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Medical and Psychotherapy Privileges and Confidentiality: On Giving With One Hand and Removing With the Other

BY STEVEN R. SMITH*

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INTRODUCTION

After a casual review of most states' statutes, a reader could conclude that strong protection exists for the confidences revealed in medical treatment, especially for those revealed in psychotherapy.[1] Professionals' general duty to maintain the confidentiality of their patients and clients often is supplemented with statutory testimonial privileges intended to protect confidences from invasion by courts and other governmental bodies.[2] This seems to be the age of psychotherapy and medical privileges.

A more detailed reading of all the statutes, however, along with related cases, general legal principles, and commentaries could lead a careful reader to a somewhat different conclusion. The protection the law has given with one hand has all too often been taken away with the other. Privileges, and the general obligation of confidentiality, increasingly have been subject to exceptions and limitations, effectively reduced by inconsistent federal and state rules, and threatened by changes in health care

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[1] "Psychotherapist" has no single meaning. Most commonly it refers to psychiatrists and psychologists licensed for independent practice. In other cases it refers to any professional who provides counseling or mental health therapy, including social workers, psychiatric nurses, and counselors, as well as psychologists and psychiatrists.

[2] S. BRAKEL, J. PARRY & B. WEINER, THE MENTALLY DISABLED AND THE LAW 592-604 (3d ed. 1986) (providing a state by state summary of privilege statutes); J. WIGMORE, WIGMORE ON EVIDENCE §§ 2285-86, 2380-91 (J. McNaughton ed. 1961 & Supp. 1986); Churgin, *The Psychotherapist-Patient Privilege: A Search for Identity*, in 2 LAW AND MENTAL HEALTH: INTERNATIONAL PERSPECTIVES 215 (D. Weisstub ed. 1986) (an excellent summary of the law regarding privileges in psychotherapy including a state by state summary of privilege statutes); Note, *Developments in the Law—Privileged Communications*, 98 HARV. L. REV. 1450 (1985) [hereinafter *Developments*]; Comment, *Psychotherapist-Patient Privilege Under Federal Rule 501*, 75 J. CRIM. L. & CRIMINOLOGY 388, 396 (1984) (listing forty-one states which statutorily provide the psychotherapist-patient privilege).

financing. Hospitals, other health care facilities, and practitioners are in the middle of this apparent paradox.

This Article reviews both the giving and the taking away: the protections afforded to confidentiality by privileges and legal duties, and the way those protections are eroded. The duties of professionals and others to maintain confidences are noted, but testimonial privileges are emphasized. This Article proposes reforms in the way we try to protect confidentiality and suggests that the protection of therapy confidences be dealt with as a coherent whole (privileges and obligations of confidentiality should be dealt with together). Exceptions to privileges should be reduced and narrowed, and federal law should recognize the desirability of a consistent approach to confidentiality. Perhaps most importantly, the transmission of some confidential information to third parties should carry with it a duty which would require the recipient to maintain confidentiality ("extended confidentiality").

Kentucky law serves as the basis for this review of psychotherapy and medical privileges. Although each state has unique issues and approaches to confidentiality, the problems seen in Kentucky are typical of those present elsewhere. Kentucky has been a leader in adopting a variety of medical, psychotherapy, and counseling privileges, but similar privileges have been adopted in many other states.[3]

I. REASONS FOR PROTECTING CONFIDENTIALITY

There are three major reasons for protecting the confidences of medical treatment and psychotherapy. These can be broadly labelled (1) "utilitarian," (2) "patient privacy," and (3) "professional honor" reasons. Because of the social costs in protecting confidentiality, those promoting its protection bear some burden of demonstrating the benefits. Making information unavailable increases the risk of incorrect or bad decisions, tends to reduce the efficiency of organizations and society generally, and con-

[3] Like many other states, the answers to many specific questions about the interpretation of privilege statutes and duties of confidentiality in Kentucky remain uncertain. One is, therefore, left to the interpretations of other states in trying to determine what Kentucky would do with a specific question.

ceals information of significant public interest. The costs of confidentiality also extend to many other areas, such as employment decisions (e.g. medical data about an employee may not be available to a potential employer), marital decisions (medical information about one partner may not be available to the other), and political decisions (a candidate's psychiatric history may not be available to the public). These costs of confidentiality, however, most commonly arise with issues of testimonial privileges where these costs (preventing courts from having relevant information) are especially apparent.[4]

A. The Utilitarian Approach

The utilitarian approach theorizes that the protection of confidentiality is justified because the benefits to society are greater than the costs associated with confidentiality. This idea is apparent in the well-known Wigmore criteria for justifying privileges which provide that the injury to a socially important relationship that will result from disclosure of a communication must be greater than the benefit to the "correct disposal of litigation."[5]

The cost/benefit analysis, employing the Wigmore criteria, is intended to determine whether a whole *class* of communications (e.g. those between physicians and patients) should be legally protected.[6] A much different analysis determines *in each*

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[4] Early privileges apparently were based on the proposition that disclosure of information from certain relationships was morally wrong and society ought not intrude in those areas. Shuman, *The Origins of the Physician-Patient Privilege and Professional Secret*, 39 SW. L.J. 661 (1985) (calling for greater study of the history of and basis for medical privileges). *See generally* J.A. BRUCE, PRIVACY AND CONFIDENTIALITY OF HEALTH CARE INFORMATION (1984).

[5] (1) the communications must originate in the *confidence* that they will not be disclosed; (2) this element of *confidentiality must be essential* to the full and satisfactory maintenance of the relationship between the parties; (3) the *relation* must be one which in the opinion of the community ought to be sedulously *fostered*; (4) the *injury* that would inure to the relation by the disclosure of the communications must be *greater than the benefit* thereby gained for the correct disposal of litigation.

WIGMORE, *supra* note 2, at § 2285 (emphasis added). See Tabor v. Commonwealth, 625 S.W.2d 571 (Ky. 1981).

[6] *Developments*, *supra* note 2, at 1472-80 (analyzing the Wigmore criteria for privileged communications).

individual case whether a particular communication between a specific patient and physician should be protected. In the former, the issue is whether the social benefits derived from protecting all of the covered communications, and thereby protecting certain professional relationships generally, is greater than the costs in loss of information from denied access to all such communications. In the latter, the costs and benefits of protecting the single communication are considered. This second analysis, however, does not include consideration of the benefits of protecting generally a whole class of communications, such as the effects that protecting confidentiality may have on others who may engage in similar conversations in the future. Thus, an analysis that looks at costs and benefits of each individual conversation may incorrectly reveal a very high cost-benefit ratio for a specific communication. The result may be quite different if calculated as part of an overall process of protecting certain confidential communications.

B. Privacy of Patients

The privacy interests of patients are further reasons for protecting medical and psychotherapy communications.[7] The most obvious privacy interest involved is the ability to control access to personal information about oneself. Information from psychotherapy is among the most highly personal information imaginable, dealing with intimate facets of a patient's life, such as fantasies, fears, and thoughts. Medical treatment deals less frequently with highly personal information.

Another privacy interest is autonomy, the ability to make fundamental decisions for oneself without significant governmental interference. Psychotherapy depends on the patient trusting the therapist and being completely open in disclosing information. Therefore, interference with the openness or trust effectively may deny access to meaningful therapy. Confidentiality has been widely assumed to be a *sine qua non* for suc-

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[7] Smith, *Constitutional Privacy in Psychotherapy*, 49 GEO. WASH. L. REV. 1 (1980).

cessful therapy,[8] and the absence of confidentiality may interfere with a patient's decision to undertake therapy. The existence of confidentiality generally has been considered less critical for medical treatment, and thus the absence of confidentiality in this area is less of a threat to successful treatment.[9]

The constitutional right of privacy has been seen by some as providing protection for the confidences of therapy. This issue is considered later in the Article.[10]

C. *Professional Honor*

Privileges originated to protect a professional gentleman's honor by not requiring him to disclose what he promised to keep secret.[11] That rationale for confidentiality, and, in particular, testimonial privileges, has long since been abandoned as a stated basis for the legal protection of confidences. In truth, however, professional honor or obligation is still very much a part of the protection of confidentiality. Professional ethics of the medical and psychotherapy professions specifically require that confidences be maintained within the limits of the law.[12] In addition, statutory privileges seldom are adopted without a significant lobbying effort by the professionals to be covered by the privileges. The political reality is that the criteria for adopting privilege statutes often is whether the professionals seeking the privilege have sufficient lobbying strength to have a statute enacted. Thus, in practice, professional honor or ethical obligation is an important basis for privileges.

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[8] The Advisory Committee for the Supreme Court's proposed rules of evidence in its comments on the psychotherapist-patient privilege noted that "there is wide agreement that confidentiality is a *sine qua non* for successful psychiatric treatment. . . . A threat to secrecy blocks successful treatment." Proposed Federal Rules of Evidence, Rule 504, Advisory Committee's Note (quoting GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, CONFIDENTIALITY AND PRIVILEGED COMMUNICATIONS IN THE PRACTICE OF PSYCHIATRY, REP. NO. 45, at 92 (1960)), *reprinted in* 56 F.R.D. 183, 242 (1973).

[9] *E.g.*, WIGMORE, *supra* note 2, at §§ 2285, 2380a, at 527-28, 828-32; Chafee, *Privileged Communications*, 52 YALE L.J. 607, 611 (1943); Degnan, *The Law of Federal Evidence Reform*, 76 HARV. L. REV. 275, 300 (1962). *But see* Black, *The Marital and Physician Privileges—A Reprint of a Letter to a Congressman*, 1975 DUKE L.J. 45, 50-51.

[10] *See infra* notes 72-121 and accompanying text.

[11] WIGMORE, *supra* note 2, at § 2290.

[12] *See infra* notes 13-21 and accompanying text.

II. ON GIVING: CONFIDENTIALITY AND PRIVILEGES

The confidences of medical treatment and psychotherapy are protected in a variety of ways. The major mechanisms are ethical obligations, licensing statutes, the potential for civil liability based on negligence (breach of an obligation to maintain secrets) or the right of privacy (public disclosure of private facts), and testimonial privileges.

A. Ethical Obligations

Protecting the confidentiality of patients has been an ethical obligation of the helping and healing professions for centuries.[13] All major medical, mental health, and counseling professional organizations, such as physicians,[14] psychologists,[15] psychia-

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[13] Hippocrates stressed the obligation of healers to refrain from repeating any personal information they might uncover in the course of treatment. *See* S. FREUD, 2 *Collected Papers* 356 (1959 ed.); Dubey, *Confidentiality as a Requirement of the Therapist: Technical Necessities for Absolute Privilege in Psychotherapy*, 131 AM. J. PSYCHIATRY 1093 (1974); Schuchman, *Confidentiality: Practice Issues in New Legislation*, 50 AM. J. ORTHOPSYCHIATRY 641 (1980); Shah, *Privileged Communications, Confidentiality and Privacy*, 1 PROF. PSYCHOLOGY: RES. & PRAC. 56, 59 (1969); Shuman, *supra* note 4 at 679; Siegel, *Privacy, Ethics and Confidentiality*, 10 PROF. PSYCHOLOGY: RES. & PRAC. 249 (1979); Slovenko, *Psychotherapy and Confidentiality*, 24 CLEV. ST. L. REV. 375, 380, 387 (1975).

[14] AMERICAN MEDICAL ASSOCIATION, REVISED PRINCIPLES OF MEDICAL ETHICS (1980). "A physician shall respect the rights of patients, . . . and shall safeguard patient confidences within the constraints of the law." *Id.* at Principle IV.

[15] AMERICAN PSYCHOLOGICAL ASSOCIATION, Ethical Principles of Psychologists (1981).

> Principle V.—Confidentiality
>
> 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. Where appropriate, psychologists inform their clients of the legal limits of confidentiality.
>
> a. Information obtained in clinical or consulting relationships, or evaluative data concerning children, students, employees, and others, are discussed only for professional purposes and only with persons clearly concerned with the case. Written and oral reports present only data germane to the purposes of the evaluation and every effort is made to avoid undue invasion of privacy.
>
> b. Psychologists who present personal information obtained during

trists,[16] social workers,[17] and counselors,[18] recognize this obliga-

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the course of professional work in writings, lectures, or other public forums either obtain adequate prior consent to do so or adequately disguise all identifying information.

c. Psychologists make provisions for maintaining confidentiality in the storage and disposal of records.

d. When working with minors or other persons who are unable to give voluntary, informed consent, psychologists take special care to protect these persons' best interests.

[16] AMERICAN PSYCHIATRIC ASSOCIATION, The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (1981).

Section 4.

A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

1. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he/she must be circumspect in the information that he/she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.

2. A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies; business organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the student's explicit permission.

3. Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.

4. The ethical responsibility of maintaining confidentiality holds equally for the consultations in which the patient may not have been present and in which the consultee was not a physician. In such instances, the physician consultant should alert the consultee to his/her duty of confidentiality.

5. Ethically the psychiatrist may disclose only that information which is relevant to a given situation. He/she should avoid offering speculation as fact. Sensitive information such as an individual's sexual orientation or

tion in codes of ethics. These ethical codes have several common

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fantasy material is usually unnecessary.

6. Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.

7. Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same time the psychiatrist must assure the minor proper confidentiality.

8. Psychiatrists at times may find it necessary, in order to protect the patient or the community from imminent danger, to reveal confidential information disclosed by the patient.

9. When the psychiatrist is ordered by the court to reveal the confidences entrusted to him/her by patients he/she may comply or he/she may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, to unimpaired treatment, should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.

10. With regard for the person's dignity and privacy and with truly informed consent, it is ethical to present a patient to a scientific gathering, if the confidentiality of the presentation is understood and accepted by the audience.

11. It is ethical to present a patient or former patient to a public gathering or to the news media only if that patient is fully informed of enduring loss of confidentiality, is competent, and consents in writing without coercion.

12. When involved in funded research, the ethical psychiatrist will advise human subjects of the funding source, retain his/her freedom to reveal data and results, and follow all appropriate and current guidelines relative to human subject protection.

13. Ethical consideration in medical practice preclude the psychiatric evaluation of any adult charged with criminal acts prior to access to, or availability of, legal counsel. The only exception is the rendering of care to the person for the sole purpose of medical treatment.

[17] NATIONAL ASSOCIATION OF SOCIAL WORKERS, Code of Ethics (1979).

II. H.

H. Confidentiality and Privacy—The social worker should respect the privacy of clients and hold in confidence all information obtained in the course of professional service.

1. The social worker should share with others confidences revealed by clients, without their consent, only for compelling professional reasons.

2. The social worker should inform clients fully about the limits of

features. First, they offer broad statements of the confidentiality obligation. Second, they provide that the patient or client may consent to the release of confidential information. Third, they recognize exceptions to confidentiality. Generally these exceptions are stated in undefined terms such as "compelling professional reasons"[19] or "clear danger to the person or others."[20]

B. Civil Liability

Civil suits based on the release of confidential information are relatively rare, although the legal basis for such suits is fairly

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confidentiality in a given situation, the purposes for which information is obtained, and how it may be used.

3. The social worker should afford clients reasonable access to any official social work records concerning them.

4. When providing clients with access to records, the social worker should take due care to protect the confidences of others contained in those records.

5. The social worker should obtain informed consent of clients before taping, recording, or permitting third party observation of their activities.

[18] AMERICAN PERSONNEL AND GUIDANCE ASSOCIATION, Ethical Standards (1981).

2. The counseling relationship and information resulting therefrom are to be kept confidential, consistent with the obligations of the member as a professional person. In a group counseling setting, the counselor must set a norm of confidentiality regarding all group participants' . . . disclosures.

5. Records of the counseling relationship, including interview notes, test data, correspondence, tape recordings, and other documents, are to be considered professional information for use in counseling and they should not be considered a part of the records of the institution or agency in which the counselor is employed unless specified by state statute or regulation. Revelation to others of counseling material must occur only upon the expressed consent of the client.

6. Use of data derived from a counseling relationship for purposes of counselor training or research shall be confined to content that can be disguised to ensure full protection of the identity of the subject client.

7. The member must inform the client of the purposes, goals, techniques, rules of procedure and limitations that may affect the relationship at or before the time that the counseling relationship is entered.

[19] NATIONAL ASSOCIATION OF SOCIAL WORKERS, *supra* note 17, at II H-1. *See* AMERICAN PERSONNEL AND GUIDANCE ASSOCIATION, *supra* note 18, at B-2.

[20] AMERICAN PSYCHOLOGICAL ASSOCIATION, *supra* note 15, at Principle V. *See* AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 16, at Section 4-8.

clear.[21] The reason for the lack of suits may be that the normal course of a suit would probably result in additional release of very private information. In addition, the nature and extent of injury may be difficult to prove.[22]

C. *Licensing*

Licensing statutes may either directly require confidentiality as a condition of maintaining a license or cite adherence to a professional code of ethics as a necessary condition of licensure.[23] In either case, confidentiality appears to be protected somewhat by licensure provisions. Given the extremely infrequent resort to licensure discipline in the medical and mental professions, the threat of discipline likely has little impact on the protection of confidences. However, professional norms, expressed in codes of ethics, probably influence practice and help protect confidentiality.

D. *Privileges*

This section examines the existence of a variety of privileges adopted by statute. Like most states, Kentucky has statutory privileges covering physician-patient and psychotherapist-patient relationships.[24] Kentucky also has provided limited privileges for some counselors.[25] In addition to the statutory privileges, this

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[21] For an excellent review of liability for breach of confidentiality, see Eger, *Psychotherapists' Liability for Extrajudicial Breaches of Confidentiality*, 18 ARIZ. L. REV. 1061 (1976). *See also* Cooper, *The Physician's Dilemma: Protection of the Right to Privacy*, 22 ST. LOUIS U.L.J. 397 (1978); Note, *Roe v. Doe: A Remedy for Disclosure of Psychiatric Confidences*, 29 RUTGERS L. REV. 190 (1975).

[22] Patients' reluctance to file suit against psychotherapists and other reasons for the low rate of malpractice among psychotherapists are discussed extensively in the first chapter of S. SMITH & R. MEYER, LAW, BEHAVIOR, AND MENTAL HEALTH: POLICY AND PRACTICE (in press, N.Y. Univ. Press).

[23] *E.g.*, KY. REV. STAT. ANN. § 319.082(o) (Michie/Bobbs-Merrill Supp. 1986) [hereinafter KRS] (psychologists; "[i]mproperly divulged confidential information" is a ground for license discipline); KRS § 311.597(4) (Michie/Bobbs-Merrill 1983) (physicians; discipline is permitted for violating the American Medical Association (AMA) code of ethics).

[24] See *infra* notes 28-38 and accompanying text for a discussion of these privileges.

[25] KRS § 421.2151 (Michie/Bobbs-Merrill Supp. 1986) (establishing a privilege for communications between sexual assault counselor and sexual assault victim). *See also infra* notes 41-44 and accompanying text.

section reviews two other potential sources of privileges, the common law and the Constitution.[26]

E. Physician-Patient Privilege

The physician-patient privilege is the oldest medical/psychotherapy statutory privilege.[27] The Kentucky statute provides that confidential communications between physician-patient are "placed upon the same basis as those provided by law between attorney and client."[28] This statute defines a broad privilege by tying the privilege to the traditionally strong attorney-client privilege. The analogy was in some ways, however, unfortunate. Not only does it incorporate some of the uncertainties concerning the attorney-client privilege (e.g. the future crime exceptions), but it also creates uncertainties in determining how the analogy applies to medicine and the physician-patient relationship because the relationship between hospital personnel, physicians, and patients has no close analogy in law. The existence of insurance and other third-party payers in medicine also makes the attorney-client analogy difficult.

As we shall see, these questions have not been of great importance because the wording of the privilege has been construed to essentially eliminate the protection provided by it.[29]

F. Psychiatrist-Patient Privilege

All psychiatrists are physicians, and as such are included in the physician-patient privilege. Perhaps mindful of past court

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[26] In this section, the statutory privileges are identified without reference to the large number of exceptions and limits which may apply. These are considered in detail in following sections. For a recent broad review of the law of privilege, see *Developments, supra* note 2.

[27] *See id.* at 1460-63.

[28] KRS § 213.200 (Michie/Bobbs-Merrill 1982). "For the purpose of this chapter, the confidential relations and communications between physician and patient are placed upon the same basis as those provided by law between attorney and client, and nothing in this chapter shall be construed to require any such privileged communication to be disclosed." Doctors of Osteopathy are also considered to be physicians. KRS §§ 205.510(8) (Michie/Bobbs-Merrill 1982); 311.550(10) (Michie/Bobbs-Merrill 1983). The definition of physicians as including osteopaths, however, does not clearly apply to the physician-patient privilege. KRS § 213.200. Given the current status of the physician-patient privilege, this is not an issue of great practical importance.

[29] *See infra* notes 124-125, and accompanying text.

interpretations of the physician-patient privilege, in the mid-1960s, Kentucky established a psychiatrist-patient privilege providing that a privilege exists for "communications relating to diagnosis or treatment of the patient's mental condition between patient and psychiatrist, or between members of the patient's family and the psychiatrist, or . . . such persons who participate, under the supervision of the psychiatrist, in the accomplishment of the objectives of diagnosis or treatment."[30] This statute was based on the proposal by the Group for the Advancement of Psychiatry and a similar Connecticut statute.[31]

Most privilege statutes are tied directly to licensure laws, and the professionals authorized to receive privileged information are defined by the license. That is not the case, however, with the psychiatrist-patient privilege because psychiatrists need not be especially licensed or certified beyond the M.D. license. Any physician can claim to be a psychiatrist. The statute defines a psychiatrist as any physician who devotes a "substantial portion

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[30] KRS § 421.215(2) (Michie/Bobbs-Merrill 1972).

(1) As used in this section, unless the context requires otherwise:

(a) "Patient" means a person who, for the purpose of securing diagnosis or treatment of his mental condition consults a psychiatrist;

(b) "Psychiatrist" means a person licensed to practice medicine who devotes a substantial portion of his time to the practice of psychiatry, or a person reasonably believed by the patient to be so qualified;

(c) "Authorized representative" means a person empowered by the patient to assert the privilege granted by this section and, until given permission by the patient to make disclosure, any person whose communications are made privileged by this section.

(2) Except as hereinafter provided, in civil and criminal cases, in proceedings preliminary thereto, and in legislative and administrative proceedings, a patient, or his authorized representative, has a privilege to refuse to disclose, and to prevent a witness from disclosing, communications relating to diagnosis or treatment of the patient's mental condition between patient and psychiatrist, or between members of the patient's family and the psychiatrist, or between any of the foregoing and such persons who participate, under the supervision of the psychiatrist, in the accomplishment of the objectives of diagnosis or treatment.

Id. See *infra* notes 137-141 and accompanying text for a discussion of the exceptions under subsection (3).

[31] *See* GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, CONFIDENTIALITY AND PRIVILEGED COMMUNICATIONS IN THE PRACTICE OF PSYCHIATRY, REP. No. 45, at 112 (1960); Goldstein & Katz, *Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 36 CONN. B.J. 175 (1962).

of his time to the practice of psychiatry" or is reasonably believed by a patient to be so qualified.[32]

In many ways this psychiatrist-patient privilege is strong compared with other medical and psychotherapy privileges in Kentucky. It contains, however, at least one extremely broad explicit exception and a number of implicit exceptions, which have weakened it.[33]

G. *Psychologist-Patient Privilege*

Like the physician-patient privilege, the psychologist-patient privilege is based on the attorney-client privilege. "The confidential relations and communications between licensed psychologists or certificate holders and their clients are placed on the same basis as those provided by the law between attorney and client."[34] This privilege contains the same unfortunate analogy to the attorney-client privilege as discussed previously, although an analogy to the psychiatrist-patient privilege would be more appropriate.[35] An example of the breakdown of the analogy is the use of group therapy and the question of whether members of the group destroy the privilege.[36] Furthermore, the psychologist-patient privilege recognizes a privilege attached to certain

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[32] KRS § 421.215(1)(b). *See supra* note 30.

[33] See *infra* notes 137-141 and accompanying text for a discussion of the exceptions to this privilege. The major exception is that the privilege is lost when a patient is in need of hospitalization. There are also a number of other exceptions to the privilege. *See infra* notes 163-203 and accompanying text.

[34] KRS § 319.111 (Michie/Bobbs-Merrill Supp. 1986). Until 1986, the statute contained a provision that practically made it useless. *See supra* notes 127-129 and accompanying text.

[35] When the psychologist-patient privilege was adopted, the psychiatrist-patient privilege had not yet been passed, making an analogy to that privilege then impossible. Such an analogy, however, would be appropriate now.

In a recent case the Kentucky Supreme Court apparently confused the psychiatrist-patient and psychologist-patient privileges. Matthews v. Commonwealth, 709 S.W.2d 414 (Ky. 1986), *cert. denied,* 107 S. Ct. 245 (1986). Citing KRS § 421.215(2) (involving the psychiatrist-patient privilege), the court went on to say "In Kentucky the psychiatrist-patient privilege is placed 'upon the same basis as that provided by the law between attorney and client.' See Southern Bluegrass Mental Health v. Angelucci, Ky. App., 609 S.W.2d 931 (1980)." *Id.* at 419. The cited case dealt both with the psychiatrist-patient privilege and the psychologist-patient privilege.

[36] See *infra* at notes 209-213 and accompanying text for a discussion of group therapy issues.

psychologists (certificate holders) who will not be licensed for independent practice in the future. At that point, a close analogy to the attorney-client privilege is most difficult.

Until 1986, the psychologist privilege contained language that threatened to destroy it altogether.[37] A revision of 1986, however, significantly reduced this possibility, although it did not eliminate it altogether.[38]

H. Social Worker Confidentiality

Certified social workers have a limited obligation to maintain confidentiality when they are consulted by someone in their "psychotherapeutic capacity."[39] Thus, at least a limited privilege

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[37] *See* KRS § 319.111 (Michie/Bobbs Merrill 1983). *See also infra* notes 127-129 and accompanying text.

[38] *See infra* notes 127-129 and accompanying text. In one case involving this privilege, the issue of this construction apparently was not raised. *See* Southern Bluegrass Mental Health and Mental Retardation Bd. v. Angelucci, 609 S.W.2d 931 (Ky. Ct. App.), *aff'd,* 609 S.W.2d 928 (Ky. 1980).

[39] KRS § 335.170 (Michie/Bobbs-Merrill Supp. 1986):

> No licensee holding a certificate of qualification for independent practice of clinical social work may disclose any information he may have acquired from persons consulting him in his psychotherapeutic capacity except:
>
> (1) With the written consent of the person, or, in the case of death or disability, of his authorized representative, or the beneficiary of an insurance policy on his life, health, or physical condition;
>
> (2) A communication that reveals the contemplation of a crime or a harmful act;
>
> (3) When the communication indicates that the person was the victim or subject of a crime, the licensee shall be required to testify fully when properly subpoenaed by a court of competent jurisdiction in any examination, trial, or other proceeding in which the commission of such a crime is the subject of inquiry;
>
> (4) Communications made in the course of a social work examination ordered by a court of competent jurisdiction when the client has been informed before the examination that any communications made during the examination would not be privileged;
>
> (5) When the licensee is a defendant in either a civil or criminal action;
>
> (6) When the licensee is an employe [sic] of the Commonwealth of Kentucky and is performing activities solely within the confines or under the jurisdiction of the cabinet for human resources or its successor organization; and
>
> (7) If the licensee has reasonable grounds to suspect that a child has been abused or neglected, he shall report such information in compliance with provisions of KRS § 620.030.

See generally Note, *The Social Worker-Client Privilege Statutes: Underlying Justifications and Practical Operations,* 6 PROB. L.J. 243 (1985).

exists for clinical social workers, although it applies only when they are conducting psychotherapy. The statute creates an obligation to maintain confidentiality which goes beyond the privilege, yet a number of exceptions make it a very narrow privilege.[40]

I. Counselors

Certified school counselors, regularly employed by a public or private school, are "immune from disclosing . . . any communication made by the student counselee to the counselor in his professional character, or the advice thereon."[41] This statute, by itself, does not create a general obligation of confidentiality, but applies only in "any civil or criminal court proceeding."[42]

J. Sexual Assault Counselors

The most recent addition to the list of privileges is that between sexual assault counselor and victim.[43] The privilege ap-

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[40] See *infra* notes 146-153 and accompanying text for a discussion of the very broad exceptions to and limitations on this privilege.

[41] KRS § 421.216 (Michie/Bobbs-Merrill Supp. 1986).

> Any certified counselor who meets the requirements issued pursuant to the authority of KRS 161.030, and who is duly appointed and regularly employed for the purpose of counseling in a public or private school of this state, shall be immune from disclosing in any civil or criminal court proceeding, without the consent of the student counselee, any communication made by the student counselee to the counselor in his professional character, or the advice thereon. If the student counselee is less than eighteen (18) years of age, neither the communication nor advice thereon shall be disclosed in the court proceeding without the consent of the student counselee and his parent or legal guardian.

Id.

[42] *Id.*

[43] KRS § 421.2151 (Michie/Bobbs-Merrill Supp. 1986).

> (1) As used in this section the following words and phrases shall have the meaning given to them in this subsection:
>
> (a) "Rape crisis center." Any office, institution or center offering assistance to victims of sexual assault and their families through crisis intervention, medical and legal accompaniment and follow-up counseling;
>
> (b) "Sexual assault counselor." A person who is engaged in any office, institution or center defined as a rape crisis center under this section, who has undergone forty (40) hours of training and is under the control of a direct services supervisor of a rape crisis center, whose primary purpose is the rendering of advice, counseling or assistance to victims of sexual

plies to communications to someone employed in a rape crisis center "who has undergone forty (40) hours of training," who is under the control of "a direct service supervisor of a rape crisis center," and whose primary purpose is to render assistance to victims of sexual assault.[44]

K. Other Privileges

A number of other legal provisions either protect the confidentiality of or establish limited privileges for some forms of therapy. This protection may exist because other professionals who engage in treatment or counseling also have privileges, because certain kinds of treatment or records are specifically protected (even if not conducted by a privileged professional), or because the communication is with an assistant of a professional included within a privilege.

Professionals other than psychotherapists commonly engage in counseling. Ministers, for example, often provide counseling service and a number of pastoral counselors now spend full time

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assault;

(c) "Victim." A person who consults a sexual assault counselor for the purpose of securing advice, counseling or assistance concerning a mental, physical, or emotional condition caused by a sexual assault; and

(d) "Confidential communication" means all information received by a sexual assault counselor which has been transmitted between the victim and the sexual assault counselor which:

1. Was believed by the victim to have been disclosed in confidence;

2. The victim believes will not be disclosed to any other person except persons to whom disclosure is reasonably necessary for the accomplishment of the purpose for which the victim sought the assistance of the sexual assault counselor; and

3. The victim believes will not be disclosed by any other person present at the time the victim is disclosing the information to the sexual assault counselor.

Information which must be disclosed pursuant to subsection (3) of this section shall not be considered as a confidential communication.

(2) A sexual assault counselor has a privilege not to be examined as a witness in any civil or criminal proceeding without the prior written consent of the victim being counseled by the counselor as to any confidential communication made by the victim to the counselor or as to any advice, report or working paper given or made in the course of the consultation.

See *infra* notes 155-159 and accompanying text for a discussion of the exceptions.

[44] KRS § 421.2151(1)(b) (Michie/Bobbs-Merrill Supp. 1986).

providing counseling and therapy. Kentucky statutes have established a privilege covering ministers which covers confidential communications to a minister, priest, or rabbi of "an established church or religious organization." The privilege applies only if the information is received in the practitioner's "professional capacity," and its disclosure would "violate a sacred or moral trust."[45] It is not clear whether "in his professional capacity" is broad enough to include communications to a full-time pastoral counselor or whether "professional capacity" applies only to ministers in a more traditional professional/pastoral role. A disclosure must also violate a "sacred or moral trust," suggesting that, unlike other privileges, this privilege in part belongs to the professional. The application of the statute to "an established church or religious organization" may raise first amendment establishment of religion questions about this privilege.

Certain kinds of treatment are protected by limited confidentiality. Drug and alcohol treatment, which has limited protection of confidentiality in federal statutes, is an example.[46] The statute technically, however, does not establish a privilege due to the provision for release of the information subject to court order.[47]

Another example of limited protection is the privilege that covers communications involved in medical quality assurance reviews within health care institutions. Kentucky provides for

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[45] KRS § 421.210(4) (Michie/Bobbs-Merrill Supp. 1986).

> No . . . ordained minister, priest, rabbi or accredited practitioner of an established church or religious organization [shall] be required to testify in any civil or criminal case or proceedings preliminary thereto, or any administrative proceeding, concerning any information confidentially communicated to him in his professional capacity under such circumstances that to disclose the information would violate a sacred or moral trust.

[46] 42 U.S.C. §§ 290dd-3, ee-3 (1985); Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. §§ 2.1, 2.67 (1985). For a good review of this law, see Saltzman, *Protection for the Child or the Parent? The Conflict Between the Federal Drug and Alcohol Abuse Confidentiality Requirements and the State Child Abuse and Neglect Reporting Laws*, 1985 S. ILL. U.L.J. 181. On the other hand, when the effort is to obtain drugs, the result is much different. Kentucky provides that "[i]nformation communicated to a practitioner in an effort unlawfully to procure a controlled substance . . . shall not be deemed a privileged communication." KRS § 218A.280 (Michie/Bobbs-Merrill 1982).

[47] 42 U.S.C. § 290dd-3(b)(2)(c) (1986).

such a privilege.[48] A previous incarnation of this statute was declared unconstitutional by the Kentucky Supreme Court,[49] and the revised version may not completely meet constitutional requirements.[50] In any event, these statutes do not protect the patient information, but rather the deliberations and conclusions of the review committees. They are therefore of limited value in protecting patient confidences.

Other medical professionals such as nurses, physical therapists, technicians, and chiropractors do not have direct privileges. Doctors of osteopathy, however, may be considered "physicians" and might be covered by the physician-patient privilege to the extent it exists.[51] In some instances those medical professionals not covered by a privilege may be included under the privilege of another professional. This may occur when the professional is assisting a physician with the treatment of a patient.[52] For example, a nurse may be included under the psychiatrist-patient privilege while the nurse is directly assisting the psychiatrist in providing treatment. The extent to which assistants can be included within a professional privilege, however, is not entirely clear. The privilege undoubtedly applies when the assistant is present with the privileged professional and participating in the treatment; yet it is less clear whether a privilege would apply when the privileged professional is not present or is only vaguely directing the activities of the nurse or other

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[48] KRS § 311.377 (Michie/Bobbs-Merrill 1983).

> (2) The proceedings, records, opinions, conclusions and recommendations of any committee, board, commission, professional standards review organization, or other entity, as referred to in subsection (1) of this section shall be confidential and privileged and shall not be subject to discovery, subpoena, or introduction into evidence, in any civil action in any court or in any administrative proceeding before any board, body, or committee, whether federal, state, county, or city. This subsection shall not apply to any proceedings or matters governed exclusively by federal law or federal regulation.

Id.

[49] McGuffey v. Hall, 557 S.W.2d 401 (Ky. 1977) (declaring an earlier version of this section unconstitutional for being improperly labeled and being state legislation in an area preempted by federal law).

[50] It is not certain that the revised version of KRS § 311.377 would survive another constitutional attack.

[51] *See supra* note 28.

[52] WIGMORE, *supra* note 2, at § 2381.

professional. The more one acts as an independent professional, the less one is really assisting and therefore the less likely another's privileges will apply.

A variety of other Kentucky provisions protect some information gathered as part of state functions. For example, information related to civil commitment[53] and provided to the Cabinet for Human Resources[54] is protected.

Although statutes are the most common source of testimonial privileges, privileges may also arise from the common law or the United States Constitution.[55] Courts and commentators for the most part have been critical of broad medical privileges,[56] and therefore it is not surprising that they have been reluctant to adopt common law or constitutional medical privileges. A few courts have, however, provided for limited common law and constitutional psychotherapist-patient privileges.[57] Kentucky courts apparently have not yet been called upon to consider the existence of such privileges as a matter of state law, however, the Sixth Circuit has adopted a common law psychotherapist-patient privilege.[58]

L. The Common Law

Courts traditionally have been reluctant to expand the common law privileges beyond the attorney-client and husband-wife privileges because privileges deprive courts of material evidence.[59] In Kentucky, as in other states, this reluctance has been coupled with a willingness by legislative bodies to provide statutory privileges. In a few states, and in federal courts, the existence of common law privileges has been considered, although there is not yet a broadly accepted common law therapy privilege.

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[53] KRS § 202A.091 (Michie/Bobbs-Merrill 1982). *But see* KRS § 202A.096 (Michie/Bobbs-Merrill 1982) for limitations on this privilege.

[54] KRS § 205.175 (Michie/Bobbs-Merrill Supp. 1986).

[55] *See infra* notes 59-121 and accompanying text.

[56] *See supra* note 9.

[57] *See infra* notes 59-121 and accompanying text.

[58] *In re* Zuniga, 714 F.2d 632 (6th Cir.), *cert. denied,* 464 U.S. 983 (1983).

[59] Pereira v. United States, 347 U.S. 1, 7 (1954) (involving the husband-wife privilege); WIGMORE, *supra* note 2, at §§ 2311, 2326.

In *Allred v. State*,[60] the Supreme Court of Alaska recognized a common law psychotherapist-patient privilege.[61] The issue arose in this criminal case when the trial court ordered a social worker (who was assisting a psychiatrist) to testify regarding her conversations with the defendant. The lower court found that no statutory privilege applied.[62] After reviewing the history of common law privileges, however, the Supreme Court of Alaska concluded that a common law psychotherapist-patient privilege was justified on the basis of the Wigmore criteria.[63] The court held that the privilege applied only to psychiatrists and psychologists who do therapy as opposed to other professionals who do counseling.[64]

In *In re Zuniga*,[65] patients' records, subpoenaed by two grand juries as part of an investigation of insurance billing fraud,[66] were held by therapists who refused to release them. The Sixth Circuit noted that the protection of confidentiality is essential

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[60] 554 P.2d 411 (Alaska 1976).

[61] *Id.* at 418. The court could not agree on whether the privilege was broad enough to cover the communications to a social worker, as opposed to a psychotherapist. Two justices felt that communications to social workers were not covered by the common law privileges while two were of the opposite opinion, because in this case there was a therapeutic relationship and the social worker was the psychiatrist's "alter ego". *Id.* at 426. One justice found the communication between Allred and the social worker to be protected by the statute. *Id.* at 422.

A lower court in Illinois some years earlier also recognized a psychotherapist-patient privilege. Binder v. Ruvell, Civil Docket 52C2535 (Cir. Ct. of Cook County, Illinois, June 24, 1952), with Judge Harry M. Fisher presiding, *reported in* Note, *Confidential Communications to a Psychotherapist: A New Testimonial Privilege*, 47 NW. U.L. REV. 384, 384-85 (1952).

[62] 554 P.2d at 415.

[63] *Id.* at 416-18. The court relied upon Mullen v. United States, 263 F.2d 275, 279 (D.C. Cir. 1959) (Fahy, J., concurring) and Cook v. Carrol, I.R. 515, 525 (Ir. H. Ct. 1945) as examples of judicially created common law priest-penitent privileges. It also noted McTaggart v. McTaggart, 2 All E.R. 754, 755 (C.A. 1948) as an example of the English judicial doctrine of "conversation without prejudice" covering statements made to marriage counselors attempting to effectuate reconciliation, and *In re* Kryschuk and Zulynik, 14 D.L.R. 2d 676 (Sask. Magist. Ct. 1958) as establishing a similar Canadian doctrine. *Id.*

[64] 554 P.2d at 418-22.

[65] 714 F.2d 632 (6th Cir.), *cert. denied,* 464 U.S. 983 (1983).

[66] *Id. See* Note, *The Case for a Federal Psychotherapist-Patient Privilege That Protects Patient Identity*, 1985 DUKE L.J. 1217 [hereinafter *Patient Identity Privilege*]; Note, *Evidence—The Psychotherapist-Patient Privilege—The Sixth Circuit Does the Decent Thing*, 33 KAN. L. REV. 385 (1985).

to successful psychotherapy and that the "inability to obtain effective psychiatric treatment may preclude the enjoyment and exercise of many fundmental freedoms."[67] The court also noted the wide acceptance of the importance of privileges covering psychotherapy. On these bases the court recognized a limited common law privilege covering psychotherapy.[68] The court did not describe fully all the limits on the privilege, but suggested that it would consider a broad utilitarian approach.[69] For example, the court held that the names of patients and the existence of a therapy relationship would not be protected by the privilege even though the very fact that someone was in therapy could itself be highly embarrassing or harmful.[70] The court specifically rejected the existence of a medical or physician-patient privilege, limiting the decision to communications between psychotherapists and their patients.[71] The court did not explain completely the requirements for claiming the privilege, but seemed to adopt the approach taken by Rule 504 of the rules proposed by the Supreme Court (but not accepted by Congress). *In re Zuniga* is an important case in considering privileges in Kentucky because it establishes a limited psychotherapist-patient privilege for federal courts in the Sixth Circuit.

M. Constitutional Privacy and Confidentiality and Privileges

When the state obtains or shares highly sensitive medical or psychotherapy information, the constitutional right of privacy may be violated by requiring the release of very personal information (information privacy) or by imposing significant burdens on the decision to seek medical treatment or psychotherapy (autonomy privacy). For example, the threatened release of information from therapy may make some patients reluctant to

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[67] 714 F.2d at 639. " 'Mental Illness may prevent one from understanding religious and political ideas, or interfere with the ability to communicate ideas. Some level of mental health is necessary to be able to form belief and value systems and to engage in rational thought.' " *Id.* (quoting Smith, *Constitutional Privacy in Psychotherapy*, 49 GEO. WASH. L. REV. 1, 27 (1980)).

[68] 714 F.2d at 639.

[69] *Id.*

[70] *Id.* at 640.

[71] *Id.* at 639-40.

seek psychotherapy at all or may make effective psychotherapy difficult because of the absence of full disclosure or interference with a trusting relationship between therapist and patient.[72]

The Supreme Court has declined to provide substantial privacy protection to medical data, but has hinted that, at some point, the release of this information by a state could become unconstitutional. In *Whalen v. Roe*,[73] the Court permitted the state to collect and maintain certain information concerning "dangerous" drug prescriptions as part of the state effort to control drug abuse.[74] In *Planned Parenthood v. Danforth*,[75] the Court also upheld the state collection of information from physicians performing abortions.[76] The Court emphasized, however, the importance of security provisions to maintain confidentiality.[77] For example, the computerized prescription form[78] in *Whalen* and the abortion reporting system[79] in *Planned Parent-*

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[72] For a discussion of the issues regarding constitutional privacy, see Smith, *Constitutional Privacy and Psychotherapy*, 49 GEO. WASH. L. REV. 1 (1980); Winslade & Ross, *Privacy, Confidentiality, and Autonomy in Psychotherapy*, 64 NEB. L. REV. 578 (1985). Other recent commentaries concerning privacy and therapy include L. Everstine, D. Everstine, Heymann, True, Frey, Johnson & Seiden, *Privacy and Confidentiality in Psychotherapy*, 35 AM. PSYCHOLOGIST 828 (1980); Melton, *Minors and Privacy: Are Legal and Psychological Concepts Compatible?*, 62 NEB. L. REV. 455 (1983); Note, *Privacy in Personal Medical Information: A Diagnosis*, 33 U. FLA. L. REV. 394 (1980-81).

[73] 429 U.S. 589 (1977).

[74] *Id.* at 603-04 (holding that patient identification requirements of the New York State Controlled Substances Act of 1972 were constitutional under the fourteenth amendment).

[75] 428 U.S. 52 (1976).

[76] *Id.* at 80 (holding that reporting requirements "that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible").

[77] *Id.*

[78] 429 U.S. at 600-01 (1977). The Court approved a similar security arrangement in Nixon v. Administrator of Gen. Servs., 433 U.S. 425 (1977), which directed an archival staff with an " 'unblemished record for discretion,' " to review the former President's papers and to return to him any that were personal. *Id.* at 462-65 (quoting Nixon v. Administrator of Gen. Servs., 408 F. Supp. 321, 365 (D.D.C. 1976)).

[79] 428 U.S. at 81. The state claimed two purposes for requiring physicians and health facilities to compile data concerning abortions: to preserve maternal health and life by advancing medical knowledge and to monitor abortions to assure that they were performed in accordance with the law. *Id.* at 79. The Court held that "[r]ecordkeeping and reporting requirements that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible." *Id.* at 80.

hood included security provisions to avoid improper release of the medical information. In both cases, the Court indicated that the absence of security arrangements to preserve confidentiality could seriously threaten privacy and thus would present a difficult constitutional question.[80] In addition, the medical information gathered in those cases was not highly personal, as would be information from psychotherapy.

A number of lower courts have considered the question of medical information and privacy. The cases recognizing a privacy interest in preventing the release of information usually have focused on information from psychotherapy rather than physical treatment. In the following paragraphs, this Article reviews first several cases that have recognized some limited right of privacy to this information and then a few cases that have recognized a constitutionally based psychotherapist-patient privilege.

In *Hawaii Psychiatric Society v. Ariyoshi*,[81] a federal court enjoined the state of Hawaii from enforcing a statute that permitted the issuance of "administrative inspection warrants" to review the mental health records of Medicaid patients.[82] The court held that "[a]n individual's decisions whether or not to seek the aid of a psychiatrist, and whether or not to communicate certain personal information to that psychiatrist, fall squarely within" the constitutional right of privacy.[83] Characterizing the significance of the privacy interest threatened by the statute, the court stated, "[n]o area could be more deserving of protection than communications between a psychiatrist and his patient."[84]

Merriken v. Cressman[85] involved a junior high school program designed to identify emotionally handicapped students and

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[80] 429 U.S. at 601; 428 U.S. at 81.

[81] 481 F. Supp. 1028 (D. Hawaii 1979).

[82] *Id.* at 1032.

[83] *Id.* at 1038.

[84] *Id.* at 1038. In the court's opinion, Hawaii's scheme for inspecting psychiatric records would interfere with therapy by destroying a patient's willingness to disclose personal matters. Balanced against the patient's interest in privacy was the state's interest in protecting the Medicaid program from fraud, which the court accepted as compelling. Nevertheless, the court held that the state had not shown that warrants to inspect the confidential medical records of a psychiatrist were necessary to advance this compelling interest. *Id.* at 1038-41.

[85] 364 F. Supp. 913 (E.D. Pa. 1973).

provide "necessary interventions" to prevent drug abuse.[86] To identify those with a propensity toward drug abuse, students were expected to complete a questionnaire dealing with matters of a personal nature and were asked for information regarding their emotional states.[87] The court acknowledged the state's interest in correcting drug abuse, but doubted whether the program would serve this objective.[88] The court also noted that the state's subpoena power presented a threat to the confidentiality of the information.[89] Therefore, the court issued an injunction prohibiting the state from further efforts to collect sensitive psychological and emotional data.[90]

The court in *Lora v. Board of Education*[91] also found that the constitutional right of privacy protects records containing psychological information.[92] The court noted the importance of privacy in protecting information a patient reveals to a psychotherapist.[93] In granting the plaintiff's motion to review the files of fifty students, the court relied primarily on the scheme to ensure autonomy.[94] There was a genuine need for the information, and no danger of invasion of privacy existed because the information would not be released in a personally identifiable form.[95]

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[86] *Id.* at 914.

[87] *Id.* at 918.

[88] *Id.* at 920.

[89] *Id.* at 916.

[90] *Id.* at 922.

[91] 74 F.R.D. 565 (E.D.N.Y. 1977). In a suit against the New York City School Board alleging discrimination in the evaluation and placement of handicapped children, plaintiffs moved to compel production of the diagnostic and referral files of fifty students that contained sensitive psychological information. *Id.* at 568.

[92] *Id.*

[93] *Id.* at 571.

[94] *Id.* at 582-83.

> In addition to requiring that all identifying data be retracted and the files coded, the court may order that the information they contain be used solely for the purpose of the pending litigation; strict confidentiality may be enforced under penalty of contempt; the number of copies to be made of the documents may be rigidly regulated; files submitted to the court may be ordered sealed; and all material may be required to be returned to the defendants immediately upon conclusion of this suit. Under such a protective scheme the invasion of the children's privacy will be minimal.

Id.

[95] *See id. But see* J.P. v. Desanti, 653 F.2d 1080 (6th Cir. 1981), where the court

In *McKenna v. Fargo*,[96] applicants for positions as firefighters objected to the city's insistence that they undergo psychological testing as a prerequisite to being hired and to the city's maintenance of the psychological profiles after hiring decisions were made.[97] The court acknowledged that the constitutional right of privacy limits the ability of the state to collect and maintain certain kinds of very personal information concerning emotional and mental conditions, including the kind of information elicited through psychological testing.[98] Nevertheless, the court upheld the psychological testing of the applicants due to the state's overriding interest in ensuring the selection of firefighters who would be emotionally stable under stress[99] because firefighting is inherently dangerous and pressured.[100]

In *United States v. Westinghouse Electric Corp.*,[101] a somewhat similar case, objection was raised to the release of sensitive medical records.[102] The court found the information protected by the right of privacy, but found that a strong government interest and a safeguard to prevent release of the information justified the intrusion.[103]

A few courts also have recognized a constitutional psychotherapist-patient privilege; California was the first. In *In re Lifschutz*,[104] one of Dr. Lifschutz's psychiatric patients filed a

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permitted "social histories" of juveniles compiled for the juvenile court to be distributed among a number of government agencies. *Id.* at 1090.

[96] 451 F. Supp. 1355 (D.N.J. 1978), *aff'd*, 601 F.2d 575 (3d Cir. 1979).

[97] *Id.* at 1358.

[98] *Id.* at 1381.

[99] *Id.*

[100] The court characterized the state interest in psychologically screening applicants as "of the highest order" and "of an importance that would be found in very few occupations." The constitutionality of the psychological testing, however, was conditioned on the city's development of formal plans and regulations to preserve the confidentiality of the information obtained during the testing. The court further suggested that the city limit access to the information to the psychologist reviewing the applicant and to the city employees who had specific reason to use the data. As final precautions, the court recommended that the city retain the records only for a specified period of time and that it establish a system for destroying those records not necessary to serve the compelling state interest. *Id.* at 1377-82.

[101] 638 F.2d 570 (3d Cir. 1980).

[102] *Id.*

[103] *Id.* at 580-82.

[104] 467 P.2d 557 (Cal. 1970).

damage suit against another party for assault, claiming severe mental and emotional distress.[105] When the defendant tried to take Dr. Lifschutz's deposition regarding his treatment of the patient, the doctor refused to answer any questions regarding the patient and refused to produce any of the requested records.[106] The patient neither directly consented nor objected to the release of information about his treatment. Dr. Lifschutz appealed a citation for contempt. Acknowledging the sensitive nature of the confidences that patients reveal in psychotherapy, the California Supreme Court indicated that the constitutional right of privacy protects those communications.[107] The *Lifschutz* decision, in effect, recognized a constitutional psychotherapist-patient privilege.

The court, however, rejected Dr. Lifchutz's argument for an absolute psychotherapist-patient privilege,[108] holding that the constitutional right can be limited by the state when necessary to protect or to advance a "legitimate governmental interest."[109] The court thus recognized a patient/litigant exception to the constitutional privilege, but took care to emphasize that it would not sanction all inquiries into a patient's confidences under the guise of a "legitimate governmental interest."[110]

In *Caesar v. Mountanos*,[111] a case factually similar to *Lifschutz*, the United States Court of Appeals for the Ninth Circuit held that the constitutional right of privacy protects the confidentiality of psychotherapist-patient communications. Dr. Caesar had refused to answer questions about one of his patients,

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[105] *Id.*

[106] *Id.* at 559.

[107] *Id.* at 567-68.

[108] *Id.* at 573. "In sum, we conclude that no constitutional right enables the psychotherapist to assert an absolute privilege concerning all psychotherapeutic communications. We do not believe the patient-psychotherapist privilege should be frozen into the rigidity of absolutism." *Id.*

[109] *Id.* at 563.

[110] *Id.* at 569-70. The court held that even when the state demonstrates a compelling interest requiring disclosure of the confidences of therapy, it must limit its inquiry into the confidential information as narrowly as possible to avoid unnecessary invasions of privacy. In the context of the patient/litigant exception, for instance, the state may conduct only a "limited inquiry into the confidences of the psychotherapist-patient relationship." *Id.* at 567.

[111] 542 F.2d 1064 (9th Cir. 1976), *cert. denied,* 430 U.S. 954 (1977).

was held in contempt of the California state court, and then took the federal privacy claims to federal court.[112] Although the Ninth Circuit agreed that confidentiality is essential to psychotherapy and that the very nature of the communications invokes the constitutional right of privacy, it rejected the argument that an absolute privilege existed.[113] Instead, the court held that a privilege existed, but may be limited when necessary to advance a compelling state interest.[114] Apparently, the state's interest in obtaining all material evidence, coupled with the implicit waiver of the privilege by the patient in bringing her mental condition into issue, provided the necessary basis for requiring the disclosure.

In *In re B*,[115] the Pennsylvania Supreme Court, without a majority opinion, also recognized a constitutionally based psychotherapist-patient privilege.[116] Unlike the patients in *Caesar* and *Lifschutz*, the patient in *In re B* was not a party to the lawsuit for which her records were sought. Rather, the case involved a juvenile delinquency proceeding concerning "B."[117] During the course of the predisposition investigation, juvenile court personnel discovered that B's mother had received psychiatric treatment.[118] Although it ruled that the state's statutory doctor-patient privilege did not apply to the disputed records, the court held that the constitutional right of privacy protected the information from involuntary disclosure.[119] Noting that psychotherapy requires patients to reveal the most intimate details of their lives, the court concluded that the constitutional right of privacy includes protec-

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[112] *Id.* at 1065. The patient had filed suit against third parties alleging that two separate automobile accidents had caused her "pain and suffering not limited to her physical ailments."

[113] *Id.* at 1067-68.

[114] *Id.* The court proceeded to evaluate the state interest in obtaining disclosure and found that an invasion of the confidences of Dr. Ceasar's patient was justified. In reaching this conclusion, however, the court failed to identify precisely the state interest that would be furthered by the release of information. *Id.* at 1069.

[115] 394 A.2d 419 (Pa. 1978) (no majority opinion).

[116] *Id.*

[117] *Id.* at 420-21.

[118] *Id.* Dr. Roth, acting for the director of the clinic, was ordered by the juvenile court to turn over the mother's psychiatric records. Dr. Roth refused to do so without the consent of the mother and was cited for contempt of the juvenile court. *Id.*

[119] *Id.* at 425-26.

tion of the confidences revealed in therapy.[120] In *In re B*, the state sought access to patient's psychiatric files in the disposition phase of a juvenile delinquency proceeding. The importance of juvenile proceedings and the quasi-criminal nature of delinquency proceedings emphsized the state's interest in obtaining all relevant information.[121] The decision thus represents a significant endorsement of the privacy of communications between patient and psychotherapist.

Superficially, there appears to be substantial protection for the confidences of therapy, especially through privileges. Kentucky statutes provide for a number of such privileges. These privileges might be supplemented by common law or constitutional privileges. This Article turns next to the ways in which the protections of privileges and confidentiality are limited.

III. ON TAKING AWAY: LIMITATIONS ON PRIVILEGES

A. Self-Destructing Privileges

Some of the medical and psychotherapy privileges in Kentucky are so restricted that they are virtually self-destructing. Foremost among these is the physician-patient privilege.[122] The

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[120] *Id.* The court conceded that recognition of constitutional protection for the confidences of therapy might hamper the efforts of juvenile courts to obtain necessary information, but emphasized that the right of privacy must prevail over the interest of the court in obtaining the privileged information. The court also noted that the state's interest in securing access to a patient's files in such case was diminished because, as a practical matter, courts could obtain most of the desired information from sources other than the psychotherapist. *Id.* at 426.

[121] Because the information concerning the mother's therapy would have been used only in a disposition report in a juvenile proceeding, the court could have assured the confidentiality of the material by sealing the patient's records and by not disclosing the information at a public hearing. Despite the state's significant interest and the means available to limit disclosure, the court rejected the state's request because of the possibility that even a limited breach of the confidentiality of psychotherapist-patient communications could involve a significant invasion of privacy. *Id.* at 425-26. Not all courts have been enthusiastic about a constitutional psychotherapist-patient privilege. *See* Bremer v. State, 307 A.2d 503, 529 (Md. Ct. Spec. App. 1973); *cert. denied,* 415 U.S. 930 (1974) (denying the existence of a constitutional psychiatrist-patient privilege). *Cf.* Felber v. Foote, 321 F. Supp. 85, 89 (D. Conn. 1970) (the right of privacy does not extend protection to the physician-patient relationship, even when the physician is a psychiatrist).

[122] KRS § 213.200 (Michie/Bobbs-Merrill 1982).

Kentucky courts have construed the language of that privilege so as to make it nearly inoperative.[123] The physician-patient privilege contains two troublesome provisions. The statutory language begins: "[f]or the purposes of this chapter," and ends: "nothing in this chapter shall be construed to require any such privileged communication to be disclosed."[124] In 1941, the then Court of Appeals essentially gutted the physician-patient privilege by ruling that this language meant that the privilege applied only to the accumulation of vital statistics and did not provide for a general physician-patient privilege.[125] Thus, Kentucky recognizes no general physician-patient privilege.

The psychologist-patient privilege, until very recently, contained the same two phrases.[126] In 1986, the General Assembly removed the first and more troublesome phrase, "[f]or the purpose of KRS 319.005 to 319.131," which made it appear that the privilege applied only to the process of licensing psychologists.[127] Unfortunately the final provision of the privilege, "nothing in this chapter shall be construed to require any such privileged communication to be disclosed," remains.[128] Of course, nothing in chapter 319 requires the disclosure of privileged communications. Rather, that obligation arises out of the general duty to provide evidence in court. Therefore, the courts might give the psychologist-patient privilege the same treatment as the physician-patient privilege (effective abolition of the privilege). Furthermore, the psychologist-patient privilege depends for its substance on the attorney-client privilege.[129] This approach could be limiting because the analogy is not a very good one and the

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[123] *See infra* note 125 and accompanying text.

[124] KRS § 213.200.

[125] Williams v. Tarter, 151 S.W.2d 783, 787 (Ky. 1941); Boyd v. Winn, 150 S.W.2d 648, 650 (Ky. 1941).

[126] KRS § 319.111 (Michie/Bobbs-Merrill 1983).

[127] KRS § 319.111 (Michie/Bobbs-Merrill Supp. 1986). A case involving this statute did not consider the issue of the opening and closing phrases of the privilege. *See* Southern Bluegrass Mental Health & Mental Retardation Bd. v. Angelucci, 609 S.W.2d 931, 933 (Ky. Ct. App.), *aff'd*, 609 S.W.2d 928 (Ky. 1980).

[128] KRS § 319.111 (Michie/Bobbs-Merrill Supp. 1986).

[129] "The confidential relations and communications between licensed psychologists or certificate holders and their clients are placed upon the same basis as those provided by the law between attorney and client. . . ." KRS § 319.111 (Michie/Bobbs-Merrill Supp. 1986).

nature of the protections required in legal counseling and in psychotherapy are quite different. For example, the attorney-client privilege does not ordinarily preclude disclosure of whether an attorney-client relationship exists, but the very fact that a patient is in therapy may be quite damaging even if the details of the communication are not revealed.[130] The attorney-client privilege does not include discussion of future crimes, and yet psychologists may often be informed of anti-social, criminal conduct in the course of therapy; criminal conduct which may very well be continuing, therefore be a form of future crime.[131] In addition, the mode of therapy is frequently unlike the method of legal representation. For example, group therapy is a common form of psychotherapy with no clear analogy to which the attorney-client privilege can apply. Furthermore, third-party payment for services is more common in psychology than in law, raising difficult questions about the effect of disclosure of information to third-party payers.[132]

B. Explicit Exceptions

Both the physician-patient and the psychologist-patient privileges may contain provisions that significantly limit their utility. To the extent that the psychologist-patient privilege is recognized, it includes the same exceptions as the attorney-client privilege.[133] Other privileges contain explicit exceptions which

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[130] In *In re* Zuniga, 714 F.2d 632, 640 (6th Cir.), *cert. denied,* 464 U.S. 983 (1983), the Sixth Circuit Court of Appeals recognized that the release of the fact of therapy could be distressing. However, the court noted that the patients already had released that information to their health insurance companies. *Id.* at 640. *See Patient Identity Privilege, supra* note 66.

[131] For example, therapists might be told of continuing criminal activity such as petty theft, exhibitionism, homosexual activity, or drug use. The future crime exception may be considerably more important in therapy than in legal counseling. The fact that those entering therapy, at least during the initial stages, may continue this criminal activity should not destroy the privilege.

[132] Issues regarding group therapy and privilege-related difficulties associated with third-party payers are discussed *infra* at notes 209-216 and accompanying text.

[133] This might include loss of the privilege when there is discussion of future illegal acts, *see* Hughes v. Meade, 453 S.W.2d 538, 542 (Ky. 1970); when third parties (including bystanders) hear the conversation, *see* Vanhorn v. Commonwealth, 40 S.W.2d 372, 375 (Ky. 1931); or when the professional has evidence concerning the mental condition of the client, *see* Wicks v. Dean, 44 S.W. 397, 398 (Ky. 1898). It is very difficult to determine how the many rules which have grown up around the attorney-client privilege would be applied to psychologists.

dramatically limit their applicability. Notably, the psychiatrist-patient privilege,[134] the social worker privilege,[135] and the rape-counselor privilege[136] all have this difficulty.

The psychiatrist-patient privilege explicitly provides for three exceptions. The privilege is lost: 1) when the patient introduces his or her mental condition as an element of a claim or defense and the benefits of disclosure outweigh the risk of harm from the disclosure;[137] 2) when a psychiatric examination is ordered by the court and the patient is informed the communication will not be privileged;[138] and 3) "[w]hen a psychiatrist, in the course of diagnosis or treatment of the patient, determines that the patient is in need of admission to or commitment to a hospital for care of the patient's mental illness."[139] This last provision, taken literally, means that the privilege is lost whenever a psychiatrist determines that a patient is "in need of admission to" a hospital for the care of mental illness.[140] Although an argument could be made providing a narrow exception for civil commitment cases, the statute is not so limited. There is no good

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[134] KRS § 421.215 (Michie/Bobbs-Merrill 1972).

[135] KRS § 335.170 (Michie/Bobbs-Merrill Supp. 1986).

[136] KRS § 421.2151 (Michie/Bobbs-Merrill Supp. 1986).

[137] KRS § 421.215. The exceptions provided for the psychiatrist-patient privilege are as follows.

> (3) There shall be no privilege for any relevant communications under this section:
>
> (a) When a psychiatrist, in the course of diagnosis or treatment of the patient, determines that the patient is in need of admission to or commitment to a hospital for care of the patient's mental illness;
>
> (b) If a judge finds that the patient, after having been informed that the communications would not be privileged, has made communications to a psychiatrist in the course of a psychiatric examination ordered by the court provided that such communications shall be admissible only on issues involving the patient's mental condition;
>
> (c) In a civil proceeding in which the patient introduces his mental condition as an element of his claim or defense, or, after the patient's death, when said condition is introduced by any party claiming or defending through or as a beneficiary of the patient, and the judge finds that it is more important to the interests of justice that the communication be disclosed than that the relationship between patient and psychiatrist be protected.

The remainder of the privilege statute is quoted *supra* note 30.

[138] KRS § 421.215(3)(b).

[139] KRS § 421.215(3)(a).

[140] *Id.*

justification for this broad exception to the privilege. The model statute from which the language was taken is said to provide the exception "only for the purpose of securing hospitalization or instituting commitment proceedings."[141] The actual language of the exception, however, does not make this limit clear and a court might determine that the privilege is lost completely (for all purposes) whenever a patient is admitted to a hospital for mental illness. The other exceptions to the psychiatrist-patient privilege are more narrowly drawn.

One difficulty with the psychiatrist-patient privilege is determining who is a psychiatrist for purposes of the statute. The statute provides that "a person licensed to practice medicine who devotes a substantial portion of his time to the practice of psychiatry, or a person reasonably believed by the patient to be so qualified" is a psychiatrist.[142] Because no special certification or licensing is required for a psychiatrist, it is often difficult for a patient to reasonably determine whether someone devotes a "substantial portion" of his time to psychiatry. In addition, the concept of "substantial portion of his time" is itself unclear and does not promote certainty in understanding which professionals qualify for coverage under this provision.[143] The saving provision is that the patient need only "reasonably believe" the therapist meets the qualifications.[144]

The social worker privilege, by its terms, applies only to social workers who are certified for the "independent practice of clinical social work" when they are consulted in a "psychotherapeutic capacity."[145] In addition, the statute lists seven exceptions to the privilege.[146] Most of these exceptions are relatively limited; for example, information may be revealed when there is consent to the release of information,[147] when the client is

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[141] Goldstein & Katz, *supra* note 31, at 186.

[142] KRS § 421.215(1)(b).

[143] *Id.*

[144] *Id.*

[145] KRS § 335.170.

[146] *Id.*

[147] KRS § 335.170(1). The consent must be in writing. In case of death *or disability*, the consent may come from "his [the patient's] authorized representative, or the beneficiary of an insurance policy on his life, health or physical condition." *Id.*

informed that the examination is pursuant to a court order,[148] or when there is child abuse or neglect.[149] Other exceptions, however, are potentially quite broad and will remove the protection of confidentiality when "[a] communication . . . reveals the contemplation of a crime or harmful act,"[150] when "the person was the victim or subject of a crime,"[151] when the social worker "is a defendant in either a civil or criminal action,"[152] or when the social worker is a state employee performing activities under the jurisdiction of the Cabinet for Human Resources.[153] Taken together, these exceptions and limitations leave little of an effective social worker-client privilege.

The sexual assault counselor-victim privilege specifically requires that, to be privileged, the revealed information must be disclosed in confidence.[154] Therefore, the failure of the confidentiality of the communication may destroy the privilege.[155] Exceptions to the privilege are also provided when testimony is sought to establish chain of custody in evidence,[156] in matters of proof "concerning the physical appearance of the victim at the time of the injury,"[157] when the counselor "has knowledge that the victim has given perjured testimony,"[158] or "[t]o any information

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[148] KRS § 335.170(4). Technically, the language of the exception requires that the client be informed, before the examination, that any communications made during the examination would not be privileged. *Id.*

[149] KRS § 335.170(7).

[150] KRS § 335.170(2).

[151] KRS § 335.170(3). This exception is limited to proceedings in which "the commission of such crime is the subject of inquiry," when the social worker is "subpoenaed by a court." *Id.*

[152] KRS § 335.170(5).

[153] KRS § 335.170(6). This exception is limited to circumstances in which the social worker is performing activities "*solely* within the confines or under the jurisdiction of the cabinet." *Id.* (emphasis added) The meaning of "solely" is unclear. Conceivably, an activity sponsored by two state agencies might carry with it the obligation of confidentiality, while the same activity sponsored only by the Cabinet for Human Resources would not be protected under this section.

[154] KRS § 421.2151(1)(d).

[155] The statute requires only that the victim believes the information was "disclosed in confidence," KRS § 421.2151(1)(d)(1), and the victim believes it will not be disclosed to others not present or necessary for the counseling. (KRS § 421.2151(1)(d)(1)-(2)).

[156] KRS § 421.2151(3)(a).

[157] KRS § 421.2151(3)(b).

[158] KRS § 421.2151(3)(c). Strangely, this provision requires that, before the exception to the privilege exists, the defendant or state must have given "notice to the court that perjury may have been committed." *Id.*

revealed by a victim which relates to the identify of the victim's assailant."[159]

Ironically, of all the statutory privileges in Kentucky, the one with the fewest exceptions may be the school counselor privilege.[160] It requires the counselor to be certified pursuant to Kentucky Revised Statute section 161.030 and "duly appointed and regularly employed for the purpose of counseling. . . ."[161] The only explicit exception to the privilege is that information may be released with the consent of the student counselee or (if less than 18 years of age) the student and his or her parent.[162]

C. *Other Common Exceptions*

In addition to the exceptions contained in the statutes establishing privileges, there are a variety of other exceptions to privileges. These arise in different ways, including by implication from other statutory provisions, as well as from the common law. The extent of the common law exceptions is somewhat speculative, however, because there are a limited number of Kentucky decisions and, nationally, the decisions have not been uniform. Over the years Kentucky courts have manifested a dislike for medical and psychotherapy privileges which has resulted in narrowing the privileges and expanding the exceptions.[163] Therefore, the Kentucky courts might use many of the

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[159] KRS § 421.2151(3)(d).

[160] KRS § 421.216 (Michie/Bobbs-Merrill 1972).

[161] *Id.*

[162] *See supra* note 41. *See generally* Smith, *Privacy, Dangerousness and Counselors*, 15 J. L. & EDUC. 121 (1986).

[163] Examples of the tendency of the Kentucky Supreme Court (or the old Court of Appeals) to narrow privileges are Atwood v. Atwood, 550 S.W.2d 465 (Ky. 1976) (holding that in child custody cases the mental health of all individuals involved is in issue, and therefore no privilege exists regarding communications between parent and psychiatrist because KRS § 421.215(3)(c) has been satisfied); Williams v. Tarter, 151 S.W.2d 783 (Ky. 1941) (holding that the physician-patient privilege statute relates only to certain matters set out in the statute's subsections and that common law allows no privilege otherwise); Boyd v. Winn, 150 S.W.2d 648 (Ky. 1941) (holding that the physician-patient privilege statute applies only to transactions coming within the purview of the Bureau of Vital Statistics as set out in the statute, and the statute does not make all communications between physician and patients privileged). There is, more recently, some cause to hope that the courts are more accepting of mental health privileges. Amburgey v. Central Ky. Regional Mental Health Bd., Inc., 663 S.W.2d 952 (Ky. Ct.

exceptions discussed in this section to narrow the applicability of privileges.

1. *Child Abuse*

There is no medical or psychotherapy privilege for information received about child abuse.[164] These privileges are lost regardless of the source of information about the abuse.[165] For example, an abuser seeking psychotherapy to help stop being an abusive parent apparently would not be included in any psychiatrist-patient or psychologist-patient privilege, although we note below a weak argument that the psychologist-patient privilege might apply in these cases.[166] The attorney-client and the minister privileges *may* apply in cases of child abuse, but other privileges apparently do not.[167]

App. 1983) (involving psychiatrist-patient privilege). The court of appeals noted that the privilege "is absolute in the absence of the legislated and recognized exceptions." *Id.* at 953; Southern Bluegrass Mental Health & Mental Retardation Bd., Inc. v. Angelucci, 609 S.W.2d 931 (Ky. Ct. App.), *aff'd,* 609 S.W.2d 928 (Ky. 1980) (involving psychologist-patient and psychiatrist- patient privileges).

[164] KRS § 199.335(2),(7) (Michie/Bobbs-Merrill Supp. 1986). (This section is repealed, effective July 1, 1987. Thereafter substantially the same provision will be contained in KRS §§ 620.050(2), 620.030(2) (Michie/Bobbs-Merrill Supp. 1986)).

[165] Subsection (7) specifically eliminates any privileges other than the attorney-client and clergy-penitent privileges.

> (7) Neither the husband-wife nor any professional-client/patient privilege, except the attorney-client and clergy-penitent privilege, shall be a ground for refusing to report under this section or for excluding evidence regarding an abused or neglected child or the cause thereof, in any judicial proceedings resulting from a report pursuant to this section.

KRS § 199.335(7). (After July 1, 1987, this becomes KRS § 620.050(2).)

Several interesting questions arise from this provision. First, the question arises regarding whether, by implication, the attorney-client and clergy-penitent privileges are effective in cases of child abuse and neglect. The clear implication is that these two privileges survive child abuse. The second question is whether this provision exempts attorneys and clergy from the duty to report. KRS § 199.335(2). The answer to this is far from clear because the *privilege* referred to in subsection seven technically does not deal with the issue of reporting, only with court proceedings. It appears most likely, however, that the intent was to exempt these professionals from the obligation to report. A third question is whether psychologists are privileged, as opposed to being required to report, under this statute. *See infra* notes 170-171.

[166] *See infra* notes 170-172 and accompanying text.

[167] KRS § 199.335(7). (After July 1, 1987, this becomes KRS § 620.050(2).)

Child abuse and neglect are defined very broadly to include serious physical injury, emotional abuse, sexual exploitation, and neglect.[168] These terms, in turn, are undefined or are defined very broadly. This breadth of definition, as a practical matter, is of limited importance in considering the application of privileges, but is considerably more important, however, in the obligation to report abuse, discussed below.[169]

The child abuse statute provides that none of the "professional-client/patient privileges, except the attorney-client privilege and clergy-penitent privilege, shall be a ground . . . for excluding evidence regarding an abused or neglected child or the cause thereof. . . ."[170] However, in the privilege statute psychologist-patient communications are placed "on the same basis" as attorney-client communications.[171] An argument can be made that, as such, the privilege would exempt psychologists to the same extent attorneys are exempted from obligations to report and testify under the child abuse reporting statute. The courts, however, more likely would find that psychologists were not to be treated as attorneys for the purpose of this statute and that

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[168] KRS § 199.011(6) (Michie/Bobbs-Merrill Supp. 1986) provides:

> (6) "Abused or neglected child" means a child whose health or welfare is harmed or threatened with harm when his parent, guardian or other person who has the permanent or temporary care, custody or responsibility for the supervision of the child: inflicts or allows to be inflicted upon the child, physical or mental injury to the child by other than accidental means; creates or allows to be created a risk of physical or mental injury to the child by other than accidental means; commits or allows to be committed an act of sexual abuse upon the child, including sexual exploitation; willfully abandons or exploits such child; does not provide the child with adequate care and supervision; food, clothing and shelter; education; or medical care necessary for the child's well-being; provided, however, that a parent or guardian legitimately practicing his religious beliefs who thereby does not provide specified medical treatment for a child, for that reason alone shall not be considered a negligent parent or guardian. This exception, however, shall not preclude a court from ordering that medical services be provided to the child, where his health requires it.

(This provision is repealed effective July 1, 1987. The revised version, KRS § 600.020(1), is very similar to the current statute.)

[169] *See infra* notes 228-251 and accompanying text.

[170] KRS § 199.335(7). (After July 1, 1987 KRS § 620.050(2).)

[171] KRS § 319.111 (Michie/Bobbs-Merrill Supp. 1986) provides that "confidential relations and communications" between psychologist and patients "are placed on the same basis as those provided by the law between attorney and client. . . ."

the legislature meant to exclude the psychologist-patient privilege under the terms of the statute.[172]

2. *Adult Abuse*

Child abuse statutes have been models for efforts to reduce abuse against other groups. Kentucky has adopted a statute requiring the reporting of adult abuse and neglect.[173] This statute essentially applies to any abused person who is unable to protect himself or herself from neglect or hazardous situations. The statute specifically provides that "[n]either the psychologist-patient privilege nor the husband-wife privilege shall be a ground for excluding evidence regarding the abuse, neglect, or exploitation of an adult. . . ."[174] It is interesting that medical and therapy privileges other than the psychologist-patient privilege are not specifically mentioned in the statute. A strict reading of the statute would permit privileges other than the psychologist-patient privilege to apply in the case of adult abuse. For example, the physician-patient privilege,[175] the psychiatrist-patient privilege and the counselor-student privilege may not be excepted by this language. (The social worker privilege has an explicit exception that would seem to prevent it from qualifying.) Courts, however, likely would read the reference to the psychologist-patient privilege in the adult abuse statute as applying generally to all psychotherapy and medical privileges. As with the child abuse statute,

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[172] The Kentucky General Assembly undoubtedly intended to include psychologists among those required to report and testify concerning child abuse. KRS § 199.335(2) specifies that "mental health professionals" are required to report. After July 1, 1987, this provision becomes KRS § 620.030(2) (Michie/Bobbs-Merrill Supp. 1986). For the definition of abuse or neglect, see KRS § 209.020(7) (Michie/Bobbs-Merrill 1982).

[173] KRS § 209.030 (Michie/Bobbs-Merrill 1982) provides:

> (2) Any person, including, but not limited to, physician, law enforcement officer, nurse, social worker, department personnel, coroner, medical examiner, alternate care facility employed [sic], or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made in accordance with the provisions of this chapter. Death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death.

[174] KRS § 209.060 (Michie/Bobbs-Merrill 1982).

[175] The physician-patient privilege would not be important because the physician-patient privilege was essentially destroyed some time ago.

the loss of privileges here probably is not as important as the obligation to report abuse. This issue is discussed in the next section.

3. *Child Custody*

The Kentucky Supreme Court, in *Atwood v. Atwood*,[176] found an implicit exception to the psychiatrist-patient privilege (and presumably other psychotherapy privileges) for child custody cases by holding that the privilege did not preclude deposing psychiatrists with whom the mother had consulted.[177] This exception apparently arises out of the importance of the mental health of the parents in making custody decisions, the fact that those seeking custody of children put their mental conditions into issue, and the fact that child custody statutes (passed after the psychiatrist-patient privilege statute) "place the mental conditions of all family members squarely in issue."[178] *Atwood* seems particularly inconsistent with the statute creating the psychiatrist-patient privilege which appears to limit this kind of an exception to those situations where the patient was informed that the communications would not be privileged and the patient made the communications in the course of a psychiatric examination order by the court.[179]

Atwood suggests the continuation of judicial distaste for medical and psychological privileges which was manifested in the Court of Appeal's treatment of the medical privilege before World War II.[180]

4. *Dangerous Patients*

Increasingly, no medical privilege appears to exist when a mental health professional or physician has determined that a patient poses a serious risk to others. This "dangerous patient exception" to privileges may arise from several sources. The

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[176] 550 S.W.2d 465 (Ky. 1976).

[177] *Id. See* Guernsey, *The Psychotherapist-Patient Privilege in Child Placement: A Relevancy Analysis*, 26 VILL. L. REV. 955 (1980-81).

[178] 550 S.W. 2d at 467.

[179] KRS § 421.215(3)(b) (Michie/Bobbs-Merrill 1972).

[180] *See also* Allen v. Dept. Human Resources, 540 S.W.2d 597 (Ky. 1976).

psychiatrist-patient privilege, as this Article has noted, does not apply when the patient is in need of hospitalization or civil commitment,[181] nor does the social worker privilege apply when there is contemplation of a harmful act.[182] The psychologist-patient privilege and physician-patient privilege apparently adopt the exceptions inherent in the attorney-client privilege[183] and, therefore, discussion of future crimes (violence) probably will not be included within the privilege. Finally, the *Tarasoff*[184] duty to warn, described following, undoubtedly would destroy any privilege.[185]

The limitation on the privilege is not necessarily limited to situations in which the patient is threatening a dangerous crime. The social worker privilege, for example, provides for an exception for communication "that reveals the contemplation of a crime *or* a harmful act," thereby suggesting non-harmful crimes may be included in a future crime exception to that privilege.[186] The dependence on the attorney-client privilege by the psychotherapist-patient and physician-patient privileges may include a future crime exception that extends beyond violent acts.[187] Thus, the disclosure of future crimes, not an uncommon occurrence by some psychotherapy patients, may be outside these privileges.

5. *Patient Waiver*

Competent patients may consent to the disclosure of information from treatment or therapy.[188] Because the privilege belongs to the patient and not to physicians and therapists, patients voluntarily may waive the privilege without the agreement of the physician or psychotherapist. The waiver of a privilege essentially destroys that privilege, at least for the information released pursuant to the waiver; the information released is no longer confidential.

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[181] KRS § 421.215(3)(a).

[182] KRS § 335.170(2) (Michie/Bobbs-Merrill Supp. 1986).

[183] KRS §§ 213.200 (Michie/Bobbs-Merrill 1982), 319.111 (Michie/Bobbs-Merrill Supp. 1986).

[184] Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334 (Cal. 1976).

[185] The "duty to warn" is discussed *infra*, at notes 258-289 and accompanying text.

[186] KRS § 335.170(2).

[187] KRS §§ 213.200, 319.111.

[188] *See infra* note 191.

Although professionals cannot refuse to release information when a privilege of confidentiality has been waived by a competent patient, they can inform the patient of the consequences of releasing such information. The codes of ethics increasingly recognize some affirmative responsibility to inform patients of the consequences of releasing certain information. For example, the American Psychiatric Association provides "[t]he continuing duty of the psychiatrist to protect the patient includes *fully apprising* him/her of the connotations of waiving the privilege of privacy."[189] The American Psychological Association requires that "*[w]here appropriate*, psychologists inform their clients of the legal limits of confidentiality."[190]

Some privileges in Kentucky specifically recognize the consent to release information.[191] Even without an express waiver provision, however, patients should have the right to explicitly waive privileges. As this Article later discusses, patients may also implicitly waive a privilege by disclosing the information otherwise protected by the privilege or by bringing their health or mental states into issue in legal proceedings.

6. *Patient/Litigant Exception*

Patients who bring their health or mental states into question in litigation waive any privileges concerning relevant information from treatment or therapy.[192] This exception is based on the unfairness of allowing a person to raise questions about health or mental conditions and then to use the privilege to prevent opposing parties from obtaining information with which to challenge the claims. The patient/litigant exception, however, means that a patient may face the unhappy choice of abandoning either

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[189] AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 16, at Section 4-2 (emphasis added).

[190] AMERICAN PSYCHOLOGICAL ASSOCIATION, *supra* note 15, at Principle 5 (emphasis added).

[191] Examples of statutes that specifically recognize consent to release information are KRS § 335.170 (Supp. 1986) (social worker privilege); KRS § 421.2151 (Supp. 1986) (sexual assault counselor); and KRS § 421.216 (Supp. 1986) (school counselor privilege).

[192] Caesar v. Mountanos, 542 F.2d 1064, 1070 (9th Cir. 1976), *cert. denied*, 430 U.S. 954 (1977) (holding plaintiff who sues for mental and emotional injuries clearly puts mental condition in issue and therefore waives any psychotherapist-patient privilege). *See* Matthews v. Commonwealth, 709 S.W.2d 414, 419 (Ky. 1986).

a valid claim (or defense) or the confidentiality of therapy.[193] This patient/litigant exception is universally accepted as a part of statutory, common law, or constitutional privileges.[194]

Too often the patient/litigant exception becomes a serious infringement on the privacy of treatment or therapy. Having raised some issue regarding health, the patient may find his or her entire physical or mental health history subject to discovery. Courts could narrow intrusions into the confidences of treatment and therapy by limiting this exception to conditions that are directly relevant to the lawsuit and by examining questionable evidence *in camera* to determine if its introduction will do more harm than good.[195] Especially in the area of mental health information, courts should be reluctant to permit broad discovery unless there is some reason to expect that the information is relevant. For example, claims of emotional distress or suffering should not be the basis for an unlimited discovery of the patient's previous mental health condition.[196] Unfortunately, courts have been slow to provide protection for the confidences of psychotherapy when the patient/litigant exception is invoked. As a result, the exception too often has been an excuse for opposing counsel to conduct a thorough fishing expedition into the mental and emotional history of a patient.[197]

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[193] The ease with which the privilege can be lost is illustrated by Allen v. Dept. Human Resources, 540 S.W.2d 597 (Ky. 1976) in which in a proceeding to terminate parental rights a mother stated that "she has been under the care of a psychiatrist but is nevertheless able to provide for her children." The court held that this was sufficient to "have introduced [her] mental condition as an element of [her] claim" and therefore to have waived the psychiatrist-patient privilege. *Id.* at 598-99.

[194] *See, e.g., In re* Zuniga, 714 F.2d 632 (6th Cir.), *cert. denied,* 464 U.S. 983 (1983); Caesar v. Mountanos, 542 F.2d 1064 (9th Cir. 1976), *cert. denied,* 430 U.S. 954 (1977); Allred v. State, 554 P.2d 411 (Alaska 1976); *In re* Lifschutz, 467 P.2d 557 (Cal. 1970).

[195] Judge Hufstedler has proposed that, to avoid unnecessary invasion of the confidences of therapy, the patient-litigant exception should ordinarily be limited to ascertaining the time, length, cost, and ultimate diagnosis of treatment. An adverse party would be permitted to demand additional information concerning therapy only if the party demonstrated a compelling need for the information. 542 F.2d at 1074-75 (Hufstedler, J., concurring and dissenting).

[196] 467 P.2d at 567.

[197] Slovenko, *Psychotherapist-Patient Testimonial Privilege: A Picture of Misguided Hope,* 23 CATH. U.L. REV. 649 (1974).

7. *Criminal Defense Exception*

To present an adequate defense to criminal charges, a defendant may require information revealed by another in therapy. A defendant, for example, might wish to present evidence of an adverse witness' statements to a therapist which were inconsistent with the witness' courtroom testimony, but a privilege may restrict the ability to obtain or present this evidence. The United States Supreme Court, in *Davis v. Alaska*,[198] suggested that a state ban on the use of juvenile records in court was unconstitutional when those records were crucial to the defense of a criminal case.[199] Although the actual holding in *Davis* was relatively narrow, it has prompted some courts to hold that the constitutional rights of criminal defendants compel the disclosure of evidence which is protected by privileges.[200] At the present time, however, such rights are not well defined and seem to be rather limited.

In the case of sexual assault counselor-victim privilege there is a limited criminal defense exception when the victim has given perjured testimony.[201] This exception also extends to any information a victim reveals relating to his assailant's identity.[202] Whether criminal defense exceptions would be recognized in other privileges is not certain.

8. *Requirements for the Privilege*

A number of exceptions to the protections of confidentiality arise because of requirements that must be met for a privilege to be effective. Whether or not explicitly stated, almost all

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[198] 415 U.S. 308 (1974).

[199] *Id.* AUTHOR'S NOTE: See recent case Penn v. Ritchie, 107 S. Ct. 989 (1987).

[200] Salazar v. State, 559 P.2d 66, 79 (Alaska 1976) (holding marital privilege does not preclude cross-examination of wife regarding incriminating statements made by husband when he is not a defendant in a criminal trial, but a witness for the prosecution); State v. Hembd, 232 N.W.2d 872, 876 (Minn. 1975) (holding medical records of plaintiff are not privileged when necessary to insure defendant's constitutional right to confront a witness); State v. Roma, 357 A.2d 45, 51 (N.J. Super. Ct. App. Div. 1976) *aff'd on reargument,* 363 A.2d 923 (N.J. Super. Ct. App. Div. 1976) (holding marriage counselor privilege yields to defendant's constitutional right to present an adequate defense).

[201] KRS § 421.2151(3)(c).

[202] KRS § 421.2151(3)(d).

privileges will be effective only if the following criteria are met:

1. The communications must be to a licensed or certified professional, as described by the statute, or to an assistant of the professional. Thus, communication to someone not licensed or qualified as a professional (within the meaning of the privilege) is not privileged.[203]

2. A professional relationship must exist between the patient or client and the professional. An informal conversation not within the professional relationship is not protected.

3. The communication must be related to the provision of professional services.

4. The communication must be confidential. This usually means that the communication may not be released to third parties. In addition, the communication must be made with an expectation of confidentiality.

The privilege requirement most likely to cause difficulty is that the communication be confidential and made with the expectation that it will remain confidential. This has implications for court-ordered examinations, group therapy, students and assistants, and the release of information to third-party payers such as insurance companies.

9. *Court-Ordered Examinations*

Examinations made for courts or for litigation cannot be made with a reasonable expectation of confidentiality because the subject should understand that the information from the interview will be transmitted to others. For example, an examination as part of the civil commitment process will be reported in court, and an examination in a civil case to assess disability will be revealed to the opposing party and perhaps revealed in court. A state is not constitutionally required to inform a patient

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[203] In some instances, a reasonable belief that someone is qualified as a covered professional is sufficient to protect the communication. The Federal Rules of Evidence proposed by the Supreme Court, for example, provided that the patient's belief that a psychotherapist qualified for the privilege was sufficient to establish the privilege. Proposed Federal Rules of Evidence, Rule 504, *reprinted in* 56 F.R.D. 183, 240-41 (1973). The Kentucky psychiatrist-patient privilege contains a similar provision. KRS § 421.215(1)(b).

of *Miranda*[204] rights as part of most examinations, even if the examination might lead to involuntary civil commitment or incarceration as part of a sexual psychopath law.[205] Therefore, patients being interviewed by a physician or mental health professional may not know of the special limits on confidentiality. The Kentucky psychiatrist-patient privilege appears to limit the use of information from court-ordered examinations to circumstances in which the patient is informed that the communications are not privileged.[206] The Kentucky Supreme Court, however, at least has implied that other exceptions expand the circumstances in which such testimony could be used.[207] Despite this uncertainty about the psychiatrist-patient privilege, any examination ordered by a court or done with the expectation that it will be used in court probably is not included in a privilege.[203]

Perhaps those civilly committed should have particularly strong protection of their confidences. As involuntary patients they have little choice except to undergo therapy. Therefore, society may have an obligation to minimize the invasion of these involuntary patients' privacy interests by providing strong protection for confidentiality. The psychiatrist-patient privilege is therefore especially unfortunate in limiting the privilege for patients who are civilly committed.

10. *Group Therapy*

Group therapy involves a number of patients who, although they may be active to varying degrees in each other's therapy, are present primarily for the diagnosis and treatment of their own conditions.[209] By definition, third parties are present during group psychotherapy. Thus, group therapy poses special prob-

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[204] Miranda v. Arizona, 384 U.S. 436 (1966).

[205] Allen v. Illinois, 106 S. Ct. 2988, 2995 (1986) (regarding commitment subject to sexual psychopath laws); French v. Blackburn, 428 F. Supp. 1351, 1358-59 (M.D.N.C. 1977), *summarily aff'd,* 433 U.S. 901 (1979) (regarding involuntary civil commitment procedures).

[206] KRS § 421.215(3)(b).

[207] Atwood v. Atwood, 550 S.W.2d 465, 467 (Ky. 1976). *But see* Amburgey v. Central Kentucky Regional Mental Health Bd., 663 S.W.2d 952 (Ky. 1983).

[208] *See* Marlowe v. Commonwealth, 709 S.W.2d 424 (Ky. 1986), *cert. denied,* 107 S. Ct. 427 (1986).

[209] Meyer & Smith, *A Crisis in Group Therapy,* 32 AM. PSYCHOLOGIST 638 (1977).

lems in determining the existence of privileges. A close analysis of traditional rules concerning the presence of third parties suggests that communications revealed in group therapy are not privileged.[210] The third parties are not assistants of the therapist, they are present for their own therapy. Furthermore, to the extent the conversation is between the group members rather than between a group member and the therapist, the communication may be between patients rather then between professional and patient.

The Kentucky psychiatrist-patient privilege attempts to deal with this problem by providing that the privilege applies to communications "between patient and the psychiatrist, or between members of the patient's family and psychiatrist, or between any of the foregoing and such persons who participate, under the supervision of the psychiatrist, in the accomplishment of the objectives of diagnosis or treatment."[211] A court reasonably could interpret this language as applying to group therapy. A court, however, possibly could find this language to require that "the such persons who participate" be participating for the purpose of accomplishing the objectives of diagnosis or treatment of the *patient* claiming the privilege. In fact group members are participating for the objective of the diagnosis or treatment of *their own* conditions. Furthermore, a court could hold that the language applies only when there is a clear expectation of privacy, which may not always be present during group therapy.

Whatever the uncertainties of group therapy coverage under the psychiatrist-patient privilege, the coverage is greater than under the other privileges which do not contain even implicit reference to group therapy. The better position is to include

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[210] *Id. See generally* Cross, *Privileged Communications Between Participants in Group Psychotherapy*, 1970 L. & SOC. ORDER 191, 193-94; Morgan, *Must the Group Get Up and Testify? An Examination of Group Therapy Privilege*, 2 GROUP 67, 70-73 (1978); Note, *Group Therapy and Privileged Communication*, 43 IND. L.J. 93, 98-100 (1967). For discussions of the effect of third parties on the applicability of the attorney-client privilege, see Note, *The Attorney-Client Privilege in Multiple Party Situations*, 8 COLUM. J.L. & SOC. PROBS. 179 (1972); Note, *Legal Professional Privilege and Third Parties*, 37 MOD. L. REV. 601 (1974); Note, *Evidence—Privileged Communication in Divorce Actions: Psychiatrist-Patient and Presence of Third Parties*, 40 TENN. L. REV. 110 (1972).

[211] KRS § 421.215(2).

group therapy within the privilege, at least when there is a clear understanding that each of the group members is to maintain silence about the confidences revealed.[212] This expectation of privacy could be bolstered, as later discussed, if a cause of action existed against group member who violated this expectation of confidentiality.[213]

11. *Students and Assistants*

Those who are necessary or useful in assisting the professional with the provision of services usually are not considered to be third parties who destroy the confidentiality of information. Therefore, nurses, records and office assistants, and the like are within the privileges to the extent they are directly under the supervision of, and assisting, the professional who is covered by a privilege. At some point, however, the assistants become so independent that the assistants are no longer included within the privilege. Where this point occurs in medical treatment and psychotherapy is not adequately defined in Kentucky. For example, it is unclear whether a professional (such as physician's assistant or social worker) who is working under broad practice protocol is covered by the privilege. The privilege probably is lost when the supervision of the treatment of a patient is somewhat indirect and performed entirely by a secondary or paraprofessional.

The same principles apply to treatment by those in training, but not yet licensed. A psychology student taking a practicum course or an internship would be covered by the privilege only to the extent that the student is seeing patients as an assistant to a covered professional. Again, the line-drawing here is particularly difficult. In a recent Georgia case, a lower court suggested that patients seen by a student were not included within

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[212] This position was persuasively taken in State v. Andring, 342 N.W.2d 128, 133-34 (Minn. 1984).

[213] The final section of this Article argues for the concept of extended confidentiality in which some of those receiving confidential information have a legal obligation to maintain those secrets.

the psychotherapist-patient relationship covered by a privilege,[214] but the status of those in training is far from certain.

12. *Third-Party Payers*

A considerable portion of medical treatment, and to a lesser degree psychotherapy, is covered by third-party payers such as private insurance, Medicare, Medicaid, or a variety of other government programs. These third-party payers require the release of varying amounts of information from medical treatment or psychotherapy as a condition of payment for the services. The patient ordinarily must consent to the release of this information, and the refusal of consent means that the third-party payer will not cover the services or that the patient is in breach of the contract of insurance. Having given the information to the third-party payer, a patient voluntarily has disclosed information from therapy and thereby may have lost the protection of a privilege covering that information, and potentially other information from therapy.[215] Thus, the otherwise privileged information, if released to an insurance company or other third-party payer, may no longer be considered privileged.[216]

13. *Privileges After Death*

Medical and psychotherapy privileges may die with their holders. In theory, at least, the release of very private infor-

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[214] *See* Hall v. State, 336 S.E.2d 812 (Ga. 1985) in which the Georgia Supreme Court noted that an appellate court had refused to apply the psychologist-patient privilege to a student in training (the Georgia Supreme Court did not decide the issue). Students should be considered assistants of a therapist (faculty supervisor) under whose direction the evaluation or therapy is undertaken. Recently, however, some question has been raised about this principle. In People v. Gomez, 185 Cal. Rptr. 155, 159 n.3 (Cal. Dist. Ct. App. 1982) the court held that family court interns were not covered by the privilege unless they were working under the supervision of a therapist to whom the privilege attached.

[215] Note, *The Psychotherapist-Patient Privilege: Are Patients Victims in the Investigation of Medicaid Fraud?*, 19 IND. L. REV. 831 (1986).

[216] *See In re* Zuniga, 714 F.2d 632, 640 (6th Cir.), *cert. denied,* 464 U.S. 983 (1983) (holding patients who have disclosed their names to an insurance company have waived their privilege); *In re* Pebsworth, 705 F.2d 261 (7th Cir. 1983) (holding patient waived privilege when authorized disclosure of records to medical insurance carrier for reimbursement).

mation following death does considerably less harm than its release before death and, therefore, there is no sufficient reason to withhold relevant information from courts. In Kentucky, only the psychiatrist-patient privilege specifically speaks to this issue, and then only as it relates to the patient/litigant exception when the patient's condition "is introduced by any party claiming or defending through or as a beneficiary of the patient" and the judge finds that such release would be appropriate.[217] Wigmore had argued for a death limitation on the exercise of privileges and Kentucky courts probably would be inclined to follow this in the medical and psychotherapy areas.[218]

D. Federal Cases and State Privileges

The Federal Rules of Evidence do not explicitly provide for a physician-patient or any other psychotherapist-patient privilege. The United States Supreme Court proposed federal rules which enumerated several specific privileges including a psychotherapist-patient privilege, but not including a physician-patient privilege.[219] Rule 504 of the proposed rules was based on the assumption that an assurance of confidentiality is essential to effective psychotherapy, but not essential to most medical care.[220] Congress, however, rejected the Supreme Court's specific proposals because of a complicated debate over which privileges should be adopted and whether privileges are a matter of substantive or procedural law.[221] Congress chose instead to replace all of the enumerated privileges with one general rule, Rule 501, governing all privileges.[222]

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[217] KRS § 421.215(3)(c).

[218] WIGMORE, *supra* note 2, at § 2387. *See* Proposed Federal Rules of Evidence, Rule 504(d)(3), *reprinted in* 56 F.R.D. 183, 241 (1973).

[219] Proposed Federal Rules of Evidence, Rule 504, *reprinted in* 56 F.R.D. 183, 240-41 (1973).

[220] *Id.* at 241-42.

[221] *See* 10 MOORE'S FEDERAL PRACTICE ¶ 500.01, at 1 (2d ed. 1979); Friedenthal, *The Rulemaking Power of the Supreme Court: A Contemporary Crisis*, 27 STAN. L. REV. 673, 682-85 (1975); Moore & Bendix, *Congress, Evidence and Rulemaking*, 84 YALE L.J. 9, 22-27 (1974); Schwartz, *Privileges Under the Federal Rules of Evidence—A Step Forward?*, 38 U. PITT L. REV. 79, 81 (1976).

[222] FED. R. EVID. 501.

Rule 501 of the Federal Rules of Evidence provides for different rules of evidence depending on whether a case is based on state law (diversity case) or federal law ("federal" case).[223] In cases "as to which state law supplies the rule of decision, the privilege . . . shall be determined in accordance with State law."[224] In federal cases, to which federal law applies, privileges are 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."[225] In other words, in federal courts, state law regarding privileges governs in diversity cases, and federal law regarding privileges governs in federal question cases. Therefore, even in states with strong privileges, federal cases in federal courts may not have any medical or psychotherapy privileges at all.

The Sixth Circuit, as noted earlier, has adopted a limited psychotherapist-patient privilege as a matter of federal common law.[226] Kentucky, therefore, is one of the states in which a limited federal common law psychotherapist-patient privilege applies in federal cases. The full dimensions of the Sixth Circuit's common law privilege are not known, although the decision establishing the privilege suggested it may be quite narrow.[227] Depending on the course of future decisions, ironically, the federal common law privilege for psychotherapy may actually exceed the protections provided by statute in Kentucky.

E. To Whom Does the Privilege Apply?

A major purpose of privileges is to assure patients that they can be open in therapy and that their confidences will not be revealed as part of litigation. If privileges are to accomplish this purpose, some level of certainty in the application of privileges is essential. Limitations should be narrow and clear. With this

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[223] *Id.*

[224] *Id. See* Comment, *supra* note 2.

[225] FED. R. EVID. 501.

[226] *See In re* Zuniga, 714 F.2d 632, 636, 639 (6th Cir.), *cert. denied,* 464 U.S. 983 (1983).

[227] *Id.* at 639-40. "[T]he appropriate scope of a privilege . . . is determined by balancing the interests protected by shielding the evidence sought with those advanced by disclosure." *Id.*

in mind, imagine what a patient entering medical care or psychotherapy should be told if he or she asks whether revealed information may be subject to disclosure in court. If the patient is seeking medical treatment he or she will have to be told that there probably will be little or no protection and that information revealed may be released in court.

If the patient asks a psychiatrist, psychologist, social worker, pastoral counselor, or school counselor about a privilege, the answer will vary from professional to professional, but broadly he or she will be told the following: "The protection your information from therapy will have depends first on where the case arises. If it arises in a federal case in the Sixth Circuit there will be at least some possibility that it will not have to be disclosed; if it arises in a federal case in most of the rest of the country it is likely that there will be no protection and that all the information will have to be disclosed to the extent it is relevant. If your information is relevant in a case in a Kentucky court (or diversity case in a federal court) the information you reveal in therapy will probably be protected unless you agreed to the release of the information, you reveal information about child abuse or adult abuse, you threaten serious harm to others, you are in need of hospitalization, you become embroiled in a child custody case, you bring your own mental condition into court in any kind of a case, you are treated by someone other than a covered professional, (perhaps) your information becomes essential for someone else's defense to a criminal act, you release the information to an insurance company or other third-party payer, you become involved in group therapy (that information might not be covered by the privilege), or you die."

Having heard all of this, the patient might conclude that he or she does not have much assurance that revealed information will be protected by Kentucky's statutory privileges. Should the patient ask about protection of confidentiality outside of court, he or she might be distressed further.

IV. REMOVING EVEN MORE: LIMITS ON CONFIDENTIALITY

The patient probably understands that a variety of legal doctrines protect confidentiality and that, therefore, he or she need not seriously worry about confidentiality unless embroiled

in a lawsuit. What the patient may not understand are the limits to these protections. Limitations on the confidentiality of medical care and psychotherapy arise from statutory exceptions to confidentiality (required disclosure); special relationships between therapist, patients, and others; the review of care given by health care providers; and methods of financing health care. This Article considers these as they affect confidentiality.

A. Privileges

In the absence of effective privileges, one interference with confidentiality, as discussed, is government required disclosure of medical and psychotherapy information. Some exceptions apply even if the patient himself never becomes involved in a lawsuit. For example, patients' files may be used or reviewed by a third-party payer or the government to prove a physician's insurance or Medicare fraud. Thus the absence of strong, effective privileges is the first, significant threat to confidentiality.

B. Child Abuse

Current statutes require that anyone (specifically including most medical personnel) knowing of or suspecting child abuse report that abuse to state authorities (child protective services agencies).[228] The commendable purpose of these statutes is to reduce violence against children by permitting early intervention by state authorities. In practice, however, poorly written and

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[228] KRS § 199.335(2) (Michie/Bobbs-Merrill Supp. 1986) provides:

> (2) Any physician, osteopathic physician, nurse, teacher, school personnel, social worker, coroner, medical examiner, child caring personnel, resident, intern, chiropractor, dentist, optometrist, health professional, peace officer, mental health professional or other person who knows or has reasonable cause to believe that a child is an abused or neglected child, shall report or cause a report to be made in accordance with the provisions of this section. When any of the above specified persons is attending a child as part of his professional duties, he shall report or cause a report to be made in accordance with the provisions of this section. Nothing in this section is intended to relieve individuals, agencies or organizations of their obligation to report.

On July 1, 1987, this section is repealed and is replaced by KRS § 620.030(1), (2), which contains language similar to KRS § 199.335(2),(3) (Michie/Bobbs-Merrill Supp. 1986).

very broad abuse reporting statutes may interfere with therapy and in some cases even be counterproductive.[229] This affirmative obligation to report child abuse is of more practical importance, in terms of its effect on confidentiality, than the loss of privileges under these statutes. The abuse reporting statutes require that physicians and psychotherapists take affirmative action to breach the confidences of therapy.[230]

Mandatory child abuse reporting statutes are relatively new and have been the subject of many changes during their short history. For some time, physicians have had a duty to report certain conditions, most notably serious communicable diseases, primarily to protect third parties (the community) from the patient. In 1963, the United States Children's Bureau proposed "legislation on reporting of the physically abused child."[231] Reporting laws were adopted at a rapid rate and within four years all 50 states had them.[232] Kentucky now has a very broad child abuse reporting statute which requires that anyone knowing or having reason to believe that child abuse has occured report such to a protective services agency.[233] Virtually all medical personnel and those involved in delivering psychotherapy have a specific obligation to report known or suspected child abuse, whatever the source of information. This obligation arises when physicians or nurses see evidence of abuse while treating a child for physical injuries or when psychiatrists, psychologists, and counselors see emotional abuse while treating a child, or when an abusive parent seeks therapy to stop the abuse.

Child abuse is defined very broadly to include serious physical injury, emotional injury, sexual exploitation, and neglect.[234]

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[229] *See* Newberger, *The Helping Hand Strikes Again: Unintended Consequences of Child Abuse Reporting*, 12 J. CLINICAL CHILD PSYCHOLOGY 307 (1983).

[230] KRS § 199.335(2).

[231] U.S. CHILDREN'S BUREAU, THE ABUSED CHILD-PRINCIPLES AND SUGGESTED LANGUAGE FOR LEGISLATION ON REPORTING ON THE PHYSICALLY ABUSED CHILD (1963). THE MEDICAL COMMUNITY COUNTERED WITH ITS OWN PROPOSED MODEL ACT. *See* American Medical Association, Physical Abuse of Children—Suggested Legislation (1965).

[232] Besharov, *Child Protection: Past Progress, Present Problems, and Future Directions*, 17 FAM. L.Q. 151, 153-54 (1984). *See* Fraser, *A Glimpse at the Future: A Critical Analysis of the Development of Child Abuse Reporting Statutes*, 54 CHI.-KENT L. REV. 641, 650-67 (1977-78).

[233] KRS § 199.335.

[234] KRS § 199.011(6) (Michie/Bobbs-Merrill Supp. 1986). The definition of abuse

These terms, however, are essentially left undefined.[235] It is difficult, therefore, for those obligated to report to know with certainty what events must be reported. This uncertainty naturally has lead to confusion about what constitutes child abuse and neglect and undoubtedly adversely affects the ability of authorities to discover and successfully deal with abuse.

The *National Study of Child Abuse* found that nearly 60% of the cases reported to child protection agencies as suspected child abuse could not be substantiated.[236] The problem of overreporting is significant; recent estimates are that this year as many as 1.8 million children will be reported as abused.[237] Ironically, the uncertainty concerning the definitions may also contribute to significant underreporting. The National Study found that 68% of the children thought to be within the scope of abuse and neglect were not known to the child protection agency.[238] In fact, only 21% of the cases known to those outside the child protection agencies were reported to those agencies.[239] If any-

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is set out *supra* note 168. *See* J. GIOVANNONI & R. BECERRA, DEFINING CHILD ABUSE 4-13, 257-59 (1979).

[235] Sexual exploitation, however, is defined in some detail. KRS § 199.011(16).

> (16) "Sexual exploitation" includes but is not limited to a situation in which a parent, guardian or other person having custodial control or supervision of a child or responsible for his welfare, allows, permits, or encourages the child to engage in an act which constitutes prostitution under Kentucky law; or a parent, guardian or other person having custodial control or supervision of a child or responsible for his welfare, allows, permits, or encourages the child to engage in an act of obscene or pornographic photographing, filming, or depicting of a child as provided for under Kentucky law.

On July 1, 1987, this section becomes KRS § 600.020(36).

On July 1, 1987, several other important terms will also be defined. These definitions, however, are not very useful. For example, "physical injury" means "substantial physical pain or any impairment of physical condition." KRS § 600.020(27) (Michie/Bobbs-Merrill Supp. 1986).

[236] U.S. CENTER ON CHILD ABUSE AND NEGLECT, NATIONAL STUDY OF THE INCIDENCE AND SEVERITY OF CHILD ABUSE AND NEGLECT (1981) [hereinafter NATIONAL STUDY OF CHILD ABUSE]. The NATIONAL STUDY estimated that 1.1 million children were reported as abused or neglected each year, and more than 600,000 of these could not be substantiated even using fairly broad definitions of abuse and neglect.

[237] A later report suggests that by 1983 the annual number of children reported as abused or neglected has risen to 1.5 million. D. WHITCOMB, E. SHAPIRO & L. STELLWAGEN, *When the Victim is a Child* 2 (1985). With continued increases it is not unreasonable to expect that by now the figure is closer to 1.8 million.

[238] NATIONAL STUDY OF CHILD ABUSE, *supra* note 236.

[239] *Id.*

thing, the actual rate of reporting nationwide may be lower than indicated by that study.[240] A significant price is paid for the confusion about what is required to be reported.[241] Abuse that is not dealt with may result in serious harm to the child, and false reports (even if made in good faith) may disrupt families, invade privacy, and make some relationships more difficult to maintain.[242]

Statutes contain some incentive for overreporting because the failure to report known or suspected child abuse or neglect may result in criminal or civil liability or professional discipline.[243] Although Kentucky, unlike some states, does not provide statutorily that a child who is injured after someone's failure to make the required report has a civil claim against that person, such liability is possible. The liability might be based on a form of negligence *per se*,[244] on the basis of ordinary malpractice negligence,[245] or on the *Tarasoff*[246] statutory liabilities discussed

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[240] The definition used by the NATIONAL STUDY has been criticized by some, particularly as it relates to the definition of sexual abuse and the requirement that the abuser be a parent or other caretaker. Finkelhor & Hotaling, *Sexual Abuse in the National Incidence Study of Child Abuse and Neglect: An Appraisal*, 8 CHILD ABUSE & NEGLECT 23 (1984).

[241] *See generally* J. GIOVANNONI & R. BECERRA, *supra* note 166, at 3-4; Bourne & Newberger, *"Family Autonomy" or "Coercive Intervention?" Ambiguity and Conflict in the Proposed Standards for Child Abuse and Neglect*, 57 B.U.L. REV. 670 (1977); Swoboda, Elwork, Sales & Levine, *Knowledge of and Compliance With Privileged Communication and Child Abuse Reporting Laws*, 9 PROF. PSYCHOLOGY: RES. & PRAC. 448 (1978).

[242] Child rearing or family integrity are part of the constitutionally protected right of autonomy privacy. *See, e.g.*, H.L. v. Matheson, 450 U.S. 398, 410 (1981); Prince v. Massachusetts, 321 U.S. 158, 166 (1944); Pierce v. Society of Sisters, 268 U.S. 510, 535 (1925). The constitutional issues raised by state intervention to protect children are discussed in Note, *Constitutional Limitations on the Scope of State Child Neglect Statutes*, 79 COLUM. L. REV. 719 (1979).

[243] KRS § 199.990(7) (Michie/Bobbs-Merrill 1982). Failure to report is a Class B misdemeanor. *Id.*

[244] The failure to adhere to a duty described in a criminal, or similar, statute may result in negligence *per se* liability if the statute was designed to protect the class of persons of which the plaintiff is a member and against the risk of harm and injury which occurred. W.P. KEETON, D. COBBS, R. KEETON, D. OWEN, PROSSER & KEETON ON TORTS, 229-31 (W.D. Keeton 5th ed. 1984).

[245] Landeros v. Flood, 551 P.2d 389 (Cal. 1976); Brown & Truitt, *Civil Liability in Child Abuse Cases*, 54 CHI.-KENT L. REV. 753, 758-64 (1977-78). For a discussion of the negligence liability of the failure to report child abuse, see Besharov, *Child Abuse and Neglect: Liability for Failing to Report*, 22 TRIAL Aug. 1986, at 67; Issacson, *Child*

following.[247] In addition, the failure to meet the reporting obligations could result in professional discipline.[248] On the other hand, inaccurate reporting, if done in good faith, is protected from criminal and civil liability.[249] Therefore, penalties exist for underreporting but not for overreporting, evidencing some bias in favor of overreporting.

One danger of abuse reporting statutes is that abusers who wish to stop the abuse might be driven from psychotherapy. If abusers seek therapy and admit to the abuse, they must be reported to a state agency and their statement (confession) might be used against them if they are criminally charged. To reduce the problems with child abuse reporting laws, the definition of abuse and neglect should be narrowed and sharpened through more precise definitions. The statutes should be modified to eliminate the reporting requirement when abusers voluntarily seek psychotherapy. The therapist should be obligated to report child abuse when there is the threat of serious, permanent, physical harm to the child or when therapy is not continuing and the threat of child abuse may continue. Psychotherapist-patient privileges, however, should not be abrogated when the abuser reveals information intended to help stop the abuse.[250]

Abuse Reporting Statutes: The Case for Holding Physicians Civilly Liable for Failure to Report, 12 SAN DIEGO L. REV. 743 (1974-75); Paulsen, *Child Abuse Reporting Laws: The Shape of the Legislation*, 67 COLUM. L. REV. 1, 34-36 (1967); Note, *Physicians' Liability for Failure to Diagnose and Report Child Abuse*, 23 WAYNE L. REV. 1187 (1977). *See also* Note, *Civil Liability for Teachers' Negligent Failure to Report Suspected Child Abuse*, 28 WAYNE L. REV. 183 (1981-82).

[246] Tarasoff v. Regents of the Univ. Cal., 551 P.2d 334 (Cal. 1976).

[247] *See infra* notes 258-289 and accompanying text.

[248] Disciplinary action may be taken against psychologists for violating statutes (including misdemeanors) related to the practice of psychology. KRS § 319.082(f),(m) (Michie/Bobbs-Merrill Supp. 1986). Physicians can be disciplined for conduct that would be "malpractice," or for failure to conform to prevailing standards of medical practice. KRS § 311.597(3),(4) (Michie/Bobbs-Merrill 1983). Either of these statutes easily could be interpreted to permit discipline for criminal failure to report abuse.

[249] KRS § 199.335(6). "Anyone acting upon reasonable cause in the making of a report . . . shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed." *Id.*

[250] Regarding these reforms generally, see Besharov, *"Doing Something" About Child Abuse: The Need to Narrow the Grounds for State Intervention*, 8 HARV. J.L. & PUB. POL'Y 539 (1985); Hurley, *Duties in Conflict: Must Psychotherapists Report Child Abuse Inflicted by Clients and Confided in Therapy*, 22 SAN DIEGO L. REV. 645 (1985); Note, *Vanishing Exception to the Psychotherapist-Patient Privilege: The Child Abuse*

Abusers also might be encouraged to seek therapy if limited immunity from prosecution were provided for abusers who voluntarily seek psychotherapy. The immunity would not apply, however, if therapy were entered into in contemplation of prosecution or if death or serious, permanent, physical harm resulted from the abuse, or if the abuse continued after therapy began.[251]

C. *Adult Abuse*

Medical and mental health workers and others also are required to report adult abuse and neglect.[252] Adult abuse applies to spouse abuse, elder abuse, and the abuse of others unable to protect themselves from neglect or hazardous situations.[253]

The adult abuse law generally is based on child abuse reporting laws and most of the comments made about the child abuse laws apply to the adult abuse reporting statute.[254] There is an affirmative obligation to report abuse or neglect and the failure to do so may lead to criminal liability,[255] and perhaps to civil liability or licensure discipline.[256]

Reporting Act, 16 PAC. L.J. 335 (1984-85).

Some courts have begun to protect psychotherapist privileges in child abuse cases. State v. Andring, 342 N.W.2d 128, 133-34 (Minn. 1984); Missouri *ex rel.* D.M. v. Hoester, No. 47744 (Mo. Ct. App. Dec. 20, 1983), *reported in* 8 MENTAL & PHYSICAL DISABILITY L. REP. 121-22 (1984). *See generally* Saltzman, *supra* note 46.

[251] This proposal is described in greater detail in Smith & Meyer, *Child Abuse Reporting Laws and Psychotherapy: A Time for Reconsideration*, 7 INT'L J.L. & PSYCHIATRY 351 (1985). *See* Coleman, *Creating Therapist-Offender Exception to Mandatory Child Abuse Reporting Statutes—When Psychiatrist Knows Best*, 54 CIN. L. REV. 1113 (1986).

[252] KRS § 209.030 (Michie/Bobbs-Merrill 1982). *See supra* note 173.

[253] KRS § 209.020(4) (Michie/Bobbs-Merrill Supp. 1986) provides:

> (4) "Adult" means a person eighteen (18) years of age or older or a married person without regard to age, who because of mental or physical dysfunctioning, or who is the victim of abuse or neglect inflicted by a spouse, is unable to manage his own resources, carry out the activities of daily living, or protect himself from neglect, hazardous or abusive situations without assistance from others and . . . may be in need of protective services.

[254] *See* Note, *Mandatory Reporting of Elder Abuse: A Cheap But Ineffective Solution to the Problem*, 14 FORDHAM URB. L.J. 723 (1986).

[255] KRS § 209.990(1) (Michie/Bobbs-Merrill Supp. 1986).

[256] *See supra* notes 244-247 and accompanying text.

D. Warnings Regarding Dangerous Patients

Both child and adult abuse reporting laws recently have been supplemented by a new statute which appears to impose civil liability on physicians and mental health professionals who fail to warn intended victims and the police of dangerous patients.[257] In 1986, the General Assembly adopted a statute requiring "qualified mental health professionals" (including physicians) to warn intended victims of dangerous patients.[258] This statute was in response to *Tarasoff v. Regents of the University of California*,[259] a California case which imposed on psychotherapists the obligation to take reasonable steps to protect potential victims from their dangerous patients. This duty is commonly referred to as a "duty to warn" intended victims.[260] One of the arguments against imposing this form of liability is that it breaches the confidentiality of therapy and makes violent people less likely to enter therapy.[261]

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[257] KRS § 202A.400 (Michie/Bobbs-Merrill Supp. 1986).

[258] *Id.*

[259] 551 P.2d 334 (Cal. 1976).

[260] *Id.* The case has been the basis of a number of excellent articles. *E.g.*, Roth & Meisel, *Dangerousness, Confidentiality, and the Duty to Warn*, 134 AM. J. PSYCHIATRY 508 (1977); Stone, *The* Tarasoff *Decision: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976); Note, *Imposing a Duty to Warn on Psychiatrists: A Judicial Threat to the Psychiatric Profession*, 48 U. COLO. L. REV. 283 (1977).

[261] The arguments against imposing *Tarasoff*-type liability include the following: the duty to warn is based on the ability of mental health professionals to predict dangerousness, and such predictions cannot be made with any degree of confidence; warning intended victims will require that the confidences of therapy be revealed, and this breach of confidence will interfere with therapy among the very persons (the potentially dangerous) whom society would like to have in therapy; the breach of the confidences of therapy will interfere with the privacy of those in therapy; there are substantial overpredictions of dangerousness, so many persons who are in fact not dangerous will have their therapy interrupted by unnecessary warnings to victims; it is unusual and unfair to require "rescue" of third parties; once patients who have aggressive feelings understand that there is a duty to warn, they will not reveal these feelings in therapy for fear of the disclosure and therefore over the long run the duty to warn will largely be self-defeating by discouraging disclosure of aggression; even if some good can be accomplished by a duty to warn, the costs to therapy exceed the potential benefits of such disclosures. These arguments and other issues regarding *Tarasoff* are discussed in S. SMITH & R. MEYER, *supra* note 22, at Ch. 1.

Among the arguments in favor of imposing a *Tarasoff*-type duty to warn are the following: the opportunity to avoid unnecessary death or serious injury; avoiding unnecessary death or injury is so important that interference with therapy or the right of

It is impossible to determine precisely what effect this duty to warn has had on therapy, but there is some indication that the impact is not overwhelming. It may have made therapists more concerned about dangerous patients and made some patients more reluctant to discuss violence.[262] And although there has been some increase in the breach of confidentiality to warn potential victims, to a considerable degree, these warnings occurred before *Tarasoff*.[263]

The tendency to emphasize the "duty to warn" aspect of *Tarasoff* and to focus on the existence of a "known" victim[264] is unfortunate. In many instances some other appropriate action might allow greater protection for potential victims (the public) while avoiding interferences with therapy confidences. Warnings have the advantage of being easy to prove (either they were given or they were not), but they are rarely flexible enough to provide the protection the law should seek. The duty should be defined more clearly to include actions other than warning. Therapists around the country apparently already act as though *Tarasoff*

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privacy is comparatively trivial; the duty imposed is not without precedent because professionals are sometimes required to act in the interest of society rather than in the interest of a client or patient (e.g., the duty to isolate or report some serious infectious diseases); patients are not likely to refuse to disclose matters in therapy because of the threat that the therapist will warn potential victims; although the prediction of dangerousness is not perfect, it is sufficiently accurate to be the basis of a warning when a patient is apparently dangerous; if these predictions can be the basis for involuntary commitment, they surely are accurate enough to provide the basis for a warning; overpredictions of dangerousness resulting in some unnecessary warnings are a relatively small price to pay to avoid murders and serious injury. See *id.* for a discussion of these issues also.

[262] Goodman, *From* Tarasoff *to* Hopper*: The Evolution of the Therapist's Duty to Protect Third Parties*, 3 BEHAV. SCI. & L. 195 (1985); Note, *Professional Obligation and the Duty to Rescue: When Must a Psychiatrist Protect His Patient's Intended Victims?*, 91 YALE L.J. 1430 (1982).

[263] Givelber, Bowers & Blitch, Tarasoff*: Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 443; Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of* Tarasoff, 31 STAN. L. REV. 165 (1978). *See* Comment, *Psychotherapists' Duty to Warn: Ten Years After* Tarasoff, 15 GOLDEN GATE U.L. REV. 271 (1985).

[264] Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983). Although *Tarasoff* did not speak solely in terms of the duty to warn, that has been the emphasis of many commentators and the courts. *See generally* Crocker, *Judicial Expansion of the* Tarasoff *Doctrine: Doctor's Dilemma*, 13 J. PSYCHIATRY & L. 83 (1985); Merton, *Confidentiality and the "Dangerous" Patient: Implications of* Tarasoff *for Psychiatrists and Lawyers*, 31 EMORY L.J. 263 (1982).

applies to them, with many therapists identifying a "duty to warn" as an ethical or moral duty as well as a legal duty.[265]

One issue regarding *Tarasoff*, yet to be resolved, is the question of how much information the therapist can give to victims *following* the warning. It would not seem unusual for a potential victim who is warned of danger to want more information about the dangerous patient. It is probably safe to assume that sufficient information may be given to allow potential victims to protect themselves. Defining that level of information, however, is extremely difficult.

Most state courts considering the question have adopted an approach similar to California,[266] although some have been reluctant to impose liability.[267] The California legislature, attempting to clarify the liability arising out of *Tarasoff*, adopted a statute which provides a duty to warn only if the patient has told the therapist of a "serious threat of violence against a reasonably identifiable victim or victims."[268] The duty is discharged by "reasonable effort to communicate that threat to the victim . . . *and* to a law enforcement agency."[269]

Kentucky enacted a *Tarasoff* statute even though the Kentucky courts had not yet adopted the *Tarasoff* duty.[270] The Kentucky statute is hardly a model of clarity. It was, curiously, made a part of Chapter 202A, dealing with the Hospitalization of the Mentally Ill (civil commitment). The statute requires that a "qualified mental health professional" warn or "take reasonable precautions to provide protection from violent behavior" if there is 1) an actual threat of physical violence against a reasonably identifiable victim or 2) the patient has communicated

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[265] *See* Givelber, Bowers & Blitch, *supra* note 263.

[266] *E.g.*, Bradley Center, Inc. v. Wessner, 296 S.E.2d 693 (Ga. 1982); McIntosh v. Milano, 403 A.2d 500 (N.J. Super. Ct. App. Div. 1979); Peck v. Counseling Serv. of Addison County, 499 A.2d 422 (Vt. 1985) (this case is particularly interesting because it involved property damage rather than injury to persons).

[267] Furr v. Spring Grove Hosp., 454 A.2d 414 (Md. 1983). For a discussion of the issues see Note, *The Scope of a Psychiatrist's Duty to Third Persons: The Protective Privilege Ends Where the Public Peril Begins*, 59 NOTRE DAME L. REV. 770 (1984).

[268] CAL. CIV. CODE § 34.92 (West 1986) (emphasis added).

[269] *Id.*

[270] KRS § 202A.400 (Michie/Bobbs-Merrill Supp. 1986).

an "actual threat of some specific violent act."[271] The statute does not make it clear when the duty is one to warn and when it is one to take other precautions (seek civil commitment).

The duty to warn an identifiable victim is discharged when the professional takes reasonable efforts to "communicate the threat to the victim, *and* to notify the police department closest to the patient's and the victim's residence of the threat of violence."[272] When there is threat of a specific violent act but the victim is not identifiable, the duty to warn is met if "reasonable efforts are made to communicate the threat to law enforcement authorities."[273]

In addition to the "duty to warn," the Kentucky statute speaks in terms of a "duty to take reasonable precautions to

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[271] *Id.*

> (1) No monetary liability and no cause of action shall arise against any qualified mental health professional for failing to predict, warn of or take precautions to provide protection from a patient's violent behavior, unless the patient has communicated to the qualified mental health professional an actual threat of physical violence against a clearly identified or reasonably identifiable victim, or unless the patient has communicated to the qualified mental health professional an actual threat of some specific violent act.
>
> (2) The duty to warn of or to take reasonable precautions to provide protection from violent behavior arises only under the limited circumstances specified in subsection (1) of this section. The duty to warn a clearly or reasonably identifiable victim shall be discharged by the qualified mental health professional if reasonable efforts are made to communicate the threat to the victim, and to notify the police department closest to the patient's and the victim's residence of the threat of violence. When the patient has communicated to the qualified mental health professional an actual threat of some specific violent act and no particular victim is identifiable, the duty to warn has been discharged if reasonable efforts are made to communicate the threat to law enforcement authorities. The duty to take reasonable precaution to provide protection from violent behavior shall be satisfied if reasonable efforts are made to seek civil commitment of the patient under this chapter.
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> (3) No monetary liability and no cause of action shall arise against any qualified mental health professional for confidences disclosed to third parties in an effort to discharge a duty arising under subsection (1) of this section according to the provisions of subsection (2) of this section.

[272] KRS § 202A.400(2). Some confusion undoubtedly will arise from the requirement that the professional notify "*the* police department closest to the *patient's* and the *victim's* residence. . . ." *Id.* (emphasis added). In some cases, of course, the same police department will not be closest to both patient and victim.

[273] *Id.*

provide protection from violent behavior."[274] The duty to take "reasonable precautions" is discharged by seeking civil commitment under Chapter 202A.[275] There is no indication when the duty is to warn and when it is to take the reasonable precautions. Conceivably, both duties could arise in a single case, as where a patient is quite dangerous, has made threats against a specific individual, and cannot be found. The failure to define more clearly which duty arises when will create some hardship for medical and psychological practitioners. It is not, however, the only matter which is unclear in the statute.

The statute provides protection from liability for disclosing confidences to third parties in an effort to discharge the duties arising under the statute.[276] However, the extent to which confidences may be released after a warning has been given is not clear. Because the degree to which a professional may answer questions from the victim or authorities is not specified, presumably the professional is permitted to release information as long as the disclosure is "reasonable."

This statute potentially extends the breach of confidentiality from medical care and psychotherapy in ways that are considerably greater than those established by the *Tarasoff* decision. The Kentucky statute requires, when there is a known victim, that both the victim *and* the police be warned of the threat of violence.[277] The Kentucky statute also provides for a duty to warn even when there is no specific victim identified; when a specific violent act is threatened there is an obligation to inform law enforcement authorities.[278]

Furthermore, the statute speaks in terms of the obligations of "qualified mental health professionals" to take these actions.[279] The civil commitment statute, to which the *Tarasoff* law was attached, includes as "qualified mental health professionals": psychiatrists,[280] psychologists at the doctoral or master's

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[274] *Id.*

[275] *Id.*

[276] KRS § 202A.400(3).

[277] KRS § 202A.400(2). See *supra* note 272.

[278] KRS § 202A.400(2).

[279] *Id.*

[280] KRS § 202A.011(11)(b) (Michie/Bobbs-Merrill 1982). A psychiatrist is defined

level designated as competent to make examinations under Chapter 202A,[281] nurses with a master's degree in psychiatric nursing and two years clinical experience,[282] social workers licensed for independent practice,[283] and physicians licensed to practice medicine or osteopathy (including medical officers of the United States).[284] Thus, the classes of professionals required to issue warnings under the statute are very broad and include all physicians.

The scope of the statute is further confused by the definition of the term "patient."[285] The *Tarasoff* statute describes duties that arise when a "patient" makes a threat of violence. However, the term "patient" is defined in Chapter 202A as someone who is *in a hospital* as part of the civil commitment procedure.[286] If this definition were literally followed, the *Tarasoff* statute would be so narrow as to be nearly ineffective. Most likely, therefore, the courts would interpret the context in which "patient" is used to mean anyone in a professional relationship with a qualified mental health professional, rather than to follow the definition in Chapter 202A.[287]

In addition, the statute seems to require that a warning (or other action) be taken upon the communication of "an actual

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as a licensed M.D. or osteopath "who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology, Inc." *Id.* Because the definition of qualified mental health professional includes licensed physicians, specifically including psychiatrists within the definition adds very little.

[281] KRS § 202A.011(11)(c).

[282] KRS § 202A.011(11)(d). "A licensed registered nurse with a master's degree in psychiatric nursing from an accredited institution and two (2) years of clinical experience with mentally ill persons."

[283] KRS § 202A.011(11)(e). "A certified social worker licensed for the independent practice of clinical social work under the provisions of KRS chapter 335."

[284] KRS § 202A.011(11)(a).

[285] KRS § 202A.400(1) (the Tarasoff statute) describes the duty as arising when "*the patient* has communicated to the qualified mental health professional on actual threat of physical violence . . . against a reasonably identifiable victim, [or when] *the patient* has communicated . . . to the qualified mental health professional an actual threat of some specific violent act." KRS § 202A.400(1) (emphasis added).

[286] KRS § 202A.011(9). "Patient means a person under observation, care or treatment in a hospital pursuant to the provisions of this chapter [202A]." *Id.*

[287] The definitions section of KRS Chapter 202A invites a modification of its definition when the context requires. KRS § 202A.011 defines terms used in 202A "unless the context otherwise requires." KRS § 202A.011.

threat of some specific violent act."[288] The statute does not make it clear that the professional must believe this threat. Therefore, the statute could be read to require warnings or action every time a specific violent act is communicated, whether or not it is a believable threat. Because many specific threats are made that are not likely to result in violence, this uncertainty may expand considerably the number of times that a professional would be required to give warnings.

The expansion of the obligation to report as defined in the new Kentucky statute may present a significant threat to confidentiality in medical treatment and psychotherapy. Predictions of dangerousness are notoriously inaccurate with substantial overprediction of dangerousness.[289] This suggests the possibility of substantial interference with the confidences of treatment and therapy. The significant uncertainties left by the new statute are likely to confuse therapists and patients, to the extent they are aware of, or understand, the new law.

E. Employers (Institutions) and Children

Confidentiality may be compromised when medical treatment or psychotherapy is conducted "for" an institution rather than the patient or client.[290] In such a case, the person or institution paying for the diagnosis or treatment may demand information from the consultation. An example is the industrial psychologist who consults with employees of a corporation. Suppose that during therapy an employee discloses personal information that

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[288] KRS § 202A.400(1).

[289] J. MONAHAN, PREDICTING VIOLENT BEHAVIOR (1981) (at best only one prediction in three of violence is correct); Kahle & Sales, *Due Process and the Attitudes of Professionals Toward Civil Commitment*, in NEW DIRECTIONS IN PSYCHOLEGAL RESEARCH (Lipsitt & Sales eds. 1980); Albers, Pasewark & Meyer, *Involuntary Hospitalization and Psychiatric Testimony: The Fallibility of the Doctrine of Immaculate Perception*, 6 CAP. U.L. REV. 11 (1976); Cocozza & Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084 (1976); Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974). There is some reason to believe that the ability to predict violence in the short-run may be improving somewhat. Monahan, *The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy*, 141 AM. J. PSYCHIATRY 10 (1984).

[290] For a review of access to medical records by someone other than the patient see W. Roach, S. Chernoff & C. Esley, *Medical Records and the Law* 72-110 (1985).

strongly suggests to the therapist that the person should not be promoted to a higher management position. Is the therapist obligated to report the information to the corporation or to maintain the confidences of the employee? Similar questions may arise from examinations conducted by school psychologists or state mental facility therapists.

Strong arguments can be made both for the importance of maintaining confidentiality and for the right of the therapist to disclose information. The degree to which confidentiality should be maintained may depend on the purpose of the consultation and the expectations of the participants.[291] For example, if a corporation wishes to provide counseling to help promote the emotional welfare of employees, confidentiality should be ensured. If, however, the corporation wishes to assess the emotional stability of its employees to determine job suitability, confidentiality cannot be fully protected. Serious problems arise when the purpose is unclear or in cases where there are a number of incompatible purposes. An employee often does not fully realize that there will be a breach of confidentiality if the institution seeks the information. And in some instances the employee unknowingly may have given a blanket consent to release of information. Arguably, therefore, there is some obligation for practitioners and therapists to ensure that patients have a clear understanding about confidentiality before any information is revealed in diagnosis or treatment.[292]

Two of the statutes discussed previously claim to protect confidentiality rather than establish a privilege.[293] As such, these

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[291] *See* Cooper, *Minors Participation in Therapy Decisions: A Written Therapist-Child Agreement*, 1 J. CHILD & ADOLESCENT PSYCHOTHERAPY 93 (1984); Kobocow, McGuire & Blau, *The Influence of Confidentiality Conditions on Self-Disclosure of Early Adolescents*, 14 PROF. PSYCHOLOGY: RES. & PRAC. 435 (1983); Melton, *supra* note 175; Melton, *Toward "Personhood" for Adolescents: Autonomy and Privacy as Values in Public Policy*, 38 AM. PSYCHOLOGIST 99 (1983) (adolescents are competent to make decisions); Messenger & McQuire, *The Child's Conception of Confidentiality in the Therapeutic Relationship*, 18 PSYCHOTHERAPY: THEORY, RES. & PRAC. 123 (1981). For a broader review of children's mental health rights, see N. REPPUCCI, L. WEITHORN, E. MULVEYS & J. MONAHAN, CHILDREN, MENTAL HEALTH AND THE LAW (1984); Kaser-Boyd, Adelman & Taylor, *Minors Ability to Identify Risks and Benefits of Therapy*, 16 PROF. PSYCHOLOGY: RES. & PRAC. 398 (1985).

[292] In some cases the codes of ethics suggest this is appropriate, *see supra* notes 15-18.

[293] KRS §§ 319.111, 335.170 (Michie/Bobbs-Merrill Supp. 1986).

statutes might be the basis for a refusal to reveal information without the consent of the patient. The social worker statute provides that the social worker may not "*disclose any information* . . . acquired from persons consulting him in his psychotherapeutic capacity. . . ."[294] Less clear is the psychologist-patient privilege which provides that "the *confidential relations* and *communications* between" psychologist and patients "are placed upon the same basis as those provided by law between attorney and client. . . ."[295] Arguably this creates a legal obligation of confidentiality similar to that of an attorney-client relationship and limits the ability (without consent) of the psychologist to release information to an institution. Unfortunately for such an argument, however, the final part of the statute implies that it was meant to provide for only a privilege and not a general obligation of confidentiality.[296] In any case, both statutes are subject to a number of exceptions which would permit a considerable breach of confidentiality.[297]

Children present similar problems because ordinarily parents have the right to receive information concerning their minor children, although this right has been modified by some states. In some circumstances a minor may object to the release of information to parents or others. The age of the child is undoubtedly a factor in determining whether information should be released to parents; a five year-old presents different problems than an adolescent. When parents are involved with the treatment, a professional could establish a contract with the parents in which the parents agree that they will not receive, or be able to demand, information from the therapy. A more difficult question arises when treatment is undertaken without a clear understanding about parental rights or without the consent of parents, and the parents later demand information. If therapy proceeded without an understanding with the minor concerning the release

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[294] KRS § 335.170 (emphasis added). This statute is quite limited in its application.

[295] KRS § 319.111 (emphasis added).

[296] The language quoted in the text seems to suggest that there is created a general protection for communications and confidential relations. However, the next phrase of the statute is, "and nothing in this chapter shall be construed to require any such *privileged* communication to be disclosed." *Id.* (emphasis added).

[297] *See supra* notes 128-218 and accompanying text.

of information, the professional justifiably would be reluctant to release any information, and refuse to release the information without a clear legal determination of the parents' right to have it. Nevertheless, parents probably could claim a legal right to access to much of the information.

The Family Educational Rights and Privacy Act permits parents to have access to their children's education records.[298] In some cases, these records may include medical or psychological information, although usually these files do not contain a great deal of medical or mental health information not already known by the parents. In addition, Kentucky law specifically permits minors to consent to some forms of treatment, yet authorizes the release of information regarding such treatment to parents when it would be in the best interest of the child.[299] Outside of these narrow treatment areas parents probably have substantial rights to information about their minor children. At the same time, there has been movement toward permitting some kinds of treatment without parental consent and without an absolute right of parental access to information from treatment.[300]

A strong argument can be made for the adoption of statutes that protect the confidentiality of minors' treatment and therapy. Older minors (adolescents) are competent to make treatment decisions and, in fact, make decisions much like adults do.[301]

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[298] 20 U.S.C. § 1232(g) (1982).

[299] KRS § 214.185 (Michie/Bobbs-Merrill 1982) provides that minors may consent to treatment for venereal disease, pregnancy (except abortion), alcohol or drug abuse, contraception (except sterilization), and child birth. KRS § 214.185(1). That statute also provides that "[t]he professional *may* inform the parent . . . of any treatment given or needed where, in the judgment of the professional, informing the parent or guardian would benefit the health of the minor patient." KRS § 214.185(5) (emphasis added).

There is an interesting conflict in the Kentucky statutes regarding consent to treatment for drug and alcohol abuse. *Compare* KRS §§ 214.185(1) *and* 222.440 (Michie/Bobbs-Merrill 1982) (permitting minors to give consent), *with* 222.260 (Michie/Bobbs-Merrill 1982 and Supp. 1986) (which requires the consent of the minor and the parent).

[300] *See generally* Planned Parenthood of Kansas City v. Ashcroft, 462 U.S. 476 (1983); Bellotti v. Baird, 442 U.S. 622 (1979); Carey v. Population Serv's., 431 U.S. 678 (1977); Planned Parenthood of Mo. v. Danforth, 428 U.S. 52 (1976); Note, Carey, *Kids and Contraceptives: Privacy's Problem Child*, 32 U. MIAMI L. REV. 750 (1978).

[301] American Academy of Pediatrics, *A Model Act Providing for Consent of Minors to Health Services*, 51 *Pediatrics* 293 (1973); Melton, *Children's Participation in Treat-*

Protecting the confidentiality of minors is important, especially when psychotherapy is involved. In any event, the limits on confidentiality, if any, should be clearly understood before confidences are revealed.

F. Third-Party Payment and Confidentiality

The increasing use of insurance, government-funded programs, and other third-party payments for treatment may threaten confidentiality in several ways. Payers require some information concerning the basis of, reason for, and extent of therapy. This information often will include specifics about the mode of treatment, the diagnosis and factual basis for diagnosis, and the frequency of treatment. It may include additional information about history and prognosis. This information may be shared with other institutions and insurance companies and in some instances also may be available to an employer who is paying for the insurance. In addition, third-party payers increasingly are establishing auditing and review systems that require the release of information to review committees or commissions. Hospitalization is particularly likely to cause this extensive review. Finally, if the professional is accused of fraud for wrongful billing, the criminal investigation may result in the subpoena of a wide range of patient records to establish proof of fraud.[302]

Because the release of information may be necessary to obtain payment for services, professionals may have a conflict between obtaining payment and protecting confidentiality. This conflict has resulted in objections by mental health professionals to peer review of therapy.[303] The problems, however, extend beyond peer review.

Long-term storage and transfer of information from therapy poses additional threats to confidentiality. Rules regarding med-

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ment Planning: Psychological and Legal Issues, 12 PROF. PSYCHOLOGY: RES. & PRAC. 246 (1981); Roth, Meisel & Lidz, *Test of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279 (1977).

[302] *See, e.g., In re* Zungia, 714 F.2d 632 (6th Cir.), *cert. denied*, 464 U.S. 983 (1983); *In re* Pebsworth, 705 F.2d 261 (7th Cir. 1983); Commonwealth v. Kobrin, 395 Mass. 284, 479 N.E.2d 674 (1985).

[303] *See* Theaman, *The Impact of Peer Review on Professional Practice*, 39 AM. PSYCHOLOGIST 406 (1984).

ical information are not sufficient to protect the more sensitive information regarding therapy.[304] Information given to one third-party payer may be transferred to other persons or used for purposes other than payment for services. For example, information given to an insurance company might be given to the employer who is providing the insurance; the employer then might use the information to make decisions about employment status. Information released to third-party payers and related investigators is one of the most important limits on confidentiality because these releases are so common and the information is so poorly protected from review by others.

G. Consent

In many of the exceptions to confidentiality noted in this section, confidentiality is breached based on the consent of the patient. Often, however, the consent is not fully voluntary in the sense that the patient will suffer significant penalties for failing to reveal the information. For example, insurance benefits or employment may be denied to those who refuse access to the information. This is at best a coerced consent to the release of information which, as discussed, may carry with it a secondary release of information to others. In other instances patients may not realize that they are waiving certain confidentiality rights, or recognize the full consequences of the waiver. The current law provides very little legal protection against coerced consent or secondary release and sharing of information.

H. Group Therapy

Because group psychotherapy involves a number of patients in therapy together, information revealed in the group may not remain confidential. Even where members of the group agree not to reveal outside of the group any information disclosed in the group sessions, there is little effective legal protection for that information. Several legal theories might be used to impose

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[304] *See* Bent, *Multidimensional Model for Control of Private Information*, 13 PROF. PSYCHOLOGY: RES. & PRAC. 27 (1982). The issue of the confidentiality of records has presented special problems. *See* Sloan & Hall, *Confidentiality of Psychotherapeutic Records*, 5 J. LEGAL MED. 435 (1984).

liability on group members who breach confidentiality, including a contract of nondisclosure or negligence based on the mutual duty of nondisclosure. Such remedies, however, are speculative, and the actual protection of information revealed in a group, as a practical matter, is limited.

I. Assistants, Teaching, and Research

The use of assistants in providing medical care and psychotherapy increases the number of persons with access to information. Such assistants normally would be expected to have the obligation to maintain the confidentiality of any information they received. Therefore, the chance of a breach of confidentiality associated with the release of information to them probably is not great.

Clinical training of students and others results in still further dissemination of information about patients. Students also should have a legally enforceable obligation of confidentiality.

Research also may extend the availability of patient information to others, sometimes without patient consent. For example, "chart studies," in which patient files are examined without contacting or involving the patient, commonly are undertaken without informed consent.[305] Although the use of patients as research subjects or teaching subjects should increase only modestly the risk of breaches of confidentiality, patients should be free to decide whether or not they want to accept the additional risk.[306]

J. When Will Confidentiality Apply?

The physician or psychotherapist comforting a nervous patient with the assurance of confidentiality, if completely truthful, would have to hedge substantially the promise of confidentiality. The professional could promise complete confidentiality as long as the patient's condition did not become a matter of a court case (when the professional would describe the limits on privi-

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[305] *See* 45 C.F.R. § 46.101(5) (1986) (permitting chart studies without Institutional Review Board approval).

[306] A good review of the issues of confidentiality, privacy, and research is Adams, *Medical Research and Personal Privacy*, 30 VILL. L. REV. 1077 (1985).

leges noted previously) and could tell the patient further: "I can assure you of confidentiality unless you or others disclose instances of child abuse or neglect or adult abuse or neglect, in which case I would have to report that to the state. If you describe activities that are dangerous to others I probably will have to warn the victims and law enforcement authorities. The discovery of some other dangerous conditions, such as certain highly contagious diseases, may require that I report that to local authorities. If you seek to receive payment from an insurance company or other third-party payer, I will have to release some information about treatment or therapy to that institution and they possibly will share that information with others. Furthermore, if I [the professional] am investigated for insurance or Medicare or Medicaid billing problems or fraud, your records may be reviewed by government investigators, prosecutors, grand juries, and others. In the normal course of quality review, your records may be seen by other professionals, although there is every reason to hope that they will maintain the confidentiality of the information in the records. If your employer is paying for your health insurance, the employer may have access to your records or at least those submitted for third-party reimbursement.[307] Should you enter group therapy, of course, other members in the group may release the information disclosed in group. A variety of assistants, students, and researchers also may have access to your records, although they probably will not disclose private information to very many other persons. If you are a minor, your parents may demand access to the information concerning your treatment or therapy; and if your employer is providing the services, the employer may also have access to information. Other than that, however, you can feel quite secure that your confidences will be adequately protected."

This account regarding confidentiality, of course, is exaggerated somewhat. Nevertheless, it suggests the wide range of in-

[307] If the employer is directly providing the care, treatment, or service (that is, if the professional is also an employee of or direct contractor with the employer), then the chance that the employer will have access to information from therapy or treatment is increased. If that relationship exists, the patient would be given additional information. There is a hint of this issue near the end of this discussion.

vasions that are now possible in what are referred to as confidential relationships.

K. Why the Threat Now?

Several trends taken together have reduced the protection of confidentiality for medical care and psychotherapy. Among the most important of these has been the increased use of third-party payers to cover the expenses of medical care and psychotherapy and the involvement of employers in providing health care insurance. This has increased the information that must be transferred to third parties to ensure payment and has made more medical and psychotherapy information available to employers. This trend has been compounded by the ease and reduced cost of storing, sorting, and transmitting data, which have resulted in the ability to transfer and share information about medical care and psychotherapy. The process of investigating legitimate claims, as well as fraud, by third-party payers further requires an invasion of confidential information. In addition, quality assurance mechanisms involve some breach of confidentiality. Another trend has been toward the adoption of common law or statutory duties to breach confidentiality to protect third parties from harm.[308] In the aggregate, child abuse reporting, adult abuse reporting, infectious disease reporting, and *Tarasoff*[309] obligations are developing an obligation to breach confidentiality when a patient may in some way be dangerous to any other person. In addition, the increasing reliance on medical and psychological testimony results in greater demand for information which previously might have remained confidential because no one thought it was important or sought to rely on it.

Traditional legal concepts arguably are no longer adequate to deal with the threats to confidentiality. If confidentiality is important, new mechanisms of protection are required.

V. ARE CONFIDENTIALITY AND PRIVILEGES REALLY NECESSARY?

We commonly assume that confidentiality is important both in medical care and psychotherapy, as reflected in codes of ethics

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[308] *See* Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334 (Cal. 1976); KRS § 202A.400 (Michie/Bobbs-Merrill Supp. 1986).

[309] 551 P.2d 334.

and broad statements of practitioners' duty of confidentiality. Nevertheless, the law has sanctioned a broad range of exceptions to it. In considering what protections the law should give to confidentiality, a critical issue is the importance of confidentiality and how it compares with other important social interests.

A. Reasons for Protecting Confidentiality

The necessity of protecting confidentiality must be measured in light of the goals of that protection: enhancing individual privacy, promoting successful treatment and therapy, and recognizing professional obligations of secrecy. Of these goals, the third is the least important for both medical practitioners and psychotherapists. In fact, that goal may depend on the other two for its legitimacy.[310] Patient or client welfare is the ultimate reason for professional ethical obligations of secrecy.

In considering the degree to which confidentiality is necessary, separation of medical care information from psychotherapy information may be important. This distinction has been recognized by commentators,[311] and model rule drafters and the Supreme Court,[312] on the theory that the information from psychotherapy is considerably more sensitive than information from other medical treatment.

The privacy interests protected by confidentiality include information privacy and autonomy privacy.[313] Sensitivity of medical information varies considerably in intensity. Some medical information (e.g. the birth of a child or having been vaccinated for rubella) ordinarily is not particularly sensitive and most

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[310] As noted earlier in this Article, as a practical matter, professional obligations may play an important role in defining and pressing for protection of confidentiality. This is particularly true in the development and enactment of privileges.

[311] WIGMORE, *supra* note 2, at § 2285, 2380a; Chafee, *supra* note 9, at 611; Degnan, *supra* note 9, at 300; Purrington, *An Abused Privilege*, 6 COLUM. L. REV. 388, 395 (1906). *But see* D. LOUISELL & C. MUELLER, 2 *Federal Evidence* § 215, at 593-603 (1978); Black, *supra* note 9, at 50-51.

[312] Proposed Federal Rules of Evidence Rule 504 adopted a psychotherapist-patient privilege, but rejected a physician-patient privilege.

[313] Smith, *supra* note 72. *See supra* notes 74-121 and accompanying text. Autonomy privacy relates to the decision to enter therapy or to be candid in therapy. The utilitarian analysis described below, concerning confidentiality as a tool to promote effective care, is closely related and autonomy privacy is considered there.

people would not care who knows the information. Other information (e.g. treatment for a venereal disease or drug abuse) is of a type many people would consider sensitive because it could be embarrassing or harmful if released to employers, friends, or others.

As distinguished from medical treatment, the information revealed in psychotherapy is among the most private imaginable. That information deals not only with the most personal and intimate details of life, but often with fantasies, fears, and imaginations that are not revealed elsewhere. The very fact that someone has entered therapy may be a matter of embarrassment or potential harm if revealed to employers or others. Therefore, the information revealed in psychotherapy is likely to be considerably more sensitive than that disclosed as part of medical care and, thus, the sense of privacy or the desire to protect that information is likely to be greater.

Promotion of effective care is the additional reason to protect the confidentiality of medical care and psychotherapy. This generally has been the basis for recognizing privileges, as reflected in the Wigmore criteria.[314] The physician-patient privilege has been poorly received in recent years because it is viewed as unnecessary to promote medical care when those seeking medical care have a strong interest in their own well being and the information revealed is ordinarily not very sensitive. In most instances, people will reveal the necessary information in the interest of their own health. This may be contrasted with psychotherapy where much more sensitive information is revealed and where the necessity for therapy may be less apparent to the patient. Furthermore, the absence of confidentiality may prevent the level of trust, on which successful therapy often depends, from developing between patient and therapist. This level of trust is often less essential in the treatment of physical disorders.

B. The Importance of Confidentiality and Privileges

Several studies have been undertaken to consider the importance of confidentiality.[315] For the most part, these studies have

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[314] WIGMORE, *supra* notes 2 and 5.

[315] R. Kahl, *The Effects of Awareness of the Importance of Confidentiality and*

dealt with psychotherapy, placing an emphasis on the importance of privileges to successful therapy.

Patients seem somewhat confused about the level of legal protection afforded confidences of therapy. Some studies indicate that there are some kinds of information patients would reveal without legal protections for confidentiality.[316] Other studies indicate that people believe that they generally would be less open in therapy without the assurance of confidentiality.[317] A study of inpatients indicates that they highly value confidentiality but have a very limited understanding of the legal protections of their rights.[318] Some patients may be reluctant to discuss violent feelings if they know that the therapist has an obligation to protect intended victims.[319] These studies may provide some

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Lack of Privileged Communication Statutes for Group Psychotherapy (dissertation 1978); Meyer & Smith, *supra* note 147; Miller & Thelen, *Knowledge and Beliefs About Confidentiality in Therapy*, 17 PROF. PSYCHOLOGY: RES. & PRAC. 15 (1986); Rosen, *Why Clients Relinquish Their Rights to Privacy Under Sign Away Pressure*, 8 PROF. PSYCHOLOGY: RES. & PRAC. 17 (1977); Shuman & Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C. L. REV. 893 (1982); Simmons, *Client Attitudes Toward Release of Confidential Information Without Consent*, 24 J. CLINICAL PSYCHOLOGY 364 (1968); Weiner & Shuman, *Privilege—A Comparative Study*, 12 J. PSYCHIATRY & L. 373 (1984); Note, *Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine*, 71 YALE L.J. 1226 (1962).

[316] Rosen, *supra* note 315; Shuman & Weiner, *supra* note 315 (a thorough examination of the attitudes of lay persons, patients, therapists, and judges); Simmons, *supra* note 315; Weiner & Shuman, *supra* note 315 (finding little difference between a state with a privilege and another without).

[317] Meyer and Smith found that 81.8% of respondents to a questionnaire on confidentiality indicated that they would refuse to enter group therapy or would be substantially less inclined to be open in therapy without the assurance of confidentiality. (The respondents were third-year university students.) Meyer & Smith, *supra* note 209, at 639-40. Another survey revealed that a substantial number of people felt they would be less open in therapy if they knew a psychotherapist was legally obligated to release information from therapy. Note, *supra* note 315, at 1262. *See generally* Miller & Thelen, *supra* note 315 (general population does not understand limits of confidentiality, but patients would like to have this information when in therapy). *But see* R. Kahl, *supra* note 315; & studies cited *supra* note 316.

[318] Schmid, Appelbaum, Roth & Lidz, *Confidentiality in Psychiatry: A Study of the Patient's View*, 34 HOSP. & COMMUNITY PSYCHIATRY 353 (1983). *See* Appelbaum, Kapen, Walters, Lidz & Roth, *Confidentiality: An Empirical Test of the Utilitarian Perspective*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 109 (1984).

[319] A survey of therapists revealed that, within one year, about a fourth of them had observed patients' reluctance to discuss violent tendencies when patients were informed of the possibility of a breach of the confidences of therapy. Note, *Where the*

indirect information about the importance of confidentiality and privileges to therapy. They suggest that confidentiality plays a role in, but is not critical to, successful therapy. However, they do not measure directly the effects confidentiality actually has on therapy.[320]

The studies thus far are somewhat inconclusive and even inconsistent regarding the importance of privileges to psychotherapy. Most patients, however, probably do not understand the limits of confidentiality, even those limits relative to privileges. Additional studies are needed to fully outline the importance of confidentiality in psychotherapy and particularly to indentify the kinds of information that require the most protection. For the moment, most patients probably do not understand adequately the limits of confidentiality, although confidentiality is important to them and threats to confidentiality pose at least some barrier to openness and trust in therapy relationships.

VI. PROVIDING MEANINGFUL PROTECTION

Like that of most states, Kentucky's protection of the confidences of medical care and psychotherapy has been inconsistent and confusing. This protection should be rationalized and clarified. Only if the protection is relatively certain can the goals of protecting privacy and promoting effective therapy and treatment be accomplished at the lowest possible social cost.[321]

Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff, 31 STAN. L. REV. 165, 183 (1978). *See* Beck, *When the Patient Threatens Violence: An Empirical Study of Clinical Practice After* Tarasoff, 10 BULL. AM. ACAD. PSYCHIATRY & L. 189 (1982); Givelber, Bowers & Blitch, *supra* note 263. For a case study of using the "duty to warn" to therapeutic advantage, see Wulsin, Bursztajn & Gutheil, *Unexpected Clinical Features of the* Tarasoff *Decision: The Therapeutic Alliance and the "Duty to Warn,"* 140 AM. J. PSYCHIATRY 601 (1983).

Willage and Meyer found that subjects were more open and candid in answering personality inventories when confidentiality was assured than if they thought the results of their survey might be released. Willage & Meyer, *The Effects of Varying Levels of Confidentiality on Self-Disclosure*, 2 GROUP 88 (1978).

[320] One effort to provide such information was inconclusive. *See* D. Willage, *The Effects of Informing Patients on the Limits of Confidentiality on Group Therapy*, in 4 DISSERTATION ABSTRACTS INTERNATIONAL 3595 (1981).

[321] It is important to recall that protecting confidentiality carries some social costs because protected information is no longer available. This in turn may result in incorrect or inefficient decision-making, greater costs associated with gathering some kinds of

Unfortunately no single state can fully achieve these purposes through state laws and procedures. As noted later in this section, in some cases real protection of confidentiality requires a national approach. Nevertheless, a single state can do much to rationalize its laws protecting confidentiality.

A. Medical Treatment

The confidences from medical treatment require different protection than those of a more sensitive nature from psychotherapy. Although significant protection for the confidences of psychotherapy is necessary, intense protection of medical information probably is needed only in comparatively narrow areas such as drug and alcohol abuse, matters related to sexual activities, and counseling that is in the nature of psychotherapy. Under the current law there is broad protection of medical information confidentiality, which may be broken when there is even a modest societal interest in having the information. Conversations with medical practitioners suggest that the current laws are widely misunderstood, in part because there is no single, coherent statement of them.

The current physician-patient privilege statute, which is useless, should be replaced with a comprehensive statute defining the obligation of confidentiality in medical care and detailing the exceptions. These exceptions could generally track those currently recognized. Communications in specially defined sensitive subjects could be treated as information released in psychotherapy. A limited number of very sensitive areas of medical services, as noted above,[322] should be defined and provided special protection.

B. Psychotherapy

Current laws regarding confidentiality and psychotherapy, including testimonial privileges, are a hodgepodge of uncertainty

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information, and reduced accountability (e.g., insurance payments for services). One goal of the law should be to reduce social costs as much as possible while maintaining an acceptable level of confidentiality.

[322] Drug and alcohol abuse treatment, matters related to sexual activities, and counseling in the form of psychotherapy were suggested as such areas.

and exceptions. The following proposals could reduce unnecessary invasions of privacy while protecting the most critical social interests in having information from therapy.

1. Confidentiality and privileges should be dealt with together in a coordinated and comprehensive manner. This suggests a single statute dealing with all psychotherapy privileges as a part of the broader obligation of confidentiality.[323]

2. There should be a single psychotherapist-patient privilege as opposed to the variety of privilege statutes currently available in Kentucky. The difficulty here is in defining which professions should be included as "psychotherapists." The answer to this question must be clear so that patients can easily understand whether their communications to a professional will be covered. The major problem is deciding which professionals should qualify as psychotherapists. Psychotherapist should be defined as narrowly as possible to avoid unnecessarily removing information from courts. It is perhaps important to distinguish between psychotherapy and counseling, the former often involving a more probing and detailed analysis.[324] Counseling does involve some sensitive and very confidential matters, yet those might be handled in a manner similar to that proposed for medical care (certain sensitive subjects would be protected from disclosure).

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[323] The current social worker privilege accomplishes this to some degree. KRS § 335.170 (Michie/Bobbs-Merrill Supp. 1986). A very few jurisdictions have moved in this direction, notably the District of Columbia and Illinois. The D.C. ordinance, passed in 1978, with a provision to limit disclosure of mental health patient information, was challenged by the insurance industry, including Blue Cross and Blue Shield. The ordinance limited the release of information to a brief statement of the fact of treatment, length of treatment and diagnosis, and provided for independent professional review in the case of dispute between an insurance company and mental health professional. District of Columbia Mental Health Information Law, D.C. CODE ANN. § 6-2001 (1981); Illinois Mental Health and Developmental Disabilities Confidentiality Act, ILL. ANN. STAT. ch. 91 1/2, ¶ 801 & ch. 110, ¶ 8-802 (Smith-Hurd Supp. 1985). More recently, Massachusetts has made a similar effort.

[324] For a good review of this issue, see Allred v. State, 554 P.2d 411, 419 (1976), which limited a psychotherapist-patient privilege to psychologists and psychiatrists. "Counseling [as opposed to therapy] either does not, or should not, have as its aim a deep penetration into the psychic processes of the patient or client. The need for a privilege to foster the counselor-client relationship is, correspondingly, less readily apparent." *Id.* The rules proposed by the Supreme Court (Rule 504(a)(2)) and other rules have adopted a similar approach. *See* Note, *The Psychotherapist-Client Testimonial Privilege: Defining the Professional Involved*, 34 EMORY L.J. 777 (1985).

This analysis suggests that psychiatrists and psychologists licensed for independent practice should be covered by "strong" confidentiality protections including a psychotherapist-patient privilege. School counselors, social workers, psychiatric nurses, psychologists not certified for independent practice, rape counselors, and similar professionals should be considered counselors with privilege status similar to physicians.[325]

A related question about the existence of a privilege involves the use of assistants and students in providing therapy. To suggest a narrow privilege, professionals not directly qualified for the privilege who are, in effect, in independent practice should not be permitted to claim the privilege as an assistant of a covered professional. Only when a person is in fact the patient of the privilege-qualified professional or receiving services from someone working under that person's direct supervision should the strong confidentiality and privilege exist. Professionals (such as physicians' assistants or nurses) seeing patients under a broad or general protocol established by a professional should not be included within the privilege as an assistant to the professional. When these professionals are providing specific kinds of services in very sensitive areas, however, then their patients should have the special confidentiality and limited privilege suggested for medical care.

Most privileges are tied to licensing statutes. A difficulty in this area arises in psychiatry because no formal licensing is

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[325] This formulation has the difficulty of including within the protection of strong confidentiality only the professions which tend to be the most expensive. This raises the potential problem of discrimination based on economic ability to pay for services. Arguments have been made for including social workers or some counselors within the privilege. *See e.g.*, Reynolds, *Threats to Confidentiality*, 21 J. NAT'L AM. SOC. WORKERS 108 (1976); Robinson, *Testimonial Privilege and the School Guidance Counselor*, 25 SYRACUSE L. REV. 911 (1974); Note, *Underprivileged Communications: Extension of the Psychotherapist-Patient Privilege to Patients of Psychiatric Social Workers*, 61 CALIF. L. REV. 1050 (1973); Note, *Testimonial Privileges and the Student-Counselor Relationship in Secondary Schools*, 56 IOWA L. REV. 1323 (1971).

It has in fact been suggested that a privilege limited to psychologists and psychiatrists is unconstitutional in that it violates the right of privacy and equal protection. Comment, *The Psychotherapist-Patient Privilege: Are Some Patients More Privileged Than Others?*, 10 PAC. L.J. 801 (1979).

On the necessity for putting *some* limitations on all of these *see generally* Slovenko, *Commentaries on Psychiatry and Law: Shielding Communications With a Pet*, 10 J. PSYCHIATRY & L. 405 (1982); Note, *supra* note 324.

required of psychiatrists. One possibility would be to permit the Board of Medical Licensure to designate practitioners as psychiatrists for the purpose of the privilege statute thereby giving patients some assurance of the privilege.

3. The patient/litigant exception to the psychotherapist-patient privilege should be limited both in the circumstances in which it applies and in terms of the information which may be sought under it.[326] A strict test of the information's relevance should be used in determining whether the information is subject to the exception.[327] For example, a claim for pain and suffering in a personal injury case should not give rise to the exception unless there is a claim that the suffering is specifically relevant to a special emotional condition. Even then, only information directly relevant to the issue should be available to the adverse party. Courts should be required to use *in camera* inspections of material to determine relevance and to protect patients from the unnecessary release of information to opposing parties.[328]

4. The abuse and dangerousness exception to the psychotherapist-patient privilege should be narrowed considerably. This exception should apply only when the warning already has

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[326] *See* Note, *The Case for a Federal Psychotherapist-Patient Privilege That Protects Patient Identity*, 1985 DUKE L.J. 1217.

[327] The Massachusetts court held that fraud investigations that sought information from psychotherapy should be limited to records that document the times and length of patient appointments, fees, patient diagnoses, treatment plans and recommendations, and somatic therapies [such as provision of medication or electroconvulsive [shock] therapies]. Commonwealth v. Kobrin, 479 N.E.2d 674, 681 (1985). The court said the records that "reflect patients' thoughts, feelings, and impressions, or contain the substance of the psychotherapeutic dialogue . . . need not be produced." *Id.*

The Massachusetts court probably provided for excessive disclosure when it permitted the routine release of diagnoses, treatment plans, and somatic treatments. These may include extremely private information which may not significantly promote a fraud investigation.

[328] Judge Hufstedler has proposed meaningful limits on the use of the patient/litigant exception. She sought to identify precisely the competing interests of the state and the patient/litigant and to balance these interests in a manner that would maximize protection of the patient's privacy. A party invoking the patient/litigant exception in civil litigation, she proposed, in general should be limited to ascertaining the time, length, cost, and ultimate diagnosis of the treatment. Under the exception, an adverse party should be permitted to demand additional information concerning treatment and related confidential communications only if that party demonstrates a compelling need for this evidence. Caesar v. Mountanos, 542 F.2d 1064, 1073 (9th Cir. 1976), *cert. denied*, 430 U.S. 954 (1977) (Hufstedler, J., concurring and dissenting).

breached significantly the confidentiality of therapy, thereby destroying the secrecy of the information. (These issues are discussed following.)

5. Most other exceptions to the psychotherapy-patient privilege should be eliminated as unnecessary or because they do more harm than good. A narrow criminal defense exception which permits *in camera* inspection of information to determine relevance and importance would be appropriate. Examinations conducted pursuant to court order or with an eye toward litigation should not be included within the privilege because there is no expectation of confidentiality. However, before the consultation with the therapist the patient should be informed of the absence of confidentiality.

6. Revealing information to certain third parties, if done with the expectation of continued privacy, should not destroy a privilege. The concept of extended confidentiality described below would permit such a doctrine to exist. Group therapy, for example, clearly should be within a privilege where the other members of the group have a duty to maintain the confidences of the group. The release of information to an insurance company or other third-party payer should not destroy any part of the privilege when the third party has an obligation to maintain the revealed confidences. Third-party disclosures that in fact destroy the confidentiality of a communication, however, should continue to destroy the privilege.

7. The federal approach to psychotherapy privileges should be modified to provide for a psychotherapist-patient privilege. Most states recognize such a privilege in some form. Without federal recognition of a privilege, however, federal law will interfere with the state policy of protecting the confidences of therapy and encouraging openness and honesty in psychotherapy. Ironically, the Federal Rules of Evidence, which appear to promote state policy in diversity cases, actually may be frustrating the purpose of state law by making the application of privileges inconsistent in federal cases.

Of even greater importance than modifying the rules regarding privileges, however, is extending the duty of confidentiality as part of a integrated protection of confidentiality. The following would help ensure that psychotherapy confidentiality is protected meaningfully.

8. The concept of "extended confidentiality" should be recognized. When information from psychotherapy is released to others, it should be with a duty for the recipient to maintain the confidentiality of the information in the same way that the pyschotherapist had a duty to protect it. For example, information given to third-party payers should carry with it a duty to maintain the privacy of that information. Recipients would not be permitted to transfer or share the information with others. Group therapy members, if they have so agreed, should be legally obligated to maintain the confidences of other members of the group. A breach of these duties should give rise to civil liability the same as if a therapist breached the duty of confidentiality.

9. To make the extended obligation of confidentiality meaningful, patients should not be required to waive it. For example, insurance carriers, as a condition of insurance or payment for services, should not be permitted to require that a patient waive the carrier's obligation of confidentiality. Any information gathered in the course of an insurance or Medicare fraud investigation should carry with it this form of extended or secondary confidentiality also.

Although a state, through insurance regulation, at least partially could implement such a system, it would be accomplished much more effectively and efficiently if the interstate aspects of it were controlled by federal law requiring that third-party payers maintain confidentiality. As a practical matter, in the future this may be among the most important assurances of confidentiality. The information available to insurers and others would be reduced somewhat, but these losses would be modest compared with the significant potential for advancing the protections of confidentiality in psychotherapy.

10. The obligation to report child and adult abuse and to warn potential victims of dangerous patients should be narrowed. The Kentucky statutes in these three areas are vague and overly broad. Abuse reporting should not be required when an abuser is seeking treatment to stop the abuse and no immediate threat to a child or adult is present. The duty to warn of dangerous patients should be narrowed to require a warning to the intended victim *or* law enforcement authorities, *or* the commencement of civil commitment proceedings, and should be

required only when the therapist believes a patient's threat represents a significant danger to the patient or others.

11. Confidentiality should apply to minors (including students) and to those receiving psychotherapy as part of an institutional arrangement. Minors may consent to certain forms of psychotherapy without parental consent and the confidences they reveal in such therapy should be protected. That is, the information should not be provided to parents unless the information otherwise fell within one of the exceptions to confidentiality. Similar protections should apply to employees and others who obtain therapy as part of an institutional arrangement. Only if it is clear throughout therapy that information will be provided to an employer should that information be available.[329] As with insurance claims, employers should not be permitted to release information after therapy as condition of the patient's continued employment or to demand or request a waiver of this obligation of confidentiality.

12. A most difficult question is whether the patient should be informed of the limits of confidentiality during therapy. If confidentiality is to be breached other than in ways *required* by law, then the patient should be informed of this. This may be as important as the informed consent required for other procedures. Therefore, when the therapist knows that a breach of confidentiality will or is likely to occur, but is not required by law, the therapist should have an informed consent obligation to tell the patient. A strong argument also can be made for requiring provision of information to patients regarding the circumstances in which the law requires that a therapist reveal confidential information.

CONCLUSION

The promise of medical and psychotherapy confidentiality suggested by the Kentucky statutes, as well as by the statutes of many other states, is a "misguided hope."[330] In reality, uncer-

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[329] The "throughout therapy" requirement might be met if the employee were reminded at the beginning of each session of therapy that confidentiality would not be protected.

[330] Slovenko, *supra* note 197.

tainty and limitations surround the privileges. More importantly, a variety of factors has had the practical effect of reducing the confidentiality protection. Examples of these factors are the increased use of third-party payers, the availability of inexpensive electronic storage and transmission of data, and increased dependence on medical and psychological evidence in court. This presents a problem in medical care, in psychotherapy it is a much more critical issue.

The solution to this problem is to restructure statutes dealing with confidentiality and to include privilege protections as part of the overall protection of confidentiality. In psychotherapy this should include a narrow, but strong, privilege with very limited exceptions. It should also include a strong duty of confidentiality ("extended confidentiality") not only for therapists who receive information but also for those who receive confidential information from therapists. That notably includes insurance companies and other third-party payers.

The promise to protect intensely personal medical care and psychotherapy information need not be misguided or unrealized. Careful drafting of a comprehensive, coherent, and consistent statute could go a long way toward realizing the hope of confidentiality.