, state and federal reported opinions from Alabama and elsewhere help explain what is legislatively intended through their promulgation.

1. Quality Assurance

Section 22-21-8 of the Alabama Code covers confidentiality of accreditation and quality assurance credentialing materials. It states:

> (a) Accreditation, quality assurance and similar materials as used in this section shall include written reports, records, correspondence, and materials concerning the accreditation or quality assurance or similar function of any hospital, clinic, or medical staff. The confidentiality established by this section shall apply to materials prepared by an employee, advisor, or consultant of a hospital, clinic, or medical staff and to materials prepared by an employee, advisor or consultant of an accrediting, quality assurance or similar agency or similar body and to any individual who is an employee, advisor or consultant of a hospital, clinic, medical staff or accrediting, quality assurance or similar agency or body.
>
> (b) All accreditation, quality assurance credentialing and similar materials shall be held in confidence and shall not be subject to discovery or introduction in evidence in any civil action against a health care professional or institution arising out of matters which are the subject of evaluation and review for accreditation, quality assurance and similar functions, purposes, or activities. No person involved in preparation, evaluation or review of accreditation, quality assurance or similar materials shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the course of preparation, evaluation, or review of such materials or as to any finding, recommendation, evaluation, opinion, or other action of such accreditation, quality assurance or similar function or other person involved therein. Information, documents, or records otherwise available from original sources are not to be construed as being unavailable for discovery or for use in any civil action merely because they were presented or used in preparation of accreditation, quality assurance or similar materials nor should any person involved in preparation, evaluation, or review of such materials be prevented from testifying as to matters within his knowledge, but the witness testifying should not be asked about any opinions or data given by him in preparation, evaluation, or review of accreditation, quality assurance or similar materials.[191]

a. Definitions of the Terms in Section 22-21-8

Alabama's statute refers to "accreditation materials," "quality assurance credentialing materials," "accreditation function" and "quality

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[191] ALA. CODE § 22-21-8 (2015).

assurance function," "an employee, adviser, or consultant of an accrediting agency or body," and "an employee, advisor or consultant of a quality assurance agency or body." What do these words and phrases mean? "Accreditation" is defined as "the act or process of accrediting," while "accredit" is defined as "to give official authorization to or approval of . . . to vouch for officially: recognize or clear officially as bona fide, approved, or in conformity with a standard."[192] As an adjective, "credential" is defined as "warranting credit or confidence—used chiefly in the phrase *credential letters*."[193] As a noun, a "credential" is "something that gives a title to credit or confidence."[194] Thus, "accreditation" is to give official approval of, and "credentialing" is to give a title or a claim—a credential—to credit or confidence. An accrediting agency or body is therefore one that can give official approval, and a credentialing agency or body is one that can give a title or a claim to credit or confidence, i.e., can issue a credential. What then must a quality assurance credentialing agency or body be?

"Quality" has many definitions, but the ones best fitting the phrase "quality assurance" in section 22-21-8 are "degree of excellence" and "degree of conformance to a standard (as of a product or workmanship)."[195] "Assurance" includes "something that inspires or tends to inspire confidence," "being certain in the mind," and "security."[196] "To assure" is "to make safe (as from risks or against overthrow): insure," "to give confidence to," "to inform positively," and, perhaps most applicable here, "to make certain the coming or attainment of: guarantee."[197]

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[192] *Accredit*, MERRIAM-WEBSTER DICTIONARY (2017), https://www.merriam-webster.com/dictionary/accredit. "Accreditation materials" and "similar materials" are also exempted, but "similar materials" must be "of the same nature or class as those named in the specific list." *Ex parte* Mitchell, 989 So. 2d 1083, 1091 (Ala. 2008) (stating the rule of *ejusdem generis*); *Ex parte* Emerald Mountain Expressway Bridge, L.L.C., 856 So. 2d 834, 842–43; *Ex parte* Fairfield Nursing & Rehab. Ctr., LLC., 22 So. 3d 445, 456, n.6 (Murdock, J., dissenting). Thus, for example, peer review proceedings to grant or retain a physician's staff privileges are in the nature of credentialing the physician. A hospital's ordinary personnel files, its bylaws, and its rules and regulations are not prepared for presentation to an accreditation agency or a credentialing body and so are outside the scope of section 22-21-8.

[193] *Credential,* MERRIAM-WEBSTER DICTIONARY (2017), https://www.merriam-webster.com/dictionary/credential.

[194] *Id.*

[195] *Quality,* MERRIAM-WEBSTER DICTIONARY (2017), https://www.merriam-webster.com/dictionary/quality.

[196] *Assurance,* MERRIAM-WEBSTER DICTIONARY (2017), https://www.merriam-webster.com/dictionary/assurance.

[197] *Assure,* MERRIAM-WEBSTER DICTIONARY (2017), https://www.merriam-webster.com/dictionary/assure.

"Quality assurance credentialing" by a regulatory body would therefore be to grant a credential, a "title or claim," indicating the recipient has attained a degree of excellence or conformance to a standard.

This close examination of section 22-21-8's provisions reveals two legislative goals: first, the legislature obviously intended a narrow application of the phrase "quality assurance" to a "function" that involves presentation of materials to a "quality assurance or similar agency or similar body" for "evaluation and review" by that body for the sake of determining whether to issue a credential. Second, only "evaluation and review" by an accreditation or credentialing body, or preparation of materials to present to such a body for evaluation or review, are the functions intended to be protected from discovery or admissibility. These legal conclusions are confirmed in the fifth sentence of Section 22-21-8, which expressly excepts documents available from original sources and testimony by persons regarding their own knowledge.

b. Construction and Application of Section 22-21-8

The Alabama Supreme Court construed Section 22-21-8 in *Ex parte Krothapalli*.[198] The Court explained:

> Section 22-21-8 was enacted as Act No. 81-801, Ala. Acts 1981. The title to that Act reads: To provide for the confidentiality of all written materials and activities concerning the accreditation, quality assurance, or similar function of any hospital, clinic, or medical staff . . . It seems clear to us . . . that the purpose of a peer-review statute is to encourage full candor in peer-review proceedings and that this policy is advanced only if all documents considered by the committee or board during the peer-review or credentialing process are protected.[199]

In *Ex parte Anderson*, the Court explained: "Section 22-21-8 . . . provides that . . . information and documents produced by hospitals, their agencies, or bodies, in furtherance of their official duties and activities in regard to the peer-review process are not discoverable."[200]

In *Ex parte Cryer*, the Court held that the phrase "medical staff" in section 22-21-8 does not extend to the activities of physicians within their own associations or corporations.[201] The Court asked: "Did the Legislature intend for the shareholder physicians of a private corporation to qualify as a 'medical staff' under the provisions of § 22-21-

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[198] 762 So. 2d 836 (Ala. 2000).

[199] *Id.* at 839; *see also*, *Ex parte* Fairfield Nursing and Rehab. Ctr., LLC, 22 So. 3d 445 (Ala. 2009).

[200] 789 So. 2d 190, 202 (Ala. 2000).

[201] 814 So. 2d 239, 245 (Ala. 2001).

8?"[202] In answering this question, the Court concluded "the Legislature intended only to provide for the confidentiality of all written materials and activities concerning hospitals and clinics, not private associations or corporations or individual physicians."[203]

In *Ex parte St. Vincent's Hospital*, the Court observed that standing hospital committees, such as the Infection Control Committee, are not covered under section 22-22-8 if they do not function as accreditation or quality assurance committees.[204]

Insight may also be gleaned from how courts in other states treat comparable statutes. For example, *Atkins v. Pottstown Memorial Medical Center* held an incident report of a patient's fall before surgery at a hospital prepared by the hospital's risk manager was admissible over a claim of quality assurance and peer review privileges.[205]

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[202] *Id.* at 244.

[203] *Id.* at 245.

[204] 652 So.2d 225, 230 (Ala.1994).

[205] 634 A.2d 258 (Pa. Super. Ct. 1993); *see* Julius W. Cohn, David C. Start, *Medical Malpractice–Use of Hospital Records*, 22 AM. JUR. 2D PROOF OF FACTS 1, § 10.3 (1980) (Supp. 2016) (cataloguing cases); *see also* William D. Bremer, *Scope and Extent of Protection from Disclosure of Medical Peer Review Proceedings Relating to Claim in Medical Malpractice Action,* 69 A.L.R. 5th 559 (1999). The introduction shows that such statutes apply to matters presented to, evaluated by, and reviewed by medical review committees:

> Many states have enacted peer review statutes protecting medical review committee proceedings from disclosure, in order to foster frank evaluations and discussion and to ultimately improve health care. In a number of medical malpractice cases, courts have been called upon to determine the scope and extent of protection of these statutes as to peer review proceedings relating to the underlying action. For example, in Chicago Trust Co. v. Cook County Hosp., 298 Ill. App. 3d 396, 232 Ill. Dec. 550, 698 N.E.2d 641, 69 A.L.R. 5th 771 (1st Dist. 1998), a medical malpractice/products liability action brought on behalf of the estate of a hospital patient, the court held that, although the applicable peer review statute protected against disclosure of the mechanisms of the peer review process, including information gathering and deliberations leading to the ultimate decision rendered by a hospital peer review committee, the statute did not protect against the discovery of information generated before the peer review process began, nor did the statute protect against disclosure of the peer review committee's recommendations after completion of the peer review process. This annotation collects and analyzes medical malpractice cases dealing with the scope and extent of statutes providing protection as to peer review proceedings relating to the underlying action.

69 A.L.R. at 559. This national survey of the law demonstrates that legislatures and courts in other states treat as confidential only matters specifically prepared for evaluation and review committees. For example, summarizing *Columbia/HCA Healthcare Corp. v. Eighth Judicial Dist. Court in and for County of Clark*, 936 P.2d 844 (1997), the annotation states: "The court reasoned that allowing the peer review statute to become an impenetrable bulwark of damaging factual information would defeat the purpose of the evidence code of which the privilege is a part, i.e., to secure fairness in administration to the end that truth

2. Peer Review

Section 6-5-333 of the Alabama Code addresses dentists, chiropractors, and physicians serving on professional committees. It states:

> (a) Any dentist, chiropractor, or physician licensed to practice medicine in Alabama who serves on a peer review or a utilization and quality control committee or professional standards review committee or a similar committee or a committee of similar purpose or any dentist, physician, chiropractor, or individual who serves as a consultant or employee to one of said committees established either by a dental society or dental association or by a chiropractic society or chiropractic association or by a state medical association or county medical society to review any aspect of dental care, chiropractic care, or medical care at the request of a government agency, a patient, dentist, provider of dental benefits, chiropractor, provider of chiropractic benefits, physician licensed to practice medicine in Alabama, or third party insurer shall not be liable to any person for damages as a result of any action taken or recommendation made by him within the scope of his function as a member of or employee or consultant to such review committee if such action was taken or recommendation made without malice and in a reasonable belief that such action or recommendation is warranted by the facts made known to him. No dental association or dental society, chiropractic association or chiropractic society, or state medical association or county medical society shall be liable for damages for any action taken or recommendation made by a review committee or any member of said committee or consultants or employees to said committee.
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> (b) Within the words and meaning of this section, a "committee" shall mean members of a committee of dentists, chiropractors, or physicians licensed to practice medicine in Alabama formed or appointed to evaluate the diagnosis or the performance of services of other dentists or dental auxiliary personnel, chiropractors or chiropractic auxiliary personnel or physicians licensed to practice medicine in Alabama or physician auxiliary personnel when such evaluation is requested by a government agency, by the fiscal intermediary responsible for the administration of group health care programs, by the recipient of dental, chiropractic, or medical services, or by a dentist, chiropractor, or physician licensed to practice medicine in Alabama.
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> (c) The provider or recipient of dental services evaluated by a review committee described in subsections (a) and (b) of this section shall have the right to appeal the decisions of said review committee to the Alabama Dental Association. No provider of dental care services or recipient of same or fiscal intermediary or government agency shall be bound by a ruling of a review committee established pursuant to this

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may be ascertained and proceedings justly determined."
69 A.L.R. at 597–98.

> section on a controversy, dispute, or question unless he agrees in advance either specifically or generally to be bound by the ruling.
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> (d) All information, interviews, reports, statements, or memoranda furnished to any committee as defined in this section, and any findings, conclusions, or recommendations resulting from the proceedings of such committee are declared to be privileged. The records and proceedings of any such committees shall be confidential and shall be used by such committee and the members thereof only in the exercise of the proper functions of the committee and shall not be public records nor be available for court subpoena or for discovery proceedings. Nothing contained herein shall apply to records made in the regular course of business by a hospital, dentist, dental auxiliary personnel, chiropractor, chiropractic auxiliary personnel, physician, physician auxiliary personnel, or other provider of health care and information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any civil proceedings merely because they were presented during proceedings of such committee.[206]

a. Definition of the Terms in Section 6-5-333

Section 6-5-333(d) applies, by its express terms, to "information, interviews, reports, statements, or memoranda furnished to any committee as defined in this section." Of course, section 6-5-333(b) defines the meaning of "committee." Section 6-5-333(d)'s privilege also applies to "any findings, conclusions, or recommendations resulting from the proceedings of such committee[s]" as defined by section 6-5-333(b). Thus, this statute privileges information provided to committees and findings, conclusions, and recommendations from such committees of designated licensed Alabama healthcare providers formed or appointed to evaluate the diagnosis or performance of services of the other designated Alabama healthcare providers.

b. Construction and Application of Section 6-5-333

In *Ex parte Anderson*, the Alabama Supreme Court stated: "This provision mandates that information gathered or formulated within the scope of business conducted by such [peer review] committees is privileged from external review."[207]

In *Ex parte Mendel*, the court held the Alabama Dental Review Board constituted a "committee" for the purpose of protecting its proceedings with the privilege afforded by Section 6-5-333.[208]

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[206] ALA. CODE § 6-5-333 (2014).

[207] *Ex parte Anderson*, 789 So. 2d at 202.

[208] 942 So. 2d 829 (Ala. 2006). This is so even though the state Alabama Administrative Procedures Act requires that public agencies like the Dental Board must make all final

National commentators stress that such statutory peer review privileges are intended to be limited in scope:

> The peer review privilege was enacted to prohibit discovery of records of internal proceedings where one member of the healthcare profession presents evidence of negligence or incompetence against another. The purpose of the peer review privilege is to promote candor and foster aggressive critiquing of medical care by the provider's peers and to encourage healthcare professionals to monitor the competence and professional conduct of their peers in order to safeguard and approve the quality of patient care. But the privilege does not extend so far as to permit the concealment of routinely accumulated information. The peer review privilege must not be permitted to become a shield behind which a physician's incompetence, impairment, or institutional malfeasance resulting in medical malpractice can be hidden.[209]

3. Utilization Review

Section 34-24-58 of the Alabama Code governs the admissibility of decisions, opinions and other actions of utilization review committees. It states:

> (a)The decisions, opinions, actions and proceedings rendered, entered or acted upon in good faith and without malice and on the basis of facts reasonably known or reasonably believed to exist of any committee of physicians or surgeons, acting as a committee of the Medical Association of the State of Alabama, or any state, county or municipal medical association or society, or as a committee of any licensed hospital or clinic, or the medical staff thereof, undertaken or performed within the scope and function of such committee as legally defined herein shall be privileged, and no member thereof shall be liable for such decision, opinion, action or proceeding.
>
> (b)Within the words and meaning of this section, a committee shall include one formed or appointed as a utilization review committee, or similar committee, or committee of similar purpose, to evaluate or review the diagnosis or treatment or the performance of medical services which are performed with respect to private patients or under public medical programs of either state or federal design, with respect to any physical or mental disease, injury or ailment or to define, maintain or apply the professional or medical standards of the association, society, hospital, clinic or medical staff from, by or for which it was appointed.[210]

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orders, decisions, and opinions available for public inspection and copying (except those expressly made confidential or privileged by statute or order of court). However, the supreme court nevertheless held that § 6-5-333(d) made confidential and privileged any Dental Review Board materials that would constitute final orders. *Id.*

[209] 81 AM. JUR. 2d WITNESSES, § 502 (2015).

[210] ALA. CODE § 34-24-58 (2010).

a. Definition, Construction, and Application of the Terms in Section 34-24-58

Unlike Sections 22-21-8 and 6-5-333(d), Section 34-24-58 does not contain any provision rendering information, documents, or medical records provided to or considered by utilization review committees privileged or confidential.

b. Construction and Application of Section 34-24-58

Section 34-24-58 was construed in *Ex parte St. Vincent's Hospital*, in which the court wrote: "The discovery sought by Zeneca is not privileged under . . . § 34-24-58. The Infection Control Committee is a standing hospital committee, coordinated by . . . a registered nurse. . . . St. Vincent's has produced no evidence that the Infection Control Committee served as a utilization review committee . . . ."[211] More recently, former Alabama Supreme Court Chief Justice Roy Moore described the statute in his dissenting opinion in *Lindsay v. Baptist Health System, Inc.*:

> Section 34-24-58, Ala. Code 1975, protects from legal action the acts of any physicians' committee of a licensed hospital, but only if the committee's decisions were made in good faith and without malice and on the basis of facts reasonably known or reasonably believed to exist. . . . The qualified immunity, however, is not absolute. In a majority of cases immunity only applies when the investigation is conducted in good faith, without malice, and based upon the reasonable belief that the committee's action is warranted.[212]

4. Medical Records are Discoverable from Original Sources even when Privileged by Sections 22-21-8, 6-5-333(d), or 34-24-58.

Alabama's legislature expressly provided that medical evidence used or considered by accreditation, peer review, and quality assurance committees are discoverable and admissible when obtained from sources other than such committees. Section 22-21-8(b) specifies:

> Information, documents or records otherwise available from original sources are not to be construed as being unavailable for discovery or for use in any civil action merely because they were presented or used in preparation of accreditation, quality assurance or similar materials, nor should any person involved in preparation, evaluation, or review of such materials be prevented from testifying as to matters within his knowledge, but the witness testifying should not be asked about any

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[211] 652 So. 2d 225, 230 (Ala. 1994).

[212] 154 So. 3d 90, 92 (Ala. 2014) (Moore, C.J., dissenting) (internal quotation marks omitted) (quoting George E. Newton, II, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 723, 730 (2001)).

> opinions or data given by him in preparation, evaluation, or review of accreditation, quality assurance or similar materials.

Likewise, Section 6-5-333(d) states:

> All information, interviews, reports, statements, or memoranda furnished to any committee as defined in this section, and any findings, conclusions, or recommendations resulting from the proceedings of such committee are declared to be privileged. The records and proceedings of any such committee shall be confidential and shall be used by such committee and the members thereof only in the exercise of proper functions of the committee and shall not be public records nor be available for court subpoena or for discovery proceedings. Nothing contained herein shall apply to records made in the regular course of business by a hospital, dentist, dental auxiliary personnel, chiropractor, chiropractic auxiliary personnel, physician, physician auxiliary personnel, or other provider of health care and information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any civil proceedings merely because they were presented during proceedings of such committee.

Section 34-24-58, by contrast, contains no provision shielding information, documents, or medical records used or considered by utilization review committees with any privilege or confidentiality.[213]

In *Ex parte Krothapalli*, the Court construed Section 22-21-8(b) to provide documents obtainable from original sources are indeed discoverable and admissible as evidence at trial: "Accordingly, § 22-21-8 does not protect information if it is obtained from alternative sources. Hence, a plaintiff seeking discovery cannot obtain directly from a hospital review committee documents that are available from the original source, but may seek such documents from the original source."[214] This language was quoted favorably in *Ex parte Qureshi*: "Neither our decision in *Krothapalli* nor our holding here today prevents [the plaintiff] from obtaining documents that originated from sources other than [the hospital's] credentialing committee."[215] The court expressly adopted the reasoning of the Arizona Court of Appeals in *Humana Hospital Desert Valley v. Superior Court*, which recognized, in pertinent part, that: "[I]nformation which is available from original sources is not immune from discovery or use at trial merely because it was used by a medical review committee."[216]

In *Ex parte Anderson*, the court likewise held:

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[213] ALA. CODE § 34-24-58 (2010).

[214] *Ex parte Krothapalli*, 762 So. 2d at 839.

[215] 768 So. 2d 374, 380 (Ala. 2000).

[216] *Id.*at 379 (quoting *Humana Hosp. Desert Valley*, 742 P.2d at 1386).

> [D]iscovery of information regarding Dr. Anderson's privileges is barred by § 6-5-333(d). . . . However, records made in the regular course of business, exclusive of official committee functions, and otherwise available from their original sources are discoverable and not privileged. Thus, [the plaintiff] is not entitled to discover records or documents prepared by a hospital or other health-care provider unless they were prepared in its regular course of business; however, she is not precluded from seeking the same from Dr. Anderson as the original source.[217]

The *Anderson* court rejected Dr. Anderson's argument. He averred:

> [T]hat the statutory framework . . . serves to absolutely insulate him, his documents, and other information concerning the Trotter case, whether obtained from him personally, from the hospital, or from other committees. We do not completely agree. His contention regarding the material gathered from the hospital or review committees is correct; documents from those sources generated pursuant to hospital or committee business [are] absolutely not discoverable. . . . However, the information and documents that specifically concern the Trotter incident and that may be obtained from Dr. Anderson himself as an "original source" are discoverable.[218]

Therefore, even though documents, information, or medical records may have been used by a peer review or quality assurance committee, that fact does not on its own exempt the materials from discovery or from use at trial.

5. The Party Opposing Discovery Bears the Burden of Proving Privilege and Prejudice

Alabama Rule of Evidence 501 provides in full:

> Except as otherwise provided by the Constitution or statute or by these or other rules promulgated by the Supreme Court of Alabama, no person has a privilege to:
>
> (1)refuse to be a witness;
>
> (2)refuse to disclose any matter;

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[217] *Ex parte Anderson*, 789 So. 2d at 199.

[218] *Id.* at 203 (citations omitted; emphasis added). The court arguably got off track in *Ex parte Fairfield Nursing*, stating: "The language of § 22-21-8 does not require that a quality-assurance 'committee' exist, nor does it limit the privilege to materials created solely *at the direction of* such a committee." *Ex parte Fairfield Nursing*, 22 So. 3d at 452 (emphasis in original). As shown above, section 22-21-8 does require that the materials in question have been prepared for, produced to, or presented to an agency or body with an accreditation or quality assurance credentialing function. Although the *Ex parte Fairfield Nursing* court correctly noted that the word "committee" does not appear in section 22-21-8, it failed to take into consideration that section 22-21-8 pertains only to materials prepared for, produced to, or presented to an accrediting or credentialing "agency or body." *Id.*

> (3)refuse to produce any object or writing; or
>
> (4)prevent another from being a witness or disclosing any matter or producing any object or writing.

All privileges are to be strictly construed. "[E]xceptions to the demand for every man's evidence are not lightly created nor expansively construed."[219] The public has the right "to every man's evidence, and exemptions from the general duty to give testimony that one is capable of giving are distinctly exceptional."[220]

In *Ex parte Fairfield Nursing*, the Alabama Supreme Court reaffirmed the principle that a party asserting a privilege as a reason for withholding documents sought in discovery has the burden of proving both its existence and the prejudice that would be caused by their production.[221] In that case, Fairfield offered affidavits of the executive director of its facility and of the former director of nursing at the facility. Based upon that *unopposed* evidentiary showing, the supreme court sustained a finding of privilege: "We agree with Fairfield that the evidence presented in the affidavits submitted in support of the assertion of the privilege is substantially similar to the evidence presented in the affidavits in *Kingsley* [*v. Sachitano*] and *Ex parte Qureshi*."[222]

An "affidavit must be made on personal knowledge, must set forth facts that would be admissible in evidence, and must show affirmatively that the affiant is competent to testify to the matters stated."[223] "Where it appears from the face of an affidavit that the affiant had no personal knowledge of the matters to which he deposed and that he must have secured his information concerning those matters from others, then the affidavit is based on hearsay and should not be admitted."[224]

6. Privileges May Be Waived

Alabama Rule of Evidence 510, which covers waiver of privilege by voluntary disclosure, provides:

> A person upon whom these rules confer a privilege against disclosure waives the privilege if the person or the person's predecessor while holder of the privilege voluntarily discloses or consents to disclosure

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[219] United States v. Nixon, 418 U.S. 683, 710 (1974).

[220] Garner v. Wolfinbarger, 430 F.2d 1093, 1100 (5th Cir. 1970).

[221] Ex parte Coosa Valley Health Care, Inc., 789 So. 2d 208 (Ala. 2000) (reaffirming principle that party asserting the privilege under § 22-21-8 has the burden of proving the existence of the privilege and the prejudicial effect of disclosing the information).

[222] *Ex parte Fairfield Nursing*, 22 So. 3d at 450.

[223] Sanders v. Smitherman, 776 So. 2d 68, 72 (Ala. 2000) (citation omitted).

[224] Home Bank of Guntersville v. Perpetual Federal Sav. & Loan Ass'n, 547 So. 2d 840, 841 (Ala. 1989) (quoting Williams v. Dan River Mills, Inc., 246 So. 2d 431 (1971)).

> of any significant part of the privileged matter. This rule does not apply if the disclosure itself is privileged.

Professor Charles W. Gamble's "Author's Statement of the Rule" explains: "Even after a privilege attaches, its protection may be waived by the holder or a predecessor holder. Waiver customarily arises through the holder's disclosure, or consenting to disclosure, of the privileged matter to a third party."[225]

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[225] CHARLES W. GAMBLE, GAMBLE'S ALABAMA RULES OF EVIDENCE: A TRIAL MANUAL FOR MAKING AND ANSWERING OBJECTIONS § 510 (1995).