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# The Liability of Psychotherapists for Breach of Confidentiality

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# THE LIABILITY OF PSYCHOTHERAPISTS FOR BREACH OF CONFIDENTIALITY

ELLEN W. GRABOIS<sup>1</sup>

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## I. INTRODUCTION

### A. *Confidentiality as a Major Component of the Therapeutic Relationship*

Since its earliest beginnings, psychotherapy has been concerned with confidential communications. When a patient and a psychotherapist enter into a therapeutic relationship, the patient starts to reveal details about his thoughts and feelings that he or she may have told no other. The therapist becomes the "keeper of the secrets."<sup>2</sup> Freud, himself, was concerned about revealing case histories of his patients.<sup>3</sup> When he wrote about the hysteria of his patient Dora, and that her symptoms were the expression of her most secret and repressed

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<sup>2</sup>Paul V. Trad, *The Paradox of Confidential Communications*, 47 AM. J. PSYCHOTHERAPY 1 (1993).

<sup>3</sup>Sigmund Freud, *Fragment of an Analysis of a Case of Hysteria*, ("Dora"), in THE FREUD READER 172-73 (Peter Gay ed., 1989). Freud wrote "Prefatory Remarks" before presenting the case of Dora. Dora was the first of Freud's five major case histories, and Freud intended, as Peter Gay notes, to do an adjunct to his INTERPRETATION OF DREAMS. This case history was a record of a failure, in that Freud admitted he failed to pay sufficient attention to the transference phenomenon. Freud said he could avoid causing direct personal injury to his patient by taking every precaution in not disclosing her identity. She was from a provincial town and was not known in Vienna. Only one other physician knew she was a patient of his. He waited four years to publish this case.

wishes, he felt it necessary to discuss the intimacies of which she had spoken. This was, in effect, a betrayal of her secrets.<sup>4</sup> Freud said, "It is certain that the patients would never have spoken if it had occurred to them that their admissions might possibly be put to scientific uses, and it is equally certain that to ask them themselves for leave to publish their case would be quite unavailing."<sup>5</sup> Freud felt a greater obligation as a physician to publish what he believed to be the causes of his patient's disease, in order to educate others, and stated it was cowardice to neglect to do so.<sup>6</sup>

Although confidentiality has been a major component of the psychotherapeutic relationship since Freud, sometimes there is a breach of that confidentiality. Patients will seek to hold the therapist liable for the breach. This paper will touch upon the nature of a cause of action of breach of confidentiality by psychotherapists, and how the courts have handled these cases. It will discuss the scarcity of cases in this area of the law, and why this scarcity exists. It will also explain why there is confusion in the courts as to how to rule in breach of confidentiality cases. In 1982, one commentator<sup>7</sup> noted that the courts were "just beginning to formulate an adequate common law remedy for unconsented disclosures of personal information in breach of confidence."<sup>8</sup> This same commentator stated that while some courts had clearly recognized a breach of confidence tort, most courts had resorted to "a confused tangle of legal theories, including invasion of privacy, implied term of contract, implied private cause of action in statute, and tortious breach of confidence."<sup>9</sup> In 1997, this "confused tangle of legal theories" has not always been made clearer by the plaintiffs, by the defendants, or by the courts.

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<sup>4</sup>*Id.* at 173.

<sup>5</sup>*Id.* at 173-74.

<sup>6</sup>*Id.* at 174. *See also* Trad, *supra* note 2, at 1-2. Trad noted, "After all, Freud was keenly aware of the revolutionary insights emerging from his experimental treatment. As one who wanted to share this material with his fellow physicians, as well as one who was ambitious and eager for recognition, Freud may have felt that the duty to disclose for the purpose of sharing scientific information weighed almost if not equally heavily as the duty to share new information with the medical community."

<sup>7</sup>Alan B. Vickery, *Breach of Confidence: An Emerging Tort*, 82 COLUM. L. REV. 1426 (1982). Vickery's Note included cases mainly about patients suing physicians, and clients suing banks for breach of confidential relations. Although Vickery recognized that other relationships have a confidential component, such as lawyer-client, counselor-advisee, priest-penitent, and accountant-client, he said there was no explanation for the low incidence of cases involving these relationships. Vickery postulated that possibly physicians and banks more frequently break confidences. Vickery also noted that every member of society engages in relationships of trust and confidence, because we turn to others for assistance in matters beyond our individual knowledge or capacities.

<sup>8</sup>*Id.*

<sup>9</sup>*Id.* at 1437.

This paper will try to reconstruct the legal and ethical underpinnings of the confidential relationship of psychotherapist and patient, and will also touch upon the psychotherapist-patient testimonial privilege and its exceptions. It will then describe the liability of psychotherapists for breach of confidentiality based on contract and tort. It will conclude with some evaluation of this type of cause of action, and its future usefulness in the law.

More than ever before, the public has become aware of breach of confidentiality of the therapeutic relationship. In 1986, when Diane Wood Middlebrook was writing an authorized biography of the poet Anne Sexton, Anne Sexton's psychiatrist made 300 therapy tapes available to the biographer.<sup>10</sup> Although Anne Sexton had provided detailed instructions in her will about the disposition of her papers, including some therapy notebooks and four audio tapes of therapy sessions with her psychiatrist Dr. Martin Orne,<sup>11</sup> she had left 300 tapes in Dr. Orne's possession, with no instructions as to their disposition. Dr. Orne had the permission of Sexton's daughter and literary executor, Linda Gray Sexton, to allow Middlebrook to hear the tapes.<sup>12</sup>

This release of Sexton's therapy tapes caused great consternation in literary and psychiatric circles.<sup>13</sup> One psychiatrist called Dr. Orne's actions a "betrayal of his patient and his profession."<sup>14</sup> Another noted the right of confidentiality survives the patient's death, and only the patient can give a release. The family's wishes did not matter.<sup>15</sup> Dr. Orne believed Anne Sexton would have jumped at the chance to share the tapes.<sup>16</sup> Charges were brought against Dr.

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<sup>10</sup>Tamar R. Lehrich, *To Bedlam and Part Way Back: Anne Sexton, Her Therapy Tapes and the Meaning of Privacy*, 2 UCLA WOMEN'S L.J. 165, 167 (1992). See also, DIANE W. MIDDLEBROOK, *ANNE SEXTON: A BIOGRAPHY* (1991). The preface, at page xxii of this work, contains the author's reference to the use of the 300 tapes in writing her biography.

<sup>11</sup>Lehrich, *supra* note 10, at 166-67. Anne Sexton had committed suicide in 1974. Her daughter, Linda Gray Sexton, as her literary executor, placed her papers, notebooks and the four audio tapes at the University of Texas. When Linda Sexton asked Middlebrook to be her mother's biographer in 1980, she gave the Stanford English professor access to all the materials. When Middlebrook interviewed Dr. Orne, he offered the additional 300 tapes to Middlebrook. Linda Gray Sexton had complete veto power over what went into the biography. See also Alessandra Stanley, *Poet Told All; Therapist Provides the Record*, N.Y. TIMES, July 15, 1991, at A1, C13. As a result of listening to the tapes, Middlebrook completely rewrote her manuscript of Sexton's life. Dr. Orne, Sexton's children and Sexton's friends believed Anne Sexton would have agreed to the release of the tapes.

<sup>12</sup>See Martin T. Orne, *The Sexton Tapes*, N.Y. TIMES, July 23, 1991, at A21. Dr. Orne stated he offered to return the tapes to Sexton when he moved from Massachusetts, where he treated Sexton. Sexton asked him to keep the 300 tapes to use them as he saw fit to help others.

<sup>13</sup>Stanley, *supra* note 11, at A1.

<sup>14</sup>*Id.*

<sup>15</sup>*Id.*

<sup>16</sup>*Id.* Dr. Orne said Anne Sexton chose disclosure of her therapy in keeping with what she stood for as a confessional poet. See Orne, *supra* note 12, at A21.

Orne for violations of the Code of Ethics of the American Psychiatric Association, but a decision was made that no ethical violation occurred.<sup>17</sup>

Although no cause of action for breach of confidentiality took place with the release of Sexton's therapy tapes, the public uproar is instructive concerning the new challenges patients and their therapists face as confidentiality is redefined.<sup>18</sup> Professionals and clients have widely divergent attitudes, beliefs, expectations, and values concerning confidentiality.<sup>19</sup> When those attitudes clash, a suit for breach of confidentiality may be the only recourse for the client.

### B. Paucity of Cases

One prefatory note to this paper must be the dearth of cases reported for breach of confidentiality in psychotherapy. Over the years, many articles have been written by legal commentators on malpractice in the area of psychiatry and psychotherapy, without great numbers of illustrative cases. The reasons for the paucity of cases can vary. When referring to malpractice and psychotherapy in general, commentators note that the elements of a case of negligence are difficult to prove.<sup>20</sup> The standard of care for a psychotherapist is not as clearly defined as it is in other areas of medicine,<sup>21</sup> and causation and damages may be hard to prove.<sup>22</sup> There are large numbers of schools of thought in psychotherapy and this complicates defining a clear standard of care.<sup>23</sup> One author puts the number at 450 different schools of psychotherapy, and feels this number is increasing.<sup>24</sup>

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<sup>17</sup>William Winslade, *Confidentiality*, in 1 *Encyclopedia of Bioethics* 451, 454 (Warren Reich, ed., 1995). See also Lehigh, *supra* note 10, at 168-169. Lehigh noted that the psychiatric establishment and the media saw the key issue as whether Sexton herself would have wanted the therapy tapes to be made available to her biographer and, therefore, to the public. It was impossible to know what Sexton would have wanted, and the question should have been whether to release the tapes at all, without clear evidence of her preference.

<sup>18</sup>Lehigh, *supra* note 10, at 169.

<sup>19</sup>Winslade, *supra* note 17, at 454.

<sup>20</sup>Steven R. Smith, *Mental Health Malpractice in the 1990s*, 28 *HOUS. L. REV.* 209, 213 (1991). See also Hope R. Conte & Toksoz B. Karasu, *Malpractice in Psychotherapy: An Overview*, 44 *AM. J. PSYCHOTHERAPY* 232, 233 (1990); Richard B. Margulies, *Psychiatric Negligence*, 23 *DRAKE L. REV.* 640 (1974); H. Richard Beresford, *Professional Liability of Psychiatrists*, 21 *DEFENSE L.J.* 122, 123 (1972); DONALD J. DAWIDOFF, *THE MALPRACTICE OF PSYCHIATRISTS: MALPRACTICE IN PSYCHOANALYSIS, PSYCHOTHERAPY AND PSYCHIATRY* 19 (1973).

<sup>21</sup>Smith, *supra* note 20, at 214.

<sup>22</sup>*Id.*

<sup>23</sup>*Id.*

<sup>24</sup>ROBERT I. SIMON, *CLINICAL PSYCHIATRY AND THE LAW*, 399 (1987). Simon states "it is almost impossible to establish a general standard of care among psychiatrists when so many disagree concerning the indications and effectiveness of the myriad therapeutic modalities now in existence." *Id.* Trying to prove proximate cause of psychic damage is

A second reason for a paucity of malpractice cases with respect to psychotherapy is that there is rarely a physical injury; negligence in this area usually only exacerbates a pre-existing emotional disorder.<sup>25</sup> Courts are slower providing remedies for purely emotional injuries,<sup>26</sup> and larger damages usually are awarded where the mental injuries relate to a physical harm.<sup>27</sup> A third reason for the paucity of cases is that patients are reluctant to expose their mental health problems to the world.<sup>28</sup> The patient's personal problems become open to family and friends, and are made part of a public record.<sup>29</sup> Patients prefer not to sue in order to avoid the exposure. A fourth reason for potential plaintiffs not suing their therapists includes frequency of contacts, which leads to good rapport between therapist and patient.<sup>30</sup> Patients and therapists may have an intense relationship.<sup>31</sup> Patients are therefore reluctant to file suit.<sup>32</sup> Two additional factors may explain the lack of claims by patients against their therapists. These factors have a close connection to the intensity in this type of therapeutic relationship. One factor is that patients do not recognize the psychotherapist's role in their distress,<sup>33</sup> and the other is that

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difficult to establish because many factors influence the course of an emotional illness. What one therapist sees as damage, another might see as progress. *Id.* See also J. Scott Rutan & James E. Groves, *The Value System of the Psychotherapist*, in *PSYCHOTHERAPY FOR THE 1990'S*, at 3 (J. Scott Rutan, ed., 1992), "One of the intriguing aspects of the current psychotherapy scene is the multitude of competing philosophies and theories about how psychotherapy is supposed to work. Each theory has some accumulated research and much subjective data to support the hypothesis that it is a viable theory that yields effective therapeutic technique. Perhaps it is important to recognize that no 'correct' answer is yet available to explain the human condition fully."

<sup>25</sup>Conte, *supra* note 20, at 232. See also Smith, *supra* note 20, at 215.

<sup>26</sup>*Id.*

<sup>27</sup>Smith, *supra* note 20, at 215. Smith notes that emotional injury is real and painful, but to a jury it is not as obvious or gruesome as a physical injury.

<sup>28</sup>Samuel Knapp & Leon VandeCreek, *Malpractice as a Regulator of Psychotherapy*, 18 *PSYCHOTHERAPY: THEORY RES. & PRAC.* 354, 356 (1981). See also Smith, *supra* note 20, at 216.

<sup>29</sup>Smith, *supra* note 20, at 216.

<sup>30</sup>Conte, *supra* note 20, at 233. See also Smith, *supra* note 20, at 217; Patrick S. Cassidy, *The Liability of Psychiatrists for Malpractice*, 36 *UNIV. PITT. L. REV.* 108, 130-31 (1974). Cassidy feels that the patient regards the psychiatrist as his friend. When you add in the transference phenomenon, the patient would no sooner think of suing the psychiatrist than most people would think of suing their parents. There is an inverse correlation between the contact a physician has with his patient, and the incidence of malpractice actions.

<sup>31</sup>Conte, *supra* note 20, at 233. See also Smith, *supra* note 20, at 217.

<sup>32</sup>*Id.*

<sup>33</sup>Conte, *supra* note 20, at 233. See also Beresford, *supra* note 20, at 123.

psychotherapists are experts at handling people and their emotions.<sup>34</sup> If a patient is dissatisfied, the therapist can satisfy his or her doubts, or dissuade the patient from his or her anger.<sup>35</sup>

One author gives two reasons for the small number of breach of confidentiality cases.<sup>36</sup> One is that psychiatrists, about whose malpractice he wrote, are probably very conscientious about guarding their patients' confidentiality, and secondly, many of these types of cases are settled out of court.<sup>37</sup> Breach of confidence is relatively easy to determine, damages are low, and the defenses of the psychiatrist are few.<sup>38</sup>

The scarcity of cases in this area of malpractice can be illustrated by statistics. In 1968, a study in California showed that 1.5 claims were filed per 100 psychiatrists annually, as opposed to 25 claims per 100 physicians annually.<sup>39</sup> That same figure was reported nationally in 1975.<sup>40</sup> In 1980, the National Association of Insurance Commissioners reported the results of a study between 1974 and 1978, and said the rate of claims against psychiatrists represented only three-tenths of one percent of all malpractice actions against physicians nationwide.<sup>41</sup> The average indemnity paid was only \$31,000, and the data illustrate that psychiatry had one of the best malpractice records of all medical specialties.<sup>42</sup> Claims of malpractice in psychotherapy represented only a small figure, and "technical legal problems," including breach of confidentiality, accounted for about half of these psychotherapy claims.<sup>43</sup> In

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<sup>34</sup>Cassidy, *supra* note 30, at 131.

<sup>35</sup>*Id.* See also Lawrence P. Hampton, *Malpractice in Psychotherapy: Is There A Relevant Standard of Care?*, 35 CASE W. RES. L. REV. 251 (1984). Hampton states that the psychotherapist may convince the patient that he was not harmed in therapy, and often the patient has difficulty proving that the treatment caused the injury.

<sup>36</sup>Seymour L. Halleck, *Malpractice in Psychiatry*, 6 PSYCHIATRIC CLINICS N. AM. 567, 570 (1983).

<sup>37</sup>*Id.*

<sup>38</sup>*Id.*

<sup>39</sup>Paul F. Slawson, *Psychiatric Malpractice: A Regional Incidence Study*, 126 AM. J. PSYCHIATRY 1302 (1970). See also, Paul F. Slawson, *Psychotherapist Malpractice: An Emerging Risk*, 23 CURRENT PSYCHIATRIC THERAPIES 161, 162 (1986).

<sup>40</sup>Chester L. Trent & William P. Muhl, *Professional Liability Insurance and the American Psychiatrist*, 132 AM. J. PSYCHIATRY 1312 (1975). See also Slawson, *supra* note 39, at 162.

<sup>41</sup>Paul F. Slawson & Frederick G. Guggenheim, *Psychiatric Malpractice: A Review of the National Loss Experience*, 141 AM. J. PSYCHIATRY 979 (1984). Of the 71,788 malpractice claims filed against physicians, only 217 were against psychiatrists. See also, Conte, *supra* note 20, at 232.

<sup>42</sup>*Id.* One third of the claims were closed without payment.

<sup>43</sup>*Id.* at 980. Of the 217 claims made against physicians practicing psychiatry, psychoanalysis or psychosomatic medicine between 1974 and 1978, only 16 were in the psychotherapy area. The total number of malpractice claims against physicians was



1988, the chance that a psychologist would be sued was reported at one-half of one percent, and the chance that a social worker would be sued was reported at an even lower rate.<sup>44</sup>

In 1983, a figure of three and one-half percent of malpractice claims against psychiatrists was reported, as opposed to other medical specialists, with the potential that the figure could reach five or six percent.<sup>45</sup> In a more recent study in Maryland in 1991, psychiatric claims were only two percent of all the medical malpractice claims closed against all health providers.<sup>46</sup> The number of claims against therapists, while low, was going up.<sup>47</sup> Damage awards were going up also. The average psychiatric claim in the mid-1970s was estimated at \$5,000, and by the mid-1980s was \$70,000.<sup>48</sup> In 1991, damage awards began to reach one and a half million dollars.<sup>49</sup> The American Medical Association reported during the years 1985 to 1993 that the rate of annual professional liability claims per 100 physicians varied from 0.6 to 5.1 for psychiatrists.<sup>50</sup> The rate in 1985 was 2.9 and in 1993 was 4.2. This was the second lowest rate of all the specialties included, and showed generally an increase.<sup>51</sup>

While the claims against therapists are low, they are on the rise for a number of reasons. There is a more open attitude about psychotherapeutic treatment, coupled with increased expectations of its efficacy. There is more emphasis on mental patients' rights and new legal duties imposed on therapists arising out of the therapist-patient relationship. Of course, the larger judgments coming out of lawsuits based on psychiatric malpractice may encourage new plaintiffs to bring suit.<sup>52</sup>

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more than 71,000. The study was reassuring to psychiatrists that so few claims were filed against them.

<sup>44</sup>Conte, *supra* note 20, at 232. Conte and Karasu reported that, in 1988, the Chairman of the American Psychological Association Insurance Trust estimated these figures.

<sup>45</sup>Slawson, *supra* note 39, at 162.

<sup>46</sup>Laura L. Morlock, et al., *Psychiatric Malpractice Claims in Maryland*, 14 INT'L. J. L. & PSYCHIATRY 331, 334 (1991). The study covered the years 1978 to 1985. All claims were filed with the Maryland Health Claims Arbitration Office (HCAO). Data came from 13 insurance companies responsible for writing 85% of the medical liability insurance in Maryland.

<sup>47</sup>Slawson, *supra* note 39, at 162.

<sup>48</sup>*Id.*

<sup>49</sup>Morlock, *supra* note 46, at 340.

<sup>50</sup>AMERICAN MEDICAL ASSOCIATION, CENTER FOR HEALTH POLICY RESEARCH, SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE 32 (1995). The average annual rate of professional liability claims per 100 physicians was 9.8 in 1993. The rate for psychiatrists was well below that figure.

<sup>51</sup>*Id.* Only pathologists had lower rates of professional liability claims.

<sup>52</sup>Sheila Taub, *Psychiatric Malpractice in the 1980's: A look at Some Areas of Concern*, 11 LAW, MED. & HEALTH CARE 97 (1983).

## II. WHAT IS PSYCHOTHERAPY AND WHO ARE THE PSYCHOTHERAPISTS?

### A. What is Psychotherapy?

Psychotherapy is a process involving a special kind of relationship between a person who asks for help with a psychological problem (the patient) and a person who is trained to provide that help (the therapist).<sup>53</sup> It is traditionally thought of as a procedure or treatment that restores the mentally ill person to health.<sup>54</sup> Psychotherapeutic treatment can be broken down into two basic treatment approaches: physical therapy and verbal psychotherapy.<sup>55</sup> Physical treatments include the use of psychotropic drugs and electroconvulsive therapy (ECT), consisting of chemical, hormonal or physical measures which affect the brain directly or indirectly, and thereby produce behavioral changes.<sup>56</sup> Physical treatments are commonly used in institutional settings. Verbal psychotherapy is the more prevalent mode of practice in a private, noninstitutional setting.<sup>57</sup>

Psychotherapy accords primacy to individual self-fulfillment or self-actualization. This includes maximum self-awareness, unlimited access to one's own feelings, increased autonomy and creativity.<sup>58</sup> The individual is seen as the center of his moral universe, and concern for others is believed to follow from his own self-realization.<sup>59</sup> The power of the psychotherapist derives from his socially sanctioned role as a healer, which he achieves by undergoing special training. Together with his personal qualities, this enables the patient to form a trusting, emotionally charged relationship with the psychotherapist.<sup>60</sup>

Furrow lists three predominant systems in psychotherapy: directive or behavioral, dynamic and experiential.<sup>61</sup> Directive psychotherapy includes primarily "techniques based upon behavioral therapy that require the patient to follow certain behavioral procedures intended to modify or remove symp-

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<sup>53</sup>C.H. PATTERSON, *THEORIES OF COUNSELING AND PSYCHOTHERAPY* 1 (1980).

<sup>54</sup>1 DANIEL HOGAN, *THE REGULATION OF PSYCHOTHERAPISTS; A STUDY IN THE PHILOSOPHY AND PRACTICE OF PROFESSIONAL REGULATION* 205 (1979).

<sup>55</sup>BARRY R. FURROW, *MALPRACTICE IN PSYCHOTHERAPY* 4,5 (1980).

<sup>56</sup>*Id.*

<sup>57</sup>*Id.*

<sup>58</sup>OVERVIEW OF THE PSYCHOTHERAPIES 8 (GENE USDIN, ed., 1975). *See also* William B. Stiles, *Psychotherapeutic Process: Is There A Common Core?* *THE NEWER THERAPIES: A SOURCEBOOK* 8 (Lawrence E. Abt & Irving R. Stuart, eds., 1982). Stiles writes that most models of personality describe a healthy individual as having a wide range of options. Freedom from psychopathology opens up many paths rather than converging on a single pattern of good adjustment.

<sup>59</sup>*Id.*

<sup>60</sup>*Id.* at 9.

<sup>61</sup>FURROW, *supra* note 55, at 5.

toms rather than to explore underlying motivation."<sup>62</sup> Dynamic therapy involves a trained person who establishes a professional relationship with the patient, using verbal or nonverbal communication to review the sources of the difficulties in the patient's past. The goal is to promote positive personality change and development.<sup>63</sup> Classical psychoanalysis is one approach of dynamic psychotherapy. It was originated by Freud<sup>64</sup> and the patient experiences the transference phenomenon.<sup>65</sup> The therapist interprets and reveals to the patient the unconscious impulses motivating his distorting behavior. This leads to an intense emotional relationship between the therapist and patient, involving considerable dependency, and sustains the patient through painful explorations which must ultimately be resolved.<sup>66</sup> The patient foists his fantasy wishes concerning objects of the past on the analyst.<sup>67</sup>

The third system of psychotherapy, as listed by Furrow, is experiential. It embraces a variety of approaches based upon a "mystical, nonscientific orientation."<sup>68</sup> Each of these three systems may have a variety of methods, and it is not surprising therefore, that there are a myriad of psychotherapeutic schools of thought.<sup>69</sup> Furrow finds doctrinal differences in all of these, but also finds common features: goals accepted by both patient and therapist, a provision of new information through precept or self-discovery, the furnishing of success experiences, aiding the patient to arouse his emotions, and,

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<sup>62</sup>*Id.* See also DAWIDOFF, *supra* note 20, at 8. Dawidoff calls this therapy analytically oriented ameliorative therapy. The therapy is an attempt to identify the behavior pattern which the patient is undergoing. This process of analysis gives the patient command of their symptoms and enables them to overcome their behavior by their own control. This insight helps the patient control their damaging behavioral symptoms.

<sup>63</sup>*Id.*

<sup>64</sup>CURRENT PSYCHOTHERAPIES 5 (Raymond J. Corsini, ed., 1979 [hereinafter PSYCHOTHERAPIES]).

<sup>65</sup>SIX APPROACHES TO PSYCHOTHERAPY 29 (James L. McCary, ed., 1955) [hereinafter PSYCHOTHERAPY].

<sup>66</sup>*Id.*

<sup>67</sup>PSYCHOTHERAPIES, *supra* note 64, at 17. See also, DAWIDOFF, *supra* note 20, at 9-10. Dawidoff notes that during psychotherapy, the therapist indulges in what is called counter-transference. The therapist engages in a counteraction to the patient, which is his own anxious reaction toward the patient. He must control this reaction in himself as he leads the patient's transference into coherent paths.

<sup>68</sup>FURROW, *supra* note 55, at 5.

<sup>69</sup>PSYCHOTHERAPY, *supra* note 65, at 2-4. McCary lists the different psychotherapeutic schools as both supportive and reconstructive methods. Supportive methods give direct assistance to the patient through persuasion, relaxation, etc., and include techniques such as music therapy, dance therapy, desensitization, hypnotherapy, reassurance, rest and others. Reconstructive methods are more intense and try to effect a permanent reorganization of the patient's personality structure. These include classical psychoanalysis, Gestalt therapy, client-centered therapy, analytic group therapies, and others.

especially, an emotionally charged relationship in which confidences are revealed.<sup>70</sup>

### B. Who are the Psychotherapists?

The therapist's task is to give the patient once again the intellectual and emotional experience of the unhealthy child-parent relationship, and to point out and allow the patient to realize the faultiness of his behavior pattern, or at least its consequences in his own life, so that the patient may give up any damaging patterns. The therapist may give the patient his own model to steer by, and to emulate. The patient, therefore, has something to hold onto that is strong and healthy while he is in a state of search. After the patient has more confidence, he may be able to locate where his own patterns of living would be and to follow them.<sup>71</sup>

A variety of professionals may fulfill the role of psychotherapist. Freud himself was a physician, with an interest in neurology, who came to develop psychoanalysis.<sup>72</sup> Today, medical doctors can specialize in psychiatry, and do psychotherapy and psychoanalysis. Physicians have the ability, in conjunction with doing psychotherapy, of prescribing medication for patients. Clinical psychologists, including those with doctorate and master's degrees, may also do psychotherapy. Additional professionals who establish psychotherapeutic relationships are social workers, marital and family counselors and the clergy. This paper will focus mainly on cases involving psychiatrists and psychologists, but may include references to other professionals doing psychotherapy.

### C. Nature of the Relationship Between Psychotherapist and Patient

#### 1. Necessity of Confidentiality

Guttmacher and Weinhofen have noted that the psychiatric patient "confides more utterly than anyone else in the world."<sup>73</sup>

He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins, and his shame. Most patients who undergo psychotherapy know that this is

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<sup>70</sup>FURROW, *supra* note 55, at 5.

<sup>71</sup>DAWIDOFF, *supra* note 20, at 9.

<sup>72</sup>PSYCHOTHERAPIES, *supra* note 64, at 6.

<sup>73</sup>MANFRED GUTTMACHER & HENRY WEINHOFEN, *PSYCHIATRY AND THE LAW* 272 (1952). See also, *Taylor v. United States*, 222 F.2d 398, 401 (D.C. Cir. 1955) and *State v. Sullivan*, 60 Wash. 2d 214, 225, 373 P.2d 474, 480 (1962). In *Taylor*, the court quoted Guttmacher and Weinhofen in a discussion of the physician-patient privilege, and said the policy behind the statute was especially necessary with respect to mental patients. A psychiatrist must have his patient's confidence.

what will be expected of them, and that they cannot get help except on that condition.<sup>74</sup>

Communications between a patient and a psychotherapist are, by their very nature, confidential. Patients often reveal thoughts to psychotherapists that they have revealed to no one else. Patients who express hidden thoughts and desires generally expect that such information will be kept confidential.<sup>75</sup> Unless patients are assured of confidentiality, they may be reluctant to communicate all their thoughts. This silence defeats the purpose of psychotherapeutic treatment, and would make the treatment ineffectual.<sup>76</sup> Citizens who address and resolve mental health problems are able to cope and are productive members of society.<sup>77</sup>

## 2. Confidentiality and Privacy

Winslade and Ross tell us confidentiality presupposes a relationship between two (or more) persons, one of whom exposes himself or herself in some way to the other(s) or discloses personal information to the other(s). Confidentiality may be expected because the recipient promised it, because the law recognizes it or because professional ethics demand it.<sup>78</sup> Confidentiality flows not simply from the character of the information, but from the context of the disclosure and from the nature of the relationship between the discloser and the recipient of the information.<sup>79</sup>

Confidentiality is not the same concept as privacy. In fact, the two concepts are often confused. Winslade and Ross remind us that which is private is isolated, singular, is owned by or belongs to one. That which is confidential is shared.<sup>80</sup> Another commentator likens privacy to images of ubiquitous clouds that envelop individuals, shielding what is within from the senses of others. We bring into these clouds only those to whom we are willing to expose certain personal matters. Few people disagree that we each have certain expectations

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<sup>74</sup>*Id.*

<sup>75</sup>William W. Hague, *The Psychotherapist-Patient Privilege in Washington: Extending the Privilege to Community Mental Health Clinics*, 58 WASH. L. REV. 565, 569 (1983).

<sup>76</sup>*Id.* at 569-70.

<sup>77</sup>Bridget McCafferty, *The Existing Confidentiality Privileges as Applied to Rape Victims*, 5 J.L. & HEALTH 101, 115-16 (1990-91).

<sup>78</sup>William J. Winslade & Judith W. Ross, *Privacy, Confidentiality and Autonomy in Psychotherapy*, 64 NEB. L. REV. 578, 594 (1985).

<sup>79</sup>*Id.* at 595.

<sup>80</sup>*Id.* at 583. See also, Walter J. Friedlander, *The Bases of Privacy and Autonomy in Medical Practice* 16 SOC. SCI. & MED. 1709, 1710 (1982). Friedlander calls privacy a voluntarily selected degree of isolation obtained by the construction of a wall or boundary which separates the person from the rest of the world. This delimiting border permits the person to be a distinct entity.

of privacy that should be protected from the intrusions of others.<sup>81</sup> Privacy is bound up with self-respect and personal integrity; confidentiality is important because it protects the privacy of the individual.<sup>82</sup>

The individual's need for privacy is also sometimes confused with right to privacy protected by federal constitutional law.<sup>83</sup> Warren and Brandeis first recognized this right in their famous article in the Harvard Law Review in 1890, in which they noted a "general right of the individual to be let alone."<sup>84</sup> They also said that the common law secured to each individual the right of determining to what extent his thoughts, sentiments and emotions should be communicated to others.<sup>85</sup> The United States Supreme Court has enforced this right to be let alone, and for the individual to make decisions free of governmental interference in the areas of marriage,<sup>86</sup> procreation,<sup>87</sup> family relationships,<sup>88</sup> child rearing<sup>89</sup> and education.<sup>90</sup> The Constitution does not explicitly delineate this right to privacy in fundamental relationships and interests, but the individual is guaranteed to have certain zones of privacy found in the penumbras of the Bill of Rights.<sup>91</sup> In fact, one court has held that the dimensions of a zone of privacy will include the interest to independently

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<sup>81</sup>David Hayden, *Should There Be A Psychotherapist Privilege in Military Courts-Martial?* 123 MIL. L. REV. 31, 42 (1989).

<sup>82</sup>James Murray, *New Concepts of Confidentiality in Family Practice*, 3 J. FAM. PRACTICE 229, 230 (1986). Confidentiality makes possible, within the professional relationship, an exchange of information of an intimate kind, aiding communication and providing a basis of trust between physicians and patients.

<sup>83</sup>Winslade & Ross, *supra* note 78, at 581. In *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977), the Supreme Court concluded there is an individual interest in avoiding disclosures of personal matters, and a more general interest in making certain kinds of important decisions independently. *See also*, *Paul v. Davis*, 424 U.S. 693, 713 (1976).

<sup>84</sup>Samuel D. Warren & Louis D. Brandeis, *The Right To Privacy*, 4 HARV. L. REV. 193, 205 (1890). Warren and Brandeis noted the intensity and complexity of modern life had rendered to men the necessity of some solitude or retreat from the world. Their article was provoked as a reaction to the invention of the flash photograph, and the immediate circulation of photographs and publicity in newspapers. There must be protection of one's thoughts, and if an individual chooses to express those thoughts, one can fix the limits of publicity given to them.

<sup>85</sup>*Id.* at 198.

<sup>86</sup>*Loving v. Virginia*, 388 U.S. 1 (1967).

<sup>87</sup>*Skinner v. Oklahoma*, 316 U.S. 535 (1942).

<sup>88</sup>*Prince v. Massachusetts*, 321 U.S. 158 (1944).

<sup>89</sup>*Pierce v. Society of Sisters*, 268 U.S. 510 (1925).

<sup>90</sup>*Meyer v. Nebraska*, 262 U.S. 390 (1923).

<sup>91</sup>*Griswold v. Connecticut*, 381 U.S. 479 (1965). *See also*, *Roe v. Wade*, 410 U.S. 113 (1973) and *Lora v. Bd. of Educ.*, 74 F.R.D. 565 (E.D.N.Y. 1977).

make choices that effect personal physical or mental health, or more specifically - the right to be free to seek benefit from psychotherapeutic counseling.<sup>92</sup>

### 3. Necessity of Trust and the Freedom to Disclose in Psychotherapeutic Relationship

Not only is confidentiality necessary in psychotherapy, but the patient must trust and feel free to disclose all pertinent information to the therapist. Winslade and Ross tell us that if an individual sits down beside a stranger and begins to divulge private information, there is no expectation of confidentiality, for confidentiality assumes a relationship to another with trust. Between strangers, there is no implicit trust.<sup>93</sup> Especially when there is a professional relationship of doctor and patient, one court has concluded that the patient will repose a great deal of trust in the skill of the physician and on his discretion as well.<sup>94</sup> When an "aura of trust" is introduced into a physician-patient relationship, and there is an expectation of confidentiality resulting from that trust, the physician becomes a fiduciary with the similar obligations that a trustee has for the *cestui que trust*.<sup>95</sup>

Once a trusting relationship is established between therapist and patient, the patient should feel free to disclose all the information necessary to help him gain insight during therapy. In *Hammonds v. Aetna Casualty & Surety Co.*,<sup>96</sup> the court noted that nothing is more important or intimate to man than the health of his mind and body. A layman is unfamiliar with the road to recovery and cannot sift through the circumstances of his life and habits to determine what information is pertinent to his health. As a consequence the patient must disclose all information - even that which is embarrassing, disgraceful or incriminating. There can be no reticence, no reservation, or no reluctance on the part of the patient. Yet all disclosures must be private.<sup>97</sup>

Lipkin stresses that in all psychotherapeutic relationships there is a common feature: a person turns to a stranger and reveals deeply personal and intimate details about his private life that is information no one else may know. This information is not just a compilation of isolated details concerning the person's past, but is information revealing the person's basic nature, his techniques for

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<sup>92</sup>Lora v. Bd. of Educ., 74 F.R.D. 565 (E.D.N.Y. 1977).

<sup>93</sup>Winslade & Ross, *supra* note 78, at 595.

<sup>94</sup>Hammonds v. Aetna Casualty & Surety Co., 243 F. Supp. 793, 802 (N.D. Ohio 1965). In this Ohio case, a physician's insurer induced the physician to divulge confidential information gained in the doctor-patient relationship, on a false pretext that the patient was contemplating a malpractice suit against the physician. This was a violation of the physician's legal and ethical responsibility to the patient not to divulge confidential information. The insurer was held to have induced a breach of the trustee's (the physician's) duty of loyalty, and was therefore liable to the patient.

<sup>95</sup>*Id.* at 803.

<sup>96</sup>*Id.* at 802.

<sup>97</sup>*Id.* at 801.

dealing with stress and his strategies for interacting with other people. The process by which the information is revealed sheds new light on the structure of the individual's personality in ways that can surprise, sadden, and shock even the person himself.<sup>98</sup> For the patient to reveal his personality, he needs the protection of confidentiality so that there is no fear of recriminations from others.<sup>99</sup>

### III. A LOOK BACK AT HOW CONFIDENTIALITY DEVELOPED BETWEEN PSYCHOTHERAPIST AND PATIENT

#### *A. Professional and Ethical Codes*

Professional and ethical codes have long protected the confidentiality of patients in their relations with health care professionals. Since the Fourth Century B.C., the Hippocratic Oath has called on physicians to maintain the confidentiality of patient communications: "And whatsoever I shall see or hear in the course of my profession, as well as outside my profession, in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secret."<sup>100</sup> Freud, as a physician, was bound by the Hippocratic Oath, and was concerned with the disclosures of his patients' confidences. The American Medical Association, early in its history, also was concerned with the ethics of its physician members<sup>101</sup> and has continually affirmed the importance of confidentiality in its Code of Medical Ethics. In 1992, the Current Opinions of the Code included a section on confidentiality:

The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the

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<sup>98</sup>Robert Lipkin, *Intimacy and Confidentiality in Psychotherapeutic Relationships*, 10 THEORETICAL MED. 311 (1989). Lipkin theorizes that psychotherapeutic relationships cannot be explained in terms of intimacy, but instead are a form of moral advice. This dimension poses a natural limit on confidentiality. The moral nature of the relationship restricts the scope of confidentiality. If a therapist sees that his patient is about to harm a third person, the therapist has a legal duty to warn the third person, but also has a duty to his patient to see that he doesn't ruin his own life.

<sup>99</sup>*Id.* at 323.

<sup>100</sup>Robert Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Privacy*, 62 N.C. L. REV. 255, 267 (1984), quoting 1 Hippocrates 164-65 (W. Jones trans., 1923).

<sup>101</sup>The American Medical Association (AMA) adopted its first Code of Ethics in 1847 and it was based on Thomas Percival's Code of Medical Ethics of 1803. Percival had stated that, "Secrecy and delicacy, when required by peculiar circumstances, should be strictly observed." Any confidential communications during professional visits should be used "with discretion." The AMA, using Percival's language, included in its Code that a physician could only breach his obligation of secrecy when imperatively required to do so. After several Principles of Medical Ethics were written in 1902, 1912, 1957, and 1980, the 1980 version was reduced to eight fundamental concepts. Confidentiality was the fourth principle. See Gellman, *supra* note 100, at 255.



greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.<sup>102</sup>

The American Psychiatric Association has published for its physician members both the Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatry,<sup>103</sup> and also the Guidelines on Confidentiality.<sup>104</sup> In the Principles of Medical Ethics, psychiatrists are told they must respect the rights of patients, colleagues, and other health professionals, and that they must safeguard patient confidences within the constraints of the law.<sup>105</sup> The Guidelines on Confidentiality also tell psychiatrists that they should not discuss their patients with anyone who is not directly involved in their patients' care. Any material entered into patient records should be only that which is clearly necessary to the patient's care, and must be divulged only with the patient's freely given and informed consent.<sup>106</sup>

Other therapists are bound by ethical codes to keep information within the therapeutic relationship confidential. The American Psychological Association, in its Ethical Standards of Psychologists,<sup>107</sup> informs therapists that

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<sup>102</sup>AMERICAN MEDICAL ASSOCIATION, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS, CURRENT OPINIONS 5.05 (1992). The Code contains additional confidentiality sections on attorney-physician relations, computers, insurance company representatives, and physicians in industry. See Secs. 5.06-5.09. See also, AMERICAN MEDICAL ASSOCIATION, PROTECTING THE CONFIDENTIALITY OF PATIENT INFORMATION; CRITICAL SAFEGUARDS NEEDED FOR THE ELECTRONIC TRANSMISSION OF HEALTH DATA (1995).

<sup>103</sup>AMERICAN PSYCHIATRIC ASSOCIATION, THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY (1989) [hereinafter PRINCIPLES].

<sup>104</sup>American Psychiatric Association, *Guidelines on Confidentiality*, 144 AM. J. PSYCHIATRY 1522 (1987) [hereinafter *Guidelines*]. See also, American Psychiatric Association, MODEL LAW ON CONFIDENTIALITY OF HEALTH AND SOCIAL SERVICE RECORDS, 136 AM. J. PSYCHIATRY 138 (1979). The Model Law has definitions of "confidential information," "patient/client" and other terms. It also discusses authorized disclosures, waivers, insurance, personal notes of the therapist and other topics.

<sup>105</sup>Principles, *supra* note 102, at 5.

<sup>106</sup>Guidelines, *supra* note 103, at 1522.

<sup>107</sup>AMERICAN PSYCHOLOGICAL ASSOCIATION, ETHICAL STANDARDS OF PSYCHOLOGISTS 4 (1979). See Principle 5. Principle 5d on Confidentiality states: "The confidentiality of professional communications about individuals is maintained. Only when the originator and other persons involved give their express permission is a confidential professional communication shown to the individual concerned. The psychologist is responsible for informing the client of the limits of the confidentiality."

"safeguarding information about an individual that has been obtained by the psychologist in the course of his teaching, practice, or investigation is a primary obligation of the psychologist."<sup>108</sup> The National Association of Social Workers also has a Code of Ethics in which the social worker is told he or she should respect the privacy of clients and hold in confidence all information obtained in the course of professional service.<sup>109</sup> The social worker will share with others confidences revealed by clients, without their consent, only for compelling professional reasons.<sup>110</sup> All clients must be informed by the social worker of the limits of confidentiality in a given situation.<sup>111</sup> The American Counseling Association requires its members to adhere to a Code of Ethics which has a full section on confidentiality.<sup>112</sup> Counselors must respect their clients' right to privacy, and avoid illegal and unwarranted disclosures of confidential information.<sup>113</sup>

*B. Statutory Basis of Confidentiality: The Psychotherapist-Patient Privilege*

Not only do professional codes require the therapist to keep patient confidentiality, but therapists in many states are bound by rules of privileged communications. Privilege is the legal right of a person to remain silent on the witness stand.<sup>114</sup> Privileged communications are an exception to the general rule that all relevant facts may be inquired into by a court of law.<sup>115</sup>

There is a legal difference between the concepts of privilege and confidentiality. Privilege is an exception to the general rule that the public has a right to every man's evidence; confidentiality is an ethic that protects a patient

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<sup>108</sup>*Id.*

<sup>109</sup>National Association of Social Workers, *Code of Ethics* (1979) in BENJAMIN M. SCHUTZ, *LEGAL LIABILITY IN PSYCHOTHERAPY* 98-105 (1982). See also, National Association of Social Workers, *Standards for the Private Practice of Clinical Social Work* in BENJAMIN M. SCHUTZ, *LEGAL LIABILITY IN PSYCHOTHERAPY* 106-11 (1982).

<sup>110</sup>*Id.* at 98-105.

<sup>111</sup>*Id.*

<sup>112</sup>AMERICAN COUNSELING ASSOCIATION, *CODE ETHICS AND STANDARDS OF PRACTICE B* (1995).

<sup>113</sup>*Id.* at B 1 (a).

<sup>114</sup>Ralph Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 176 (1960).

<sup>115</sup>Brian Domb, *I Shot The Sheriff, But Only My Analyst Knows: Shrinking the Psychotherapist-Patient Privilege*, 5 J.L. & HEALTH 209, 211 (1990-91). The word privilege comes from the Latin words *private lex*, a prerogative given to a person or group of persons. A privilege was originally a judicially recognized point of honor among lawyers in England. The only privilege allowed under early common law was that of attorney and client. See also, Jonathan Baumel, *The Beginning of the End for the Psychotherapist-Patient Privilege*, 60 CINN. L. REV. 797 (1992). The physician-patient privilege and the psychotherapist-patient privilege did not exist at common law. Statutory recognition of the physician-patient privilege goes back to 1828 in New York.

or client from an unauthorized disclosure of information.<sup>116</sup> The presence of confidentiality alone is not enough to support a privilege. Without a privilege statute, a professional may be charged with contempt of court if he chooses not to testify. Confidentiality is a professional duty to refrain from speaking about certain matters, while privilege is a relief from the duty to speak in court proceedings.<sup>117</sup> Testimonial privileges serve a useful purpose in preserving the sanctity of confidential relationships that must, in the public interest, be fostered and protected.<sup>118</sup>

Dean Wigmore, in writing about privilege, noted that a privilege should meet four fundamental criteria to be legally recognized. These four criteria are universally accepted. First, the person must have made the communication in confidence; secondly, confidentiality must be essential to the relationship; thirdly, society must wish to foster such relationships; and fourthly, the injury to the relationship that would result from the disclosure must be greater than the benefit to the fact-finder resulting from disclosure.<sup>119</sup>

Some form of a psychotherapist-client privilege has been adopted in all states.<sup>120</sup> The privilege has received broad support within the legal commun-

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<sup>116</sup>*Id.* at 212.

<sup>117</sup>*Id.*

<sup>118</sup>Hayden, *supra* note 81, at 31-32.

<sup>119</sup>J. Wigmore, EVIDENCE § 2285 (1961). *See also*, David Snyder, *Disclosure of Medical Information under Louisiana and Federal Law*, 65 TULANE L. REV. 169, 175 (1990). *See also*, Hayden, *supra* note 81 at 35. Wigmore's four criteria are a good example for proponents of the existence of privilege based on a utilitarian theory. An unfavorable privilege is tolerated when harm to the confidential relationship from disclosure outweighs any advantage gained in the enhanced likelihood of accuracy in litigation. Society is best served by the privilege. Other theorists say the privilege is necessary to protect a person's right to privacy. This is the deontological or humanistic school. Society must recognize the individual's dignity by protecting certain relationships from unnecessary intrusions.

<sup>120</sup>Catharina Dubbelday, *The Psychotherapist-Client Testimonial Privilege: Defining the Professional Involved*, 34 EMORY L.J. 777, 796 (1985). *See also*, Baumoel, *supra* note 115, at 802. The psychotherapist-patient privilege statutes include: Alabama, ALA. CODE § 34-26-2 (1991); Alaska, ALASKA STAT. § 08.86.200 (1994); Arizona, ARIZ. REV. STAT. ANN. § 32-2085 (1992); Arkansas, ARK. CODE ANN. § 16-41-101 (Michie 1994); California, CAL. EVID. CODE § 1012 (West Supp. 1994); Colorado, COLO. REV. STAT. § 13-90-107(g) (1994); Connecticut, CONN. GEN. STAT. § 52-146 c, d (West Supp. 1995); Delaware, DEL. CODE ANN. tit. 24, § 3013 (1994); District of Columbia, D.C. CODE ANN. § 14-307 (1995); Florida, FLA. STAT. ANN. § 90.503 (West Supp. 1995); Georgia, GA. CODE ANN. § 24-9-21 (5) (1982); Hawaii, HAW. REV. STAT. § 33-626-1 (1988); Idaho, IDAHO CODE § 54-2314 (1994); Illinois, ILL. REV. STAT. ch. 225, para. 107/75 (1995); Indiana, IND. CODE ANN. § 25-33-1-17 (Burns 1995); Iowa, IOWA CODE ANN. § 622.10 (West Supp. 1995); Kansas, KAN. STAT. ANN. § 74-5323 (1992); Kentucky, KY. REV. STAT. ANN. § 422A.0507 (Michie/Bobbs-Merrill 1992); Louisiana, LA. REV. STAT. ANN. § 2363 (West 1988); Maine, ME. REV. STAT. ANN. tit. § 32, § 7005 (West 1988) (Social workers only); Maryland, MD. CODE ANN., CTS. & JUD. PROC. § 9-109 (1995); Massachusetts, MASS. GEN. LAWS ANN. ch. 233, § 20B (West Supp. 1995); Michigan, MICH. STAT. ANN. § 14.15 (18237) (Callaghan

ity.<sup>121</sup> Many commentators agree that the psychotherapist-patient privilege fulfills Wigmore's four conditions.<sup>122</sup> First, communications between a patient and a psychotherapist are, by their very nature, confidential. Patients expect their revelation to remain confidential. Secondly, numerous authorities maintain that confidentiality is essential to the maintenance of the psychotherapist-patient relationship. Otherwise, patients will be reluctant to communicate their thoughts. Thirdly, the psychotherapist-patient relationship is one that society fosters. Psychotherapeutic treatment has the potential to prevent or reduce antisocial and psychological ills before they are manifested in the form of delinquent social acts. Fourthly, in balancing the need for truth in the courtroom and the need for confidentiality in certain relationships, the need for confidentiality should be favored because the use of the privilege encourages people to seek treatment.<sup>123</sup>

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1994); Minnesota, MINN. STAT. ANN. § 595.02(g) (West Supp. 1995); Mississippi, MISS. CODE ANN. § 73-31-29 (1995); Missouri, MO. ANN. STAT. § 337.055 (Vernon 1989); Montana, MONT. CODE ANN. § 26-1-807 (1993); Nebraska, NEB. REV. STAT. § 27-504 (1994); Nevada, NEV. REV. STAT. ANN. § 49.215 (Michie 1986); New Hampshire, N.H. REV. STAT. ANN. § 330-A:19 (1995); New Jersey, N.J. STAT. ANN. § 45:14B-28 (West 1995); New Mexico, N.M. STAT. ANN. § 61-9-18 (Michie 1993) (effective July 1, 1996); New York, N.Y. CIV. PRAC. L. & R. 4507 (McKinney 1992); North Carolina, N.C. GEN. STAT. § 8-53.3 (1986); North Dakota, N.D. CENT. CODE § 503 (1994); Ohio, OHIO REV. CODE ANN. § 4732.19 (Anderson 1994); Oklahoma, OKLA. STAT. ANN. tit. 12, § 2503 (West 1993); Oregon, OR. REV. STAT. § 40.230 (1988); Pennsylvania, 42 PA. CONS. STAT. ANN. § 5944 (1995); Rhode Island, R.I. GEN. LAWS § 9-17-24 (1994); South Carolina, S.C. CODE ANN. § 44-22-90 (Law. Co-op 1994); South Dakota, S.D. CODIFIED LAWS ANN. § 19-13-7 (1995); Texas, TEX. R. CIV. EVID. 510; Utah, UTAH R. EVID. 506; Vermont, VT. STAT. ANN. tit. 12, § 1612 (1995); Virginia, VA. CODE ANN. § 8.01-400.2 (Michie 1992); Washington, WASH. REV. CODE ANN. § 18.83.110 (West Supp. 1995); West Virginia, W. VA. CODE § 27-3-1 (1992); Wisconsin, WIS. STAT. ANN. § 905.04 (West 1993); Wyoming, WYO. STAT. § 33-27-123 (1995).

<sup>121</sup>Marcia Templeton, *The Psychotherapist-Patient Privilege: Are Patients Victims in the Investigation of Medicaid Fraud?* 19 IND. L. REV. 831, 839 (1986). The psychotherapist-patient privilege is not the same as the physician-patient privilege. If a therapist is a physician, he or she may have protection from either privilege, or both. See also, Kathleen Cerveny & Marian Kent, *Evidence Law - The Psychotherapist-Patient Privilege in Federal Courts*, 59 NOTRE DAME L. REV. 791, 795 (1984). Cerveny and Kent write that the patient receiving psychiatric treatment needs more protection than the general patient of a physician. Confidentiality is critical to the psychiatric patient, to the psychotherapist, and to society.

<sup>122</sup>Hague, *supra* note 75, at 569.

<sup>123</sup>*Id.* at 569-71. Hague states that there are two additional arguments to support the justification for the psychotherapist-patient privilege. One is that forced disclosure will violate the patient's constitutional right to privacy. California and Pennsylvania recognize a constitutionally based psychotherapist-patient privilege. See *In re Lifschutz*, 467 P.2d 557 (1970); *In re B*, 394 A.2d 419 (1978). The second argument favoring the privilege is the "cruel trilemma." The psychotherapist must choose one of three undesirable results: (1) violate the trust imposed on him by his clients and profession; (2) lie and commit perjury; or (3) refuse to testify, and be held in contempt of court. See also, *Developments in the Law - Privileged Communication*, 98 HARV. L. REV. 1450 (1985).

Rule 501 of the Federal Rules of Evidence governs all questions of privilege in federal courts.<sup>124</sup> The question of privilege is "governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience." In civil actions,

with respect to an element of a claim or defense to which state law supplies the rule of decision, the privilege . . . shall be determined in accordance with state law. Basically, the rule means that in diversity cases, state law concerning privileges will apply, and with respect to federal question cases, federal law will apply.<sup>125</sup>

There had been a proposal in Congress in 1972 to establish specific federal privileges, including a psychotherapist-patient privilege,<sup>126</sup> but only rule 501 was passed.<sup>127</sup> The federal courts therefore began to develop the law of privilege on a case-by-case basis.<sup>128</sup>

The federal courts in different circuits disagreed as to the existence of the psychotherapist-patient privilege. Some circuit courts had equated the psychotherapist-patient privilege with the physician-patient privilege, and since no physician-patient privilege existed at common law, the psychotherapist-patient privilege could not exist in the absence of a statute.<sup>129</sup>

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<sup>124</sup>FED. R. EVID. 501 provides:

Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority, the privilege of a witness, person, government, state, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof shall be determined in accordance with State law."

<sup>125</sup>Cerveney, *supra* note 121, at 801-02 (citing FED. R. EVID. 501).

<sup>126</sup>The Supreme Court had submitted the 13 proposed rules to the Congress in 1972, including nine specific privileges. The rules created issues in Congress concerning federalism and the allocation of power in society. Congress therefore adopted only Rule 501. Proposed Rule 504 was the psychotherapist-patient privilege. "A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications, made for the purpose of diagnosis or treatment of his mental or emotional condition." Rule 504 was not adopted by Congress. *See* Cerveney, *supra* note 121, at 803-08 (citing proposed FED. R. EVID. 504).

<sup>127</sup>*Id.* at 806.

<sup>128</sup>*Id.* at 809.

<sup>129</sup>The Fifth, Ninth, Tenth, and Eleventh Circuit Courts of Appeal have rejected the psychotherapist-patient privilege, each interpreting Rule 501 as limiting the development of privileges to those recognized by the common law. *See*, United States v. Burtrum, 17 F.3d 1299 (10th Cir. 1994) (declining to recognize a psychotherapist-patient privilege in a criminal child sexual abuse case); *In re* Grand Jury Proceedings, 867 F.2d 562 (rejecting assertion of a psychotherapist-patient privilege by

Other federal circuit courts had been more willing to consider factors besides the absence of the privilege at common law. In *In re Zuniga*,<sup>130</sup> the Sixth Circuit Court of Appeals recognized that Rule 501 gives federal courts the ability to participate in the continuing development of privilege law. The court said Congress did not intend to preclude judicial recognition of a psychotherapist-patient privilege. The court balanced the societal interest in the availability of evidence in the courts against the interest promoted by a recognition of the privilege.<sup>131</sup> The court concluded that there was a compelling necessity for the privilege, since some level of mental health is necessary to be able to form belief and value systems, and to engage in rational thought.<sup>132</sup> In a recent case, *Jaffee v. Redmond*, the United States Supreme Court recognized the psychotherapist-patient privilege should exist in federal courts.<sup>133</sup>

There are exceptions to the psychotherapist-patient privilege. The patient waives his right to confidentiality when he places his physical or mental condition into issue in litigation.<sup>134</sup> Another exception is the duty of the

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target of grand jury murder investigation) (9th Cir. 1989), *cert. denied*, 493 U.S. 906 (1989); *United States v. Corona*, 849 F.2d 562 (11th Cir. 1988); *cert. denied*, 489 U.S. 1084 (1989) (refusing to recognize a psychotherapist-patient privilege in federal criminal firearms case); *United States v. Meagher*, 531 F.2d 752 (5th Cir. 1976), *cert. denied*, 429 U.S. 853 (1976) (rejecting criminal defendant's assertion of psychiatrist-patient privilege in bank robbery trial).

130714 F.2d 632 (6th Cir. 1983), *cert. denied*, 464 U.S. 983 (1983). See also, *In re Doe*, 964 F.2d 1325 (2d Cir. 1992); *Lora v. Bd. of Educ.*, 74 F.R.D. 565 (E.D.N.Y. 1977). In *Lora*, the issue was whether the school district had to produce fifty anonymous files of schoolchildren identified for placement in a program for emotionally handicapped children. The court employed a balancing test weighing the privacy interest of the individual against the need for full developments of the facts in federal litigation. The court cited Proposed Rule 504 as a "useful standard."

<sup>131</sup>*In re Zuniga*, 714 F.2d 632, 637 (6th Cir. 1983).

<sup>132</sup>*Id.* at 639.

<sup>133</sup>64 U.S.L.W. 4490 (U.S. June 13, 1996) (No. 95-266). A police officer was involved in a fatal shooting and sought counseling later with a clinical social worker. The deceased man's family sued the officer and the police department, and attempted to subpoena the confidential records of the officer's psychotherapeutic sessions with the social worker. The social worker refused, except for releasing some notes about the events leading up to the shooting. The trial court made it clear to the jury that it could draw an adverse inference from the defendant's failure to produce further notes from her therapist. The Seventh Circuit Court of Appeals disagreed, and recognized a psychotherapist-patient privilege under Rule 501 of the Federal Rules of Evidence. The privilege protected the confidential communications between the officer and her therapist. The United States Supreme Court agreed. It said effective psychotherapy depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. This privilege serves the public interest by facilitating appropriate treatment for individuals.

<sup>134</sup>See *In re Lifschutz*, 467 P.2d 557 (Cal. 1970). The patient-litigant exception allows only a limited inquiry into the confidences of the psychotherapist-patient relationship, compelling disclosure of only those matters directly relevant to the nature of the specific emotional or mental condition which the patient has voluntarily disclosed and tendered

psychotherapist to report the occurrence of child abuse revealed during therapy. All fifty states have child abuse reporting statutes to protect the child, and many state evidence codes explicitly recognize such testimony to be an exception to the privilege.<sup>135</sup> A third exception is the duty of the psychotherapist to warn potential victims of the violence threatened by their patients.<sup>136</sup> Other jurisdictions might also exclude the use of the privilege in involuntary commitment proceedings,<sup>137</sup> or when the accused in a criminal proceeding is charged with homicide or inflicting injuries on another human being.<sup>138</sup>

### C. Early Case Law Involving Breach of Confidentiality

In England, the action for breach of confidence has been well-developed since the case of *Prince Albert v. Strange*,<sup>139</sup> and there is "an extensive body of law delineating actionable breaches of confidence in English common law."<sup>140</sup> The use of breach of confidence to protect personal privacy in American common law has taken a more circuitous route, but recently has had a renaissance.<sup>141</sup>

Early cases in the United States involved a breach of confidentiality by physicians, not psychotherapists, with respect to information revealed to the physicians by their patients during the course of treatment.<sup>142</sup> The very first

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in his pleadings, or in answer to discovery inquiries.

<sup>135</sup>Domb, *supra* note 115, at 233.

<sup>136</sup>*Tarasoff v. Regents of the University of California*, 551 P.2d 334 (Cal. 1976). *Tarasoff* was later limited to an identifiable or identified victim in *Thompson v. County of Alameda*, 614 P.2d 728 (Cal. 1980). In *Tarasoff*, the plaintiffs, the parents of a woman killed by a patient of a psychologist, claimed that the psychologist should be held liable in negligence for failure to warn them of impending danger, and for failure to bring about the patient's confinement. The patient had confided his intention to kill the plaintiffs' daughter to the psychologist. The court held the therapist incurs an obligation to use reasonable care to protect the intended victim when the patient presents a serious danger of violence to another. *See also*, *Schuster v. Altenberg*, 424 N.W. 2d 159 (Wis. 1988).

<sup>137</sup>TEX. R. CIV. EVID. 509(d)(7).

<sup>138</sup>D.C. CODE ANN. § 14.307(b)(1) (1995). The District of Columbia statute will prevent the disclosure of confidential medical information by a physician or mental health professional, but excludes from the privilege "evidence in criminal cases where the accused is charged with causing the death of, or inflicting injuries upon, a human being, and the disclosure is required in the interests of public justice."

<sup>139</sup>41 Eng. Rep. 1171 (Ch. 1849).

<sup>140</sup>G. Michael Harvey, *Confidentiality: A Measured Response to the Failure of Privacy*, 140 U. PA. L.R. 2385, 2396 (1992).

<sup>141</sup>*Id.* at 2399.

<sup>142</sup>Early case law begins in the 1920s when psychotherapy was not a well developed science or treatment.

cases involved physicians making extrajudicial disclosures of confidential information to third parties, in violation of state licensing statutes. In both *Simonsen v. Swenson*<sup>143</sup> and *Berry v. Moench*<sup>144</sup> the court held that the physicians' breach of confidentiality was unprofessional conduct violating the licensing statute of the state, because of a betrayal of a professional secret. The physician-patient privilege also implied that physicians must keep patient information confidential,<sup>145</sup> and that physicians have an ethical duty to keep silent.<sup>146</sup> Yet in these early cases, some confusion becomes apparent. In *Simonsen*, the court states there is "a wrongful breach of such confidence,"<sup>147</sup> but also discusses principles of libel and slander, and the necessity of the physician acting "in entire good faith" and "without malice."<sup>148</sup> In *Berry*, the Utah Supreme Court discusses defamation and lack of proof of malice, although the case concerns a physician who must not "reveal information obtained in confidence in connection with the diagnosis and treatment of his patient."<sup>149</sup> No breach of confidentiality cause of action is identified.

In *Clark v. Geraci*,<sup>150</sup> and in *Hague v. Williams*,<sup>151</sup> the physicians involved made extra judicial disclosures of patient information to third persons, yet the courts discussed the necessity of balancing the need for patient confidentiality and the need of society's supervening interests.<sup>152</sup> In *Clark*, the physician disclosed to the armed services the reasons for his patient's frequent absences from work, and thereby disclosed information the patient did not want revealed. The court held the physician was bound by accepted usage, the

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<sup>143</sup>177 N.W. 831 (Neb. 1920). In *Simonsen*, a physician surmised that his patient had a contagious disease, and told the owner of the hotel where his patient was staying. The patient was forced to leave the hotel. *See also*, *Smith v. Driscoll*, 162 P. 572 (Wash. 1917).

<sup>144</sup>331 P.2d 814 (Utah 1958). In *Berry*, the physician Moench wrote a letter about his patient to another physician, answering an inquiry on behalf of a young woman who was keeping company with the former patient. Dr. Moench's letter contained information about his patient's previous psychiatric treatment.

<sup>145</sup>*Simonsen*, 177 N.W.2d at 832.

<sup>146</sup>*Id. But see*, *Quarles v. Sutherland*, 389 S.W.2d 249 (Tenn. 1965) for the proposition that Tennessee common law did not impose on a physician a duty to keep a medical report confidential and to not disclose the report to a store's attorney. The patient had been injured in the store, and the physician who treated her was the store's physician.

<sup>147</sup>*Id.*

<sup>148</sup>*Id.*

<sup>149</sup>*Berry*, 331 P.2d at 817.

<sup>150</sup>208 N.Y.S. 2d 564 (Sup. Ct. 1960). In *Clark*, the patient was an alcoholic and was repeatedly absent from work. The physician filled out a medical certificate saying the patient was an alcoholic, and the patient eventually was discharged from the Air Force. The patient sued his physician claiming his discharge was due to the physician's disclosures.

<sup>151</sup>181 A.2d 345 (N.J. 1962).

<sup>152</sup>*Id.* at 349.



doctor's Hippocratic Oath, and statutes defining unprofessional conduct to keep medical information confidential, but the doctor's duty to his government outweighed any duty to keep silent.<sup>153</sup> The *Clark* court states that "a disclosure<sup>154</sup> may be actionable," but confuses the issue with a discussion of the defamatory nature of the disclosure, and whether it was with or without malice.<sup>155</sup> Similarly, in *Hague*, the doctor made a disclosure to an insurer about the plaintiff's child, and the court held that the disclosure was necessary to the public interest in the litigation that ensued after the child's death, and the supervening interests of society.<sup>156</sup>

In *Felis v. Greenberg*,<sup>157</sup> a physician was found liable for violating the privileged and confidential relationship with his patient by falsely reporting to her insurer that he had treated her for a particular condition when in fact he had treated her for another condition. As a result, the patient lost her insurance benefits. Although the court writes about the violation of the confidential relationship between the physician and patient, and that the remedy for the violation is in traditional tort, it adds to the confusion in the breach of confidentiality area by stating that "the tort need not have a name."<sup>158</sup>

It was not until the 1985 case of *Humphers v. First Interstate Bank*,<sup>159</sup> that the Supreme Court of Oregon began to define breach of confidentiality in a case of an unauthorized extrajudicial disclosure made by a physician about a former patient. The court specifically identified the plaintiff's claim for invasion of privacy and her claim for breach of confidentiality. The court noted that only one who holds information in confidence can be charged with breach of confidence, while a tortious invasion of privacy can be committed by anyone.<sup>160</sup> Because the physician in this case had not invaded the plaintiff's

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<sup>153</sup>*Clark*, 208 N.Y.S.2d at 569.

<sup>154</sup>*Id.* at 567. The court cites Regulations of the Commissioner of Education on Unprofessional Conduct in the practice of medicine.

<sup>155</sup>*Id.* at 568-69. The physician had written a letter to the U.S. Air Force establishing the patient's absences from work were due to alcoholism.

<sup>156</sup>*Hague*, 181 A.2d at 349.

<sup>157</sup>273 N.Y.S.2d 288 (Sup. Ct. 1966). The physician in this case reported he had treated the patient for cervical osteoarthritis, when in fact he had treated the patient for cerebral concussion. Since the patient had never informed her insurer of the correct nature of her treatment, she lost her disability benefits.

<sup>158</sup>*Id.* at 290.

<sup>159</sup>696 P.2d 527 (Or. 1985). In *Humphers*, the defendant physician gave the plaintiff's daughter a letter saying he had treated the plaintiff with diethylstilbestrol before the birth of her daughter. The plaintiff's daughter had been adopted by another couple, and the doctor lied about giving the medication diethylstilbestrol to the biological mother in order for the daughter to breach the confidentiality of, and open the records concerning her birth and adoption. The daughter's interest in her identity confronted her biological mother's interest in concealing her past.

<sup>160</sup>*Id.* at 530. The physician's professional role was relevant to the claim of breach of confidence. *But see*, *Horne v. Patton*, 287 So. 2d 824 (Ala. 1974) in which the plaintiff's

privacy, but had made a disclosure to her daughter in violation of his duty of secrecy to the plaintiff, he could be held liable for breach of confidence.<sup>161</sup> The court based the physician's liability on a duty created in a state statute that a doctor must not willfully or negligently divulge a professional secret.<sup>162</sup> In *Humphers*, breach of confidentiality by a health care provider is a clearly recognized cause of action.

#### IV. LIABILITY OF PSYCHOTHERAPISTS FOR BREACH OF CONFIDENTIALITY

##### *A. Harm Caused by Psychotherapists: In General*

As Furrow points out, psychotherapy "has the potential for harm as well as for cure."<sup>163</sup> Normally, the psychotherapist "does not guarantee a cure and will not be held responsible for the effects of the illness itself."<sup>164</sup> "[T]herapy viewed in the aggregate shows some ability to produce improvements in patients, but in a significant percentage of cases, it may also cause deterioration to a level below that at which the patient entered therapy. . . . [t]he relevant question is whether the intervention of professional psychotherapists cause patients to deteriorate."<sup>165</sup> Deterioration is "the worsening of the patient's symptomatic picture and the exaggeration of existing symptoms."<sup>166</sup> "The sources of patient deterioration in psychotherapy might be therapist characteristics, client characteristics, therapeutic techniques, or errors" such as malpractice.<sup>167</sup>

Dawidoff, in writing about the psychiatrist and his patient, says that the psychiatrist has a duty to bring all his skill and care to the psychotherapeutic relationship.<sup>168</sup> The psychiatrist is also a fiduciary, and as a trustee he is expected to pursue the emotional well-being of the patient, rather than his own emotional demands or financial objectives when these interests are in conflict. The psychiatrist must keep in mind the consequences of the task, the risks of failure, and the skill necessary to minimize any dangers to the patient.<sup>169</sup> As a trustee, the psychiatrist has to separate out his own interests; yet there is a

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claim for invasion of privacy by his physician was held actionable. The physician revealed information to the plaintiff's employer.

<sup>161</sup>*Humphers*, 696 P.2d at 535.

<sup>162</sup>*Id.* The state statute is OR. REV. STAT. § 677.190(5) (1989) that provides for the suspension or revocation of a license of a physician for "wilfully or negligently divulging a personal secret."

<sup>163</sup>FURROW, *supra* note 55, at 9.

<sup>164</sup>*Id.*

<sup>165</sup>*Id.*

<sup>166</sup>*Id.* at 10.

<sup>167</sup>FURROW, *supra* note 55, at 12.

<sup>168</sup>Donald J. Dawidoff, *The Malpractice of Psychiatrist*, 1966 DUKE L.J. 696, 700-01 (1966).

<sup>169</sup>*Id.* at 702-03.

professional medical opinion that, in the transference relationship, it is not possible to separate social and professional conduct.<sup>170</sup> The courts have disagreed. In the English case of *Landau v. Werner*,<sup>171</sup> a male psychiatrist treated a woman patient and instead of terminating treatment after the patient was better, the psychiatrist decided to embark on a series of social visits with the patient. The patient deteriorated when the visits stopped, and the patient sued. The court held the social visits to be a deviation from the standard practice in psychiatric treatment, and to be negligence.<sup>172</sup> In *Zipkin v. Freeman*,<sup>173</sup> a psychiatrist influenced his patient to transfer all her affection from her family to him, and was found liable for humiliating the plaintiff, and creating anguish in the patient.<sup>174</sup>

Slawson reported in 1989 that the American Psychiatric Association authorized a study of more than 700 closed cases between 1974 and 1984 to review different aspects of psychiatric malpractice.<sup>175</sup> About two-thirds of the patients who sued were receiving psychotherapy or medication or both, and Slawson was able to classify the plaintiffs' complaints.<sup>176</sup> The most common complaints involved improper medication, improper treatment, failure to diagnose a physical complaint, and suicide.<sup>177</sup> Breach of confidentiality was

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<sup>170</sup>*Id.* at 704-05.

<sup>171</sup>105 Sol. J. 257, *appeal dismissed*, 105 Sol. J. 1008 (Q.B. 1961).

<sup>172</sup>*Id.* at 258.

<sup>173</sup>436 S.W.2d 753 (Mo. 1968). *See also*, *Hammer v. Rosen*, 165 N.E.2d 756 (N.Y. 1960), in which a psychiatrist was held liable for malpractice after he beat his schizophrenic patient, as part of her treatment, on different occasions.

<sup>174</sup>*Id.* at 755.

<sup>175</sup>Paul Slawson, *Psychiatric Malpractice: Ten Years Loss Experience*, 8 MED. & LAW 415 (South Africa 1989). *See also*, Paul Slawson, *Psychiatric Malpractice: Recent Clinical Loss Experience in the United States* 10 MED. & LAW 129 (South Africa 1991) for supplementary figures in which Slawson analyzed about 800 additional claims for psychiatric malpractice.

<sup>176</sup>*Id.* at 420. 41.7% were receiving psychotherapy and medication, 15.6% were receiving just psychotherapy and 13% were getting medication only.

<sup>177</sup>*Id.* at 422. Slawson's list of legal complaint allegations against psychiatrists included improper medication, 24.6%; improper treatment, 16.8%; failure to diagnose (physical), 15.8%; suicide, 13.2%; failure to restrain, 9.5%; wrongful detention, 9.1%; breach of confidentiality, 6.4%; failure to secure consent, 6.4%; undue familiarity, 6.4%; wrong diagnosis, 6.4%; libel/slander, 6.3%; intentional injury to self, 6.0%; accidental injury to self, 5.6%; abandonment, 5.6%; failure to diagnose (mental), 3.7%; injury to others, 3.2%. In the article by Beresford, *supra* note 20, it is clear that psychiatrists and other therapists may be sued for a variety of non-physical and physical injuries to patients. Physical injuries may include those during electroconvulsive shock therapy (ECT), adverse drug reactions, falls, drug-induced shock, fractures, and assault and battery. Non-physical injuries might include improper diagnosis, improper treatment, fee disputes, defamation, violation of civil rights, and breach of confidentiality. *See also*, ROBERT G. MEYER ET. AL., LAW FOR THE PSYCHOTHERAPIST (1988); Cassidy, *supra* note 30; Howard N. Morse, *The Tort Liability of the Psychiatrist*, 16 BUFF. L. REV. 649 (1967);

the seventh category listed and involved 6.4% of the cases reviewed in the study.<sup>178</sup> Although breach of confidentiality is certainly not the most frequent complaint in lawsuits against therapists, its position in the top half of all types of lawsuits filed against psychiatrists is significant.<sup>179</sup>

*B. Liability for Breach of Confidentiality Founded Upon Breach of Contract*

One approach that plaintiffs use when there has been a breach of confidentiality is through contract law.<sup>180</sup> Contract actions in this area are an infrequent approach, because the law has been ambiguous as to how it views the nature of psychotherapeutic relationship.<sup>181</sup> For the approach to work, as in any cause of action against a therapist, a therapist-patient relationship must exist. For instance, in a case where a psychiatrist was paid a fee to report to the court in a custody case, and the psychiatrist had to examine the parents to help the court decide which parent should have custody of their son, the court held no physician-patient relationship existed between the court-appointed psychiatrist and the plaintiff husband.<sup>182</sup> This physician was not retained by the plaintiff to perform or to act for him.<sup>183</sup>

Once the therapist-patient relationship is established, the therapist and patient enter into a contractual agreement. In *Doe v. Roe*,<sup>184</sup> a psychiatrist and her psychologist husband published a book about a wife and her late husband eight years after the couple terminated psychotherapeutic treatment with the psychiatrist. The book reported extensively and verbatim about the patients' thoughts, feelings, emotions and fantasies, and about the disintegration of the plaintiff's marriage. The plaintiff and her deceased husband were both patients

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Howard N. Morse, *The Tort Liability of the Psychiatrist*, 19 BAYLOR L. REV. 208 (1967).

<sup>178</sup>*Id.*

<sup>179</sup>*Id.*

<sup>180</sup>BENJAMIN M. SCHUTZ, LEGAL LIABILITY IN PSYCHOTHERAPY 12 (1982).

<sup>181</sup>*Id.*

<sup>182</sup>*Anderson v. Glismann*, 577 F. Supp. 1506 (D. Colo. 1984). In *Anderson*, the plaintiff husband sued Dr. Glismann for invasion of privacy, fraudulent misrepresentation, professional malpractice and simple negligence. The defendant psychiatrist had recommended custody of the son in favor of the plaintiff's ex-wife. Anderson argued his conversations with the psychiatrist were confidential and privileged under the Colorado privilege statute. The court did not agree. Dr. Glismann never had a psychotherapeutic relationship with Anderson.

<sup>183</sup>Charles Eger, *Psychotherapists' Liability for Extrajudicial Breaches of Confidentiality*, 18 ARIZ. L. REV. 1061, 1065 (1976). See also, SCHUTZ, *supra* note 180, at 13; DAWIDOFF, *supra* note 20, at 11.

<sup>184</sup>400 N.Y.S. 2d 668 (Sup. Ct. 1977). See also, Case Note, *Doe v. Roe: A Remedy for Disclosure of Psychiatric Confidences*, 29 RUTGERS L. REV. 190 (1975). In *Doe*, the psychiatrist and her psychologist husband admitted they had no written consent to publish a book about the plaintiff and her deceased husband, but claimed they had oral consent given during the plaintiff's course of treatment.

of the defendant psychiatrist. The plaintiff sued for breach of contract, and in tort, for both violation of a statute establishing a public policy of confidentiality between physician and patient, and for invasion of privacy.<sup>185</sup> The *Doe v. Roe* court held that the defendant psychiatrist had entered into an agreement with her patients to provide medical attention.<sup>186</sup> The contract was one between private parties to retain in confidence matters that should be kept in confidence.<sup>187</sup>

If a court holds that a contract is established between therapist and patient, the court will usually not term it an express contract. Of course, the therapist can use an explicit contract to reflect accurately what he feels he can provide for the fee he charges.<sup>188</sup> But reducing the complex relationship in psychotherapy to a small portion of the interaction covered in the explicit contract may increase the likelihood of litigation. The patient may say "I didn't get what I paid for."<sup>189</sup> In *Doe v. Roe*, the court states that the physician impliedly covenants to keep in confidence all disclosures made by the patient concerning the patient's physical or mental condition "as well as all matters discovered by the physician in the course of examination or treatment."<sup>190</sup> The court said that this was particularly true in the psychiatric relationship, for in the dynamics of psychotherapy, the patient is called upon to discuss in a candid and frank manner personal material of the most intimate and disturbing nature.<sup>191</sup> The patient will bring up "all manner of socially unacceptable instincts and urges, immature wishes, perverse sexual thoughts - in short the unspeakable, the

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<sup>185</sup>*Id.* at 671. The plaintiffs argued that the defendant psychiatrist and her husband violated provisions of Education Law in New York State, and the Regulations of the Commission of Education. The public policy of New York to keep communications to physicians confidential gave rise to a cause of action in tort.

<sup>186</sup>*Id.* at 674.

<sup>187</sup>*Id.* at 675.

<sup>188</sup>SCHUTZ, *supra* note 180, at 13.

<sup>189</sup>*Id.*

<sup>190</sup>*Doe v. Roe*, 400 N.Y.S.2d 668, 674 (Sup. Ct. 1977). In *Hammonds*, *supra* note 94, at 801, the court stated, "Any time a doctor undertakes the treatment of a patient, and the consensual relationship of physician and patient is established, two jural obligations (of significance here) are simultaneously assumed by the doctor. Doctor and patient enter into a simple contract, the patient hoping that he will be cured and the doctor optimistically assuming that he will be compensated. As an implied condition of that contract, this Court is of the opinion that the doctor warrants that any confidential information gained through the relationship will not be released without the patient's permission. Almost every member of the public is aware of the promise of discretion contained in the Hippocratic Oath, and every patient has a right to rely upon this warranty of silence. The promise of secrecy is as much an express warranty as the advertisement of a commercial entrepreneur. Consequently, when a doctor breaches his duty of secrecy, he is in violation of part of his obligations under the contract." *Accord*, *Horne v. Patton*, 287 So.2d 824 (Ala. 1973).

<sup>191</sup>*Id.* at 674.

unthinkable, the repressed."<sup>192</sup> In *MacDonald v. Clinger*,<sup>193</sup> the plaintiff sued his psychiatrist, from whom he had received psychotherapeutic treatment, for disclosing personal information to the plaintiff's wife without his consent.<sup>194</sup> The court held the parties had a relationship that gave rise to an implied covenant which, when breached, was actionable.<sup>195</sup>

Although plaintiffs sue their therapists for breach of confidentiality using a contract action, this cause of action has not worked well in the courts. As Vickery has noted, often the traditional bases of liability, such as a breach of contract action, that might protect confidential relationships are muddled and unclear,<sup>196</sup> and the courts will stretch to find liability.<sup>197</sup> In *Doe v. Roe*, the psychiatrist who treated the plaintiff and her husband was held liable on a breach of contract basis, but her psychologist husband, who was a co-author and an "avid, co-violator of the patient's rights," was not in a contractual or physician-patient relationship with the plaintiff.<sup>198</sup> The court held him equally liable as a co-violator.<sup>199</sup> In *MacDonald*, the court found the breach of contract action of the plaintiff inadequate for a recovery for his mental distress, loss of employment and deterioration of his marriage. The court however found the defendant psychiatrist had an additional extraneous duty that sprang from the contract that he had with the plaintiff, and the duty was actionable in tort.<sup>200</sup>

The weakness of a contract cause of action for breach of confidentiality between therapist and patient is that, generally, the contract cannot be a rigid one.<sup>201</sup> Dawidoff calls the contract with the therapist an oral contract with

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<sup>192</sup>*Id.* at 674-75.

<sup>193</sup>446 N.Y.S. 2d 801 (Sup. Ct. 1982).

<sup>194</sup>*Id.* at 802. The plaintiff also sued for breach of confidence in violation of public policy and breach of the right of privacy. The plaintiff alleged that his marriage deteriorated, he lost his job, he suffered financial difficulty and had such emotional distress that he required further psychiatric treatment.

<sup>195</sup>*Id.* at 804.

<sup>196</sup>Vickery, *supra* note 7, at 1449.

<sup>197</sup>*Id.* at 1448.

<sup>198</sup>*Doe*, 400 N.Y.S.2d at 678. Mr. Doe, the defendant's husband/ psychologist, knew the source of the book was the plaintiff's production in psychoanalysis. He saw to it that the work was written, manufactured, advertised and circulated. The court saw no difficulty in calling him equally liable, but since he had not contracted with the plaintiff, the basis for his liability is muddled and confused. Perhaps the court was relying on a tort cause of action and making the husband a joint tortfeasor. The plaintiff also sued for breach of privacy. The court noted that the right of privacy was found in a New York statute that barred *physicians* from revealing confidences of their patients.

<sup>199</sup>*Id.*

<sup>200</sup>*MacDonald*, 446 N.Y.S.2d at 804. The duty was one of confidentiality and trust.

<sup>201</sup>DAWIDOFF, *supra* note 20, at 12.

many implied terms. It might be evidenced in the notes of the therapist, or in bills rendered and checks paid.<sup>202</sup> Additionally, damage awards permitted plaintiffs are restricted to compensating the nonbreaching party and putting him in a position as if the contract had been performed fully.<sup>203</sup> The plaintiff may suffer mental distress as a result of the breach of confidentiality, and he will not be able to sue for the distress, or for punitive damages if the conduct of the defendant is not willful or malicious.<sup>204</sup>

### C. Liability for Breach of Confidentiality Founded in Tort

#### 1. Introduction

The more common approach for a plaintiff wanting to sue a psychotherapist for breach of confidentiality is to bring an action in tort. Vickery defined the tort of breach of confidentiality as an "unconsented, unprivileged disclosure to a third party of non-public information that the defendant has learned within a confidential relationship."<sup>205</sup> He proposed in 1982 that any duty attached to the tort should be limited to nonpersonal relationships customarily understood to carry an obligation of confidence.<sup>206</sup> In 1982, he called the tort rudimentary, and noted that "its contours are not well articulated."<sup>207</sup>

Most professional liability claims arise under the law of unintentional torts or malpractice (negligence). Malpractice is a special case of negligence. We all have a basic duty to exercise reasonable care to safeguard others, and professionals have an obligation to adhere to a higher standard in the course of their work.<sup>208</sup> The standard is determined by the basic level of knowledge, skill and expertise utilized by others in the same profession. Malpractice occurs when there are actions by a professional that do not comport with the conduct of reasonable and prudent practitioners in a given field.<sup>209</sup>

#### 2. Elements Establishing a Tort Action in Malpractice

The plaintiff in a malpractice action based on tort must establish four elements to make out a prima facie case. He must show (1) that there was a legal duty or obligation requiring the person to conform to a certain standard of care in treating the plaintiff; (2) that there was "a failure on the person's part to conform to the standard required: a breach of the duty;" (3) that there was

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<sup>202</sup>*Id.*

<sup>203</sup>Eger, *supra* note 182, at 1069.

<sup>204</sup>*Doe*, 400 N.Y.S.2d at 679.

<sup>205</sup>Vickery, *supra* note 7, at 1455.

<sup>206</sup>*Id.* at 1460.

<sup>207</sup>*Id.* at 1451.

<sup>208</sup>Meyer, *supra* note 177, at 13.

<sup>209</sup>*Id.*

a "reasonably close causal connection between the conduct and the resulting injury." This is the proximate cause; and (4) that there "was actual loss or damage resulting to the interests of another."<sup>210</sup> When the plaintiff is a patient and the defendant is the patient's therapist, Schutz tells us that the four key elements necessary to prove malpractice are: "(1) that a therapist-patient relationship was established; (2) that the therapist's conduct fell below the acceptable standard of care; (3) that this conduct was the proximate cause of the injury to the patient; and (4) that an actual injury was sustained by the patient."<sup>211</sup> In the particular case of a patient suing a therapist for breach of confidentiality, the most difficult hurdles to overcome, showing malpractice has taken place, are "whether the standard of care to which the psychotherapist is obliged to conform encompasses confidentiality, whether the duty is breached by disclosure and whether recoverable damages are incurred."<sup>212</sup>

In *MacDonald v. Clinger*, the court held that the patient who was the plaintiff should not be limited to a breach of contract action.<sup>213</sup> Otherwise, the plaintiff would be limited to damages of an economic loss flowing directly from the breach, and could not recover for "mental distress, loss of employment, and for the deterioration of his marriage."<sup>214</sup> The court believed that the relationship of a psychotherapist and his patient is not just a contractual one, but there is "an additional duty springing from but extraneous to the contract and that the breach of such duty is actionable in tort."<sup>215</sup> It is an action in tort for a breach of a duty of confidentiality and trust.<sup>216</sup> The *MacDonald* court recognized that sometimes the line of demarcation between torts and contract is not clear, and that the essence of a tort consists in the violation of some duty due to an individual that is different from a mere contractual obligation. Especially when the duty grows out of relations of trust and confidence, the tort is more easily separable from the mere breach of contract.<sup>217</sup>

In trying to clarify where the contract action ends and the tort action begins in breach of confidentiality cases, the *MacDonald* court in many ways heightens

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<sup>210</sup>W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 30, at 185, 187 (5th ed. 1984).

<sup>211</sup>SCHUTZ, *supra* note 180, at 2.

<sup>212</sup>Eger, *supra* note 183, at 1083.

<sup>213</sup>*MacDonald*, 446 N.Y.S.2d at 804.

<sup>214</sup>*Id.*

<sup>215</sup>*Id.*

<sup>216</sup>*Id.*

<sup>217</sup>*MacDonald*, 446 N.Y.S.2d at 804. The court cites *Rich v. New York Cent. & Hudson River R.R.*, 87 N.Y. 382 (1882). See also, *Allen v. Smith*, 179 W. Va. 360, 368 S.E.2d 924 (1988). In *Allen*, the Supreme Court of West Virginia held that in this jurisdiction there was no general cause of action for unauthorized disclosure of medical records, but if there were, it would be in tort.



our confusion. The court cites both the *Doe v. Roe*<sup>218</sup> case and *Hammonds*<sup>219</sup> which were breach of confidentiality cases based on a contract action, not an action in tort, in which a physician impliedly covenanted to not disclose confidential information. In a later case, *Werner v. Kliever*,<sup>220</sup> in which a wife brought suit against her psychiatrist for revealing confidential information in a letter to a trial court with jurisdiction over her divorce from her husband, the court had a somewhat clearer explanation of when the contract action is appropriate and when the action should be one in tort. In *Werner* the court stated that

when the act complained of is a breach of the specific terms of the contract, without any reference to legal duties imposed by law upon the relationship created, the action is in contract. When there is a contract for services which places the parties in such a relation to each other that, in attempting to perform a promised service, a duty imposed by law as a result of the contractual relationship between the parties is violated through an act which incidently prevents the performance of the contract, then the gravamen of the action is a breach of the legal duty and not of the contract itself.<sup>221</sup>

Since therapists and their patients rarely enter into express contracts for psychotherapy, and provide for damages when therapists breach the confidentiality of their professional relations, we are again somewhat unclear as to when the plaintiff should sue in contract or in tort. In *Alberts v. Devine*,<sup>222</sup> when a minister sued his psychiatrist for disclosing confidential information about his diagnosis and treatment to two clerical superiors, and the minister was not reappointed to his church position, the court said that although a contract had existed between the therapist and patient, the duty of confidentiality arose from the physician-patient relationship. The violation of the duty gave rise to a cause of action in tort.<sup>223</sup>

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<sup>218</sup>*Doe v. Roe*, 400 N.Y.S.2d 668 (Sup. Ct. 1977).

<sup>219</sup>*Hammonds*, 243 F. Supp. at 793.

<sup>220</sup>710 P.2d 1250 (Kan. 1985). In *Werner*, the plaintiff sued her psychiatrist after he treated her for stress over her impending divorce and custody battle of her children. The plaintiff had taken an overdose of medication and had suicidal thoughts. The psychiatrist wrote a letter to the court, at her husband's request, about the plaintiff's state of mind. The plaintiff sued her therapist for invasion of privacy, and for breach of contract including an express warranty to maintain the confidentiality of the patient's thoughts and feelings.

<sup>221</sup>*Id.* at 1258.

<sup>222</sup>479 N.E. 2d 113 (Mass. 1985), *cert. denied*, 474 U.S. 1014 (1985).

<sup>223</sup>*Id.* at 120. The court cited both *MacDonald* and *Hammonds* showing the contractual nature of the relationship between the minister / patient and his psychiatrist. The court said there were fiduciary aspects to their relationship as well as contractual, and the psychiatrist had a duty to keep confidential all the disclosures made to him by his patient.

### 3. The Duty of the Therapist to Conform to a Standard of Care Encompassing Confidentiality, and its Breach

In psychotherapy, the practitioner is not an insurer of a perfect cure. The practitioner is also not required to exercise the highest degree of skill possible or even extraordinary skill or care. He or she must exercise only reasonable care under the circumstances.<sup>224</sup> This standard of care applies, of course, once the therapist-patient relationship is established.

"Courts look to the psychotherapist's special knowledge and skill when determining what is reasonable under the circumstances. . . . The psychotherapist is held to the standard of care exercised by other professionals in his or her field of expertise who are similarly situated."<sup>225</sup> Prosser writes that professional persons, including doctors, who have unusual skill or knowledge superior to that of the ordinary person must conduct themselves consistently with the standard of the superior skill or knowledge.<sup>226</sup> "Professional [men] in general, and those who undertake any work calling for special skill, are required not only to exercise reasonable care in what they do, but also to possess a standard minimum of special knowledge and ability."<sup>227</sup> When dealing with the standard of care of psychotherapists, which is a specialty profession, courts have to determine the standard appropriate to specialists.<sup>228</sup> In psychotherapy, since there are so many schools of thought that advocate different treatment approaches to the same problem, professionals practicing therapy may set the legal standards of conduct by in-house expert testimony.<sup>229</sup> In the Restatement (Second) of Torts we are told that: "Where there are different schools of thought in a profession, or different methods are followed by different groups engaged in trade, the actor is to be judged by the professional standards of the group to which he belongs."<sup>230</sup> Yet in the Restatement, we are also told that there may

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<sup>224</sup>Lawrence P. Hampton, *Malpractice in Psychotherapy: Is There a Relevant Standard of Care?* 35 CASE W. RES. L. REV. 251, 261 (1984).

<sup>225</sup>*Id.*

<sup>226</sup>KEETON ET AL., *supra* note 210, § 32, at 185, 187.

<sup>227</sup>*Id.* at 185.

<sup>228</sup>Hampton, *supra*, note 224, at 206. Hampton also writes that courts must determine whether the standard of care is local or national, whether the patient's informed consent will serve as a defense for the therapist, and whether the "respectable minority" rule will be applicable in deciding the standard of care for unconventional therapies. The RESTATEMENT (SECOND) OF TORTS § 299A (1965) states that the professional "who undertakes to render services in the practice of a profession or trade is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities."

<sup>229</sup>SCHUTZ, *supra* note 180, at 3.

<sup>230</sup>RESTATEMENT (SECOND) OF TORTS § 299A cmt. f (1965).

be "minimum requirements of skill applicable to all persons, of whatever school of thought, who engage in any profession or trade."<sup>231</sup>

In breach of confidentiality cases, the courts need not concern themselves so much with the school of thought to which a therapist belongs; rather, the key question is whether the standard of care to which the therapist should adhere encompasses confidentiality. The courts have used three mechanisms to find that confidentiality exists within the standard of care for therapists, that is, for both physician therapists and non-physician therapists. These mechanisms include confidentiality requirements in professional ethical codes, privilege and licensing statutes, and public policy justifications.

*a. Breach of Confidentiality by Physician/Therapists*

Physicians who are therapists are clearly held to a standard of care encompassing confidentiality, and the court will point to the Hippocratic Oath that physicians take, and also the Principles of Medical Ethics published by the American Medical Association. In *Doe v. Roe*,<sup>232</sup> the court refers to a number of cases, including *Hammonds*<sup>233</sup> and *Horne v. Patton*,<sup>234</sup> in which the conclusion was reached "that a medical doctor is under a general duty not to make extrajudicial disclosures of information acquired in the course of the doctor-patient relationship."<sup>235</sup> The *Doe v. Roe* court held that this was particularly true within the dynamics of psychotherapy, and includes a quotation of Section 9 of the Principles of Medical Ethics,<sup>236</sup> and a reference to the Hippocratic Oath.<sup>237</sup> In the case of *McIntosh v. Milano*,<sup>238</sup> in which a psychiatrist failed to warn the plaintiff that his patient had murderous

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<sup>231</sup>*Id.*

<sup>232</sup>*Doe v. Roe*, 446 N.Y.S.2d 668 (Sup. Ct. 1977).

<sup>233</sup>*Hammonds*, 243 F. Supp. 793.

<sup>234</sup>*Horne*, 287 So.2d 824.

<sup>235</sup>*Doe v. Roe*, 400 N.Y.S.2d 668 (Sup. Ct. 1977). The court also cites to *Clark v. Geraci*, 208 N.Y.S.2d 564 (Sup. Ct. 1960), *Felis v. Greenberg*, 273 N.Y.S.2d 288 (Sup. Ct. 1966); *Smith v. Driscoll*, 162 P.572 (Wash. 1917); and *Hague v. Williams*, 181 A.2d 345 (N.J. 1962).

<sup>236</sup>*Id.* Section 9 of the Principles states, "A physician may not reveal the confidence 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."

<sup>237</sup>*Id.*

<sup>238</sup>403 A.2d 500 (N.J. Super. Ct. Law. Div. 1979). Dr. Milano's patient was convicted of murdering the plaintiff's daughter. The plaintiff sued for wrongful death, and the psychiatrist moved for summary judgment on the grounds that he owed the plaintiff's deceased daughter no duty to warn her of his patient's intentions. The patient had a schizoid personality, and Dr. Milano knew that his patient had romantic feelings about the plaintiff's daughter. He also knew that his patient was jealous of the deceased girl's boyfriends, and had the potentiality for violence. The court denied the doctor's motion for summary judgment because there was a substantial fact issue as to whether the

intentions toward his deceased daughter, the court discussed confidentiality between the psychiatrist and the patient. The court said "a patient is entitled to freely discuss his symptoms and condition to his physician in confidence" and the court refers to Section 9 of the Principles of Medical Ethics and the Hippocratic Oath.<sup>239</sup> The court discusses that a psychiatrist must keep the patient's thoughts and feelings confidential, but may have to disclose those thoughts and feelings when the patient or the community needs to be protected from imminent danger.<sup>240</sup>

Privilege and licensing statutes governing physician-patient relationships also imply that physicians who do psychotherapy must keep patient matters confidential. In *Mrozinski v. Pogue*,<sup>241</sup> a psychiatrist treated a father and daughter in family therapy, but disclosed confidential information from therapy sessions to the attorney of the mother,<sup>242</sup> who had sued for custody of the daughter. The father sued his psychiatrist for wrongful disclosure of privileged information, and breach of confidential relations. The court discussed the Georgia privilege statute, and that the plaintiff had waived no right to confidentiality.<sup>243</sup> In fact, the plaintiff had sought the assurance of his psychiatrist that everything in his therapy sessions would be confidential, and the doctor had given the assurance.<sup>244</sup> The court mentioned the psychiatrist-patient communications privilege, and said it was not diminished by the fact that the plaintiff sought treatment jointly with his daughter. The object of the privilege was to encourage the full trust of the patient "so as to persuade him to reveal his innermost feelings and private acts." Only in this way could the psychiatrist give effective treatment.<sup>245</sup> In *Alberts v. Devine*,<sup>246</sup> the Supreme Court of Massachusetts wrote about the Massachusetts evidentiary privilege that required that communications between psycho-

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psychiatrist breached his duty to warn the plaintiff or his daughter.

<sup>239</sup>*Id.* at 512-13.

<sup>240</sup>*Id.* at 513.

<sup>241</sup>423 S.E.2d 405 (Ga. Ct. App. 1992).

<sup>242</sup>*Id.* at 407. The psychiatrist had divulged in a discharge summary and affidavit the father's conduct and reactions during family therapy, and the doctor's observations and conclusions as to the interaction between father and daughter. The psychiatrist had a negative view of the father's conduct and reactions.

<sup>243</sup>*Id.* at 407-09. The court cited GA. CODE ANN. §§ 24-9-40, 24-9-21(5) (1995).

<sup>244</sup>*Id.* at 407-08. The defendant psychiatrist argued that the privilege statute did not protect observations, opinions and conclusions of the psychiatrist and that these statements were not confidential. The court disagreed. The psychiatrist could not reveal indirectly what he could not reveal directly, and he could not couch revealing communications by calling them inferences, evaluations, observations or conclusions.

<sup>245</sup>*Id.* at 408.

<sup>246</sup>479 N.E.2d 113 (Mass. 1985), *cert. denied*, 474 U.S. 1014 (1985).

therapist and patient be kept confidential.<sup>247</sup> The court used the privilege as a justification to declare that "all physicians owe their patients a duty . . . not to disclose, without the patient's consent, medical information about the patient, except to meet a serious danger to the patient or to others."<sup>248</sup> In *Renzi v. Morrison*, when a wife's psychiatrist discussed voluntarily her psychological tests and evaluations in a custody hearing for the benefit of her husband, the court held the Illinois Mental Health Act was violated.<sup>249</sup> The privilege statute authorized disclosure of confidential information only when the court examines testimony in camera and determines if it is relevant, admissible and it is more important to the interest of justice than the patient's right to confidentiality.<sup>250</sup>

Courts may also hold that in a particular jurisdiction there is a public policy that requires all communications between physician/therapists and patients be kept confidential. In *MacDonald v. Clinger*, the court mentions that "public policy favors confidentiality."<sup>251</sup> In *Werner v. Kliever*, the court gave great deference to "the public policy embodied in the physician-patient privilege, and to the physician's duty to maintain the confidentiality of the physician-patient relationship."<sup>252</sup> In *Alberts v. Devine*, the court noted that physicians have a duty of confidentiality and that there must be a "cause of action to enforce that duty."<sup>253</sup> The duty is based on a determination that "public policy favors the protection of the patient's right to confidentiality."<sup>254</sup>

#### *b. Breach of Confidentiality by Non-Physician/Therapists*

The courts use similar means to hold non-physician therapists to a standard of care encompassing confidentiality. In *Mississippi State Board of Psychological Examiners v. Hosford*, a psychologist was suspended from practice by the state

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<sup>247</sup>*Id.* at 119.

<sup>248</sup>*Id.*

<sup>249</sup>618 N.E. 2d 794 (Ill. App. Ct. 1993).

<sup>250</sup>*Id.* at 795-96. The court said that Dr. Morrison was not appointed by the court in the custody hearing to evaluate Ms. Renzi. Her testimony was voluntary and she was therefore liable in damages to Ms. Renzi. *But see*, *B.B. v. People*, 785 P.2d 132, 140 (Colo. 1990) (en banc).

<sup>251</sup>84 A.D.2d 482 (N.Y. App. Div. 1982).

<sup>252</sup>*Werner*, 710 P.2d at 1258. In *Werner*, the Supreme Court of Kansas said the public policy of maintaining confidentiality in the psychiatrist-patient relationship had to be balanced with its public policy protecting children. The defendant psychiatrist was held not to be liable for writing a letter to the judge deciding who should have custody of the *Werner* children. The psychiatrist had some concerns about the plaintiff's ability to care for her children. The court did warn the psychiatrist not to have offered the information about the plaintiff voluntarily.

<sup>253</sup>*Alberts*, 479 N.E.2d at 119.

<sup>254</sup>*Id.*

board for revealing confidential information about his patient.<sup>255</sup> The patient and her husband had sought the psychologist's help with marital difficulties, and the psychologist voluntarily and unilaterally revealed information about his patient in a subsequent divorce and child custody action.<sup>256</sup> The court reviewed the American Psychological Association's Ethical Principles,<sup>257</sup> the psychologist-patient privilege,<sup>258</sup> and a "public imperative that the psychology profession as a whole enjoy a [sic] impeccable reputation for respecting patient confidences."<sup>259</sup>

*c. Breach of Fiduciary Duty to Maintain Confidentiality*

Sometimes plaintiffs will characterize the action that they bring against a therapist as a "breach of fiduciary duty"<sup>260</sup> or as a "breach of the fiduciary duty of confidentiality."<sup>261</sup> This characterization of the cause of action adds to the confusion in this area of the law. Eger calls the action for breach of fiduciary duty a creature of the equity courts.<sup>262</sup> The patient does place his trust and confidence in the therapist; even though the therapist is not involved with the

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<sup>255</sup>508 So. 2d 1049 (Miss. 1987). *But see*, *Creamer v. Danks*, 700 F. Supp. 1169 (D.Me. 1988) *aff'd*, 863 F.2d 1037 (1st Cir. 1988), in which the court said that there was no tort remedy for breach of confidentiality for patients to sue a social worker who was testifying in court to collect professional fees for services rendered.

<sup>256</sup>*Hosford* at 1051-52. The defendant psychologist, in an affidavit, volunteered that his patient would not be as good a parent as her ex-husband.

<sup>257</sup>*Id.* at 1052. Principle 5 of the American Psychological Association's Ethical Principles of Psychologists (1972) is quoted in the opinion.

Psychologists have a primary obligation to respect the confidentiality of information obtained from persons in the course of their work as psychologists. They reveal such information to others only with the consent of the person or the person's legal representative, except in those unusual circumstances in which not to do so would result in clear danger to the person or to others.

*Id.* at 1052 n.2.

<sup>258</sup>*Id.* at 1053, 1055. The court cites MISS. CODE ANN. § 73-31-29 (1972) and M.R. EVID. 503.

<sup>259</sup>*Id.* at 1055.

<sup>260</sup>*Zim v. Benezra*, 545 N.Y.S.2d 893 (Sup. Ct. 1989); *Watts v. Cumberland County Hosp. System, Inc.*, 75 N.C. App. 1, (1985) *rev'd*, 317 N.C. 321 (1986). *Watts* was reversed only on the issue of the defendant assisting the plaintiff's physicians in fraudulently concealing the nature of her physical condition.

<sup>261</sup>*Oringer v. Rotkin*, 162 A.D.2d 113 (N.Y. App. Div. 1990); *MacDonald*, *supra* note 193. In *Oringer*, the plaintiff incorrectly pleaded a cause of action for disclosure of confidential information under a New York rule of evidence creating the psychologist-patient privilege. The court said the facts alleged did make out a case for breach of fiduciary duty of confidentiality.

<sup>262</sup>Eger, *supra* note 183, at 1076.

patient in a pecuniary way, the relationship is still called a fiduciary one.<sup>263</sup> Physicians are often termed fiduciaries in their relationships with patients.<sup>264</sup> And the one-to-one structure of therapy requires a similar role for all psychotherapists.<sup>265</sup> Yet the action for breach of a therapist's fiduciary duty does not indicate whether the relationship between therapist and patient carries with it the legally enforceable duty of confidentiality.<sup>266</sup> "A fiduciary relationship is one founded upon trust or confidence reposed by one person in the integrity and fidelity of another."<sup>267</sup> The relationship exists where influence has been acquired and has been betrayed, and there can be informal relationships in which a man trusts in, and relies upon, another. Not every confidential relationship involves a fiduciary relationship.<sup>268</sup>

Not only do legal commentators question the link between breach of confidentiality and fiduciary responsibility, but case law further confuses us. In *MacDonald v. Clinger*, the court characterized a psychiatrist's wrongful disclosure of personal information about his former patient as a "breach of the fiduciary duty of confidentiality."<sup>269</sup> The psychiatrist's actions were "not merely a broken contractual promise, but a violation of a fiduciary responsibility to the plaintiff implicit in the doctor-patient relationship."<sup>270</sup> A concurring Justice agreed in the result of the case, but preferred to characterize the case as a malpractice action.<sup>271</sup> He stated that besides proving that there was a professional relationship, a disclosure of confidential information and damages, one must prove that the disclosure was wrongful.<sup>272</sup> The physician violated "his duty to supply the quality of care promised when he undertook

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<sup>263</sup>*Id.* at 1074.

<sup>264</sup>*Hammonds*, 243 F. Supp. at 796-97.

<sup>265</sup>Eger, *supra* note 183, at 1075.

<sup>266</sup>Vickery, *supra* note 7, at 1459.

<sup>267</sup>*Schmidt v. Bishop*, 779 F. Supp. 321, 325 (S.D.N.Y. 1991) (quoting *Penato v. George*, 52 A.D.2d 939, 942 (N.Y. 1976), *appeal dismissed*, 366 N.E.2d 1358 (1977)). In *Schmidt*, a pastor was held to be in a fiduciary relationship to a member of his church whom he counseled, but the court refused to recognize a tort of clergy malpractice.

<sup>268</sup>*Id.*

<sup>269</sup>*MacDonald*, 84 A.D.2d at 483.

<sup>270</sup>*Id.* at 805.

<sup>271</sup>*Id.* See also, *Skrzypiec v. Noonan*, A.2d 716 (Conn. 1993). *But see*, *Martin v. Baehler*, No. Civ. A. 91C-11-008, 1993 WL 258843 (Del. Super. Ct. May 20, 1993), in which a non-therapist physician was held liable when her employee revealed confidential information about the plaintiff. The court said breach of confidentiality is a tort, but is not a malpractice action. The court said the physician has an independent duty to keep patient communications confidential. Not every negligent act is malpractice; *Tighe v. Ginsberg*, 146 A.D.2d 268 (N.Y. App. Div. 1989).

<sup>272</sup>*Id.* at 806.

to treat the patient."<sup>273</sup> A North Carolina court reached this same result in *Watts v. Cumberland County Hosp. System, Inc.*<sup>274</sup> In that case, the plaintiff sued for negligence, breach of fiduciary duty and fraudulent concealment. The court again characterized the case as a medical malpractice action, based on the provider's breach of duty to maintain the patient's trust and confidence.<sup>275</sup> Although the plaintiff had sued for breach of the therapist's fiduciary duty, she had alleged all the essential elements of a malpractice case.<sup>276</sup>

It is clear that for plaintiffs and the courts to include the word "fiduciary" in a breach of confidentiality cause of action adds little in the way of clarification. Psychotherapists are generally fiduciaries in their relationships with their patients, but a breach of the fiduciary duty of the therapist does not necessarily encompass confidentiality.

#### 4. Proximate Cause and Damages

Once it is shown the psychotherapist has deviated from the standard of care and that the patient suffered injury, it must be shown that the actions of the therapist were the proximate cause of the patient's injury. Expert testimony is usually required to show causation.<sup>277</sup> A therapist may be negligent in his pursuit of therapy, but at the same time this negligence may not be the cause of the patient's injury. There could be external factors of life that may cause an emotional decline.<sup>278</sup> Experts are practitioners in the particular field of practice or other expert witnesses equally familiar with and competent to testify regarding the field of practice. The expert witness has to have adequate knowledge of the customary standards of practice to be of help to the jury.<sup>279</sup>

In breach of confidentiality cases, sometimes proximate cause can be established by testimony by the parties that a publication was done or a

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<sup>273</sup>*Id.*

<sup>274</sup>*Watts*, 75 N.C. App. 1.

<sup>275</sup>*Id.* at 249.

<sup>276</sup>*Id.* at 250. *Watts* was reversed only on the issue of fraudulent concealment.

<sup>277</sup>*Cassidy*, *supra* note 30, at 135. *See also*, *Watts*, 75 N.C. App. 1 at 252.

<sup>278</sup>*Cassidy*, *supra* note 30, at 135. *See also*, *FURROW* *supra* note 55, at 26. Furrow states that a conservative attitude toward proof of causation no longer governs. A liberal use of circumstantial evidence is increasingly common. While the plaintiff must show an actual and not merely speculative causal connection between the defendant and the bad result, causation may be shown by circumstantial as well as by direct evidence.

<sup>279</sup>*Watts*, 75 N.C. App. 1 at 252. *See also*, *Cassidy*, *supra* note 30. There are two exceptions to the requirement that expert testimony is necessary to establish causation. These are (1) in matters that are within the common knowledge of the layman, and (2) where the negligence or injury is so gross and readily apparent that the injury must have been caused by the negligence. Due to the complexity of the therapeutic process, the common knowledge exception is used infrequently. For additional source materials in this area see *FURROW*, *supra* note 54, at 27; *Hogan*, *supra* note 54, at 323-26 (Volume III); and *DAWIDOFF*, *supra* note 20 at 61.



disclosure was made without the consent of the plaintiff, and the court will term the wrongful publication, or the disclosure, the proximate cause of the damage.<sup>280</sup> In *Doe v. Roe*, when the defendant psychiatrist and her psychologist/husband published a book about the plaintiff, the court called the wrongful publication "the proximate cause of the damage."<sup>281</sup> Yet in other cases, an expert witness may be necessary to testify as to the therapist's deviation from the standard of care and its breach, therefore showing the breach caused the plaintiff's damages. In *Watts v. Cumberland County Hosp. System, Inc.*, the defendant Hall was a pastoral, marital and family counselor who discussed the plaintiff's therapeutic treatment with other professionals, without the plaintiff's consent.<sup>282</sup> The plaintiff submitted to the court an affidavit of another pastoral counselor who swore to the defendant's deviation from the standard of care of pastoral, marital and family counselors.<sup>283</sup> This deviation from the standard of care - the disclosure of confidential information - was the cause of the plaintiff's injuries.

Once proximate cause is established, plaintiffs will ask, generally, for remedies for the breach of confidentiality. Sometimes an equitable remedy is necessary, as in *Doe v. Roe*, in which the plaintiff sued for a permanent injunction to stop the defendants' publication of a book that contained the plaintiff's thoughts and feelings revealed in her psychotherapeutic treatment.<sup>284</sup> Generally, though, most plaintiffs will ask for monetary damages for a breach of confidentiality. Monetary damages can be compensatory, nominal or

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<sup>280</sup>*Doe*, 400 N.Y.S.2d at 679. In *MacDonald*, 440 N.Y.S.2d at 802, the court said that, "Examination of cases which have addressed this problem makes it apparent courts have immediately recognized a legally compensable injury in such wrongful disclosure based on a variety of grounds for recovery; public policy; right to privacy; breach of contract; breach of fiduciary duty. In *Zim*, 545 N.Y.S.2d at 894, the court said, "It has been held that a psychiatrist breaches a duty of confidentiality when the physician reveals personal information to a third party which results in direct economic or emotional loss to a patient."

<sup>281</sup>*Doe*, 400 N.Y.S.2d at 668.

<sup>282</sup>*Watts*, 75 N.C. App. 1 at 6-7.

<sup>283</sup>*Id.* at 251-52. The trial court had ruled that the affidavit of the expert witness, a pastoral counselor and priest of the plaintiff's family, was not to be considered marital and family counselor in North Carolina. The appellate court disagreed and held that, "It is enough that, through study or experience, the witness is better qualified than the jury to form an opinion on the particular subject." *Id.* at 252. A witness need not be a specialist, or have a license from an examining board, or have had experience with the exact subject matter involved, or be engaged in any particular profession. *See also, Alberts*, 479 N.E.2d at 121-22. The court heard deposition testimony that established that the plaintiff's superiors knew the plaintiff had a psychotherapeutic relationship with the defendant psychiatrist, and intended to induce the psychiatrist to divulge confidential information about his patient.

<sup>284</sup>*Doe*, 400 N.Y.S.2d at 679. The court said that, in this case, damages did not provide an adequate remedy. The defendants had published 220 copies of the book, and to allow more copies to be circulated would cause the damage to "accrue anew."

punitive.<sup>285</sup> Compensatory damages are based on the principle that the plaintiff should be restored as much as possible to his or her pre-injury condition.<sup>286</sup> Compensatory damages can include payment for impairment to work, for past and future loss of earnings, for care taking, for medical expenses, and for physical and mental pain and suffering, including loss of normal life, inconvenience and humiliation.<sup>287</sup> Nominal damages are awarded in cases in which there is an actual or technical wrong that cannot be translated into dollar terms.<sup>288</sup> Punitive damages are awarded to punish the offender for reckless, malicious, willful or wanton conduct.<sup>289</sup>

In breach of confidentiality causes of action, plaintiffs will sue for a variety of compensatory damages. In *MacDonald* and *Alberts*, the plaintiffs asked for damages for financial loss, such as loss of earning capacity and loss of a job.<sup>290</sup> This is a direct economic loss.<sup>291</sup> These same plaintiffs sued for emotional distress or mental anguish because of humiliating damage to reputation.<sup>292</sup> Often the mental anguish will lead to more treatment and, therefore, additional medical expenses.<sup>293</sup> The plaintiff may suffer impaired emotional health because the shame over a disclosure of confidential information may cause sleeplessness, nightmares and other physical symptoms.<sup>294</sup>

Do plaintiffs sue for punitive damages in breach of confidentiality cases, and are they successful? They might sue for punitive damages, but are generally not successful. In *Doe v. Roe*, the plaintiff sought punitive damages for the wrongful publication of a book about her. The plaintiff alleged the publication was "willful" and "malicious" and "morally culpable."<sup>295</sup> The plaintiff claimed the defendants' actions were "actuated by evil and reprehensible motives."<sup>296</sup> The court refused to declare the defendants' acts willful, malicious or wanton;

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<sup>285</sup>SIMON, *supra* note 24, at 451.

<sup>286</sup>*Id.* The court may make a distinction between general and special damages. Special damages include medical expenses, past and future lost wages, and other out-of-pocket expenses.

<sup>287</sup>*Id.*

<sup>288</sup>*Id.* at 452.

<sup>289</sup>*Id.*

<sup>290</sup>*MacDonald*, 446 N.Y.S.2d at 802; *Alberts*, 710 P.2d at 1253.

<sup>291</sup>*Zim*, 545 N.Y.S.2d at 894.

<sup>292</sup>*Alberts*, 479 N.E.2d at 116. *See also*, *Schuster*, 424 N.W.2d at 161. In *Schuster*, the defendant psychiatrist was charged with negligent failure to manage his patient. The patient caused a car accident. The patient died, and the plaintiff/daughter was injured. The plaintiff sued for, among other things, pain and suffering.

<sup>293</sup>*Doe*, 400 N.Y.S.2d at 679.

<sup>294</sup>*Id.*

<sup>295</sup>*Id.*

<sup>296</sup>*Id.*

it called their acts "merely stupid."<sup>297</sup> The defendants believed they were rendering a public service in publishing their book and they had no motive to harm.<sup>298</sup>

##### 5. A Related Tort to Breach of Confidentiality: Invasion of Privacy

Very often, plaintiffs who sue for breach of confidentiality also sue for invasion of privacy. This fact leads to more confusion in the courts' decisions. It is necessary to identify each action, i.e. breach of confidentiality and invasion of privacy, and to deal with each action separately. It is also important to label each properly. An action for invasion of privacy is a tort with four subcategories: intrusion, appropriation, publicity which puts the plaintiff in a false light in the public eye, and public disclosure of private facts.<sup>299</sup> Generally, public disclosure of private facts is the cause of action most closely related to breach of confidentiality by psychotherapists.<sup>300</sup> This is publicity, "of a highly objectionable kind, that gives private information about the plaintiff, even though it is true, no action would lie for defamation."<sup>301</sup> There are limitations on this branch of the right of privacy. The disclosure of private facts must be a public disclosure, and not a private one; there must be publicity; the facts disclosed to the public must be private facts, and not public ones; and the matter made public must be one which would be offensive and objectionable to a reasonable man of ordinary sensibilities.<sup>302</sup>

Eger states that the cause of action for public disclosure of private facts does not depend on a special relationship between the plaintiff and defendant.<sup>303</sup> Matters revealed to psychotherapists "are likely to be regarded as private, and

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<sup>297</sup>*Doe*, 400 N.Y.S.2d at 679.

<sup>298</sup>*Id.*

<sup>299</sup>KEETON ET AL., *supra* note 210, § 117, at 849-69. Intrusion is an invasion of privacy upon the plaintiff's physical solitude or seclusion, as by invading his home. Appropriation is the act, for the defendant's benefit or advantages, of using the plaintiff's name or likeness, such as using the plaintiff's picture or likeness, without his consent, in an advertisement of the defendant's product. False light consists of publicity which places the plaintiff in a false light in the public eye, such as publicly attributing to the plaintiff some opinion or utterance in a spurious book or article.

<sup>300</sup>Eger, *supra* note 183, at 1077-78. Eger states, "A breach of confidentiality on the part of the psychotherapist is not only a breach of trust, but an infringement of the privacy of the patient. An action in tort, then, for invasion of the right of privacy is possible. Although there are four subcategories of the tort, only one is applicable to breaches of confidentiality: 'public disclosure of private facts.'" *See also*, *Doe v. Roe*, 400 N.Y.S.2d 668 (Sup. Ct. 1977).

<sup>301</sup>KEETON ET AL., *supra* note 210, at 856.

<sup>302</sup>*Id.* at 856-57.

<sup>303</sup>Eger, *supra* note 183, at 1078. This fact distinguishes the public disclosure of private facts cause of action from a breach of confidentiality cause of action.

therefore a disclosure presumably fulfills the private facts requirement."<sup>304</sup> And Eger also states that the requirement that a large number of people receive the information has been liberally construed.<sup>305</sup> The third element of the cause of action, that the information disclosed be offensive to a person of ordinary sensibilities, is not so liberally construed and must be met. If a person is in therapy and finds the disclosure objectionable, the disclosure may not be objectionable to a person of ordinary sensibilities.<sup>306</sup> Most cases dealing with an invasion of privacy claim involve physicians who have published photographs or films of a patient.<sup>307</sup> A plaintiff will use the cause of action to vindicate his or her right of private personality and emotional security. Publication of photographs of a nonpublic person without his or her consent is a violation of the right of privacy.<sup>308</sup> "The conflict between the public's right to information and the individual's right to privacy requires a balancing of the competing interests."<sup>309</sup>

If the case for public disclosure of private facts is used by the plaintiff against a psychotherapist who discloses confidential information, the plaintiff does not seem to fare as well in an invasion of privacy action as he does in a breach of confidentiality cause of action. In *Vassiliades v. Garfinckel's*, the court noted that an invasion of privacy cause of action is subject to traditional privileges (such as public safety, fraud, crime, self-defense, and interests of third persons), the First Amendment, and the public's right to know.<sup>310</sup> With the tort of breach of confidentiality, the public right-to-know privilege is more restrictive. "A defendant is not released from an obligation of confidence merely because the

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<sup>304</sup>*Id.* See also, *Jarallah v. Schwartz*, 413 S.E.2d 210 (Ga. Ct. App. 1991).

<sup>305</sup>Eger, *supra* note 182, at 1079. Eger cites *Horne v. Patton*, 287 So.2d at 830-31.

<sup>306</sup>*Id.*

<sup>307</sup>*Vassiliades v. Garfinckel's*, 492 A.2d 580 (D.C. Ct. App. 1985). In *Vassiliades*, a patient brought suit against her plastic surgeon. The doctor had used "before" and "after" photographs of the patient's cosmetic surgery, without her permission, at a department store presentation and on television. The patient sued for unreasonable publicity given to her private life, and for breach of fiduciary duty. She also sued for publicity placing her in a false light, and appropriation of her likeness for commercial purposes. The court ruled that the patient's privacy had been invaded with publicity of private facts, and that the plastic surgeon had breached his fiduciary duty to the patient. The court also discussed that the surgeon here had breached his patient's right of confidentiality, and had made an unconsented, unprivileged disclosure to a third party of nonpublic information that the defendant had learned about in a confidential relationship. Because the defendant here was a physician, he had to adhere to the AMA's Principles of Medical Ethics, and maintain the confidential relationship he had with his patient. Mrs. Vassiliades did not bring her breach of confidentiality cause of action separately, but only as a separate theory within the cause of action for invasion of privacy, for which she was compensated.

<sup>308</sup>*Id.* at 587.

<sup>309</sup>*Id.* at 589.

<sup>310</sup>*Id.* at 591.

information learned constitutes a matter of legitimate public interest."<sup>311</sup> In *Doe v. Roe*, the plaintiff alleged in her complaint that the defendants had invaded her privacy and had given her "unreasonable publicity."<sup>312</sup> The court said that the defendants had not violated any statutes in New York for using the plaintiff's name, portrait or picture in their book.<sup>313</sup> The court noted that the "right of privacy" was not without confusion.<sup>314</sup> The court simply returned to justifying the liability of the defendant with the public policy that a physician impliedly promises to keep in confidence all matters disclosed to him by his patient.<sup>315</sup>

In other cases, such as *Childs v. Williams*, a woman sought counseling for stress related to her job, and her therapist revealed in a letter to her employer that his patient had severe emotional disorders.<sup>316</sup> The court found that there had been no public disclosure in this case, because only a few supervisors at the plaintiff's place of employment knew about the letter from her therapist.<sup>317</sup> The court said it did not matter if private facts are communicated even to a large group of persons if the communication is not made public.<sup>318</sup> In *In re Viviano*, the court held that no actionable invasion of privacy occurred when a psychiatrist and psychologist revealed to law enforcement officials and a judge that a patient was threatening the judge's life.<sup>319</sup> The disclosure of the confidential information was reasonable when balanced against the patient's privacy interests.<sup>320</sup> In *Werner v. Klierer*, the plaintiff sued for invasion of privacy and breach of contract when her psychiatrist wrote to a judge hearing the patient's divorce action.<sup>321</sup> The letter written by the psychiatrist alleged the plaintiff might harm her children.<sup>322</sup> The court held that the letter written by the psychiatrist was not highly offensive to a reasonable person, and every-

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<sup>311</sup>*Vassiliades*, 492 A.2d at 591.

<sup>312</sup>*Doe*, 400 N.Y.S.2d at 675. See N.Y. CIV. RIGHTS LAW §§ 50, 51 (McKinney 1992).

<sup>313</sup>*Id.* at 675. The court also cited N.Y. EDUC. LAW §§ 6509-6511 (McKinney 1985), and a New York Regulation § 60.1, subd. (d)(3).

<sup>314</sup>*Id.* at 675.

<sup>315</sup>*Id.* at 674.

<sup>316</sup>825 S.W.2d 4 (Mo. App. 1992).

<sup>317</sup>*Id.* at 9.

<sup>318</sup>*Id.*

<sup>319</sup>645 So.2d 1301, 1307-08 (La. App. 1994). The court held that the therapists in this case were not negligent, and that their actions were within the applicable standard of care as to the revelation of confidential information. It was also not necessary for the therapists to have involuntarily committed the patient.

<sup>320</sup>*Id.* at 1307.

<sup>321</sup>*Werner*, 710 P.2d at 1253-54.

<sup>322</sup>*Id.* at 1254.

thing in it would have been obtainable through customary discovery procedures.<sup>323</sup> The plaintiff never denied the truth of what was in the letter.<sup>324</sup> In addition, the letter was not publicly disclosed, and only a few court officers, the judge and the attorneys knew of its contents.<sup>325</sup> The court was much more receptive to arguments that statutes such as the physician-patient privilege, and the need for physicians to maintain professional conduct could be binding on a doctor in a psychotherapeutic relationship to maintain confidentiality.<sup>326</sup>

#### V. CONCLUSION

Breach of confidentiality is a viable cause of action that must be more clearly defined by the parties who bring suit, and by the courts. In a world in which psychotherapy is becoming a more frequent treatment, the occurrence of breaches of confidentiality will only increase. Our society encourages its members to value good mental health, and to find solutions to pressing problems. If psychotherapy is to be used as a means to secure this good mental health, we must find a way to protect individuals as they proceed to divulge what is necessary for treatment.

Although there is a scarcity of cases in which patients sue their psychotherapists for breach of confidentiality, the number of cases will increase as patients expect and require that therapists provide an atmosphere of utmost confidentiality during and after treatment. In an age in which information about one's health is making it increasingly difficult to manage confidentially between one's therapist and oneself,<sup>327</sup> breach of confidentiality lawsuits will provide a mechanism for righting any wrong. Breach of confidentiality causes of action may begin to have significant relevance in an age of managed care.

Case law reveals that once a therapeutic relationship is established between therapist and patient, breach of confidentiality suits should be brought in tort, in which the therapist is held to a standard of care by which he or she has a duty to keep in confidence all privileged matters relating to therapy. Although a patient may sue a therapist for additional causes of action such as invasion

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<sup>323</sup>*Id.* at 1256.

<sup>324</sup>*Id.*

<sup>325</sup>*Werner*, 710 P.2d at 1256.

<sup>326</sup>*Id.* at 1257. The court held that the psychiatrist was not liable to the plaintiff because there was an overriding concern here for the care of the children involved in this case. The court did warn the psychiatrist that a "better procedure would be to refrain from any such disclosure except under the auspices and direction of the trial court through discovery, a motion in limine, in-camera inspection, or such other protective procedure as may be appropriate." *Id.*

<sup>327</sup>See the "Medical Records Confidentiality Act", S.1360, 104th Cong., 1st. Sess. (1995), introduced by Senator Robert F. Bennett (R-Utah), which would set a national standard for the handling of identifiable physical and mental health information of individuals. See also, Thomas W. Marino, *Doubts Raised at Committee Hearing on the Enclosed Medical Records Confidentiality Act of 1995*", COUNSELING TODAY, December, 1995 at 1, 8.

of privacy, a breach of confidentiality cause of action must be utilized and must be clearly labeled. The duty to keep all matters in confidence in therapy may arise from professional ethical codes, from licensing and privilege statutes, and from public policy considerations. Plaintiffs will most likely sue for compensatory damages, although pleading for equitable remedies such as an injunction should be an additional consideration.

Confidentiality between psychotherapist and patient will commonly arise in most psychotherapeutic relationships. For most licensed and trained psychotherapists, this confidential relationship will be spelled out in professional ethical codes and state statutes. Therapists, therefore, must be alert to situations in which they are called upon to reveal information about their patients. Therapists are protected by privilege statutes, but exceptions do exist. Psychotherapists must educate themselves with respect to these statutes, especially since we live in a time in which third party payors and others will seek to know more about the patient's prognosis and the usefulness of the psychotherapy. Patients, too, must be alert and inquisitive, and ask that their therapists inform them of any requests for confidential information.