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NORTH CAROLINA LAW REVIEW

Volume 54 | Number 2

Article 2

1-1-1976

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Recommended Citation

James J. Gobert, *Accommodating Patient Rights and Computerized Mental Health Systems*, 54 N.C. L. REV. 153 (1976).

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ACCOMMODATING PATIENT RIGHTS AND COMPUTERIZED MENTAL HEALTH SYSTEMS

JAMES J. GOBERT†

I. INTRODUCTION

It is difficult to be ambivalent about computers. Their proponents predict a technological era in which machines accomplish in seconds what would take a man months to do. A greater assumption of work by computers will be accompanied by a concomitant increase in the time available for leisure activities or other work-related endeavors. Computers also make possible tasks too complex for manual achievement. The compilation, recordation, comparison, and analysis of vast amounts of information can be efficiently accomplished only with the assistance of computer technology. Sophisticated retrieval systems render computer-stored data instantaneously available to administrators.

However, this capacity to collect and retrieve virtually unlimited amounts of data portends a negative side to the computer coin. The danger is that centralization of vast quantities of personal information, and its resulting potential availability to government officials, employers, police departments, credit companies, and countless others for both legitimate and illegitimate purposes, threaten to make privacy obsolete. The term dossier is distasteful to Americans. Yet today's computer data banks are tomorrow's dossiers. The transformation requires only unscrupulous leaders willing to utilize computerized personal data for self-serving ends. The unfortunate experience of ex-President Nixon's attempt to harness supposedly confidential internal revenue records for use against political "enemies" indicates that this threat is not a Cassandra-like complaint. While the danger of dossiers has always existed, the efficiencies of computerization and the economic realities of computer use (the more they are used, the cheaper they are to use) combine to encourage data collection on a far wider scale than has been contemplated previously. Even if the collected data are never misused, the paranoia engendered by the possibility threatens the mental health of many Americans.

Analyses of the pros and cons of computerization have been un-

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dertaken elsewhere,¹ and it is not the author's intent to reexamine the subject in general. Rather, the purpose is to focus on the merits and dangers of computer systems in the mental health field. Here, there are unique benefits that can accrue to states, professional personnel, and patients from centralized computer recording systems.² But the potential dangers are magnified because of the highly stigmatic nature of the data collected.

Lest anyone doubt the accuracy of the preceding statement, or question whether mental health information would ever be sought by unauthorized individuals, recent history provides some sobering examples. In 1972 Thomas Eagleton was the Democratic Party's nominee for Vice-President of the United States. He was forced off the ticket largely by revelations that he had at certain periods in his life sought psychiatric help. No matter how much one decries the imputation of continued mental instability to persons who have successfully completed therapy, Eagleton's experience indicates that the fact of having sought the services of a psychiatrist may be a serious political handicap.

If the Eagleton example illustrates the stigmatic nature of mental health data, the Daniel Ellsberg case indicates the length to which political opponents will go to uncover such information. Ellsberg had, without authorization, released the so-called Pentagon Papers to the *New York Times*, which had in turn published them. To discredit Ellsberg, high government officials authorized a break-in of his psychiatrist's office, presumably to obtain his psychiatric records. The need for such overt criminal activity would no doubt have been obviated had the information been accessible through a check of government computer files, and the likelihood of this invasion of privacy being discovered would have correspondingly diminished.³

Thus there are dangers in increasing the potential availability of

1. See, e.g., *COMPUTERS AND THE LAW* (2d ed. R. Bigelow 1969); HEW, *REPORT OF THE SECRETARY'S ADVISORY COMMITTEE ON AUTOMATED PERSONAL DATA SYSTEMS* (1973) [hereinafter cited as *REPORT*]; A. MILLER, *THE ASSAULT ON PRIVACY* (1971); Michael, *Speculations on the Relation of the Computer to Individual Freedom and the Right to Privacy*, 33 *GEO. WASH. L. REV.* 270 (1964); Miller, *Personal Privacy in the Computer Age: The Challenge of a New Technology in an Information-Oriented Society*, 67 *MICH. L. REV.* 1091 (1969); *Symposium: Computers, Data Banks and Individual Privacy*, 53 *MINN. L. REV.* 211 (1969); *Project, The Computerization of Government Files: What Impact on the Individual?*, 15 *U.C.L.A.L. REV.* 1371 (1968).

2. See discussion in Section II *infra*.

3. It is often exceedingly difficult to discover a computer-related crime. If one with legitimate access to computer files makes an unauthorized copy of a file, the fact that the copy was made might never come to light. See generally Porter, *Computer Raped by Telephone*, *N.Y. Times*, Sept. 8, 1974, § 6 (Magazine), at 32.

mental health information. Yet there are distinct advantages to computerization that may not otherwise be duplicable. It is therefore necessary to balance the benefits of centralized computerization against its costs, taking into account the safeguards available for minimizing the dangers involved. In conducting this inquiry, numerous complex legal issues arise. Yet case law is scanty.

It should be noted at the outset that many of the dangers of a centralized mental health computer system stem from the centralization and not from the computerization. As a practical matter, however, the two are necessarily interrelated, for without computerization, centralization is not feasible because of the difficulty of otherwise finding adequate storage space for the voluminous records that would be amassed; and without centralization, computerization is not economical, because computers are far too expensive for limited use, such as by a single mental health facility.⁴

It should also be observed that centralized mental health computer systems are not hypothetical entities. Such data systems already exist and are becoming increasingly commonplace.⁵ In 1967 the National Institute for Mental Health authorized grants for the development of a Multi-State Information System for Psychiatric Records (MSIS).⁶ By 1974 over a half dozen states were involved in the MSIS Program.⁷ Each participating facility uses specially designed forms to collect information about the patient, his problem, the prognosis, the treatment prescribed, the services rendered, and the progress toward recovery.⁸ This data is centrally stored in computer files, access to which is generally limited to the facility supplying the data. While MSIS is currently the most prevalent centralized mental health computer system, the analysis in this article will not be limited solely to that program, for the advantages and general problems posed by all such systems are deserving of attention.⁹

4. Of course, this may not remain true as advancements in scientific knowledge decrease the costs of computerization.

5. See generally PROGRESS IN MENTAL HEALTH INFORMATION SYSTEMS: COMPUTER APPLICATIONS (J. Crawford, D. Morgan, & D. Gianturco, eds. 1974) [hereinafter cited as PROGRESS].

6. Curran, Laska, Kaplan, & Bank, *Protection of Privacy and Confidentiality*, 182 SCI. 797, 798 (1973). See also Laska, *The Multi-State Information System*, in PROGRESS, *supra* note 5, at 231.

7. The states were Connecticut, Massachusetts, New York, Rhode Island, South Carolina and Vermont. Also participating are the District of Columbia and psychiatric programs in Hawaii, Tennessee and Alabama. Laska, *supra* note 6, at 231.

8. See generally Laska, *supra* note 6.

9. Other mental health computer systems are described in PROGRESS, *supra* note

This article will first analyze the need for and advantages of a centralized mental health computer system. It will then examine the policy and legal objections to such a system, and finally will attempt to balance the costs and benefits. The legislation needed to safeguard a computerized mental health system will be discussed, and suggestions for the limited, carefully controlled use of such systems will be made.

II. ADVANTAGES OF COMPUTERIZATION¹⁰

There are three principal beneficiaries of a central computerized mental health system: the state, and, indirectly, the public whose taxes support state mental health facilities; the mental health personnel charged with administration and delivery of health care services; and the patients themselves, to whom all benefits should ultimately accrue.

A. *Advantages to the State*

One obvious advantage to states of computerization lies in making the operation of their mental health systems more economical and efficient. Although the initial cost outlay for computers is high, financial savings should result over the long run. Computers can perform many routine tasks faster and more inexpensively than humans. Thus numerous record keeping and clerical employees will no longer be needed, while others will be freed to concentrate on other duties. Computers can be programmed to perform such tasks as billing patients and identifying services provided insured patients and those covered by Medicare and Medicaid. This gain in manpower time, however, may to some extent be offset by the need to employ specialists to program, maintain, and operate the machines.

A centralized computer system may save states money by reducing record duplication.¹¹ Furthermore, the pooling of all data in one central location accessible to all users will save time and energy in locating information. In addition, there is less danger of computer-stored data

5, Part 3. While the analysis in Section II *infra* might seem to posit a more sophisticated computer system than currently in existence, it would be naive not to anticipate these currently foreseen future applications of computers.

10. See generally Crawford, *Computer Applications in Mental Health: A Review*, in *PROGRESS*, *supra* note 5, at 3.

11. Cf. Michael, *supra* note 1, at 280. Whether this in fact will happen is debatable. Therapists are likely to persist in keeping their own records, as will mental health institutions, either because they believe it more convenient to do so, or because of the possibility of loss of computer records through malfunctions, vandalism or theft. If such duplicates were not kept, a disaster at the central file might destroy *all* of a state's patient records. Such a calamity cannot occur where records are decentralized.

being stolen, lost, or misplaced. While the danger of theft is to a large extent a function of the protection afforded computer files, it is obviously easier to safeguard one central location than numerous diverse locations. However, if the central files are stolen or sabotaged, the damage may be quite extensive, since all of a state's files can be affected. Thus there is a trade-off: a decreased likelihood of theft or vandalism for a potential increase in the amount of damage if such theft or vandalism should occur.

Perhaps more important than the economies and efficiencies of centralized computerization is the increased accuracy in budget planning and allocation of financial and personnel resources that is attainable. Computers can be used to ascertain the number of clients served by a state's mental health system and the types of services provided, data that will aid mental health agencies in preparing and justifying future budgetary requests. Using computers, the distribution of patients and types of patients' problems among a state's various mental health facilities can be charted. With this information, a state can allocate specialists and financial resources to institutions where they are needed. The desirability of staff development and training programs can be assessed and responded to, as can the need for constructing additional facilities. Finally, by having the computer describe the demographic characteristics of clients receiving mental health services, administrators can judge what types of services and programs should be developed for the future. For example, a computer study might indicate that a certain class of citizens, such as the elderly, was not taking advantage of available services. Research could then be undertaken on the reasons for non-use. The research might reveal the need for an information dispensation system to inform the elderly of the availability of these services. But this might never occur without the computer's capacity to describe client characteristics. Theoretically, such information could be compiled by surveys of individual institutions, but the time required to do so might prove prohibitive.¹²

In addition to assisting administrators in planning future mental health budgets and programs, computers can be used to evaluate how well funds appropriated in the past have been expended. By comparing funds allocated and results obtained, a state can assess whether its dollars have been wisely spent. If inefficient expenditures appear, state officials can then concentrate on analyzing the reasons for such ineffi-

12. Furthermore, analysis of data is made easier with the assistance of computers, and more sophisticated and complex types of analyses can be undertaken.

ciencies. The ultimate result of these efforts may be the weeding out of incompetent therapists from the system. This ability to compare institutions and personnel comes about in part from the fact that computerization requires uniformity in record keeping, making meaningful comparisons possible. Comparisons of various institutions can also lead to development of statewide norms and standards.

B. Advantages to Mental Health Professionals

The advantages to the state previously discussed will also redound to the benefit of mental health professionals. Their time will be less sapped by the paperwork required for record keeping since computerization will only necessitate their filling out check lists.¹³ Needed data on patients will be more readily available and the incidence of lost or misplaced files should diminish. Furthermore, increased accuracy in budget planning and personnel deployment will result in a more even distribution of patients and resources among therapists. No longer will some be overloaded with clients while others have insufficient patients to fill their working hours.

Computerization may also foster salutary changes needed for efficient computer operation that could be, but have not been, accomplished in the absence of computer requirements. For example, standardization of terminology is necessary for computer filing, and is advisable (though to some extent currently lacking) regardless of computer requirements. Computer check list forms will help promote completeness of medical records, an obviously desirable development. Computer printouts are legible, a quality often not found in the scribbles of therapists. Data retrieval is facilitated by the computer's uniform filing system, as compared to the large number of individualistic filing systems used by mental health professionals.

The use of computer technology to make comparisons, in addition to helping states hold institutions accountable for allotted funds, portends particular promise for mental health clinicians. For decades debate has raged among proponents of various treatment techniques, each extolling the virtues of a different type of therapy. Psychoanalysis, behavior modification, group therapy, chemotherapy, electroshock treatments, psychosurgery, and a host of other remedies all claim en-

13. On the other hand, many therapists may opt to continue to maintain their own narrative records. See note 11 *supra*. If so, the centralized computer system will only represent additional paperwork for them.

thusiastic adherents. Computer technology will facilitate meaningful comparisons of results obtained with each of these therapy methods on patients having similar backgrounds and problems.¹⁴ Thus, systematically derived scientific knowledge about the effects and effectiveness of various modes of therapy will be attained.

A centralized computer system will also facilitate the exchange of information and new ideas among mental health professionals. Therapists contemplating innovative treatments will be able to run a computer check on which of their colleagues have attempted similar therapy, and with what results.¹⁵ A detailed combing of the vast and not always up-to-date psychotherapeutic literature will be less necessary.¹⁶ Likewise, therapists will be able to readily obtain information about gross categories of patients. For example, if one wished to ascertain the various treatments which had been used with juvenile heroin addicts, the computer could quickly supply this data. This capacity to retrieve rapidly vast amounts of empirical data makes computerization particularly attractive to researchers who would otherwise have to spend considerable time collecting and compiling such information from individual institutions. Researchers will also benefit from the more sophisticated forms of analysis that can be performed by computers, analyses that might not otherwise be undertaken because of the time or cost involved.

Computers can also be programmed to assist therapists in formulating diagnoses. The patient's symptoms are fed into the computer, which, in turn, indicates the illnesses that display those symptoms.¹⁷ While responsibility for the final diagnosis must ultimately rest with the treating therapists, the computer might well alert them to a possibility that might otherwise be overlooked.

14. However, for these comparisons to be meaningful, greater uniformity in what constitutes a diagnostic category will have to be achieved than exists today. Comparisons of treatment modalities will be useless if five therapists seeing the same patient all believe he has a different illness. See text accompanying note 21 *infra*.

15. Followup contacts with those therapists would of course be available for more detailed information regarding the success or lack of success of the therapy.

16. One advantage of computer analyses over examination of the professional literature is that therapists will generally not write articles publicizing their failures. Thus, the journal articles are not as complete as the computer banks which will contain reports of both successes and failures.

17. See generally Gianturco & Ramm, *Computer Aided Patient Evaluation: A Goal Oriented Approach*, in *PROGRESS*, *supra* note 5, at 121; Spitzer & Endicott, *Computer Diagnosis in Automated Record Keeping Systems: A Study of Clinical Acceptability*, in *PROGRESS*, *supra* note 5, at 73; Freed, *Legal Aspects of Computer Use in Medicine*, 32 *LAW & CONTEMP. PROB.* 674, 679 (1967).

C. *Advantages to Patients*

As the advantages of centralized computerization to the state rebound to the benefit of mental health professionals, so too do the advantages to states and mental health professionals ultimately benefit patients. For example, efficient allocation of resources will mean that therapists and facilities will be available when required. Likewise, computerization will facilitate the transfer of patients to institutions where needed services are available. Greater accuracy in a diagnosis resulting from a computer's suggestions of possible illnesses will be of obvious benefit to patients. The ability to compare various treatment techniques will mean that therapists will be able to select the treatment empirically indicated as most likely to be effective for a patient's particular disorder. Computers can also check whether a patient is receiving continued treatment (e.g., by producing a printout on all patients who have not received services in a specified time span)¹⁸ and whether the treatment is producing effective results. If not, compensatory steps can be taken. Thus, the danger of patients becoming "lost" in mental hospitals will be reduced.

Computer systems will also increase the likelihood that client abuses will be detected and corrected. For example, if one patient on a ward contracts a communicable disease which is not immediately discovered, a computer could quickly compile a list of patients who had been exposed to the disease by virtue of having been on the same ward. This tracking capability could likewise be employed to identify patients who had been discharged because no cure was known at the time they sought help, but for whose illness an effective treatment or medication was later discovered. Similarly, the computer could be used to help locate patients who had been prescribed medication subsequently determined to have harmful side effects.

A central computer file will also prove beneficial to the discharged patient who is later hospitalized in another part of the state. While normally such patients will be able to inform their therapists of previous treatment, in some instances they may forget, or may be in no condition to communicate with anyone. A quick check of computer records could save countless hours in obtaining background information and preparing a diagnosis. Previous successful or unsuccessful treatments could assist the therapist in formulating a treatment plan. Allergic reactions

18. Conversely, computers can help spot situations in which a patient is receiving duplicative treatment, as, for example, when the patient obtains the same narcotic drug prescription from two different physicians.

to medications noted in the computer file could prevent a psychiatrist from making a disastrous prescription. All such information would be immediately available through a computer printout.

III. OBJECTIONS TO COMPUTERIZATION

A. *Policy Objections*

(1) *Shortcutting*

While clearly there are advantages to centralized mental health computer systems, there are also potential perils. Many of the dangers stem from the temptation for overworked therapists to take shortcuts made possible by computers. For example, consider the patient who has been previously hospitalized for mental illness who subsequently seeks help at a different institution. When the patient complains of seemingly similar symptoms, a therapist might be tempted to base a diagnosis and treatment recommendation on information in the individual's computer file rather than on the patient's current symptoms. But the computer file might not include critical facts that came into being after the patient's release that might drastically alter a treatment plan. While this tendency to rely on stale data because it is "there" and readily available can be reduced by required destruction of individual files after passage of a specified time, such destruction would limit the utility of computer records.

The preceding example, however, is only reflective of a more pervasive danger that already exists but is magnified with the emergence of computer technology—the danger of responding to labels rather than persons.¹⁹ If a patient is diagnosed as paranoid schizophrenic, for instance, it is seductively simple to check the computer for treatments that have proven effective with paranoid schizophrenics and prescribe them for that patient. Unfortunately, psychiatric labels are not sufficiently exact to make such transferences reliable. Individual patients are affixed a psychiatric label based on a constellation of symptoms. But not all patients given a particular label have all the symptoms in the constellation, though all have most of the symptoms. Yet the presence or absence of a symptom may be critical to accurate treatment formulation. Moreover, if the initial labelling is incorrect, resort to the computer for treatments for the erroneously diagnosed illness compounds the problem. These dangers, fortunately, are avoidable by

19. See generally Rosenhan, *On Being Insane in Insane Places*, 179 *Sci.* 250, 252 (1973).

conscientious mental health personnel who make diagnoses and treatment recommendations based on their evaluation of an individual patient's symptoms. Computerized data can be a useful tool in helping them formulate a treatment plan, but it should never be the sole or predominant basis for such a plan.

(2) Errors

Another problem with computerization is the increased likelihood of errors. Without computers, the therapist records and files information deemed important in an individual case. With the existence of computers, in addition to the therapist there may be involved a programmer who writes instructions for the computer, a coder who translates the raw data into a form the computer can recognize, a keypunch operator who puts the coded data on computer cards, an individual who feeds the cards into the computer, and a person charged with maintenance of the machinery. If any of these individuals err, inaccurate information about a patient can be recorded. Obviously, the potential for human error is increased when computers are utilized, because the number of humans involved is increased. Furthermore, the loss of direct control over information by the treating therapist makes more difficult the discovery and correction of information erroneously recorded at the outset.

Computerization also can lead to a compounding of errors. If a therapist incorrectly diagnoses a patient's symptoms or mislabels an illness, the data contained in the computer records will also be erroneous. Then, if another therapist were to compare treatment modalities for the incorrectly diagnosed disorder, he might discover that the treatment employed had proven ineffective, but never learn that the reason for the treatment's ineffectiveness was its inappropriateness for the patient's real malady.

In addition to human errors, there is also the possibility of machine malfunctions. As one noted commentator has cogently observed: "[A] minor mechanical failure or variations in electric current—let alone a power failure—can result in data being lost, distorted, or misdirected to an unauthorized recipient in a remote-access system."²⁰

(3) Stultification

A centralized mental health computer system may have several

20. A. MILLER, *supra* note 1, at 28.

inhibiting effects. First, stultification of psychiatric thought can result from computer language requirements. Therapists may come to think only in terms recognized by the computer. Given the current imprecision in psychiatric nomenclature, this would indeed be unfortunate, especially since the quality of computer output is a direct function of the quality of input.²¹

A second inhibiting effect relates to potential patients. Some may refuse to come forward knowing that their mental problems will become grist for the government's files.²² Others may be less open and candid in therapy.²³ Discussion of these "chilling effect" aspects of computerization, however, will be deferred to a subsequent section²⁴ because of the legal issues involved.

A third stultifying effect of computerization concerns the types of information recorded by therapists. Many mental health professionals are firmly convinced that absolute trust must prevail for their relationship with a patient to be successful. Further, they believe that knowledge of the existence of computerized records²⁵ may undercut this relationship of trust because they may be perceived by patients as

21. This is the so-called garbage-in garbage-out phenomenon. Computer analyses cannot rise above the limitations imposed by the quality of the data fed into the computer. Another human factor limiting the usefulness of computers is the quality of the programmers. If they are incompetent, their incompetence will be reflected in the computer's output.

22. One response by a potential patient placed in this situation might be to use a false identification. If the name and other identifying characteristics supplied are those of a real person, the latter may wind up with a computerized record of mental illness. In any event, use of a fictitious-name will render the computer records meaningless for certain purposes, such as when a therapist attempts to check the file of a patient unable to communicate with anyone, and whom the therapist suspects to have been previously treated.

23. That either of these effects will occur is obviously to some extent conjectural. Patients who do not come forward because of the existence of a computerized data bank may never be known. Moreover, individuals who can be so easily deterred from entering therapy may not be in very great need of it. Whether a patient is holding back information because of the existence of a computer data bank rather than for some other reason will also be difficult to ascertain. At best it can be said that a logical case can be made that these effects will occur. To what degree they will take place, and with what consequences, will most likely never be known. Patients' affirmative claims that they will drop out of therapy because information about them will be fed into a computer should perhaps not be given that much credence. Simply stated, the patients may be bluffing. In *Roe v. Ingraham*, 73 Civ. 1303 (S.D.N.Y. Aug. 13, 1975), patients testified to withdrawing from treatment upon being informed that information about them went into a computer data bank. However, some resumed treatment after realization that discontinuance would not help cure their mental problems. See notes 66-77 & accompanying text *infra*.

24. See text accompanying notes 101-21 *infra*.

25. As to why patients will have knowledge of the existence of computerized records, see notes 38-39 and accompanying text *infra*.

having a split loyalty—to the patient and to the state. Their solution to this dilemma might consist of abandonment of the practice of making any written records. A similar phenomenon has already occurred when therapists have been threatened with subpoenas to produce their records in court.²⁶

B. *Legal Considerations*

The objections to centralized mental health computer systems so far discussed have been on a policy level. The issues become more complicated when the legal rights of patients come into play. There are three principal groups of legal rights germane to the present inquiry: a) the patient's rights of privacy and confidentiality;²⁷ b) the patient's privilege against self-incrimination; and c) the citizen's right to obtain state-provided mental health care.²⁸

26. See, e.g., READINGS IN LAW AND PSYCHIATRY 252 (R. Allen, E. Ferster & J. Rubin, rev. ed. 1975) (Dr. Hollender). Notice that this effect may occur not because of any actual reaction on the patient's part but because of the potential patient reaction as perceived by the therapist. Those therapists who opt for this solution lose, of course, all the benefits generally associated with the maintenance of records. Even if the therapist has an excellent memory, so that recordation is unnecessary for him, patients will be disadvantaged if, for example, the therapist should die and another therapist must pick up the treatment.

27. An argument can be made that the therapist's, in addition to the patient's, rights are at stake. If prospective patients cannot trust therapists to keep confidences secret, they may refrain from seeking treatment. The result may constitute an unconstitutional "taking" of the therapist's right to practice his profession. Such an argument, however, has been rejected on the ground that "although all compelled disclosures may interfere with an individual's performance of his work, such requirements have been universally upheld so long as the compelled disclosure is reasonable in light of a related and important governmental interest." *In re Lifschutz*, 2 Cal. 3d 415, 425, 467 P.2d 557, 563, 85 Cal. Rptr. 829, 835 (1970). The *Lifschutz* court also stated, in rejecting the therapist's claim of a personal constitutionally based right of privacy in patient disclosures, that "the psychotherapist, though undoubtedly deeply involved in communicative treatment, does not exert a significant privacy interest separate from his patient." *Id.* at 424, 467 P.2d at 562, 85 Cal. Rptr. at 834. See generally Louisell & Sinclair, *Foreword: Reflections on the Law of Privileged Communications—The Psychotherapist-Patient Privilege in Perspective*, 59 CALIF. L. REV. 30, 46-51 (1971).

28. In addition, there may be equal protection issues if the computer records are only required of public patients in state hospitals, which is likely to be the case. Why should individuals who desire to seek mental health care be subjected to this requirement solely because of their poverty? Cf. *Boddie v. Connecticut*, 401 U.S. 371, 383 (1971) (Douglas, J., concurring); *Griffin v. Illinois*, 351 U.S. 12 (1956); Michelman, *Foreword: On Protecting the Poor Through the Fourteenth Amendment*, 83 HARV. L. REV. 7 (1969). However, this is probably not a sufficiently invidious discrimination to constitute a violation of the equal protection clause. Cf. *United States v. Kras*, 409 U.S. 434, 446-48 (1973). Nevertheless, restricting the computerized record requirement to public patients will have repercussions. For example, the research data generated will be skewed along economic lines.

(1) Confidentiality and Privacy

The potential for violation of a patient's rights of privacy and confidentiality in a centrally computerized mental health system occurs at two junctures: first, *when* the information given by the patient to the therapist is passed on by him to computer personnel for coding and filing; second, *if* the information stored in the computer is divulged to third parties not involved in the treatment of the patient. The first situation (divulgence of information to computer personnel) will virtually always occur, while the second (divulgence to nontreating third parties) need not take place if effective restrictions on dissemination of computer files exist. The two problems will be analyzed separately.

(a) Confidentiality

The divulgence of patient confidences by the therapist to computer specialists who translate the information into a form readable by the computer and who feed the resulting data into the computer is primarily a problem of confidentiality. Confidentiality is normally expected as a concomitant of a patient's professional relationship with his therapist. One does not expect personal information disclosed for treatment purposes to be revealed to third parties. Indeed, it has been held that confidentiality is an implied condition of the treatment contract.²⁹

The therapist, for his part, is under an ethical obligation not to divulge confidences. Therapists who are physicians have taken the Hippocratic Oath, wherein they pledge that "whatsoever I shall see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as holy secrets."³⁰ Other

29. *Hammonds v. Aetna Cas. & Sur. Co.*, 243 F. Supp. 793, 801 (N.D. Ohio 1965). *But cf. Quarles v. Sutherland*, 215 Tenn. 651, 657, 389 S.W.2d 249, 252 (1965) (dictum). See also Furner & Thomason, *Physician-Patient Confidences: Legal Effects of Computerization of Records*, 31 ALA. LAW. 193, 197-98 (1970). It has also been suggested that a doctor has a fiduciary duty similar to that of a trustee to respect a patient's confidences. See *id.* at 199-200.

30. See also MEDICAL ETHICS AND DISCIPLINARY MANUAL, Section 9 (1965): "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community." Confidentiality is arguably more critical to the therapist-patient relationship than to the physician-patient relationship for generally more personal, intimate, and potentially stigmatizing details of one's life are disclosed to a therapist than to a physician.

mental health professionals who are not physicians are generally under equally stringent ethical obligations not to disclose confidences.³¹ Additionally, in many states statutes exist giving patient-physician and, in some instances, patient-therapist communications a privileged status, such that these communications cannot be disclosed except when authorized by the patient or in certain specified circumstances.³² While most of these statutes are concerned with whether the mental health professional must testify in court proceedings, the rationale behind these enactments would also apply to the preservation of confidentiality. That rationale is that the therapist-patient relationship is considered by society worthy of being fostered; that confidentiality is essential to that relationship, for without it citizens might refrain from seeking mental health care; that the communications are made with the expectation that they will not be disclosed; and that the injury to the therapist-patient relationship resulting from fear of divulgence is greater than the benefit that would be obtained by disclosure.³³ Unlike in the testimonial privilege context, a potential compromise of the truth finding function of a trial is not present as a counterweight when balancing confidentiality and computerized mental health records.

The principle of confidentiality is considered so fundamental that physicians cannot even consult with their professional colleagues about a particular patient's problem unless the patient's consent is first obtained.³⁴ If this is considered a violation of confidentiality, then it

31. See, e.g., AMERICAN PSYCHOLOGICAL ASS'N, CASEBOOK ON ETHICAL STANDARDS OF PSYCHOLOGISTS, Principle 6 (1967); AMERICAN NURSES ASS'N, THE CODE FOR PROFESSIONAL NURSES, as explained in AMERICAN NURSES ASS'N COMM. ON ETHICAL, LEGAL, AND PROFESSIONAL STANDARDS, CODE FOR NURSES WITH INTERPRETIVE STATEMENTS, II, 24 (1968).

32. The physician-patient privilege statutes are collected and compared in 8 J. WIGMORE, EVIDENCE § 2380 n.5 (McNaughton ed. 1961) [hereinafter cited as WIGMORE]; the psychologist-patient privileges, in *id.* § 2286 n.23. Since psychiatrists are also physicians, they would be covered by the physician-patient privilege. Nevertheless, about a half dozen states have enacted specific psychiatrist-patient privileges. See Slawson, *Patient-Litigant Exception*, 21 ARCH. GEN. PSYCHIAT. 347, 348 (1969). California has enacted a psychotherapist-patient privilege. CAL. EVID. CODE § 1044 (West 1974). In addition, many states have statutes providing that willful betrayal of a professional secret is grounds for revocation of a doctor's license. The statutes are collected in C. STETLER & A. MORITZ, DOCTOR AND PATIENT AND THE LAW 273 n.4 (1962).

33. See 8 WIGMORE § 2285. Using these criteria Professor Wigmore concluded that the physician-patient privilege was not needed. *Id.* § 2380a. However, Professor Slovenko, utilizing the same standards, comes out in favor of a psychotherapist-patient privilege. Slovenko, *Psychiatry and A Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175 (1960). See also Guttmacher & Weihofen, *Privileged Communications Between Psychiatrist and Patient*, 28 IND. L.J. 32 (1952); Louisell, *The Psychologist in Today's Legal World* (pt. 2), 41 MINN. L. REV. 731, 740-46 (1957).

34. See AMERICAN MED. ASS'N, JUDICIAL COUNCIL OPINIONS AND REPORTS § 9(5) (1971).

seems that disclosure to computer personnel for purposes of coding and filing would also be a violation of confidentiality.³⁵ In the latter instance, the divulgements are not made for the patient's immediate benefit, as is the case when the therapist seeks professional consultation to help formulate a treatment plan. Furthermore, the dangers of subsequent disclosures are greater because computer personnel are not under the same ethical and professional strictures regarding confidentiality as are mental health professionals. Nor is the disclosure analogous to a secretary's typing of a therapist's notes or the handling of files by a hospital clerk, for these practices are expected and presumably accepted as necessary by a prospective patient. Divulgence to computer personnel is not similarly foreseeable by a patient, and is thus not impliedly consented to.³⁶ Also, unlike the secretary or clerk, computer personnel may not be full-time employees of the therapist or mental institution but rather free lance workers or employees of a computer company.³⁷

Therefore, it appears that the therapist should have to obtain the patient's permission before divulging information to computer personnel.³⁸ This in turn means that patients would have to be apprised of the existence of the computer system, which seems only fitting since individuals voluntarily seeking mental health care should be able to decide the conditions under which they are willing to enter therapy. While not in its traditional context, the concept of informed consent would also seem to mandate disclosure of the existence of the computer system.³⁹

35. *Id.* § 9(10). But compare ABA COMM. ON PROFESSIONAL ETHICS, INFORMAL OPINION 1002, 54 A.B.A.J. 474 (1968), approving as ethical an attorney's disclosure of a client's identity to computer data processors.

Violation of confidentiality might also prove the basis for a successful suit for invasion of privacy. There may, however, be some question whether there will have been the requisite publicity to sustain a tort action. Professor Miller responds, "A doctor who reveals information from a patient's file to a third person has not given the information the type of publicity normally demanded but he may be liable because of the confidential nature of the doctor-patient relationship." A. MILLER, *supra* note 1, at 178. See also Bloustein, *Privacy as an Aspect of Human Dignity: An Answer to Dean Prosser*, 39 N.Y.U.L. REV. 962, 980 (1964).

36. As computer recordation becomes more commonplace and the practice more publicized, it will be more foreseeable that these disclosures will occur. At such time, it may be reasonable to assume patient waiver from silence.

37. They may, however, be full-time employees of the state's department of mental health.

38. See note 34 *supra*.

39. Usually, informed consent cases involve nondisclosure of the risks involved in the actual treatment. Arguably, however, the concept has broader implications and should require disclosure of any information that might affect the patient's decision to

There may, however, be a problem in obtaining a patient's consent. In some instances, patients will be mentally disabled to the extent that they are incompetent to waive their confidentiality rights; in other instances, patients will be minors. In such circumstances, the therapist will have to seek the consent of the patient's guardian. If the patient does not have a guardian, the therapist will have to resort to the statutory procedures for having one appointed. In either case, when the patient is competent, or incompetent but represented by a legal guardian, it seems advisable in order to avoid future claims of misunderstanding to have a release form signed, acknowledging waiver of confidentiality rights for purposes of computer recordation.⁴⁰

(b) *Privacy*

A more serious potential danger of computerization is that personal data within the computer system will be released without the patient's permission to third parties not involved in the patient's treatment. Such data may be divulged either deliberately by persons charged with control of the information, or as a result of artifice, such as when an unauthorized third party taps into a computer line. The possibilities for both intentional and inadvertent disclosure are increased with the creation of a centralized mental health computer system because of the increased number of persons involved in collecting, filing, coding, and recording data, some of whom are not under stringent professional ethical obligations to keep such information confidential. Furthermore, there are a greater number of places from which information can be taken without authorization. In addition to the doctor's files or hospital records, which may continue to be used,⁴¹ information can be obtained directly from the computer. The incentive to burglarize central computer files is quite great, for, having done so successfully, one comes into possession of an inordinate amount of sensitive information. A blackmailer might find sufficient grist to keep him in business forever.

Pressures on computer personnel to release mental health information will be great. Employers will naturally be curious about the mental history and present stability of their prospective employees.

undergo treatment. See generally Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 364-76 (1974).

40. Written waivers, of course, will not eliminate all misunderstandings, as the criminal law's experience with *Miranda* warnings has amply demonstrated.

41. See note 11 *supra*.

Government agencies will desire such information as an aid in determining whether individuals should be granted security clearance.⁴² Liability on life insurance contracts may depend on whether the insured committed suicide, which draws into question the mental state of the victim. Likewise, issuance of an insurance policy may turn on whether the applicant is a good mental health risk. Police departments are anxious to learn the identity of individuals being treated for drug addiction, for such persons may hold the key to control of illegal narcotics traffic.⁴³ Indeed, circumstances can exist in which police need for mental health data might be particularly acute. Consider, for example, the case of a psychopathic killer terrorizing a city. The bizarre nature of the murders suggests a deranged individual, yet clues to the killer's identity are lacking. In such circumstances a computer printout on all known mentally ill individuals in the area capable of committing the offenses might prove invaluable in solving the crimes.⁴⁴ Finally, the development of Professional Standards Review Organizations (PSRO) programs⁴⁵ requires reviewer access to medical and psychiatric records.

In all these instances and countless more, third parties will be interested in making use of the mental health information stored in computer files. To be balanced against these interests is the patient's right of privacy. Privacy in this context refers to the individual's ability to control the revelation of information about himself, and the uses to be made of that information.⁴⁶

The individual's interest in privacy has long been recognized in tort law⁴⁷ and has recently come into its own in constitutional adjudica-

42. See Creech, *Psychological Testing and Constitutional Rights*, 1966 DUKE L.J. 332, 337 n.12, 343. The day may also come when a government instituted dossier center will routinely seek such information. Law enforcement, credit, school and mental health data, all currently kept in separate and disparate files, could easily be collected and integrated into a single government file. Indeed, the costs of computerization are such that combination of records into a single computer system is economically efficient. For this reason, too, pressure will mount for increased centralization of different types of information.

43. See generally McNamara & Starr, *Confidentiality of Narcotic Addict Treatment Records: A Legal and Statistical Analysis*, 73 COLUM. L. REV. 1579 (1973). In addition, most states have statutes requiring doctors to report their discovery of suspected contagious diseases, gun or knife wounds, or child abuse. See Freed, *A Legal Structure for a National Medical Data Center*, 49 B.U.L. REV. 79, 82 nn.10 & 11 (1969).

44. The counterconsideration is, of course, that if this practice becomes known, the psychotic killer might not voluntarily seek psychiatric help. Whether this in fact would happen is unclear. See AMERICAN PSYCHOLOGICAL ASS'N, *supra* note 28, Case 6.A.

45. 42 U.S.C. §§ 1320c to c-19 (Supp. II, 1972).

46. See REPORT, *supra* note 1, at 38-42; Miller, *supra* note 1, at 1107.

47. See generally Prosser, *Privacy*, 48 CALIF. L. REV. 383 (1960). *Pavesich v.*

tions.⁴⁸ Tort suits, which are generally the vehicle for collecting damages for intrusions upon a person's private affairs⁴⁹ or for public disclosure of embarrassing private facts,⁵⁰ are largely inefficacious in the present context. This is primarily because tort actions are remedial rather than preventive.⁵¹ The mental patient's interest lies not in collecting damages for improper dissemination but in not having the information divulged in the first place. Further diminishing the importance of tort actions is the frequent difficulty of discovering that disclosure has in fact occurred.⁵² Measuring and collecting damages may also prove difficult.⁵³ For example, what price tag can be placed on Senator Eagleton's loss of the possibility of being elected Vice-President, and perhaps eventually succeeding to the White House? Moreover, many former patients who have suffered limited invasions of privacy will be reluctant to risk the more widespread publicity that may result from a lawsuit. While this problem could be partially solved by allowing suits under fictitious names, other difficulties face the potential litigant. Recovery for public revelation of private facts may be precluded unless the revelation reaches a large segment of the public.⁵⁴ Disclosure of data to a single employer or to a limited number of third parties may be insufficient "publicity" upon which to base a lawsuit, regardless of resulting injury.⁵⁵ Another consideration is that many courts will not

New England Life Ins. Co., 122 Ga. 190, 193-95, 50 S.E. 68, 69-70 (1905), may have been the first reported case recognizing privacy as a legally protectable right, but Warren and Brandeis had laid the intellectual foundation for the tort in 1890. Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890). A defamation or libel suit would be precluded because of the availability of truth as a defense. See cases cited in W. PROSSER, TORTS, 796-99 (4th ed. 1971).

48. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973); *Stanley v. Georgia*, 394 U.S. 557 (1969); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

49. See, e.g., *Zimmerman v. Wilson*, 81 F.2d 847, 849 (3d Cir. 1936) (unjustified prying by Internal Revenue Service into plaintiff's bank records constituted invasion of privacy); *Byfield v. Candler*, 33 Ga. App. 275, 125 S.E. 905 (1924) (entry into a woman's stateroom on a steamboat).

50. See, e.g., *Carson v. Baskin*, 159 Fla. 31, 30 So. 2d 635 (1945) (en banc) (description in book of woman who used profanity); *Barber v. Time, Inc.*, 248 Mo. 1199, 159 S.W.2d 291 (1942) (picture of plaintiff in hospital bed); *Griffin v. Medical Soc'y*, 11 N.Y.S.2d 109 (Sup. Ct. 1939) (pictures of plaintiff in article entitled "The Saddle Nose").

51. However, the possibility of punitive damages, which may have a greater deterrent effect, exists. Unfortunately, the likelihood of a judge's awarding such damages is reduced by the difficulty of proving that a defendant acted maliciously or with evil motive. See generally W. PROSSER, *supra* note 47, at 9-11.

52. See note 3 *supra*.

53. The further possibility must be considered that the defendant is impecunious, making any award of damages meaningless. This is likely to be the case with lower echelon computer personnel.

54. W. PROSSER, *supra* note 47, at 810.

55. *Id.* But see note 35 *supra*.

allow recovery for "intrusion" unless there has been a physical trespass.⁵⁶ Merely telling a third party the contents of an individual's computer file may not be deemed a trespass.⁵⁷ Finally, even if a plaintiff can make out a prima facie case, a successful defense, such as one based on the victim's status as a public figure⁵⁸ (as was Senator Eagleton), might be available.

From the patient's viewpoint the most desirable relief would be elimination of the computer system or, less drastically, restrictions on dissemination of computerized data to third parties not involved in the individual's treatment.⁵⁹ It might be persuasively argued that such limitations be compelled in order to avoid violation of the patient's constitutional right of privacy. Recent Supreme Court decisions have recognized the existence of this right, although it remains unclear whether its source is the first amendment, the fourth and fifth amendments, the ninth amendment, the penumbra of the Bill of Rights, or the fourteenth amendment's guarantee of personal liberty.⁶⁰ Furthermore, while the Court has invoked the right of privacy to protect the private possession of obscene materials,⁶¹ the pregnant woman's decision to opt for an abortion,⁶² and the right to obtain contraceptives,⁶³ the ultimate scope of the right is also unclear. Nevertheless, the right of privacy seems sufficiently encompassing to include the patient's interest in controlling the dissemination of mental health data about himself, and the uses to be made of that information.

The Court's most recent and detailed pronouncement on this subject occurred in *Roe v. Wade*,⁶⁴ in which the issue was whether it is with-

56. See W. PROSSER, *supra* note 47, at 390. In many cases, however, the actions of trespass and privacy seem to overlap. *Id.* See, e.g., *Newcomb Hotel Co. v. Corbett*, 27 Ga. App. 365, 108 S.E. 309 (1921); *Welsh v. Roehm*, 125 Mont. 517, 241 P.2d 816 (1952).

57. However, Prosser asserts that the interest protected is primarily mental, and that the tort is designed to bridge the gaps left by trespass, nuisance, intentional infliction of mental distress, etc. W. PROSSER, *supra* note 47, at 392.

58. *Id.* at 817.

59. See, e.g., The Privacy Act of 1974, 5 U.S.C.A. § 5522 (1974).

60. See *Roe v. Wade*, 410 U.S. 113, 153 (1973) (basis in fourteenth amendment concept of personal liberty); *Stanley v. Georgia*, 394 U.S. 557, 564 (1969) (first amendment basis); *Terry v. Ohio*, 392 U.S. 1, 8-9 (1968); *Katz v. United States*, 389 U.S. 347, 350 (1967) (fourth-fifth amendment basis); *Griswold v. Connecticut*, 381 U.S. 479, 484-85 (1965) (basis in penumbra of the Bill of Rights); *id.* at 486 (Goldberg, J., concurring) (ninth amendment basis).

61. *Stanley v. Georgia*, 394 U.S. 557 (1969).

62. *Roe v. Wade*, 410 U.S. 113 (1973).

63. *Griswold v. Connecticut*, 381 U.S. 479 (1965). See also *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

64. 410 U.S. 113 (1973).

in a woman's prerogative to terminate her pregnancy. The Court held that such a decision was protected by a woman's constitutional right of privacy. In reaching this conclusion, the Court specifically noted the potential psychological harm that might result from a contrary resolution; the fact that child care would tax the mother's mental health; the fact that an unwanted child could prove psychologically distressful; and the stigma of unwed motherhood if the woman were single.⁶⁵

These considerations support the conclusion that the patient should have some control over the dissemination and use of information concerning his mental health. Although it is unfortunate, there can be little doubt that the fact of having been treated for mental illness is extremely stigmatizing. Moreover, the pertinent data may have been collected at a time when the individual was experiencing adjustment problems, and may no longer accurately reflect the person's mental state. Revelation of such information could well have serious repercussions for the continued psychological well-being of a former patient, not to mention the possible economic impact should the patient's employer or customers not take a sympathetic view of the situation.

The first challenge along these lines to computer requirements in the health field occurred in *Roe v. Ingraham*.⁶⁶ Petitioners asserted that a state system which required, *inter alia*, computer recordation of drug recipients violated their constitutional right of privacy. The purpose of the computer requirement was to help locate diversions of legitimate drug prescriptions to illegal uses. At trial, testimony was received from mental health professionals who maintained that the existence of the computer had an adverse effect on the doctor-patient relationship,⁶⁷ and would dissuade some patients from undergoing treatment.⁶⁸ Parents, who feared that their children undergoing drug treatment would be stigmatized for life,⁶⁹ testified, as did patients who maintained that the computer system would influence their decision to remain in treatment.⁷⁰ The district court read *Roe v. Wade* and its companion case, *Doe v. Bolton*,⁷¹ as establishing the doctor-patient rela-

65. *Id.* at 153.

66. 73 Civ. 1303 (S.D.N.Y., Aug. 13, 1975). *Contra*, *Felber v. Foote*, 321 F. Supp. 85 (D. Conn. 1970), decided prior to *Roe v. Wade* and *Doe v. Bolton*.

67. 73 Civ. 1303 (S.D.N.Y., Aug. 13, 1975).

68. *Id.*

69. *Id.*

70. *Id.* *But see* note 23 *supra*.

71. 410 U.S. 179 (1973). *See also* *Paris Adult Theatre I v. Slaton*, 413 U.S. 49 (1973). In footnote thirteen the Court states:

[T]he constitutionally protected privacy of family, marriage, motherhood, procreation, and child rearing is not just concerned with a particular place,

tionship as one of the zones of privacy accorded constitutional protection.⁷² The court observed that "[a]n individual's physical ills and disabilities, the medication he takes, [and] the frequency of his medical consultation are among the most sensitive of personal and psychological sensibilities."⁷³ The court recognized that the right of privacy was not absolute,⁷⁴ but felt that the state's regulatory scheme had a "needlessly broad sweep."⁷⁵ Computerization was simply not needed to detect the abuses the state was seeking to discover. The court's belief in this regard was reinforced by the fact that only one abuse was unearthed as a result of the computer requirements.⁷⁶

The observations by the court in *Ingraham* regarding the physician-patient relationship are even more pertinent to the therapist-patient relationship. Information disclosed to a therapist is generally of a more intimate and sensitive nature than that disclosed to a physician. Patients often bare to their therapist their most personal desires, loves, hates, feelings, fantasies, and impulses. Moreover, revelation of such information is vitally important to treatment, which is generally not the case with regard to treatment of a physical illness. Finally, the fact of having consulted a therapist is usually more stigmatizing than the fact of having seen a physician.⁷⁷ Mental illness is more likely to lead to social ostracism than physical illness.

Another factor supporting a patient's right to control dissemination is that the therapist's diagnosis may in part be based on the individual's professed political beliefs, ideas, or opinions, all of which may be included in, or discernible from, the patient's computer files. Such information should come under the protection of both the first amendment and the right of privacy.⁷⁸

However, as the Court in *Roe v. Ingraham* recognized, neither the first amendment nor the right of privacy is absolute. The United States

but with a protected intimate relationship. Such protected privacy extends to the *doctor's office*, the hospital, the hotel room, or as otherwise required to safeguard the right to intimacy involved.

Id. at 66 n.13 (emphasis added).

72. 73 Civ. 1303 (S.D.N.Y., Aug. 13, 1975). See also *In re Lifschutz*, 2 Cal. 3rd 415, 431-32, 467 P.2d 567, 85 Cal. Rptr. 839 (1970).

73. 73 Civ. 1303 (S.D.N.Y., Aug. 13, 1975).

74. *Id.*

75. *Id.*

76. *Id.* It is possible, of course, that knowledge of the existence of the computer system deterred violators.

77. Professor Slovenko states that "[u]nlike the patient suffering an organic illness, a person in psychotherapy, by and large, visits his psychiatrist with the same secrecy that a man goes to a bawdy house." Slovenko, *supra* note 33, at 188 n.46.

78. Cf. 5 U.S.C.A. § 552a(e)(7) (1974).

Supreme Court has held that the constitutional protections must to some extent yield to "compelling" state interests.⁷⁹ Thus the Court in *Roe v. Wade* held that the state's interest in protecting the lives of the woman and of the viable fetus justified regulation of abortion during the second and third trimesters of pregnancy.⁸⁰ What *Roe v. Wade* means to the collection and dissemination of computerized information is that there will have to be a balance struck between the patient's interest in privacy and the justifications put forth in support of disclosure.

In effecting this balance, the state will have to safeguard the decisionmaking procedures with due process protections. In *Wisconsin v. Constantineau*⁸¹ the Supreme Court examined a statute authorizing officials to post notices forbidding the sale or gift of liquor to individuals characterized as extreme drinkers, who jeopardized the health, safety, or property of themselves, their families, or the public. The statute afforded neither notice nor the opportunity for a hearing. Because of these failings and the stigma attached to the designation, the Court struck down the statute. Since disclosure of an individual's present or former mental illness is also stigmatizing, there would likewise seem a need for due process safeguards prior to the release of mental health data.

It is unclear what would constitute a compelling state interest for the establishment of a centralized mental health computer system, or the release of information from such a system. Recordkeeping and reporting regulations have been upheld by the courts,⁸² most recently in *California Bankers Association v. Shultz*,⁸³ but none of these cases involved information as potentially stigmatizing, while not criminal, as mental illness records.⁸⁴ In *Roe v. Wade* the preservation of a woman's health during the second and third trimesters of pregnancy was deemed a compelling state interest.⁸⁵ Analogously, the state's protec-

79. See, e.g., *Roe v. Wade*, 410 U.S. 113, 155 (1973); *Griswold v. Connecticut*, 381 U.S. 479, 503-04 (1965) (White, J., concurring); *Sherbert v. Verner*, 374 U.S. 398, 406 (1963); *Bates v. City of Little Rock*, 361 U.S. 516, 524 (1960).

80. 410 U.S. at 162-65.

81. 400 U.S. 433 (1971).

82. See, e.g., *Shapiro v. United States*, 335 U.S. 1 (1948) (regulation of industries under the Emergency Price Control Act); *United States v. Darby*, 312 U.S. 100 (1941) (reporting of employee wages and hours under the Fair Labor Standards Act).

83. 416 U.S. 21 (1974) (recordkeeping requirements imposed on the banking industry for the purpose of obtaining financial information bearing on criminal, tax, and regulatory investigations of the government).

84. In *Roe v. Ingraham*, the court was of the opinion that it was the limited intrusion on privacy that resulted from recording requirements in *Schultz* that saved the act from being found unconstitutional. 73 Civ. 1303 (S.D.N.Y., Aug. 13, 1975).

85. 410 U.S. at 164-65.

tion of the mental health of its citizenry might qualify as compelling. If so, creation of a centralized mental health computer system, the advantages of which were seen in Section II of this article to ultimately accrue to the patient's benefit, and the release of stored information for treatment purposes, would appear justified.⁸⁶ Moreover, if there is an obligation on the part of states to provide mental health care,⁸⁷ courts should be relatively indulgent to all reasonable technological innovations, including computerization, that assist the states in carrying out this responsibility. However, release of data to prospective employers, or to other third parties not involved in the patient's treatment, would not seem justified in the absence of extraordinary circumstances,⁸⁸ since the preservation of the patient's health would not be at stake.

(2) Self-Incrimination

Disclosure to law enforcement personnel poses additional problems. Under fourth amendment strictures, resort to a warrant would normally be required. However, an exception to the warrant requirement exists for consensual searches,⁸⁹ and the custodian of computer files may well be able to grant police permission to conduct a warrantless search. Even then, serious fifth amendment issues remain. Drug patients, for example, may disclose to their therapists potentially incriminating information about their acquisition and use of illegal narcotics. Can such patients, on the basis of their fifth amendment privilege, refuse to allow this information to go into their computer files?

86. See also *Commonwealth v. Wiseman*, 356 Mass. 251, 249 N.E.2d 610 (1969), *cert. denied*, 398 U.S. 960 (1970). A lawyer-filmmaker had produced a motion picture depicting the deplorable conditions at a mental institution. *Id.* at 254, 249 N.E.2d at 613. Basing its decision on the inmates' right of privacy, the Massachusetts Supreme Court enjoined showing of the film to general audiences. *Id.* at 262-63, 249 N.E.2d at 618. However, the court did allow the film to be viewed by specialized audiences of mental health professionals. *Id.*

87. See text accompanying notes 102-10 *infra*.

88. See, e.g., *State ex rel. Carroll v. Junker*, 79 Wash. 2d 12, 482 P.2d 775 (1971) (en banc). The court refused to allow a law professor and two students to examine randomly selected mental illness files in the absence of establishment of adequate safeguards to ensure the privacy and confidentiality of the subjects. The patients' rights to privacy and confidentiality were granted by statute. *Id.* at 23-25, 482 P.2d at 782-83. See also *Menard v. Mitchell*, 328 F. Supp. 718 (D.D.C. 1971), *rev'd on other grounds sub nom. Menard v. Saxbe*, 498 F.2d 1017 (D.C. Cir. 1974), enjoining dissemination of arrest records absent compelling public necessity. *Id.* at 726. The court specifically prohibited disclosure to prospective private employers. *Id.* at 727.

89. Cf. *United States v. Matlock*, 412 U.S. 164 (1974); *Frazier v. Culp*, 394 U.S. 731 (1969).

There is some precedent for the assertion of one's privilege against self-incrimination under these circumstances. In *Marchetti v. United States*⁹⁰ and *Grosso v. United States*⁹¹ the Supreme Court examined income tax regulations governing wagering activities that required registration and recordkeeping. Petitioners claimed that the statutory scheme was violative of their fifth amendment rights. The majority upheld this contention, noting that wagering was an area "permeated with criminal statutes" and that individuals involved in such pursuits were "inherently suspect of criminal activities."⁹² These observations, and the Court's conclusion that the dangers of incrimination were real and substantial, ring equally true when applied to narcotics users. Of course, unlike paying income tax, citizens are not under a legal duty to seek mental health care. However, one may have a right to seek such help.⁹³ If so, the fifth amendment claim would still be viable, as exercise of lawful prerogatives cannot be conditioned on forfeiture of constitutional rights.⁹⁴ Nor is the "required records" doctrine of *Shapiro v. United States*⁹⁵ applicable.⁹⁶ Although the data to be stored in computer files is of the same kind customarily kept by the therapist, it is not imbued with "public aspects" to the same extent as the data in *Shapiro*, and, when relating to narcotics addicts, cannot be said to pertain to an "essentially non-criminal and regulatory area of inquiry."⁹⁷ The fact that prosecution is not the state's primary purpose in maintaining centralized computer records is of no more significance than that the government's principal interest in establishing income tax regulations is the collection of revenue, a fact that was not of sufficient significance to save the statutory scheme in *Marchetti* and *Grosso*.

While cases like *Marchetti* and *Grosso* harbinger fifth amendment protection for patients with mental problems stemming from their in-

90. 390 U.S. 39 (1968).

91. 390 U.S. 62 (1968).

92. 390 U.S. at 47.

93. See text accompanying notes 102-10 *infra*.

94. Compare *Spevack v. Klein*, 385 U.S. 511 (1967); *Garrity v. New Jersey*, 385 U.S. 493 (1967); and *Wiemann v. Updegraff*, 344 U.S. 183 (1952) with *United Public Workers of America v. Mitchell*, 330 U.S. 75 (1947) and *McAuliffe v. Mayor & Bd. of Aldermen*, 155 Mass. 216, 29 N.E. 517 (1882) (in which Justice Holmes stated that while an individual "may have a constitutional right to talk politics, . . . he has no constitutional right to be a policeman," *id.* at 220, 29 N.E. at 517). See generally Van Alstyne, *The Demise of the Right-Privilege Distinction in Constitutional Law*, 81 HARV. L. REV. 1439 (1968).

95. 335 U.S. 1 (1948).

96. See *Marchetti v. United States*, 390 U.S. 39, 55-58 (1968).

97. *Id.* at 57.

volvement in areas permeated with criminal statutes, they would not help the ordinary patient who reveals to his therapist that he has committed a crime. Although clearly not everyone who seeks mental health care has committed a criminal offense, there will be some who, having committed crimes, recognize that they need psychiatric help, or suffer guilt feelings for which they seek relief by obtaining professional assistance. They too should not have to fear that information voluntarily provided by them for treatment purposes will someday be used in a criminal trial against them.

Something akin to a *Miranda* warning⁹⁸ would not be feasible, for it would likely either deter such patients from seeking needed treatment, or inhibit the full disclosure necessary for an effective patient-therapist relationship. Neither result is desirable. The American Psychiatric Association has taken the view that:

[T]he individual, whatever his accountability for wrong-doing as a result of drug effects, [has] a need and a right to expect relevant treatment and, indeed, all that is implied by this in terms of the doctor-patient relationship. . . . [I]t [is] clearly incumbent on law enforcement agencies not to distort or retard advances in research, in the delivery of health care, or in the quality of medical practice available to this nation.⁹⁹

In the balancing of law enforcement and mental health care interests, the Association's position seems desirable, particularly if extended to all patients who reveal potentially incriminating information.¹⁰⁰

(3) Chilling Effects

Americans today are subjected to unprecedented psychic stress. Inflation, unemployment, job displacement, overpopulation, pollution, and threat of war all take their toll on one's mental equilibrium. Watergate and Vietnam have strained relationships between liberals and conservatives, Republicans and Democrats, parents and children. A residue of cynicism and disillusionment remains from government scandals. Technological advances breed feelings of personal helplessness as machines steadily replace human laborers. More than ever, twentieth century man needs the availability of mental health care. Furthermore,

98. *Miranda* warnings would not be required, for the patient would not be "in custody," the coercive atmosphere of the jailhouse would be lacking, and the questioning would not be for the purpose of eliciting a confession. See *Miranda v. Arizona*, 384 U.S. 436 (1966).

99. McNamara & Starr, *supra* note 43, at 1589. See also Slovenko, *supra* note 33, at 189-90.

100. See also 5 U.S.C.A. § 552a(b)(7) (1974).

such treatment may no longer be a matter of government largesse but a matter of right.¹⁰¹ And all forces, including centralized mental health computer systems, that inhibit the exercise of that right are to be looked upon with a jaundiced eye.

The idea that state-supplied mental health care is a right stems from a synthesis of statutes, old doctrines, and recent decisions. The statutes are enactments authorizing establishment of mental health facilities and opening them to patients on a voluntary basis. Such statutes exist in virtually all jurisdictions.¹⁰²

But what if the state decided to close its mental health facilities to voluntary patients? Could it do so? A negative answer may be dictated on the basis of the doctrine of *parens patriae*. This doctrine, which holds that the state is the parent of its citizens and can assume control over them for their well-being, has been often cited to justify involuntary civil commitment of individuals to mental institutions.¹⁰³ But *parens patriae* should be a two-edged sword. It should be not only a doctrine of control but also one of responsibility. States have an obligation to care for their mentally ill citizenry. If they attempt to shirk this responsibility, citizens should be able to hold them to it through legal action. Thus, there is seemingly a right to mental health care provided by the state.

This proposition is bolstered by a series of recent decisions establishing in behalf of mental patients a constitutionally based right to treatment. Beginning with *Rouse v. Cameron*¹⁰⁴ and culminating in *Wyatt v. Stickney*,¹⁰⁵ a number of federal courts have upheld the existence of this right.¹⁰⁶ However, so far the cases have involved only

101. Cf. *Doe v. Bolton*, 410 U.S. 179 (1973). The Court in *Doe*, however, was not concerned with whether the state has a duty to supply medical care.

102. See, e.g., ILL. REV. STAT. ch. 91½, § 5-1 (Supp. 1974); PA. STAT. ANN. tit. 50, §§ 4402-03 (1969); TENN. CODE ANN. 33-601 (Supp. 1974); TEX. REV. CIV. STAT. ANN. art. 5547-22 to -23 (1958).

103. See, e.g., *Hall v. Verdel*, 40 F. Supp. 941, 946 (W.D. Va. 1941); *State ex rel. Deeb v. Fabisinski*, 111 Fla. 454, 465, 152 So. 207, 211 (1933); *In re Sariyanis*, 19 N.Y.S.2d 431, 173 Misc. 881 (Sup. Ct. 1940). The doctrine of *parens patriae* refers to the power of the state to care for those who are unable to care for themselves or for their property. Under this doctrine the state protects such people both for their own welfare and for the welfare of the public.

104. 373 F.2d 451 (D.C. Cir. 1966). The right to treatment aspects of the case were in fact dicta. The court did not have to reach the constitutional issues because it found that *Rouse* had a statutory right to treatment under the 1964 Hospitalization of the Mentally Ill Act.

105. 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd in part sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

106. See, e.g., *Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974), *aff'd on other*

involuntarily committed patients. The rationale has been that when the state involuntarily deprives an individual who has not committed a crime of his liberty, it must provide a *quid pro quo* in the form of treatment.¹⁰⁷ This conclusion derives from the fact that the justifications commonly advanced for civil commitment, and the abridgement of liberties that commitment entails (such as the right to live in one's home, hold a job, pursue an education, and raise a family), are the dangers of harm posed by the individual to himself or others, and the individual's need for treatment.¹⁰⁸ If the justification for commitment is the need for treatment, it offends due process not to provide treatment. Similarly, if the justification is the danger of harm to self or others, then treatment is the price society must pay for the extra safety it derives from the denial of the individual's liberty.¹⁰⁹

But where does this leave individuals who, recognizing their need for treatment, voluntarily commit themselves? To say that they may leave the mental health facility is unsatisfactory, for by doing so they forfeit the opportunity to obtain treatment. Arguably, they have an equal protection-based claim for treatment.¹¹⁰ Once in the mental institution through the use of voluntary commitment statutes, they have a right to treatment equal to that of involuntarily committed patients. In other words, how one comes into the institution should not be determinative of one's right to treatment once there.

Moreover, there are freedom of speech and association overtones to the patient-therapist relationship. This relationship is itself an association in which individuals seek professional help in order to achieve self-understanding, and to learn how to express their true feelings. In order to accomplish these goals, therapists encourage full and open discussion by their patients. Such frank expression of views and beliefs on the part of the patient may be inhibited by knowledge that the dis-

grounds, 422 U.S. 563 (1975); *Stachulak v. Coughlin*, 364 F. Supp. 686, 687 (N.D. Ill. 1973).

107. There are other bases upon which to premise a constitutional right to treatment argument. It could be maintained that institutionalizing a mentally ill individual without treatment amounts to cruel and unusual punishment. Cf. *Robinson v. California*, 370 U.S. 660, 666 (1962). Another argument is that unless treatment is provided, classifying some individuals as mentally ill is irrational and subject to attack under the equal protection clause of the fourteenth amendment. See *Rouse v. Cameron*, 373 F.2d 451, 452-53 (D.C. Cir. 1966).

108. *Wyatt v. Aderholt*, 503 F.2d 1305, 1312 (5th Cir. 1974), *aff'g in part* 344 F. Supp. 373 (M.D. Ala. 1972), *citing* *Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974).

109. *Id.*

110. Cf. *Mills v. Board of Educ.*, 348 F. Supp. 866 (D.D.C. 1972); *Pennsylvania Ass'n for Retarded Children v. Pennsylvania*, 334 F. Supp. 1257 (E.D. Pa. 1971); *in re Bottonow*, 23 N.Y.2d 385, 244 N.E.2d 677, 297 N.Y.S.2d 97 (1968).

closed information will be sent to a state-controlled computer system.¹¹¹ As indicated previously, patients will have this knowledge because their waiver of confidentiality is necessary before information can be passed from the therapist to the computer personnel, and because voluntary patients should determine the conditions under which they will enter therapy.

In addition to exerting a potential chilling effect on the openness of discussion by patients in therapy, the existence of a centralized mental health computer system may inhibit many persons from seeking mental health care in the first place. Consider the following hypothetical. An individual has a paranoid fear that government agents are spying on him. He decides to see a therapist. The therapist informs him that he will accept him for treatment but that he, the patient, will have to make a limited waiver of confidentiality so that the information subsequently disclosed can be transferred to a state-controlled computer data bank. Might not such a revelation drive the prospective patient screaming from the therapist's office, reinforced in his belief that his worst fears were correct? While this might be the most dramatic case, numerous personal insecurities result from fear of creeping Big Brotherism, the takeover of machines, a decreasing sphere of personal privacy, and general loss of control over one's destiny. In all these instances, disclosure of the existence of the centralized computer system may actually aggravate the patient's condition and decrease the likelihood that he will seek help from a system that he sees as part of the problem. One final illustrative example. How many ambitious politicians who, being subject to the stresses of the world's problems perhaps need therapy more than most, will seek such help after the Eagleton affair?

The Supreme Court has in the past looked critically upon recordation requirements that have exerted chilling effects on fundamental rights. In *NAACP v. Alabama ex rel. Patterson*¹¹² the state had ordered production of the Association's membership lists. The Association's refusal resulted in its being held in contempt. Justice Harlan, writing for a unanimous Supreme Court, reversed, ruling that the state's action had an unconstitutional inhibiting effect on the members' right to associate for the advancement of commonly held beliefs. At one point the Court stated:

111. Cf. *Taylor v. United States*, 222 F.2d 398, 401 (D.C. Cir. 1955).

112. 357 U.S. 449 (1958).

We think that the production order, in the respects here drawn in question, must be regarded as entailing the likelihood of a substantial restraint upon the exercise by petitioner's members of their right to freedom of association. Petitioner has made an uncontroverted showing that on past occasions *revelation of the identity of its rank-and-file members has exposed these members to economic reprisal, loss of employment, threat of physical coercion, and other manifestations of public hostility*. Under these circumstances, we think it apparent that compelled disclosure of petitioner's Alabama membership is likely to affect adversely the ability of petitioner and its members to pursue their collective effort to foster beliefs which they admittedly have the right to advocate, in that it may induce members to withdraw from the Association and dissuade others from joining it because of fear of exposure of their beliefs shown through their associations and of the consequences of this exposure.¹¹³

Likewise, a centralized mental health computer system may chill exercise of the right to seek mental health care and to associate with a therapist for mental health improvement. While it may not be "incontrovertible," it is certainly arguable that, given the stigma attached to mental illness, revelation of this fact will expose individuals so identified to "economic reprisal, loss of employment . . . and other manifestations of public hostility."¹¹⁴ And while association with a therapist may not be for the advancement of politically oriented, commonly-shared beliefs, it nonetheless may be an association deserving of societal protection. Moreover, if there is a right to state supplied mental health care and treatment, it may be an association entitled also to constitutional protection.

Numerous other Supreme Court decisions have dealt with the chilling effect of state actions, although not specifically taking the form of recordation requirements. In *NAACP v. Button*¹¹⁵ the Court examined Virginia statutes regulating the practice of law. It found that, under the guise of regulatory provisions, the state was attempting to curb constitutionally protected activities of the Association. The Court refused to allow the state to do so.¹¹⁶

An analogy can be drawn between the facts of *Button* and centralized mental health computer systems. Both involve ostensibly lawful regulatory provisions, one involving the legal profession and the other the mental health profession. But despite the validity of the

113. *Id.* at 462-63 (emphasis added).

114. *Id.*

115. 371 U.S. 415 (1963).

116. *Id.* at 428-29.

state's concerns, it must not choose methods of control which deter lawfully protected activities. Furthermore, both *Button* and *Patterson* indicate that courts will guard against indirect as well as direct infringements by states of fundamental rights.

Unfortunately, a recent five-to-four Supreme Court decision, *Laird v. Tatum*,¹¹⁷ suggests that the Court might not be so vigilant in the future in offering protection against government activities that inhibit exercise of constitutional rights. *Tatum* involved Army surveillance of civilians protesting government policies. The information compiled was placed in a computer data bank and was made available to major Army posts around the country. Petitioners alleged that the Army activity deterred exercise of first amendment rights. The majority held that the case was not ripe for adjudication because petitioners were not sufficiently specific in identifying the present or future harm threatened.¹¹⁸ While the holding seems out of step with previous "chilling effect" decisions, the case is distinguishable from the centralized mental health computer situation in that in the latter the direct harm is more easily foreseeable. Mentally ill individuals who are deterred from seeking treatment or inhibited from being completely honest and candid with their therapists can expect a deterioration, or at least a non-improvement, in their conditions.

Nevertheless, as was the case in relation to the constitutional right of privacy, courts will allow states to act in ways that chill exercise of constitutional rights if there is a compelling interest behind their actions.¹¹⁹ The state interests behind the establishment and operation of a centralized mental health computer system have already been examined,¹²⁰ and conclusions as to their compelling nature similar to those drawn in regard to the privacy issue would again have to be reached.¹²¹

IV. CONCLUSION

While there are significant state interests justifying creation and operation of centralized mental health computer systems, the potential

117. 408 U.S. 1 (1972).

118. *Id.* at 13-14.

119. See cases cited note 79 *supra*. See also *Shapiro v. Thompson*, 394 U.S. 618, 634, 638 (1969). While a compelling state interest is required only if the right involved is "fundamental," it will be assumed *arguendo* that the right to seek mental health care so qualifies, for if a compelling state interest for chilling this right can be demonstrated, *a fortiori* a rational basis for the state's actions exists.

120. See discussion in Section II *supra*.

121. See notes 82-87 and accompanying text *supra*.

for infringement of first and fifth amendment rights, in addition to rights of privacy, coupled with the policy objections to centralized computerization previously examined, dictate that states proceed with the utmost caution and circumspection. A reanalysis of the benefits and costs of centralized computerization suggests the need for and desirability of certain technological and legislative restrictions.

One critical key to accommodation of these competing considerations lies in recognizing that most of the advantages of centralized computerization can be achieved by the compilation of *statistical data*, while most of the dangers stem from the recordation of *personally identifiable information*. The budget planning advantages, the ability to compare institutions and treatment modalities, the potential for analyzing future needs and for obtaining greater accuracy in the deployment of funds and personnel, and the evaluation of existing programs, can all be accomplished without computer indication of patient names. This suggests that patients be assigned number codes and that separate files be kept—one containing diagnostic and treatment information, with the patient identified only by number; and the other containing the patient's name and code number plus any clearly identifying characteristics such as address and social security number.

Such bifurcation should also be employed in the initial transfer of data to the computer. One set of coders and key punchers should work on the name-number files and another on the mental health data files. Thus, no single computer technician would learn intimate private facts about a particular patient.

Under the proposed procedures some computer personnel will know that certain individuals are patients, and thus presumably have mental problems. Since this disclosure may be a breach of the confidentiality of the patient-therapist relationship, and may be potentially stigmatizing,¹²² patients should be told of this before making the final decision to enter therapy. They should also be informed that the information supplied may subsequently be released to third parties, and of the conditions under which such disclosure would occur, the types of individuals or groups most likely to obtain the data and the possible consequences of disclosure.¹²³ The patient's written waiver of these breaches of confidentiality and privacy should then be obtained.¹²⁴ If

122. See Slovenko, *supra* note 33, at 188-89.

123. Cf. 5 U.S.C.A. § 552a(e) (3) (1974).

124. Even if a patient consents, the waiver may be suspect. Many individuals, rec-

the patient is incompetent, the consent of a lawfully appointed guardian should be sought.

After the data is incorporated into the computer system, access should be strictly limited. Because of the patient's fifth amendment rights, access for law enforcement purposes should be forbidden. On the other hand, professional personnel involved in the patient's treatment should be automatically able to obtain both name-number and diagnostic files.

Subjects of computer files should also have access to their own records and should be able to authorize disclosure to others.¹²⁵ The latter suggestion, however, is made with some trepidation, for it may result in former patients being subjected to pressure by employers and others to release their mental health files. Those who refuse may find themselves without jobs or other benefits conditioned upon waiver. Moreover, administrators are sufficiently sophisticated these days to rationalize their decisions on less improper bases. Thus a case can be made for not allowing patients to release their files. However, this would do a disservice to those who genuinely feel that release is in their best interests.

All others seeking computerized mental health data should have to justify their requests for release before an impartial tribunal designated to determine such matters. A three member board appointed by the state governor is a possibility.¹²⁶ Because it would be too cumbersome and costly to notify all persons potentially involved in hearings before the board, an advocate could be appointed by the Commissioner of Mental Health to represent the patient and protect his interests in the proceedings.¹²⁷

At the hearing, the burden should be on those seeking disclosure to justify their requests. For obtaining statistical aggregate data, such

ognizing their need for treatment, may readily agree to waive rights because they see no alternative if they are to receive therapy. Cf. Karst, "The Files": Legal Controls Over the Accuracy and Accessibility of Stored Personal Data, 31 LAW & CONTEMP. PROB. 342, 344 (1966). However, this would probably be insufficient coercion to invalidate the waiver.

125. There does not appear to be, absent statutory authority, any right of access to one's medical or psychiatric records. *Gotkin v. Miller*, 514 F.2d 125 (2d Cir. 1975).

126. Of the three members, one should be trained in law, one should be a mental health professional and the third should be a citizen with a background in neither the legal nor mental health fields. All three individuals should have at their disposal a research staff.

127. A person whose identity might be disclosed as a result of the hearing should receive personal notice and should have the right to appear with counsel. See *State ex rel. Carroll v. Junker*, 79 Wash. 2d 12, 23-24, 482 P.2d 775, 783 (1971).

as the number of patients treated for a particular illness during the year, a showing of legitimate interest should suffice. For obtaining coded diagnostic files, a higher standard, though less than a compelling interest, should be required. There is a danger, however, that individuals may be identifiable from their files even though their names are coded. For example, in a sparsely populated state, knowledge of county and date of birth, sex, race, and marital status may be sufficient to identify the person whose file is being examined. When this possibility is likely, the tribunal should examine more critically the request for disclosure, requiring, perhaps, a showing of compelling need, and, if it decides to grant a release, limit the data disclosed consistent with the needs of the applicant and the patient's right of anonymity. Finally, when applicants seek both name-number and diagnostic files, a heavy burden should have to be met. Not only should a showing of compelling need be required, but applicants should have to demonstrate that there is no alternative means of achieving their ultimate goal.¹²⁸ Whenever the board's decision might result in a patient's name being disclosed, notice should be given to that individual and an opportunity afforded him to intervene personally in the proceeding.¹²⁹

In all instances, data should only be released pursuant to a unanimous decision of the board. Records of all decisions should be kept.¹³⁰ Information released should be subject to the condition that further dissemination to others is strictly prohibited, as is any use of the data not consistent with that approved by the board.¹³¹ If either party desires to challenge the board's ruling, appeal to a court of law would be allowed.¹³²

In addition to the establishment of a tribunal for screening requests for access to information in computer files, states should pass statutes levying heavy penalties, including fines and mandatory jail terms, for unauthorized disclosure, receipt, or use of mental health data.¹³³ Such deterrent legislation is needed because of the relative

128. Cf. *Griswold v. Connecticut*, 381 U.S. 479, 504 (1965) (White, J., concurring); *Shelton v. Tucker*, 364 U.S. 479, 488 (1960).

129. See note 127 *supra*. The right to intervene should include the right to present evidence and cross-examine witnesses. Cf. *Goldberg v. Kelly*, 397 U.S. 254 (1970); *Greene v. McElroy*, 360 U.S. 474, 496-97 (1959).

130. Cf. 5 U.S.C.A. § 552a(c) (1974).

131. Cf. 44 U.S.C. § 3508 (1970).

132. The standard to be applied by the reviewing court would presumably be that applicable to administrative agency decisions in general, *i.e.* Administrative Procedure Act, 5 U.S.C. §§ 701 *et seq.* (1970); UNIFORM LAW COMMISSIONERS' REVISED MODEL STATE ADMINISTRATIVE PROCEDURE ACT §§ 15-16 (1961).

133. Cf. 18 U.S.C. § 1905 (1970). At least one court has held that an individual

inefficacy of tort damage suits,¹³⁴ although the latter would remain available for obtaining monetary compensation for past harm caused.

All feasible technical precautions that would help safeguard the system against unauthorized use, such as preserving data in scrambled form¹³⁵ and restricting access to the descrambler to those having knowledge of a specified password,¹³⁶ should be taken.¹³⁷ Security officers should be hired to guard the room in which the computer files are stored. Finally, a code of professional responsibility should be developed for and disseminated to all computer personnel involved in a centralized mental health computer system.¹³⁸

To help guard against errors, patients should be able, upon request, to inspect their own files,¹³⁹ update them and correct inaccuracies.¹⁴⁰ To avoid factual recordation errors in the initial stages of computerization, prospective patients should fill out forms indicating their conception of both their problems and the factual bases for them. In the computer file, this information would be designated as "patient supplied" rather than "therapist recorded." Corrections and additions to the file provided by the patient would likewise be designated as "patient supplied." Therapist concurrence in the "corrections" would be noted. If subsequent disagreements develop between patient and therapist concerning their understanding, or the facts underlying the patient's problem, resort to this information in the computer file may

who steals a computer program is guilty of theft, the programs qualifying as "property" subject to theft. *Hancock v. State*, 402 S.W.2d 906 (Tex. Crim. App. 1966).

134. See notes 49-58 and accompanying text *supra*.

135. This would reduce the usefulness of stealing data files.

136. The password could be changed at regular intervals to protect against its becoming common knowledge. The current password would be obtainable from the hearing board.

137. The limitations in relying too heavily on technological safeguards should be recognized. Although sophisticated technological protections can be developed, it is likely that the techniques of those who desire to gain unauthorized access to computer files will develop apace.

138. Modest steps in this direction have been taken. See *Professional Conduct in Information Processing*, 11 COMMUNICATIONS OF THE ACM 135 (1968). However, to be able effectively to implement stringent ethical standards among computer personnel, it will probably be first necessary to elevate the salaries and status of such workers. Better training of computer personnel and perhaps even licensing may be needed. Cf. 5 U.S.C.A. § 552a(e)(9) (1974).

139. Cf. 5 U.S.C.A. § 552a(d) (1974). The data, of course, would have to be made available to the subject in a readable form.

140. An exception to the rule allowing patients to inspect their files should be created when a therapist can show it would be highly detrimental to the patient's welfare to see his file. The board could pass on these cases also. The patient would not be allowed to be present. Regardless of the board's decision, the patient could still add information to his file.

help settle the controversy. Moreover, if other therapists become involved with the patient, they can check on the patient's account of his problems rather than having to rely only on another therapist's impressions.

Finally, lest stale information be relied upon in subsequent treatment, data in a patient's file should be destroyed at some specified time after the patient has left therapy. The time period should be fixed by mental health professionals, and may vary for different types of information.¹⁴¹ An absolute time limit, however, after which the patient's entire file would be destroyed, should also be established. Private information that is not clearly relevant to the patient's treatment should, of course, not be collected in the first place.¹⁴²

Centralized mental health computer systems hold both great promise and peril. To shun computers completely is to ignore the future; not to recognize the potential dangers is to ignore reality. The task facing society is to devise means of maximizing the promise while minimizing the perils. This article hopefully represents a modest beginning at achieving these ends.

141. The time when a record will be destroyed may also depend on the age of the patient at the time the information was collected. Records regarding children should perhaps presumptively be subject to destruction when the child reaches adulthood. While this may prove disadvantageous to future researchers in search of empirical data, it may spare the child from permanent stigmatization.

142. See, e.g., *Schneider v. Smith*, 390 U.S. 17 (1968); *Shelton v. Tucker*, 364 U.S. 479 (1960); cf. 5 U.S.C.A. § 552a(e)(1) (1974).

